Medicaid Program; Disproportionate Share Hospital Third-Party Payer [CMS 2445 F]
Summary of Final Rule

On February 23, 2024, the Centers for Medicare & Medicaid Services (CMS) published a final rule in the Federal Register (89 FR 13916) that addresses legislative changes to the hospital- specific limit on Medicaid disproportionate share hospital (DSH) payments that took effect on October 1, 2021, as a result of the Consolidated Appropriations Act (CAA) 2021. The rule is intended to provide more clarity on how the limit will be calculated. It also makes technical changes and clarifications to the DSH program that CMS believes will enhance administrative efficiency.

Table of Contents

I. Background

A. Overview

The Medicaid program provides funds to states to provide medical assistance to eligible individuals as specified in Title XIX of the Social Security Act (SSA) and subject to terms and conditions under statute and regulation. The Medicaid statute requires states to take into account, in establishing payment rates to hospitals, the situation of hospitals that serve a disproportionate share of low-income patients.

The final rule updates DSH regulatory requirements to reflect changes made by the CAA 2021 concerning the treatment of third-party payments when calculating Medicaid hospital-specific DSH limits. CMS also makes changes to (1) clarify regulatory payment and financing definitions and other regulatory language that it believes may be subject to misinterpretation, (2) refine administrative procedures used by states to comply with federal regulations, and (3) remove regulatory requirements that it says have been difficult to administer and do not further the program's objectives.

CMS is finalizing all provisions as proposed, with some minor phrasing changes. The provisions that carry out changes in the CAA 2021 apply retroactively as of October 1, 2021, consistent with the statute. Other provisions will take effect 60 days after publication of the final rule.

B. Disproportionate Share Hospital (DSH) Payments

1. Background

Medicaid DSH payments are separate from base payments or other supplemental payments, originating from a separate statutory authority[1] with a separate purpose. DSH payments are subject to certain limits and specific requirements. For example, states are provided with an annual allotment that they may not exceed,[2] and there are hospital-specific limits on DSH payments as well.[3] Within those parameters, states have flexibility regarding the specific hospitals to which they make DSH payments and the amount of those payments.

Federal statute requires states to provide CMS with an annual report on the DSH payments to each hospital as well as an annual independent certified audit of the state's DSH program.

2. CAA 2021 Requirements

Effective October 1, 2021, section 203 of the CAA 2021 modified the calculation of the Medicaid portion of the hospital-specific DSH limit to include only costs and payments for services furnished to beneficiaries for whom Medicaid is the primary payer for those services.[4] Thus, the hospital-specific DSH limit excludes costs and payments for services furnished to Medicaid beneficiaries with other sources of coverage, such as Medicare and commercial insurance. However, section 203 provided an exception for hospitals in the 97th percentile of all hospitals nationwide with respect to inpatient days made up of patients who, for such days, were entitled to Medicare Part A benefits and to supplemental security income (SSI) benefits, referred to as Medicare SSI days.[5]

The exception applies to hospitals that are in the 97th percentile with respect to either:

- The number of inpatient Medicare SSI days, or

[1] Section 1923(d) of the SSA (42 U.S.C. 1396r-4(d)).
[2] Section 1923(f) of the SSA (42 U.S.C. 1396r-4(f)).
[3] Section 1923(g) of the SSA (42 U.S.C. 1396r-4(g)).
[4] Section 1923(g)(1)(B)(i) of the SSA (42 U.S.C. 1396r-4(g)(1)(B)(i)).
[5] Section 1923(g)(2)(B) of the SSA (42 U.S.C. 1396r-4(g)(2)(B)).

- The percentage of total inpatient days that were made up of Medicare SSI days.

The hospital-specific limit for a DSH hospital that qualifies for the exception is equal to the higher of (1) the limit as calculated under the methodology in effect before enactment of the CAA 2021 (that is, as in effect on January 1, 2020 and which counts payments made by third party payers),[6] or (2) the limit as calculated under the methodology imposed by the CAA 2021 (which counts payments only for beneficiaries for whom Medicaid is the primary payer). CMS says that data limitations have hampered its ability to determine which hospitals qualify for the exception; the rule finalizes the proposal for how CMS will make these determinations.

3. Annual DSH Audits and Overpayments

Under the 2008 DSH audit final rule,[7] states must submit an independently certified audit of the state's DSH program annually as well as an annual report identifying Medicaid DSH payments to providers, with 18 specific data elements. One of those data elements is the total uncompensated care cost, which equals the total cost of care for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals and to individuals with no source of third-party coverage for the hospital services they receive, less the sum of other payment sources listed in §447.299(c)(16).

