# Issue Brief

FEDERAL ISSUE BRIEF

*Analysis provided for MHA by Larry Goldberg, Goldberg Consulting*

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## CMS Proposes Rule Regarding the Medicaid Program; Disproportionate Share Hospital Payments

The Centers for Medicare & Medicaid Services (CMS) issued a proposed rule regarding recent legislative changes to the Social Security Act, which governs the hospital-specific limit on Medicaid Disproportionate Share Hospital (DSH) payments, as a result of the **Consolidated Appropriations Act** (CAA) of 2021.

For the CAA-related provisions in the proposal, CMS proposes an applicability date of Oct. 1, 2021, to align with the effective date in the statute. CMS proposes that remaining provisions, if finalized, would be effective 60 days after publication of the final rule.

The 73-page document is scheduled for publication on Friday, Feb. 24.

For purposes of calculating the hospital-specific DSH limit, section 203 of the CAA modified the calculation of the Medicaid portion of the hospital-specific DSH limit to include only costs and payments for services furnished to beneficiaries for whom Medicaid is the primary payer for such services.

The CAA includes an exception to this methodology for hospitals in the 97th percentile of all hospitals with respect to inpatient days made up of patients who, for such days, were entitled to Medicare Part A benefits and to supplemental security income (SSI) benefits.

The exception provides qualifying hospitals with a hospital-specific limit that is the higher of that calculated under the methodology in which costs and payments for Medicaid patients are counted only for beneficiaries for whom Medicaid is the primary payer, or the methodology in effect on Jan. 1, 2020.

The CAA modified section 1923(f) of the Act such that the reductions occur beginning fiscal year 2024 through FY 2027, in the amount of $8 billion each year.

Section 1923(f)(7) of the Act requires the Secretary to develop a methodology to determine the annual, State-by-State DSH allotment reduction amounts based on five factors: uninsured factor (UPF), Medicaid volume factor (HMF), uncompensated care factor (HUF), low DSH state factor (LDF) and a budget neutrality factor (BNF).

The five factors are specified in section 1923(f)(7)(B) of the Act as follows.

- UPF – States with lower uninsurance rates receive higher percentage DSH reductions. Calculations performed under this factor utilize Census Bureau data that is subject to a one-year lag.
- HMF – States that target DSH payments to hospitals with high Medicaid volume receive a lower percentage reduction in their DSH allotment. Calculations performed under this factor utilize DSH audit data that is on a three-year lag.
- HUF – States that target DSH payments to hospitals with high levels of uncompensated care receive a lower percentage reduction in their DSH allotment. Calculations performed under this factor utilize DSH audit data that is on a three-year lag.
- LDF – Section 1923(f)(7)(B)(ii) of the Act requires that statutorily defined "low DSH States" receive a lower overall DSH reduction percentage than non-low DSH States. To accomplish this, low DSH States and non-low DSH States are separated into two cohorts before applying the reduction methodology.

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- BNF – DSH allotment amounts diverted for coverage expansion under section 1115 demonstrations approved as of July 31, 2009, receive a limited protection from reduction.

**Provisions of the Proposed Rule**

***When Discovery of Overpayment Occurs and its Significance (§ 433.316)***

CMS is proposing that, in the case of an overpayment identified through the DSH independent certified audit required under part 455, subpart D, CMS will consider the overpayment as discovered on the earliest of either the date that the state submits the DSH independent certified audit report required under § 455.304(b) to CMS, or of any of the dates specified in § 433.316(c): paragraph (c)(1) (the date on which any Medicaid agency official or other state official first notifies a provider in writing of an overpayment and specifies a dollar amount that is subject to recovery); paragraph (c)(2) (the date on which a provider initially acknowledges a specific overpaid amount in writing to the Medicaid agency); and paragraph (c)(3) (the date on which any state official or fiscal agent of the state initiates a formal action to recoup a specific overpaid amount from a provider without having first notified the provider in writing).

***DSH Health Reform Reduction Methodology (§ 447.294)***

CMS proposes to update the regulations at § 447.294(e)(12) to clearly specify that amounts diverted under a section 1115 demonstration approved after July 31, 2009, are subject to average reductions under the HUF and HMF so that the regulation may better reflect the policy finalized in the 2019 final rule preamble.

***Hospital-specific Disproportionate Share Hospital Payment Limit (§ 447.295)***

CMS is proposing that section 203 of the CAA, including the 97th percentile exception, be effective starting with each state's first state plan rate year (SPRY) beginning on or after Oct. 1, 2021. For example, if a state's SPRY begins July 1, then the amendments made by section 203 of the CAA would be effective starting with the SPRY beginning July 1, 2022. Conversely, if a state's SPRY begins each year on Oct. 1, then such amendments would be effective starting with the SPRY beginning Oct. 1, 2021.

Hospitals meeting the definition of a 97th percentile hospital, and therefore, qualifying for the 97th percentile exception will, by statute, calculate their hospital-specific DSH limit using the higher value of either the hospital-specific DSH limit amount determined for the hospital under section 1923(g)(1)(A) of the Act as amended by section 203 of the CAA 2021, or the amount determined for the hospital under section 1923(g)(1)(A) of the Act as in effect on Jan. 1, 2020. CMS interprets this to refer to the hospital-specific limit calculation methodology that was in effect on Jan. 1, 2020, and not the specific dollar amount that was applicable on that date.

CMS is proposing to determine a hospital's qualification for the 97th percentile exception for each SPRY on a prospective basis.

CMS would determine each hospital's Medicare SSI days for discharges occurring in the hospital's most recent cost reporting period, regardless of the length of that cost reporting period, using a data set that combines MEDPAR claims data and SSI eligibility data. If an inpatient stay begins in one cost reporting period but ends in the next cost reporting period, CMS would not count any of the inpatient stay's days toward the day count for the first cost reporting period, but instead count all of this inpatient stay's days toward the day count for the second cost reporting period.

CMS is proposing to allow one year from the posting of the 97th percentile hospital lists for states, hospitals, CMS or other interested parties to identify any mathematical or other similar technical error, according to instructions that would appear on the published lists. Upon CMS verification that an error occurred that affected the hospitals appearing on a list of 97th percentile hospitals for a given year, CMS would determine and publish a revised list as soon as practicable.

### ***Reporting DSH overpayments***

CMS is proposing to require auditors to quantify the financial impact of any finding, including those resulting from incomplete or missing data, lack of documentation, noncompliance with federal statutes or regulations, or other deficiencies identified in the independent certified audit, which may affect whether each hospital has received DSH payments for which it is eligible within its hospital-specific DSH limit.

### ***Retroactive Application of the Rule***

The ***CAA*** requires that the changes to the calculations of Medicaid hospital-specific DSH limits take effect on Oct. 1, 2021, and apply to payment adjustments made under section 1923 of the Act during fiscal years beginning on or after that date. Accordingly, these provisions of this proposed rule, if finalized, will apply retroactively as set out in statute.

## **Comment**

These changes are going to impact providers and not only states. As CMS has noted, the CAA is requiring CMS to reduce Medicaid DSH payments to states by $8 billion in FYs 2024 to 2027.

The proposal is detailed and complex.

At this juncture, the rule does not identify states and by how much reductions would be.