Issue Brief

FEDERAL ISSUE BRIEF • March 31, 2017

CMS Issues Final Rule Regarding Medicaid DSH Payments — Treatment of Third Party Payers in Calculating Uncompensated Care Costs

The Centers for Medicare & Medicaid Services has issued a final rule that "addresses the hospital-specific limitation on Medicaid disproportionate share hospital payments under section 1923(g)(1)(A) of the Social Security Act, and the application of such limitation in the annual DSH audits required under Section 1923(j) of the Act, by clarifying that the hospital-specific DSH limit is based only on uncompensated care costs.

"Specifically, this rule makes explicit in the text of the regulation, an existing interpretation that uncompensated care costs include only those costs for Medicaid eligible individuals that remain after accounting for payments made to hospitals by or on behalf of Medicaid eligible individuals, including Medicare and other third party payments that compensate the hospitals for care furnished to such individuals.

"As a result, the hospital-specific limit calculation will reflect only the costs for Medicaid eligible individuals for which the hospital has not received payment from any source."

The 29-page rule is scheduled to be published in the *Federal Register* on April 3. A copy is available at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2017-06539.pdf. This link will be superseded upon publication.

COMMENT

CMS says this rule will not have a major financial impact. CMS says further that this rule is not a change in policy and will not have significant financial effects on state Medicaid programs, nor on providers. CMS says, that the rule only makes explicit that "costs" for purposes of Section 1923(g) of the Act are costs net of third-party payments.

CMS' ANALYSIS OF AND RESPONSES TO PUBLIC COMMENTS

A. Proposed Rule is Consistent With the Statute

According to CMS, the Medicare statute states that the costs of providing services are "as determined by the Secretary;" and such language gives CMS the discretion to take Medicare and other third-party payments into account when determining a hospital's costs for the purpose of calculating Medicaid DSH payments.

continued

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B. Uninsured and Dual Eligible Patients

CMS says that "the statutory language refers to those 'eligible for medical assistance,' which means those individuals eligible for Medicaid benefits. The statutory language does not condition eligibility on whether the cost of the service was claimed, or if a Medicaid payment was received. Therefore, all costs and payments associated with Medicaid eligible individuals must be included in the hospital-specific limit calculation, regardless of whether Medicaid made a payment."

C. Effective Date

CMS notes that this rule is providing clarification to existing policy, therefore there is no issue of retroactivity, nor a need for a transition period. The rule is effective 60-days after publication.

D. No Increased Burden to States or Hospitals

CMS says that this rule ensures that "limited DSH resources are allocated to hospitals that have a net financial shortfall in serving Medicaid patients. This rule does not reflect a change in policy and the language of this final rule accurately reflects existing policy."

E. Rule Poses No Financial Impact

A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). CMS says this rule does not reach the economic threshold and thus is not considered a "significant regulatory action" under E.O. 12866, nor a "major rule" under the Congressional Review Act.

Analysis provided for MHA by Larry Goldberg, Goldberg Consulting