CMS raises the concern that, even though the audits and annual reports provide a great deal of information, it does not have the information it needs to determine if an overpayment has occurred and why. As a result, CMS is unable to ensure proper recovery of any federal share of DSH overpayments. CMS identifies reports from the Inspector General of the Department of Health and Human Services (HHS) as well as the Government Accountability Office (GAO) raising similar concerns with such overpayments. In lieu of conducting secondary reviews or audits, CMS finalizes its proposal to require states to include an additional data element that provides a dollar estimate of any Medicaid DSH provider overpayments as part of the submission of state annual reports under §447.299(c).

Under current law and regulations, when an overpayment by a state is discovered, the state has a one-year period to recover or attempt to recover the overpayment before an adjustment is made to federal payments to the state to account for the overpayment. The one-year period begins on the date of discovery of the overpayment. While the regulations in §433.316 establish how the date of discovery of an overpayment is determined, it does not specify how this relates to the independent certified DSH audits. The preamble of the 2008 DSH audit final rule addressed the return or redistribution of provider overpayments identified through DSH audits, but it did not include specific procedural requirements for returning or redistributing overpayments. CMS finalizes without modification its proposed changes to address this issue, described in greater detail below.

[6] "DSH Payments—Treatment of Third-Party Payers in Calculating Uncompensated Care Costs" final rule in the April 3, 2017 Federal Register (82 FR 16114).
[7] "Medicaid Program; Disproportionate Share Hospital Payments" (73 FR 77904; December 19, 2008).

4. DSH Health Reform Reduction Methodology

As amended by the Affordable Care Act (ACA), section 1923(f)(7) of the SSA required CMS to develop a methodology to determine annual, state-by-state DSH allotment reduction amounts to account for the anticipated decrease in uncompensated care as a result of expansions of coverage authorized by the ACA. These reductions were originally slated to occur from FY 2014 through FY 2020. However, Congress has regularly delayed the start of those reductions so that they have never taken effect. CAA 2021 delayed the reductions to federal fiscal years (FY) 2024 through 2027, at a rate of $8 billion per fiscal year. As of this writing, the DSH reductions have been delayed to March 9, 2024, by P.L. 118-35, enacted January 19, 2024.[8]

The DSH Health Reform Reduction Methodology (DHRM) is based on the following five statutory factors (section 1923(f)(7)(B) of the SSA):

- Uninsured factor (UPF): States with lower uninsurance rates receive higher percentage DSH reductions. Calculations for this factor use Census Bureau data with a 1-year lag.
- Medicaid volume factor (HMF): States that target DSH payments to hospitals with high Medicaid volume receive a lower percentage reduction in their DSH allotment. Calculations for this factor use DSH audit data with a 3-year lag.
- Uncompensated care factor (HUF): States that target DSH payments to hospitals with high levels of uncompensated care receive a lower percentage reduction in their DSH allotment. Calculations for this factor use DSH audit data with a 3-year lag.
- Low DSH state factor (LDF): "Low DSH states"[9] receive a lower overall DSH reduction percentage than non-low DSH states. Thus, low DSH states and non-low DSH states are separated into two cohorts before applying the reduction methodology.
- Budget neutrality factor (BNF): DSH allotment amounts diverted for coverage expansions under section 1115 demonstrations approved as of July 31, 2009, receive a limited protection from reduction.

CMS had twice finalized methodologies in 42 CFR 447.294 to implement these reductions—one in 2013 and a revised methodology in 2019. The 2019 final rule[10] assigned weights to the annual reduction amount for the three core factors: UPF, HMF and HUF. The remaining two factors, the LDF and the BNF, affect the allocation of the reduction amounts within the three core factors. Under this methodology, the LDF allocation is done at the front end of the calculations by shifting a portion of the reduction amount specified under section 1923(f)(7)(A)(ii) of the SSA to non-low DSH states. After this step, CMS determines the reduction calculations prescribed by the three core factors. It then performs additional reductions associated with the BNF within the HMF and HUF for states that divert DSH allotment amounts under section 1115 demonstrations. CMS then reallocates these reduction amounts away from states that do not divert DSH allotment amounts under section 1115 demonstrations, to comply with the aggregate reduction amounts specified under statute at section 1923(f)(7)(A)(ii) of the SSA.

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[8] The amendments made by section 121 of P.L. 118-35 delayed the DSH allotment reductions to begin March 9, 2024, but did not change the end date (the last day of FY 2027) of the period for the reductions, thus shortening the total period for which the reductions are scheduled to apply.

