Issue Brief

FEDERAL ISSUE BRIEF • SEPTEMBER 24, 2019

CMS Issues Final Rule Regarding State Medicaid Disproportionate Share Hospital Allotment Reductions

The Centers for Medicare & Medicaid Services issued a final rule regarding State Disproportionate Share Hospital Allotment Reductions. The Medicare statute requires aggregate reductions to state Medicaid DSH allotments annually beginning with fiscal year 2020. This final rule delineates the methodology to implement the annual allotment reductions. However, the rule does not provide specific state reductions amounts. CMS says that as of the publication of this final rule, "We have not calculated FY 2020 DSH allotment reductions."

The final rule is effective 60 days after publication. Publication of the 95- page rule is scheduled for Wednesday, Sept. 25. A copy of the document currently is available at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2019-20731.pdf.

COMMENT

As noted above, this rule does not provide individual state Medicaid reductions. Those reductions will be significant as shown below.

There is little time between now and the start of FY 2020. Thus, states and providers will be at risk for the amounts of reductions.

MAJOR PROVISIONS ARE AS FOLLOWS.

- Section 2551 of the Affordable Care Act amended section 1923(f) of the act by adding paragraph (7) to provide for aggregate reductions in federal funding under the Medicaid program for DSH payments for the 50 states and the District of Columbia. DSH allotments are not provided for the five U.S. territories.
- The statute directs the secretary to implement the annual state Medicaid DSH allotment reductions using a DSH Health Reform Methodology. This final rule amends 42 CFR
  - $4,000,000,000 for FY 2020
  - $8,000,000,000 for FY 2021
  - $8,000,000,000 for FY 2022
  - $8,000,000,000 for FY 2023
  - $8,000,000,000 for FY 2024
  - $8,000,000,000 for FY 2025

continued

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CMS notes it is finalizing its "proposed state-specific cap that limits the reduction to be applied to each state's total unreduced DSH allotment to 90 percent of its original unreduced allotment because it strikes a balance between ensuring reduction amounts are determined based on the statutory DHRM factors and ensuring states maintain the ability to make an appreciable amount of DSH payments."

THE DHRM IS BASED ON FIVE FACTORS.

1. Low DSH Adjustment Factor (LDF)

The first factor considered in the DHRM is the Low DSH Adjustment Factor identified at section 1923(f)(7)(B)(ii) of the act, which requires the DHRM to impose a smaller percentage reduction on "low DSH states" that meet the criterion described in section 1923(f)(5)(B) of the act. To qualify as a low DSH state, total expenditures under the state plan for DSH payments for FY 2000, as reported to CMS as of Aug. 31, 2003, had to have been greater than zero but less than 3 percent of the state's total Medicaid state plan expenditures during the fiscal year. Historically, low DSH states have received lower DSH allotments relative to their total Medicaid expenditures than non-low DSH states.

2. Uninsured Percentage Factor (UPF)

The second factor considered in the DHRM is the UPF identified in section 1923(f)(7)(B)(i)(I) of the act, which requires that the DHRM impose the largest percentage DSH allotment reductions on states that have the lowest percentages of uninsured individuals.

The statute also requires that the percentage of uninsured individuals be determined on the basis of data from the Census Bureau, audited hospital cost reports and other information likely to yield accurate data, during the most recent year for which such data are available.

3. High Volume of Medicaid Inpatients Factor (HMF)

The third factor considered in the DHRM is the HMF identified in section 1923(f)(7)(B)(i)(II)(aa) of the act, which requires that the DHRM impose the largest percentage DSH allotment reductions on states that do not target DSH payments to hospitals with high volumes of Medicaid inpatients.

4. High Level of Uncompensated Care Factor (HUF)

The fourth factor considered in the DHRM is the HUF identified at section 1923(f)(7)(B)(i)(II)(bb) of the act, which requires that the DHRM impose the largest percentage DSH allotment reductions on states that do not target DSH payments to hospitals with high levels of uncompensated care (excluding bad debt).

5. Section 1115 Budget Neutrality Factor (BNF)

The statute requires that CMS consider the extent to which a state's DSH allotment was included in the budget neutrality calculation for a coverage expansion that was approved under section 1115 demonstration authority as of July 31, 2009.

Analysis provided for MHA by Larry Goldberg, Goldberg Consulting