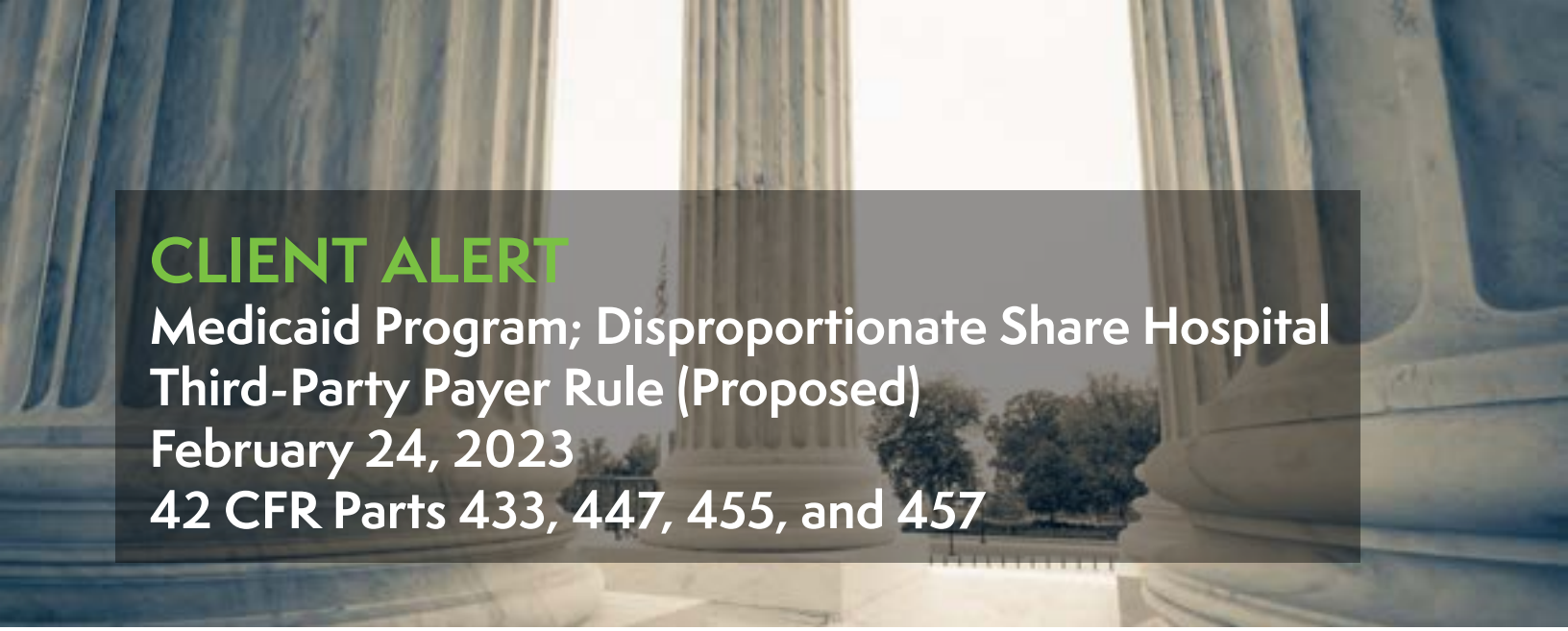

CLIENT ALERT

Medicaid Program; Disproportionate Share Hospital Third-Party Payer Rule (Proposed) February 24, 2023 42 CFR Parts 433, 447, 455, and 457

On February 24, 2023, a proposed Medicaid disproportionate share hospital (DSH) rule was published in the Federal Register by the Centers for Medicare & Medicaid Services (CMS). The proposed rule intends to address changes as a result of the Consolidated Appropriations Act (CAA) of 2021 (Pub. L. 116-260, December 27, 2020). The CAA changed the calculation of Medicaid hospital-specific DSH limits due to treatment of third-party payments. The proposed rule is focused specifically on section 203 of the CAA, *Sec. 203. Medicaid Shortfall and Third Party Payments*. Additionally the proposed rule addresses other administrative inefficiencies and DSH program clarifications. CMS proposes an applicability date of October 1, 2021 for CAA-related provisions and proposes remaining provisions would be effective 60 days after publication of the final rule. Myers and Stauffer is providing this client alert to ensure states are aware of several notable and impactful provisions. For the full proposed rule text, see https://www.federalregister.gov/documents/2023/02/24/2023-03673/medicaid-program-disproportionate-share-hospital-third-party-payer-rule.

