Issue Brief

FEDERAL ISSUE BRIEF

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CMS Finalizes Disproportionate Share Hospital Third-Party Payer Rule

The Centers for Medicare & Medicaid Services (CMS) are issuing a final rule regarding the ***Consolidated Appropriations Act*** (CAA) of 2021 which changed the hospital-specific limit on Medicaid disproportionate share hospital (DSH) payments.

Specifically, Division CC, Title II, section 203 of the CAA 2021 (herein referred to as section 203) amended section 1923(g) of the Act, which describes the methodology for calculating hospital-specific Medicaid DSH limits.

The 107-page rule is currently available at: https://public-inspection.federalregister.gov/2024-03542.pdf. The rule is scheduled for publication on February 23.

CMS is finalizing all provisions as proposed, although the agency notes that the regulations have some minor phrasing changes for consistency with current style guidelines. For the CAA 2021-related provisions of this final rule, CMS is finalizing an applicability date of October 1, 2021, to align with the effective date in the statute. This information is noted in each of the CAA 2021-related provision sections. The remaining provisions of this final rule are effective 60 days after publication of the final rule.

Comments

This rule will impact hospitals.

The CAA 2021 modified section 1923(f) of the Act such that reductions will occur from FY 2024 through FY 2027, in the amount of $8 billion each year.

Since October 1, 2021, the amendments made by section 203 changed the methodology for calculating the Medicaid shortfall portion (Medicaid costs less Medicaid payments) of the hospital-specific DSH limit to only include costs and payments for hospital services furnished to beneficiaries for whom Medicaid is the primary payer.

Additionally, the CAA 2021 provides an exception for certain hospitals that are in the 97th percentile or above of all hospitals with respect to the number of Medicare SSI days (that is, inpatient days made up of patients who, for such days, were entitled to Medicare Part A benefits and to SSI benefits) or percentage of Medicare SSI days to total inpatient days.

Provisions of the Final Rule

From June 2, 2017 to October 1, 2021 (the effective date of the CAA 2021), costs and payments for hospital services furnished to beneficiaries who were eligible for Medicaid, even when there was a third-party payer such as Medicare or other insurer that pays primary to Medicaid for inpatient and outpatient hospital services, would all be included in the calculation of Medicaid shortfall portion of the hospital-specific DSH limits in accordance with the "DSH Payments—Treatment of Third-Party Payers in Calculating Uncompensated Care Costs" final rule in the April 3, 2017, ***Federal Register***.

Section 1923(f)(7) 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).

Since October 1, 2021, the amendments made by section 203 changed the methodology for calculating the Medicaid shortfall portion (Medicaid costs less Medicaid payments) of the hospital-specific DSH limit to include only costs and payments for hospital services furnished to beneficiaries for whom Medicaid is the primary payer.

CMS says it has interpreted these new requirements to be applicable for the State plan rate year (SPRY) (SPRYs) beginning on or after" October 1, 2021, the effective date of the CAA 2021. Previously, certain statutory references to "fiscal year," such as in section 1923(g)(1) and (2) and (j)(1) have also been interpreted as referring to each State's SPRY, instead of the FFY, when establishing requirements for the hospital-specific DSH limit (and audit requirements to ensure that payments comply with hospital-specific DSH limits).

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, or the amount determined for the hospital under section 1923(g)(1)(A) as in effect on January 1, 2020, and not the specific dollar amount that was applicable on that date.

A hospital's qualification for the 97th percentile exception for each SPRY will be on a on a prospective basis.

Medicaid would not be considered the primary payer for hospital services, for purposes of the calculation of the hospital-specific DSH limit, for an individual who had Medicaid coverage for inpatient and/or outpatient hospital services but had reached coverage limits or otherwise exhausted the Medicaid hospital benefit prior to obtaining these services.

When Medicaid is determined to not be the primary payer for that service, then the associated costs and payments for that specific hospital service would not be included in the calculation of the hospital-specific DSH limit (unless so provided for a qualifying hospital under the 97th percentile exception).

This final rule does not affect the existing flexibility each State has in how it operates its DSH program or distributes its DSH payment in accordance with its State plan, but this rule does address the changes to the hospital-specific DSH limit as required by section 203.

Calculating Medicaid Shortfall

CMS proposed to revise § 447.299(c)(6), (7), (10), and (16) to reflect the statutory changes made by section 203 to update the methodology for calculating the Medicaid shortfall portion (Medicaid costs less Medicaid payments) of the hospital-specific DSH limit to only include costs and payments for hospital services furnished to beneficiaries for whom Medicaid is the primary payer, effective for the SPRY beginning on or after October 1, 2021.

CMS proposed to revise § 447.299(c)(6), which specifies that this data element should include inpatient and outpatient Medicaid fee-for-service (FFS) basic rate payments paid to hospitals, "not including DSH payments or supplemental/enhanced Medicaid payments, for inpatient and outpatient services furnished to Medicaid eligible individuals."

CMS proposed to revise § 447.299(c)(7) to remove the reference to Medicaid eligible individuals and update the regulatory text to indicate that Medicaid managed care payments for inpatient and outpatient hospital services furnished to Medicaid individuals in accordance with § 447.295(d) should be included in this data element.

CMS proposed to revise § 447.299(c)(10) to remove the reference to Medicaid eligible individuals and update the regulatory text to indicate that costs incurred by each hospital for furnishing inpatient hospital and outpatient hospital services to Medicaid individuals as determined in accordance with § 447.295(d) should be included in this data element.

Final Comments

This analysis does not contain many aspects in the final rule. Once again, CMS seems to spend more time thanking commenters who agree with the agency than making the rule easier to understand.

CMS says that in order for States to assess which hospitals meet the 97th percentile exception, "we estimate that it would take approximately 2 hours." Interesting, it has taken this writer more than 2 hours to just read through the rule.

CMS' regulatory analysis section does not contain explicit changes in payments to either states or hospitals.