April 25, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Re: CMS-2449-P: Medicaid Program; Disproportionate Share Hospital Third-Party Payer Rule

Dear Administrator Brooks-LaSure:

The Medicaid and CHIP Payment and Access Commission (MACPAC) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed Medicaid disproportionate share hospital (DSH) third-party payer rule published on February 24, 2023 (88 Fed. Reg., 11865).

The proposed rule codifies the provisions of Section 203 of the Consolidated Appropriations Act, 2021 (CAA, P.L. 116-260), which made changes to how uncompensated care is calculated for Medicaid beneficiaries (Medicaid shortfall). In addition to codifying CAA provisions, the proposed rule also makes changes to how the public is notified of DSH and State Children's Health Insurance Program (CHIP) allotments, streamlines CMS's process for recouping DSH payments, and makes changes to how DSH allotment reductions are calculated (CMS 2023).

The Commission supports many of these regulatory changes and looks forward to these provisions being further clarified when the rule is finalized. Additionally, the Commission recommends that CMS make additional technical changes that would support the implementation of the proposed DSH provisions.

Since 2015, MACPAC has devoted considerable time to analysis of Medicaid DSH payments, given its statutory requirement to report annually on these payments and their relationship to the number of uninsured individuals, levels of hospital uncompensated care, and other factors identified by Congress (MACPAC 2023, 2016). The Commission has long held that state-level limits to DSH payments, known as allotments, should share a meaningful relationship with measures of need. However, the Commission has found little meaningful relationship between DSH allotments and measures of need, because allotments are largely based on states' historical DSH spending before federal limits to DSH payments were established in 1992.

MACPAC also analyzed the effects the 2018 *Children's Hospital Association of Texas v. Azar* (*CHAT v. Azar*) district court decision would have on Medicaid shortfall among DSH hospitals (MACPAC 2019).[1] Under *CHAT v. Azar*, the U.S. District Court for the District of Columbia ruled that CMS could not subtract third-

party payments from the Medicaid shortfall calculation (i.e., third party costs were included in total costs, but third-party payments were not subtracted from total payments). This decision vacated CMS policy that had been in effect since 2010, which was that all third-party payments and Medicaid payments should be included in Medicaid shortfall calculations.

While *CHAT v. Azar* was under appeal, MACPAC focused its work on what DSH payment policy should be, not the legal issues under consideration by the courts. Ultimately, MACPAC recommended that only costs and payments for individuals for whom Medicaid is the primary payer should be counted (MACPAC 2019). The Commission recommended this approach for two reasons. First, it was administratively simpler to exclude all costs and payments for patients for whom Medicaid was not the primary payer. Second, it did not divert a large amount of DSH payments away from hospitals that have large populations of Medicaid eligible beneficiaries with private coverage (e.g., children's hospitals).

Comments on Implementing Section 203 of CAA

Section 203 of CAA changed the DSH definition of Medicaid shortfall consistent with MACPAC's recommendation but added an exception for certain hospitals to continue to count shortfall using CMS's previous policy. The CAA's exception allows hospitals to follow CMS's 2010 policy if they serve a high number or share of patients dually eligible for Medicare and Medicaid and also receive supplemental security income (SSI).[2] This exception policy is intended to allow these hospitals to continue receiving DSH payments to offset Medicare shortfall for patients dually eligible for Medicaid and Medicare. Although Medicare pays for most of the cost of care for Medicare patients and Medicaid often pays for Medicare cost sharing, hospitals had a shortfall of $930 on the average Medicare inpatient stay in 2015 (MACPAC 2019).[3]

The proposed rule implements CAA's definition of Medicaid shortfall and describes the process for determining which hospitals are eligible for the exception. However, although CMS is proposing different definitions of Medicaid shortfall for a subset of hospitals, it is not suggesting any changes to Medicaid DSH audits in response to the new definition of Medicaid shortfall.

The Commission has long held that hospital-level payment data are essential for evaluating state DSH payment policies. This level of detail helps determine whether payments are directed towards providers who serve larger shares of Medicaid and low-income patients and have higher levels of uncompensated care. In 2016, the Commission recommended that CMS should collect and report hospital-specific data on all types of Medicaid payments, and report data on the sources of the non-federal share needed to determine net payments at the provider level.

Improving Data on Medicaid Shortfall for CAA Excepted Hospitals

To understand the effect of the CAA, CMS should modify Medicaid DSH audits to separately identify costs and payments for individuals with third-party coverage from patients who use Medicaid as their primary payer among excepted hospitals. This would help policy makers and CMS better understand the extent to which DSH payments are targeted to hospitals that disproportionately serve Medicaid-only or the uninsured population among all hospitals and excepted hospitals.

Other Technical Comments

Removing the Section 1115 Budget Neutrality Factor from DSH Allotment Reduction Calculations

CMS is proposing to remove the budget neutrality factor from the DSH reduction methodology because this factor no longer has a practical effect. The budget neutrality factor is applied to DSH funding used in coverage expansions under waivers under Section 1115 of the Social Security Act as of July 2009. DSH funding used for coverage expansions is excluded from the calculation of whether DSH payments are targeted to hospitals with high Medicaid volume, or hospitals with high levels of uncompensated care, when determining DSH allotment reductions. All Section 1115 waivers from 2009 have expired. CMS now proposes to apply reductions to these diverted DSH funds.

CMS has previously noted that that it is unable to accurately calculate these factors for diverted DSH funds because of a lack of hospital-specific data. DSH funded Section 1115 supplemental payments are not reported on DSH audits, which are used to estimate other DSH targeting factors. CMS proposes to estimate the targeting of Section 1115 payments for these states by using DSH audit data from other states as a proxy.