In summary, the proposed rule includes the following topics discussed in more detail in this alert:

- **CAA DSH Requirements:**
  - Provides clarification on the data sources and calculations for the 97th percentile exception under 1923(g)(2)(B) of the Act.
  - Clarifies that the CAA DSH provisions will apply to State Plan Rate Years (SPRY) beginning on or after October 1, 2021. For most states that means DSH years beginning October 1, 2021 or July 1, 2022 (depending on the state's DSH SPRY).
- **Annual DSH Audits and Overpayments:**
  - Codifies CAA provisions to remove "Medicaid eligible" and replace wording with "Medicaid" so that services with third party payors are no longer included in the DSH uncompensated care costs (UCC) unless the hospital meets the 97th percentile exception and it benefits them.
  - Adds a new element to the DSH annual reporting requirements submitted with the DSH audit report. The new element is titled "financial impact of audit findings" and is intended to provide CMS with an estimate of the financial impact of audit findings/data caveats not included in the other data elements (not included already in the calculated DSH UCC). It is important to note that the Medicaid Fiscal Accountability Regulation (MFAR), which was withdrawn by CMS in September 2020, included similar requirements.

MYERS AND STAUFFER LC

- Codifies CMS-64 process and timeframe states have to recoup and report redistribution of DSH overpayments. Again, much of this was previously included in MFAR, which was withdrawn by CMS in September 2020.

- **DSH Health Reform Reduction Methodology:**
  - Codifies how DSH allotments diverted for 1115 demonstration waivers will be handled when DSH allotment reductions are calculated in FY 2024.
  - Since all 1115 waivers in effect on July 31, 2009, will have expired or been renewed/extended by FY 2024, all DSH allotment diverted to 1115 waivers will now result in a reduction to the high Medicaid and high uninsured factors as part of the DSH allotment reduction calculation.
- **Modernizing the Publication of DSH and Children's Health Insurance Program (CHIP) Allotments:**
  - CMS is proposing eliminating the requirement to publish the annual DSH and CHIP allotments in the Federal Register. They are proposing to post the preliminary and final DSH and CHIP allotments in the Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) and at Medicaid.gov.
  - CMS is also proposing to eliminate the April 1 date to publish the final DSH allotments.
  - Again, both of these proposals were previously included in MFAR, which was withdrawn by CMS in September 2020.

Background

Beginning with the adoption of the 2008 DSH audit rule, the cost of services related to dually-enrolled (Medicare or other third-party and Medicaid coverage) individuals has been included in the DSH calculation of UCC. However, the inclusion of the associated Medicare and other third party payments as a reduction to dually eligible costs has been the center of numerous court cases nationwide. The treatment of these payments has undergone several iterations over the years ranging from offsetting all the payments, to offsetting none of the payments, to only offsetting payments on or after June 2, 2017.

The CAA changed the DSH audit rule to only allow the inclusion of costs and payments for services for which the Medicaid state plan or waiver is the primary payer for such services. Therefore, the DSH audit beginning with Medicaid state plan rate year beginning on or after October 1, 2021, excludes both the costs and payments for services related to Medicaid individuals who have Medicare or third party coverage for those services from UCC. Some hospitals may still qualify for an exception to continue to include all Medicaid eligible individuals (costs and payments/revenues) in their UCC as is done currently under the Medicaid DSH limit calculations (methodology as of January 1, 2020), if it results in a higher DSH limit.

CAA DSH Requirements

Removal of Medicaid-Eligible

Section 203 of the CAA changes the hospital-specific DSH limit calculation. The change addresses the exclusion of Medicaid eligible claims that have Medicare or third party payers unless the hospital meets the 97th percentile exception and it benefits them.