[9] Section 1923(f)(5) of the SSA (42 U.S.C. 1396r-4(f)(5)).

[10] "Medicaid Program; State Disproportionate Share Hospital Allotment Reductions" (84 FR 50308; September 25, 2019).

5. Modernizing the Publication of Annual DSH and CHIP Allotments

Current regulations require CMS to publish in the Federal Register:

- Preliminary annual DSH allotments and national expenditure targets by October 1 of each FY (§447.297(c)), and
- Final allotments and national expenditure targets by April 1 of that federal fiscal year (§447.297(d)).

CMS finds this process to be cumbersome and unnecessary in light of more timely notification practices currently in place. Current regulations also permit CMS to publish state CHIP allotment notices in the Federal Register. CMS finalizes its proposal to codify its current process while eliminating what it describes as inefficient and duplicative publication requirements.

II. Provisions of the Rule

A. When Discovery of Overpayment Occurs and its Significance (§433.316)

Under current law and regulations, when an overpayment by a state is discovered, the state has a one-year period to recover or attempt to recover the overpayment before an adjustment is made to federal payments to the state to account for the overpayment. The one-year period begins on the date of discovery of the overpayment. Current regulations describe the date of discovery for certain overpayments, but do not describe what is meant by the date of discovery for overpayment found through an annual DSH independent certified audit. To address this, CMS finalizes amending §433.316 to add a new paragraph (f) to specify that the date of discovery of overpayments identified through a DSH audit is the earliest of the following dates:

- The date on which the state submits the certified audit report under §455.304(b); or
- Any of the dates specified in existing §433.316(c)(1), (2), or (3):
    - (c)(1) The date on which a Medicaid official first notifies a provider in writing of an overpayment and specifies a dollar amount subject to recovery;
    - (c)(2) The date on which a provider initially acknowledges a specific overpaid amount in writing to the Medicaid agency; or
    - (c)(3) The date on which any state official initiates a formal action to recoup a specific overpaid amount from a provider without having first notified the provider in writing.

Selected Comments/Responses: A couple commenters objected to the date of the audit submission being the basis of the date for an overpayment being "identified," given the potential need to perform additional review or account for redistributions of DSH payments in excess of the hospital-specific limit. CMS is finalizing its proposal without modification, noting that the date of discovery based on the audit submission is consistent with other overpayments in §433.316(c). CMS also emphasizes that this date is when the state submits the independent certified audit to CMS, not when the state's auditor first notifies the state of an overpayment. The state has up to 90 days after receipt of the independent certified audit to review it before it must be submitted to CMS in accordance with §455.304(b), which CMS believes is ample time to review the findings and resolve any disagreement.

B. DSH Health Reform Reduction Methodology (§447.294)

The DSH Health Reform Reduction Methodology (DHRM) must consider the extent to which the DSH allotment for a state was included in the budget neutrality calculation for a coverage expansion approved under section 1115 of the SSA[11] as of July 31, 2009. Under the 2019 final rule, the methodology excludes from DSH allotment reductions the amount of DSH allotment that states had approved as of July 31, 2009 under a coverage expansion section 1115 demonstration. Any DSH allotment amounts included in budget neutrality calculations for non-coverage expansion purposes under approved 1115 demonstrations are still subject to reduction regardless of when they were approved.

Further, the preamble to the 2019 final rule indicates that for any section 1115 demonstrations not approved as of July 31, 2009, these DSH allotment amounts included in budget neutrality calculations, whether for coverage expansion or otherwise, would also be subject to reduction. CMS notes that all section 1115 demonstrations approved as of July 31, 2009 have expired and the protection does not apply to renewals or extensions of those 1115 demonstrations. Thus, CMS states that there no longer exist any amounts related to coverage expansion for exclusion from future DSH allotment reductions scheduled to begin in FY 2024.

CMS does not have hospital-specific DSH audit data relating to how states expend DSH allotment amounts diverted under section 1115 demonstrations; thus, it finalizes assigning average HUF and HMF reduction percentages to these amounts. Further, it finalizes its proposal to update the regulations at §447.294(e)(12) to clearly specify that amounts diverted under a section 1115 demonstration approved after July 31, 2009, are subject to average reductions under the HUF and HMF; this was described as essentially a codification of the policy finalized in the preamble to the 2019 final rule.

