Medicaid DSH Payment Program
Treatment of Private Third-Party Payments

In 2017, the Centers for Medicare and Medicaid Services (CMS) released a final rule on how the Medicaid Disproportionate Share Hospital (DSH) payment program determines uncompensated care costs for Medicaid-eligible patients who also have a third-party source of coverage such as Medicare or private insurance. Given the number of children treated at children’s hospitals who are eligible for Medicaid and have private insurance, this policy has adversely impacted several children’s hospitals. The final rule was vacated, but the DC Court of Appeals has ruled it should be reinstated, putting the children’s hospitals again at risk of losing access to important supplemental Medicaid funding. While litigation remains ongoing with the children’s hospitals attempting to limit potential recoupment of funds with the reinstatement of the Final Rule back to June 2, 2017, prospective legislative action can ensure that further damage to children’s hospitals is minimized. The Medicaid and CHIP Payment and Access Commission (MACPAC)’s recommendation on this issue for Congress’ consideration merits consideration and the children’s hospitals favor its adoption.

MACPAC’s Recommendation
- MACPAC approved a recommendation to Congress on this issue during their April 2019 meeting and the recommendation was transmitted to Congress in mid-June. MACPAC recommends that Congress change the definition of “Medicaid shortfall” in statute to exclude costs and payments for all Medicaid-eligible patients for whom Medicaid is not the primary payer. This policy, if enacted by Congress, while financially impacting children’s hospitals would both provide certainty in budgeting in the future and would be better than the implementation of the CMS policy set forth in the Final Rule.

Role of DSH for Children’s Hospitals
Supplemental payments, including DSH, are critical to children’s hospitals and their ability to provide health care to all children. These payments play an important role for children’s hospitals in addressing Medicaid underpayment.

- Children covered by Medicaid represent over half of all children’s hospital inpatient visits.

- Even with DSH, Medicaid reimburses children’s hospitals on average only 80% of the cost of care.

Background on the DSH Third-Party Policy Change
- CMS first released its DSH third party payment policy in January 2010 in the form of frequently asked questions (FAQs), which CMS implemented and enforced prior to issuing a regulation. CMS lost multiple challenges to the policy in courts across the nation prompting CMS to withdraw the FAQs in January 2019. However, CMS promulgated the DSH third party payment policy in a Final Rule, issued in 2017. While the Final Rule was initially vacated, the DC appeals court recently ordered the rule be reinstated the Final Rule with a retroactive effective date of June 2, 2017. The children’s hospitals are doing what they can to limit the retroactive application of the rule, as well as fight the application of this financially devastating rule.
The CMS policy required that hospitals include the days, costs and revenues associated with treating Medicaid-eligible patients who have third-party coverage to determine the hospital's DSH payments. Very sick children and premature infants in the U.S. often are eligible for Medicaid due to their diagnosis even though their families have private commercial coverage. However, as the payor of last resort, Medicaid cannot pay for any care if primary coverage is available. For Medicaid-eligible patients with private insurance, this policy meant that the full private insurance payment received was included in the DSH calculation even if the hospital never billed or collected any Medicaid payments. These private insurance payments offset the total Medicaid shortfall a hospital experiences on all Medicaid patients. This policy also impacts hospitals that care for individuals eligible for Medicare and Medicaid.

Implications of DSH Third-Party Payment Rule for Children’s Hospitals

- Children’s hospitals are significantly impacted by CMS’ policy because so many of the children they treat are eligible for Medicare coverage due to serious and ongoing health needs but for whom private insurance covers the entirety of the inpatient and outpatient hospital expenses. Because of this fundamental change in policy, children’s hospitals now lose the lion’s share of their supplemental funding just because of the patients upon whom they focus their services.
  - Because Medicaid eligibility rules are more generous for children, many children with chronic or complex conditions with private insurance are also Medicaid-eligible. Some children are Medicaid-eligible by virtue of diagnosis—for example, low birth weight and transplant cases fall within this category.
  - The Medicaid-eligible children that have most affected children’s hospital DSH calculations are often NICU babies with complex needs, transplant patients, and children requiring extensive and expensive cancer treatment. Children’s hospitals have been particularly impacted by the CMS policy because they often have the unique capacity to provide the level of specialized care these patients require.

- Children’s hospitals in several states have reported their DSH payments were significantly reduced or their participation in DSH was eliminated altogether because of the CMS policy. In some cases, the changes to the DSH policy and how the hospital specific limit is calculated under DSH has had a spillover effect on other supplemental payments, such as 1115 uncompensated care (UC) pool payments, where the DSH HSL is a component of another Medicaid supplemental payment calculation.

- Because the DSH auditing process is retroactive, states seek to recoup millions of dollars from affected children’s hospitals. The calculations also impact current DSH program year interim payments. Any potential recoupment or reallocation of DSH payments in a given year does not result in state or federal savings but are instead reallocated to other Medicaid DSH hospitals within the state.

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