The proposed language for Section 447.295(d)(2) is as follows:

(2) For each State's first Medicaid State plan rate year beginning on or after October 1, 2021, and thereafter, subject to paragraph (d)(3) of this section, only costs incurred in providing inpatient hospital and outpatient hospital services to Medicaid individuals when Medicaid is the primary payer for such services, and revenues received with respect to those services, and costs incurred in providing inpatient hospital and outpatient hospital services, and revenues

received with respect to those services, for which a determination has been made in accordance with paragraph (c) of this section that the services were furnished to individuals who have no source of third-party coverage for the specific inpatient hospital or outpatient hospital service are included when calculating the costs and revenues for Medicaid individuals and individuals who have no health insurance or other source of third-party coverage for purposes of section 1923(g)(1) of the Act.

This definition includes the costs and payments of two populations:

- Medicaid individuals with no source of third-party coverage for the specific inpatient hospital or outpatient hospital services.
- Uninsured individuals (no health insurance or other source of third-party coverage).

Due to the proposed removal of Medicaid individuals with third-party payers, the language for several sections of the 42 CFR has been changed to remove references to "Medicaid eligible individuals." DSH audit reports will require an update to the new language once the proposed rule is finalized.

States may have remaining questions related to which Medicaid claims are considered Medicaid primary for purposes of the new UCC definitions and what changes may need to be made to their MMIS paid claims reports used in the DSH payment and audit calculations.

97th Percentile Exception

The proposed rule also allows for the 97th percentile exception to the new definition of the hospital-specific DSH limit. The exception to the exclusion of Medicaid services with third-party coverage can be applied to the 97th percentile hospitals, if it is beneficial for the hospital to do so. Section 447.295(d)(3) will read:

(3) Effective for each State's first Medicaid State plan rate year beginning on or after October 1, 2021, and thereafter, the hospital-specific DSH limit for a 97th percentile hospital defined in paragraph (b) of this section is the higher of the values from the calculations described in paragraphs (d)(1) and (2) of this section.

The proposed rule includes the following clarifications to the 97th percentile exception:

a. The 97th percentile list will be published by CMS annually prior to October 1st of each year.
b. The exception will apply to hospitals who are at or above the 97th percentile of all hospitals nationwide with respect to the number of Medicare supplemental security income (SSI) days or the percentage of Medicare SSI days to total inpatient days.
c. Healthcare Cost Report Information System (HCRIS), Medicare Provider Analysis and Review (MEDPAR), and SSI data from the Social Security Administration (SSA) will be the primary sources of data for the 97th percentile calculation.
d. The most recent cost report data available in HCRIS as of March 31st (prior to October 1st) will be used (regardless of audit status). If the most recent cost report available is older than 3 years from the prior September 30th, the hospital will be excluded.
e. Hospitals that do not submit Medicare cost reports or that did not provide Medicaid inpatient services will not be included.
f. Cost reports will include acute care hospitals paid under the inpatient prospective payment system, critical access hospitals, inpatient rehabilitation hospitals, and psychiatric hospitals.
g. Medicare Part A days will include both covered and non-covered.
h. Days will include all days in distinct part units (psychiatric and rehabilitation units).
i. Medicare SSI days will be on discharges occurring during the cost report period.
j. The calculation is prospective. The October 1st list will be published for use in the subsequent year's DSH payment calculation.

k. No retrospective calculation of the list will be completed; however, CMS will allow 1 year from the publish date to find any CMS mathematical or technical errors to be corrected. There will not be corrections to cost reports or hospital data allowed.

Interestingly, CMS did not require the identification or reporting of any separate information on hospitals that meet the 97th percentile exception or that benefit from the exception.

October 1, 2021 Effective Date

The proposed rule clarifies the October 1, 2021 effective date. Section 203 is to be effective starting with each state's first state plan rate year (SPRY) beginning on or after October 1, 2021. Previously released guidance suggested the effective date would be on the federal fiscal year. This has been clarified to emphasize the SPRY. Additionally, the application of the rule will be retroactive to the SPRY beginning on or after October 1, 2021. For SPRY beginning prior to October 1, 2021, the Medicaid DSH limit calculations (methodology as of January 1, 2020) will be in effect through the end of that SPRY.