CMS finalizes its proposal that the determination of diverted amounts that are subject to average reductions under the HUF and HMF will align with the state plan rate year (SPRY) for the DSH audits used in the DSH allotment reduction calculations[12] rather than the fiscal year subject to reduction. Thus, when it calculates the DSH allotment reductions for FY 2024, CMS will use data for each state's SPRY 2019 DSH audit data as it is the most recent data available to the agency. If a state did not divert its entire DSH allotment, CMS will include the amount of the state's DSH allotment diverted under a section 1115 demonstration for the time period that aligns with the associated SPRY (i.e., SPRY 2019 in the example in the preceding sentence). Each such state will then be assigned the average HUF and HMF reduction amounts for the state's respective state group based on this diverted amount.

CMS also proposed to remove the language "for the specific fiscal year subject to reduction" in paragraphs (e)(12) introductory text and (e)(12)(i) of §447.294 because it believes the current regulatory language could lead to anomalous results. The language results in a non-alignment between the SPRY 2019 DSH audit data that CMS would use to determine the HUF and HMF and the FY 2024 section 1115 demonstration budget neutrality calculation diversion amount that would be used under the current regulation; it notes that this could result in inappropriate and

[11] That is, a section 1115 demonstration to provide coverage to individuals not otherwise eligible for Medicaid.
[12] See 42 CFR 447.294(d).

illogical outcomes. It believes its proposal to assign average HUF and HMF reduction percentages to diverted amounts in the absence of DSH audit data relating to how states expend DSH allotment amounts diverted under section 1115 demonstrations is reasonable. CMS concluded that it is appropriate that the amounts diverted under section 1115 demonstrations should align with the SPRY of the DSH audit used in the DHRM and that the amounts subject to reduction do not exceed what states could have expended, either through DSH payments or diverted DSH allotment amounts, during the associated SPRY.

The agency also finalizes its proposal that the budget neutrality calculations are to be performed on the amount of each state's DSH allotment diverted under an approved 1115 demonstration during the period that aligns with the associated SPRY DSH audit utilized in the DSH allotment reductions (§447.294(e)(12)(ii)).

If a state diverts its entire DSH allotment and thus does not complete a DSH audit, CMS cannot use a SPRY DSH audit. To address this, it proposed to apply reductions under the HMF and HUF to the DSH allotment that the state would have had available during the demonstration year (DY) coinciding with the SPRY DSH audits utilized in the DHRM. It would prorate the FY allotment amount to determine this reduction in cases where the DY of the section 1115 demonstration crosses two FYs.

CMS adds that if a state that diverts its entire DSH allotment has a DY that begins July 1, 2018, and ends June 30, 2019, the agency would have to determine the reduction amount associated with the diverted DSH allotment to reflect the amount of the FY 2018 DSH allotment available from July 1, 2018, through September 30, 2018, and the amount of FY 2019 DSH allotment available from October 1, 2018, through June 30, 2019. For a state that diverts part of its DSH allotment, it would have a SPRY DSH audit already utilized in the DHRM.

Selected Comments/Responses: A commenter suggested that CMS use hospital-specific section 1115 supplemental payment data, as required by CAA 2021, to measure DSH targeting factors rather than averages. In response, CMS notes that the average reduction amounts for the respective state group (that is, low DSH versus non-low DSH) under the HMF and HUF were not proposed in this rulemaking but already appear in current regulations (§447.294(e)(12)(iii) and (iv)). Moreover, that CAA 2021 provision does not apply to DSH diversion payments nor to payments before October 1, 2021. While some of that required data may be useful for calculating the DSH allotment reductions scheduled for FY 2027, the last year of the currently scheduled DSH allotment reductions, CMS is finalizing its proposal with only a minor phrasing change.

C. Hospital-specific Disproportionate Share Hospital Payment Limit (§447.295)

As noted above, section 203 of the CAA 2021 changed the methodology for calculating the Medicaid shortfall portion (that is, 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. This provision also has an exception for 97th percentile hospitals, for which the limit is equal to the higher of (1) the limit calculated under the methodology in existence before January 1, 2020, and (2) the limit calculated under the methodology established by the CAA 2021.

The finalized changes apply for SPRYs (as opposed to fiscal years) beginning on or after October 1, 2021. CMS believes this is consistent with its past implementation of statutory effective dates for section 1923 of the SSA and that using the SPRY will avoid excessive burden on states and hospitals, compared to if the changes were implemented on an FY basis.

More specifically, CMS finalizes its proposal to add a definition of 97th percentile hospitals to §447.295(b) as follows:

> *97th percentile hospital* means a hospital that is in at least the 97th percentile of all hospitals nationwide with respect to the hospital's number of inpatient days or the hospital's percentage of total inpatient days, for the hospital's most recent cost reporting period, made up of patients who were entitled to benefits under part A of title XVIII and supplemental security income benefits under title XVI (excluding any State supplementary benefits paid).

