SMD# 21-006

New Supplemental Payment Reporting and Medicaid Disproportionate Share Hospital Requirements under the Consolidated Appropriations Act, 2021

On December 10, 2021, CMS issued State Medicaid Director (SMD) letter #21-006. This letter implements certain requirements of the Consolidated Appropriations Act, 2021 (CAA) pertaining to Medicaid supplemental payments and Medicaid shortfall calculations in the Medicaid disproportionate share hospital (DSH) program. The SMD letter addresses the following two provisions of the CAA, which are effective October 1, 2021:

1. States will be required to report information to CMS regarding Medicaid supplemental payments to providers. Information will be reported to CMS on a quarterly basis through the Medicaid Budget and Expenditure System (MBES).
2. When calculating the Medicaid shortfall portion of a hospital-specific DSH limit, the calculation will include only the costs and payments for hospital services furnished to beneficiaries for whom Medicaid is the primary payer.

More information regarding these provisions are as follows:

1. New Supplemental Payment Reporting Requirements

Section 1 of the State Medicaid Director letter addresses the new reporting requirements for supplemental payments under Section 1903(bb) of the Act. Section 1903(bb) was added to establish the parameters states must follow in reporting supplemental payment information to CMS. As described in the State Medicaid Director letter, the new reporting requirements are effective for supplemental payments made on or after October 1, 2021. CMS will make the information publicly available, although the State Medicaid Director letter does not contain information regarding this process.

Applicability of Supplemental Payments

- The new reporting requirements apply to supplemental payments made under state plan or 1115 demonstration authority, including uncompensated care (UC) pool payments, delivery system reform incentive payments (DSRIP), and possibly designated state health program (DSHP) payments, to the extent such payments meet the definition of a supplemental payment.
    - CMS notes they will provide technical assistance to states in determining whether the state's DSHP payments qualify as supplemental payments.
- The requirements do not apply to supplemental payments made under other authorities, including 1915(c) HCBS waivers. CMS notes they may revisit the issue of supplemental payments made under waiver authority in the future.
- CMS defines supplemental payments, for purposes of these requirements, as any payment in addition to the base payment, except for DSH payments. CMS clarifies that the base payment includes any payment adjustments, add-ons, or other additional payments that can be attributed to services provided to an individual beneficiary.

- CMS also notes that final reconciliation payments made under a cost reconciliation methodology are not considered supplemental payments.

Contents of Required Reporting

- The information to be reported includes narrative information and quantitative provider-specific data on supplemental payments. Specifically, states will be required to submit the following:
  - An explanation of how supplemental payments will result in payments that are consistent with section 1902(a)(30)(A) of the Act, including the standards of efficiency, economy, quality of care, and access, along with the stated purpose and intended effects of the supplemental payment.
  - The criteria used to determine which providers are eligible to receive the supplemental payment.
  - A comprehensive description of the methodology used to calculate and distribute, the supplemental payment to each provider, including:
    - Data on the amount of the supplemental payment to each eligible provider; or if the total amount is distributed using a formula for one or more fiscal years, data on the total amount of supplemental payments for the fiscal year(s) available to eligible providers.
    - The specific criteria with respect to Medicaid service, utilization, or cost data used as the basis for calculating or distributing the supplemental payment.
    - The timing of the supplemental payment made to each eligible provider.
  - An assurance that the total Medicaid payments made to an inpatient hospital provider, including the supplemental payment, will not exceed upper payment limits.
  - A UPL demonstration under 42 C.F.R. § 447.272, as applicable.
- In accordance with the statutory provisions of the 2021 CAA, the information relating to the assurance of payment levels and submission of a UPL demonstration applies to inpatient hospital services only.

Reporting System

- CMS has determined that the new information should be reported through the Medicaid Budget and Expenditure System (MBES) used for CMS-64 reporting. CMS notes that the use of MBES will allow CMS to readily review provider-level supplemental payments in the context of actual state expenditures for Medicaid provider payments. Because states submit CMS-64 reports quarterly through the MBES, the new reporting will be submitted by states quarterly. The first quarter for which the new reporting will apply will be federal fiscal year (FFY) 2022 quarter 1 (October 1, 2021 through December 31, 2021).
- CMS states they are working on a supplemental reporting form within MBES and will issue technical instructions to states regarding the lines and supplemental forms on which to enter the reporting information. The new MBES reporting functionality will collect all narrative and quantitative information on supplemental payments. Narrative information will carry over from one MBES submission to the next so states will not be required to develop narrative information each quarter, unless the information changes.

CMS states that incomplete or inaccurate reporting may result in deferral or disallowance of expenditures, although CMS acknowledges the short timeframe and notes their commitment to working with states to assist them in achieving compliance. Myers and Stauffer can assist states in complying with these new requirements, including preparing the required narratives, compiling supplemental payment amounts, and drafting responses to CMS questions.

2. Medicaid Shortfall Calculations

Section 2 of the State Medicaid Director Letter addresses changes to the Medicaid shortfall calculations under the amended section 1923(g) of the Act. Section 1923(g) was amended under the Consolidated Appropriations Act (CAA) to establish DSH limits that only include Medicaid primary and uninsured services. CMS has addressed some of the issues related to the amended Medicaid shortfall calculations in this letter.

Calculation of the 97th Percentile Exception

The CAA established a 97th percentile exception allowing hospitals, if it is to their benefit, to continue to include Medicaid secondary claims if the hospital is "in the 97th percentile or above of all hospitals with respect to the number of Medicare supplemental security income (SSI) days … or percentage of Medicare SSI days to total inpatient days." This Medicaid Director Letter addresses the following items related to the 97th percentile exception:

- CMS acknowledges that there is currently no readily available SSI data to make this determination, however once defined, they intend to make this data available to states for use in state payment methodologies.
- CMS at a minimum confirms that the 97th percentile ranking will be on a national level, and not state by state: "CMS intends to develop a data source to determine whether or not hospitals, ranked on a national level, qualify to meet the 97th percentile exception, consistent with section 1923(g)(2), as amended."
- CMS confirms that the SSI data will include all hospitals that receive Medicaid DSH including critical access, rehabilitation, and psychiatric hospitals.

Rulemaking

- Previously it was uncertain whether CMS would determine if notice-and-comment were necessary, or if they felt the Act was clear enough as written. CMS explains in the letter that they do intend to undergo notice-and-comment rulemaking. Myers and Stauffer is willing to help states draft questions during this comment period to help gain clarity related to the amended DSH limit calculations.

State Plan Amendments

It has been a source of confusion for states as to whether the amended DSH limit calculations should be applied at the time of DSH payments effective October 1, 2021 and how to implement the changes given the outstanding questions related to the SSI data.

- CMS expects states to self-implement the amended DSH limit calculations effective October 1, 2021.
- CMS encourages states to amend their DSH audit redistribution methodologies and DSH payment limit definitions to be consistent with the amendments to section 1923(g). State plan amendments (SPA) need to be submitted by the last of the SPRY to be effective for that year.

Amending state plan methodologies may be complicated due to unanswered questions, including when the new SSI data will be available for DSH payment consideration. Myers and Stauffer can work with states to review the current state plan, determine if changes are necessary, and review the SPA for any additional direction prior to the state's submittal to CMS for approval.

If you have questions regarding SMD letter #21-006, or its associated impact, please reach out to your Myers and Stauffer contact or one of the members of our leadership team.

CR/DSH, NF, and RS/FC PICs