Annual DSH Audits and Overpayments

New Data Element – Financial Impact of Audit Findings

The proposed rule introduces a new data element and includes clarification on reporting DSH overpayments. The old data element (21) will be changed to (22) and replaced with a new data element (21) *financial impact of audit findings*. The new data element is an attempt to identify actual or estimated financial impacts of audit findings.

It is unclear how CMS intends to use the proposed *financial impact of audit findings* data element and states may need to submit questions to clarify this section of the proposed rule. The definition states that this proposed reporting requirement should only include the actual or estimated audit finding if not otherwise reflected in the other data elements. However, it is unclear as to whether CMS expects states to include this proposed data element in their DSH overpayment determinations or if it is for CMS to make additional DSH overpayment determinations after their review. For example, the reported *annual uncompensated care cost* (UCC) data component (one of the existing other data elements) would not include the amounts in the proposed *financial impact of audit findings* data element. Will states be required to change their UCC when determining overpayments to include this proposed data element? If so, this could be significant depending on what actual and estimated financial impacts are reported in the proposed data element as discussed in the following sections.

Estimated Financial Impact of an Audit Finding

CMS is proposing that auditors estimate financial impacts of audit findings when the actual amount cannot be determined due to incomplete or missing data, lack of documentation, non-compliance with Federal statutes or regulations, or other deficiencies. These are findings that cannot be determined using the documentation sources in 42 CFR §455.304(c) and therefore were not included in the other data elements. The proposed rule includes several suggestions and examples of estimating the impacts of data findings and/or caveats. CMS is encouraging states and their independent auditors to quantify either the actual or estimated financial impact to gain a better understanding of the data deficiencies' effect on the DSH limit. States and hospitals may be concerned how auditors will determine "estimated financial impacts" when the actual impact is unknown. When documentation is missing, it may be necessary for auditors to use state-wide averages or the provider's historical averages to estimate amounts for the final report. These estimates could then result in increased provider overpayment determinations. CMS states that auditors may also provide an estimated range of the financial impact on audit findings. However, if a range is reported as opposed to a single estimate, how will that range be used in the DSH overpayment calculations?

Actual Financial Impact of an Audit Finding

It is not clear when an actual financial impact of an audit finding would ever need to be reported under the proposed *financial impact of audit findings* data element. Since an actual financial impact of an audit finding is defined as a finding calculated using documentation sources in 42 CFR §455.304(c), the finding would already be included in the other data elements and would not be reported again in this proposed reporting requirement. The only actual financial impacts that are normally not already reported in the other data elements are related to audit disclosures presented in the DSH examination "data caveats." These disclosures are typically due to inconsistencies in the DSH guidance or legal interpretations of DSH rules that have not been formally ruled upon by the courts or CMS. It is unclear if CMS is asking auditors to report these disclosure amounts in the proposed *financial impact of audit findings* data element. Page 11875 of the proposed rule states that the proposed data element would require auditors to quantify the financial impact of any finding including non-compliance with Federal statutes or regulations. It may be that CMS views the current auditor disclosures as non-compliance with Federal statutes or regulations but it is not clear how the auditor is to make that determination given the states' various legal interpretations, inconsistent guidance, or the lack of guidance. Many of the auditors' disclosures require legal interpretation or further guidance and are beyond the auditor's judgment.

CMS-64 Processes and Timing

A deadline to report DSH overpayments has been clarified under the proposed rule. The DSH overpayment will be considered discovered on the earliest of the following:

- The date the state submits the independent DSH audit report to CMS.
- The date the state notifies a provider in writing including the dollar amount.
- The date a provider acknowledges an overpayment amount in writing to the state.
- The date the state takes action to recoup the overpayment amount.

The proposed rule adds two new sections under 447.299 (f and g). The proposed language clarifies that overpayments should be reported on CMS-64 as a decreasing adjustment for the overpayments (and as an increasing adjustment for redistributions) corresponding to the DSH allotment and SPRY of the originally-claimed expenditure.