For each Medicaid SPRY beginning on or after October 1, 2021, CMS will prospectively identify the 97th percentile hospitals, using Medicare cost reporting and claims data sources, as well as SSI eligibility data provided by the Social Security Administration. It will also publish lists identifying each 97th percentile hospital annually in advance of October 1 of each year and only revise the list to correct a mathematical or other similar technical error identified to CMS within one year of the list's publication.

The agency finalizes its proposal to develop a data set—compiling cost report, claims, and eligibility data—to prospectively determine which hospitals, ranked on a national level, qualify for the statutory 97th percentile hospital exception. CMS will publish these data annually and reiterates that these determinations would be done on the basis of SPRYs and not FYs. CMS believes applying this exception prospectively eliminates the need to retroactively rank and qualify hospitals based on actual Medicare SSI days and ratios for services furnished during the SPRY and provides more predictability for states and hospitals.

CMS will determine each hospital's Medicare SSI days for discharges occurring in the hospital's most recent cost reporting period, regardless of the length of that cost reporting period, using a data set that combines Medicare Provider Analysis and Review (MEDPAR) claims data and SSI eligibility data. To determine each hospital's percentage of Medicare SSI days to total inpatient days, CMS will divide the Medicare SSI days by each hospital's total inpatient days for that same cost reporting period from the Healthcare Cost Report Information System (HCRIS) to obtain a percentage. Then, it will compile two lists, ranking hospitals based on (1) the absolute number of Medicare SSI days, and (2) the percentage of inpatient days that are Medicare SSI days. A hospital may qualify to meet the 97th percentile exception on the basis of either of the two lists.

For the Medicare SSI days, the 97th percentile threshold will be rounded to the nearest whole number, with x.5 or higher rounded up, and less than x.5 rounded down. For the percentage of inpatient days that are Medicare SSI days, all values will be rounded to the fourth decimal place,

including each hospital's own percentage and the 97th percentile threshold. Values of 0.xxxx5 or higher will be rounded up, and less than 0.xxxx5 will be rounded down.

CMS finalizes utilizing information from the most recent cost reporting period using an "as-submitted" cost report. However, if that most recent cost reporting period for which there is an as-submitted cost report already has an amended cost report, a settled cost report, or a reopened cost report as of the date that CMS obtains data from the HCRIS, it will use the total inpatient day count from that amended cost report, settled cost report, or reopened cost report for that period.

The agency also finalizes without modification its proposal to use both covered and non-covered Medicare Part A days when collecting data and calculating hospital percentiles. Further, it will include days furnished in distinct part units of the hospital that provide inpatient hospital services to determine a hospital's Medicare SSI days and total inpatient days. In this final rule, CMS also clarifies that days in which a swing bed in a hospital, including a critical access hospital, is used for skilled nursing facility or nursing facility services are not to be included in determining a hospital's Medicare SSI days and total inpatient days, because those days are for nursing facility services rather than inpatient hospital services.

CMS finalizes its proposal to collect data from the HCRIS as of March 31 before the beginning of a SPRY. Similarly, MEDPAR files and SSI eligibility data will be as of that same March 31 date. It believes this snapshot would provide the most recent data to apply to the upcoming SPRY. Noting that some hospitals could be omitted from the data set (for example, because of late filing of a cost report), CMS will include in the data set any hospital that has filed a cost report dating back to at least September 30 from 3 years before, in order to capture as many hospitals as possible in the data set. CMS emphasizes that it will use only data from hospitals that file a Medicare cost report.

The agency also notes that for the 97th percentile determination for SPRYs beginning during FYs 2022, 2023 and 2024, it is currently pulling the data to allow for public release of the 97th percentile hospital lists shortly after the issuance of this final rule.

As a result of the snapshot approach, future revisions may occur in a hospital's most recent cost report available in HCRIS, as well as in the hospital's number of total inpatient days as reported in that most recent cost report and number of Medicare SSI days as determined from MEDPAR and SSI eligibility data sources. The agency will not modify the 97th percentile qualification results based on a request by one or more individual hospitals (or by one or more states, with respect to one or more individual hospitals) to update or reconsider hospital cost report, claims, or eligibility data. CMS does not believe it would be prudent or reasonable to continuously revisit the 97th percentile hospital qualifications based on changing cost report, claims, or eligibility data.