CMS should use hospital-specific Section 1115 demonstration supplemental payment data in measuring DSH targeting factors for diverted DSH funds. The Commission is concerned that if CMS uses averages to calculate factors related to DSH targeting for states with DSH-financed Section 1115 demonstrations, this could discourage these states from targeting DSH payment to hospitals that need them most. MACPAC previously commented that hospital-specific data should be used to determine the extent to which Section 1115 supplemental payments are targeted to hospitals with a high Medicaid volume or have high levels of uncompensated care (MACPAC 2017). CMS is now statutorily required to collect hospital-specific data on supplemental payments authorized under Section 1115 demonstrations (Section 202 of the CAA).

Recouping DSH Overpayments

The Commission supports CMS's proposed process to expedite the recoupment of DSH overpayments to help ensure that DSH payments do not exceed a hospital's specific limit. However, it does not appear that CMS has any plans to collect hospital-level data on final DSH payment amounts after recoupments.

According to DSH audits for SPRY 2018, 422 DSH hospitals received a total of approximately $1 billion in DSH payments more than their uncompensated care costs for Medicaid-enrolled and uninsured patients (6.1 percent of all DSH payments). Many states have provisions to redistribute DSH funds from hospitals that received DSH payments above their hospital specific limit to hospitals that received DSH payments below their hospital-specific limit. However, these redistribution payments are not reported on DSH audits or publicly available information, and the audits are not updated to account for these changes, limiting our ability to understand the full amount of payments that providers have received.

CMS should require states to submit hospital level data, to reflect final DSH payment amounts to each provider after recouped payments have been redistributed. Doing so would increase payment transparency, and help policymakers evaluate whether DSH payments meet their statutory intent of supporting hospitals that serve a high share of the Medicaid and uninsured population.

Posting CHIP and DSH Allotments Online in a Timely Manner

CMS should post allotments by April 1 of each year. CMS's proposal to remove the requirement for CMS to publish DSH and CHIP allotments in the Federal Register also included removal of the requirement that these data be published by April 1 of each year. The Commission previously supported CMS's attempts to modernize its communication regarding allotments to the public (MACPAC 2020). However, it is important to maintain a target date for posting allotment data online to ensure timely availability of these data for states and stakeholders. Since most state fiscal years begin on July 1, providing data by April 1 provides time for states to incorporate the allotment amounts into their state budgets.

Thank you for the opportunity to comment on this proposed rule. The Commission believes that implementing the CAA's Medicaid shortfall provisions will broadly improve the targeting of DSH payments to hospitals that need it most. We appreciate CMS's continued efforts to strengthen oversight of DSH policy.

Sincerely,

Melanie Bella, MBA
Chair

cc: The Honorable Ron Wyden, Chair, Senate Finance Committee
The Honorable Mike Crapo, Ranking Member, Senate Finance Committee
The Honorable Cathy McMorris Rodgers, Chair, House Energy and Commerce Committee
The Honorable Frank Pallone Jr., Ranking Member, House Energy and Commerce Committee

Endnotes

[1] The policy described in the 2018 court decision is described in *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).

[2] Hospitals are eligible for the CAA exception if they are in the top 3 percent in terms of the total number or share of inpatient days for Medicare Part A beneficiaries who were eligible for SSI.

[3] If Medicaid only pays for the Medicare deductible, then hospitals would report an average shortfall of $930 per dually eligible beneficiary. 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 or policies for outpatient hospital services. For more information please refer to our compendium of payment policies for Medicare cost-sharing (MACPAC 2018).

References

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services (HHS). 2023. Medicaid program; disproportionate share hospital third-party payer rule. Proposed rule. Federal Register 88, (March 16): 11865-11887. https://www.federalregister.gov/documents/2023/02/24/2023-03673/medicaid-program-disproportionate-share-hospital-third-party-payer-rule.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2023. March Report to Congress on Medicaid and CHIP. *Chapter 4: Annual analysis of Medicaid disproportionate share hospital allotments to states*. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2023/03/Chapter-4-Annual-Analysis-of-Medicaid-DSH-Allotments-to-States.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2020. RE: CMS-2393-P Medicaid program; Medicaid fiscal accountability regulation. Comment Letter. Washington, DC: MACPAC. https://www.macpac.gov/publication/comments-on-proposed-medicaid-fiscal-accountability-regulation/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2019. June Report to Congress on Medicaid and CHIP. *Chapter 2: Treatment of third-party payments in the definition of Medicaid shortfall*. Washington, DC: MACPAC. https://www.macpac.gov/publication/treatment-of-third-party-payments-in-the-definition-of-medicaid-shortfall/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2018. State policy compendium. *State Medicaid payment policies for Medicare cost-sharing*. Washington, DC: MACPAC. https://www.macpac.gov/publication/state-medicaid-payment-policies-for-medicare-cost-sharing/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2017. RE: CMS-2394-P Medicaid program; disproportionate share hospital allotment reductions. Comment Letter. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2017/08/Comments-on-Proposed-DSH-Reduction-Rule.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2016. Report to Congress on Medicaid Disproportionate Share Hospital Payments. Washington, DC: MACPAC. https://www.macpac.gov/publication/report-to-congress-on-medicaid-disproportionate-share-hospital-payments/.

State Health Access Data Assistance Center (SHADAC). 2019. Analysis for MACPAC of the 2017 American Community Survey Public Use Microdata Sample (PUMS) file.