Overpayments to be returned to the Federal government must be done in accordance with the requirements of 42 CFR part 433, subpart F. States have one year from the date of discovery to recover or attempt to recover the overpayment before an adjustment is made to federal financial participation (FFP) to account for the overpayment. Overpayment redistribution adjustments must be reported on the Form CMS-64 within two years of the date of discovery outlined above. It appears that most of the overpayment guidance is simply codifying what CMS was already following. However, some states may not have completed redistributions within the two year requirement and could now be at risk of not being able to complete those redistributions.

It should be noted that nothing was included in relation to underpayment situations when a state still has available DSH allotment. States may want to consider whether questions should be submitted related to the process for claiming additional DSH payments to hospitals under their DSH limit.

DSH Health Reform Reduction Methodology

The final DSH health reform methodology (DHRM) was published in the Final Rule, 84 FR 50308 on September 25, 2019. The methodology is intended to outline the DSH allotment reductions that had been previously delayed. The CAA modified the reductions to occur beginning in FY 2024 through FY 2027 at $8 billion per year.

The proposed rule removes any indication that DSH funds diverted under section 1115 demonstrations after July 31, 2009, would be excluded from the reductions starting in FY 2024. The rule states that all 1115 demonstrations

approved as of July 31, 2009, have expired and the protection does not apply to renewals or extensions. Therefore, no amounts related to coverage expansion will be excluded from future DSH allotment reductions scheduled to begin in FY 2024.

For reductions calculated in FY 2024, all DSH allotments diverted for section 1115 demonstrations will be reduced by the mean high uncompensated care factor (HUF) and the mean high Medicaid volume factor (HMF) reduction percentages. The calculated DSH allotment diverted under the 1115 demonstration will align with the associated State plan rate year DSH audit utilized in the DSH allotment reductions.

Modernizing the Publication of DSH and CHIP Allotments

Currently 42 CFR §447.297 outlines when and how CMS is to publish preliminary and final allotments in the Federal Register. Included in the current rule is the requirement to publish preliminary DSH allotments by October 1 of each year and the final allotments by April 1. The proposed rule will eliminate the requirement to publish the DSH and CHIP allotments in the Federal Register. Instead, it will require the information be posted on the Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) and at Medicaid.gov. Additionally, the proposed rule removes the April 1 deadline and replaces it with "as soon as practicable."

Next Steps

The proposed rule will impact the way states and hospitals report Medicaid data for both DSH payment and DSH examination purposes. Myers and Stauffer has already begun working with several hospitals and states on the potential impact this proposed rule will have. States and hospitals should work toward updating query logic and data reports in order to properly separate Medicaid claims that have Medicare or third party coverage for Medicaid inpatient and outpatient hospital services. States also need to review their previous DSH examination data caveats and determine how the potential impact of those data caveats could impact their future DSH examinations and overpayments now that CMS is requesting an estimated fiscal impact of all audit findings.

The proposed rule is open for comments and the comment period will end April 25, 2023. Formal comments can be submitted here: Submit a Formal Comment

For More Information

Myers and Stauffer is available for meetings to discuss any issues in the proposed rule. If you have any questions about the material discussed in this client alert or you would like help drafting formal comments, please contact the following members of our DSH practice group:

Bob Hicks, CPA
(Member)
PH: 800.374.6858
BHicks@mslc.com

Tammy Martin, CPA
(Member)
PH: 800.336.7721
Tammym@mslc.com

John Kraft, CPA
(Member)
PH: 800.505.1698
JKraft@mslc.com

Johanna Linkenhoker, CPA
(Member)
888.832.0856
JLinkenhoker@mslc.com

Judy Hatfield, CPA
(Member)
PH: 800.374.6858
JHatfield@mslc.com

Jim Erickson, CPA
(Member)
PH: 800.374.6858
JErickson@mslc.com

Diane Kovar, CPA
(Member)
PH: 800.505.1698
DKovar@mslc.com

Marty Teufel, CPA
(Member)
800.336.7721
MTeufel@mslc.com

MYERS AND STAUFFER LC