However, where CMS has made a mathematical or technical error, it finalizes allowing 1 year from the posting of the 97th percentile hospital lists for states, hospitals, CMS, or other interested parties to identify any mathematical or other similar technical error. Upon CMS verification that

an error occurred that affected the hospitals appearing on a list of 97th percentile hospitals for a given year, it will determine and publish a revised list as soon as practicable.

In addition, CMS finalizes its proposal to amend §447.295(d) to clarify the two different calculation methodologies and their application. Specifically, it would designate the pre-CAA 2021 methodology as paragraph (1) with modifications to reflect its general application before October 1, 2021, as well as the exception of its continued application after that date for 97th percentile hospitals. The proposal would also add the CAA-methodology in paragraph (2) with an effective date of SPRYs beginning on or after October 1, 2021 with a similar exception for 97th percentile hospitals. Finally, the special rule for 97th percentile hospitals that provides for the higher of the limits calculated under the two methodologies would be added in paragraph (3).

Selected Comments/Responses: Many commenters expressed opposition to the statutory changes required by section 203 of the CAA 2021, particularly regarding the financial impact that decreases in the hospital-specific DSH limits will have on hospitals and their ability to provide services. Commenters urged CMS to monitor the financial impacts on hospitals and to work with Congress to mitigate the potential negative effects of section 203 of the CAA 2021. CMS responds that it is required by statute to implement the new methodology for determining hospital-specific DSH limits, including the exception for 97th percentile hospitals. Nevertheless, it says there remains considerable flexibility for states in setting DSH state plan payment methodologies to the extent that these methodologies are consistent with applicable statutes and regulations. The agency says it intends to continue to monitor the financial impact that these statutory changes have on hospitals and to provide information and technical assistance as Congress may request, as necessary to address any negative impact on providers.

Several other commenters expressed support for the CMS proposals to implement these statutory provisions.

Several commenters asked CMS to clarify how it defines "primary payer" and when Medicaid is the primary payer for inpatient and outpatient hospital services provided to Medicaid beneficiaries. CMS says this rule does not change existing rules related to Medicaid's status as primary payer for a particular service, pointing to existing rules—for example, section 1902(a)(25)(A) of the SSA and §§433.135 through 433.154. Medicaid is generally the "payer of last resort"—that is, Medicaid only pays claims for covered items and services if there are no other liable third-party payers for the same items and services, which is a concept implied in the above statute and regulations.

Nevertheless, CMS elaborates on a particular nuance. Section 1923(g)(1)(B)(i) of the SSA, as amended by section 203 of the CAA 2021, specifies that the Medicaid shortfall portion of the hospital-specific DSH limit will be limited to costs and payments of furnishing hospital services to Medicaid enrollees for whom Medicaid "is the primary payor for such services." Previously, since the prior statutory language indicated that individuals need only have Medicaid eligibility (without regard to Medicaid coverage for the particular service), inpatient and outpatient hospital services for Medicaid eligible individuals should have been captured in the Medicaid shortfall, even where the individual's Medicaid benefits were limited and did not extend to inpatient or outpatient hospital services at all. CMS interprets the statutory change specifying that Medicaid

must be the primary payer "for such services" to direct a service-specific approach to determining Medicaid's status as primary payer. This is consistent with how, under the 2014 Uninsured Rule,[13] the agency determines an individual's status as uninsured for a particular hospital service.

In sum, to determine whether Medicaid is the primary payer for a given hospital service furnished to a Medicaid beneficiary, the beneficiary must have Medicaid coverage for the hospital service, and there must not be any third-party coverage that is primary for the particular hospital service. When Medicaid is determined to not be the primary payer for that service, then the associated costs and payments for that specific hospital service will not be included in the calculation of the hospital-specific DSH limit (unless so provided for a qualifying hospital under the 97th percentile exception). For example, for an individual who had reached Medicaid coverage limits before obtaining inpatient and/or outpatient hospital services, Medicaid would not be considered the primary payer for those hospital services, and as long as there is not third-party coverage for those services this individual would be considered uninsured for those hospital services and the associated costs and payments would be captured in the uninsured portion of the hospital-specific DSH limit calculation. This change does not affect the amount captured, but merely whether particular costs and payments are captured in the Medicaid or uninsured shortfall portion of the hospital-specific DSH limit calculation.

Commenters inquired about unique circumstances—for example, if an individual has Medicaid coverage, as well as Medicare Part B, but not Medicare Part A. Thus, a beneficiary who is an inpatient would have Medicare Part B cover services that CMS considers ancillary. In such a case, CMS says it will defer to states to determine if that third-party coverage is considered coverage for inpatient hospital services. However, given the fact that Part B is structured to pay for services other than inpatient hospital services, CMS believes the state could reasonably determine that Medicaid, not Medicare Part B, is the primary payer for the inpatient hospital stay. This would avoid an outcome where Medicaid pays for the majority of services, but a small Medicare Part B payment for an ancillary service results in the exclusion of all costs and payments for the stay from the hospital-specific DSH limit.

CMS said it will monitor how states handle these scenarios and assess whether the rule results in unexpected outcomes. If so, the agency may undertake additional rulemaking in the future.

One commenter requested CMS provide guidance on a SPRY audit year that includes the October 1, 2021, effective date and how hospital-specific DSH limits should be calculated. CMS responds that hospitals already use two separate cost reports to cover the entire period where the hospital's cost reporting period does not correspond exactly to the SPRY. It has previously provided guidance on this—for example, in a 2020 FAQ document on cost report proration (Question 21) and a 2020 CMCS Informational Bulletin. The agency expects the same proration approach here. For example, if a SPRY is from July 1, 2022 to June 30, 2023, and a hospital's cost report year end is December 31, regardless of section 203 of the CAA 2021, there is a need to prorate the hospital's cost report data from both its December 31, 2022 and December 31, 2023 cost reports to determine the hospital's hospital-specific DSH limit for the SPRY.

[13] "Medicaid Program; Disproportionate Share Hospital Payments—Uninsured Definition" (79 FR 71679; December 3, 2014).

Several commenters expressed support for determining a hospital's qualification for the 97th percentile exception for each SPRY on a prospective basis. CMS was urged to release the 97th percentile exception lists, including those applicable to SPRY 2022, as soon as possible, with several hospital associations and hospitals expressing that delays may impact their ability to plan for future DSH payments. CMS says it is committed to releasing the exception lists as soon as possible, after March 31 of each year, in advance of the October 1 date. Due to the timing of this final rule, it will be releasing the exception lists retroactively for the first three years (that is, for SPRYs beginning on or after October 1, 2021, to September 30, 2024). For SPRYs beginning on or after October 1, 2024, CMS will follow the established timeline so that states and hospitals will have the exception lists prior to October 1 each year, followed by a correction list if needed, as discussed earlier.

Many commenters requested that CMS release the rankings and associated data for all hospitals used to determine the qualification for the exemption for 97th percentile hospitals, rather than just those hospitals that qualify for the exemption. CMS intends to make available the data necessary for calculating the rankings of hospitals in the dataset, which may include hospital names, Medicare provider numbers, cost report record numbers, cost reporting period, cost report status, SSI/Part A days, and total inpatient days for each hospital and its distinct part psychiatric and rehabilitation units, as applicable.

A commenter indicated there could be multiple hospitals that file under a single Medicare cost report and provider number and asked whether a Medicare hospital provider number qualifying to meet the 97th percentile exception would qualify all the hospitals associated with that provider number. CMS says yes, this would qualify all hospitals under that CMS Certification Number (CCN) to meet the exception for 97th percentile hospitals, since the agency's determination uses each Medicare-participating hospital's cost report and the inpatient days for the relevant cost reporting period—all associated with the hospital's CCN as stated on the cost report and inclusive of the CCN of any psychiatric and/or rehabilitation distinct parts that provide hospital services.

D. Limitations on Aggregate Payments for DSHs Beginning October 1, 1992 (§447.297)

CMS finalizes its proposal to eliminate from its regulations the requirement that it publish annual DSH allotments in the Federal Register. Instead, it will post that information, as well as preliminary and final national expenditure targets, on its Medicaid.gov website and in the Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES).

It also strikes the specific date (April 1) by which final national targets and allotments must be published and instead indicates that they must be published as soon as practicable. Similarly, it removes the April 1 publication date to allow for Medicaid expenditures associated with the FY DSH allotment to be finalized.

Selected Comments/Responses: All but one of the commenters opposed this proposal, citing concerns about transparency since the MBES/CBES systems are not accessible to the general

public, and about accountability since Medicaid.gov is less formal than a Federal Register publication. CMS finalizes this proposal without modification and says it will ensure ongoing transparency by publishing final amounts on a publicly accessible page on Medicaid.gov instead of simply distributing to states through MBES/CBES. The agency believes posting to Medicaid.gov provides sufficient accountability regarding the accuracy of the final amounts. It already publishes many important documents and guidance on that website and says it will ensure the postings are clear with respect to the date they are published, with versions for any necessary changes.

E. Reporting Requirements (§447.299)

1. Calculating Medicaid Shortfall

CMS finalizes its proposal to revise existing DSH reporting requirements in clauses (6), (7), (10) and (16) of §447.299(c) to reflect the changes made by section 203 of the CAA 2021 described above—that is, only including costs for which Medicaid is the primary payer and the 97th percentile hospital exception. Those 4 clauses address the following:

- Inpatient and outpatient (IP/OP) Medicaid fee-for-service (FFS) basic rate payments paid to hospitals (§447.299(c)(6)),
- IP/OP Medicaid managed care organization payments (§447.299(c)(7)),
- Total costs for the hospital to furnish Medicaid IP/OP services (§447.299(c)(10)), and
- Total annual uncompensated care costs for IP/OP services (§447.299(c)(16)).

All the references in these clauses to Medicaid "eligible" individuals will be removed, with the text updated to indicate that only payments or costs, as the case may be, reported "in accordance with §447.295(d)" (see section II.C. above) should be included in these data elements.
The effective date for this provision is to FYs beginning on or after October 1, 2021, which aligns with the effective date of the CAA 2021.

Selected Comments/Responses: A few commenters recommended that the DSH audit indicate which hospitals met the exception for 97th percentile hospitals and which methodology had a higher hospital-specific DSH limit. While CMS agrees this would be useful information and suggests auditors provide this information in the independent certified audit, future rulemaking would be necessary to impose this as a requirement because it was not proposed as a required element of the audit.

2. Reporting DSH Overpayments

CMS finalizes its proposal to add a new data element to the existing DSH reporting requirements, re-designating existing paragraph (c)(21) as (c)(22) and adding a new (c)(21) requiring auditors to include in annual DSH reports the financial impact associated with audit findings. The agency states that this data element would improve the accuracy of identifying overpayments discovered in the DSH audit process and explains that audit findings could be related to missing or improper data, lack of documentation, non-compliance with federal statutes and/or regulations, or other identified deficiencies.

For purposes of this requirement, an audit finding would mean an issue identified in the independent certified audit required under §455.304 about the methodology for computing the hospital-specific DSH limit or the DSH payments made to the hospital, including compliance with the hospital-specific DSH limit as defined in §447.299(c)(16). CMS believes that requiring the quantification of these findings would limit the burden on states and CMS of performing follow-up reviews or audits. The agency notes that auditors would have the professional discretion and the flexibility to determine how to best quantify these amounts in the audit findings. However, if the actual financial impact could not be calculated, CMS will require a statement of the estimated financial impact for each audit finding identified in the independent certified audit that is not reflected in the other data elements identified in §447.299(c).

The agency finalizes defining actual financial impact as the total amount associated with audit findings calculated using the documentation sources identified in §455.304(c). The estimated financial impact means the total amount associated with audit findings calculated on the basis of the most reliable available information to quantify the amount of an audit finding in circumstances where complete and accurate information necessary to determine the actual financial impact is not available from the documentation sources identified in §455.304(c).

CMS also finalizes codifying its policy for the handling and reporting of overpayments identified through the annual independent certified DSH audits in a new paragraph (f) of §447.299. Under the policy, DSH payments found in the independent certified audit process to exceed hospital-specific cost limits are provider overpayments that must be returned to the federal government, or redistributed by the state to other qualifying hospitals, if redistribution is provided for under the approved Medicaid State plan.

In a new paragraph (g) of §447.299, states will be required to report any overpayment redistribution amounts to CMS using Form CMS-64 within 2 years from the date of discovery that a hospital-specific limit has been exceeded, as determined under §433.316(f) in accordance with a redistribution methodology in the approved Medicaid State plan. The state will have to report redistribution of DSH overpayments as separately identifiable decreasing adjustments reflecting the return of the overpayment and increasing adjustments representing the redistribution by the state. Both adjustments must correspond to the fiscal year DSH allotment and Medicaid SPRY of the related original DSH expenditure claimed by the state.

Selected Comments/Responses: A few commenters expressed concerns about the language regarding auditors' ability to provide an estimate of the financial impact. CMS strongly emphasizes that it expects auditors to calculate an actual financial impact of their audit findings wherever possible. Some states' contracts with auditors do not require any quantification of overpayments, leaving this critical activity incomplete following completion of the audit. By finalizing this new data element proposal, CMS intends to require that state contracts with auditors must require the auditor to take the extra step of quantifying the financial impact of their findings, based on the audit work already being performed. Moreover, CMS intends to stop the practice of a state's acceptance of auditor "caveats" unaccompanied by a statement of actual or estimated financial impact, which leaves unnecessary duplicative and burdensome work to the state and CMS to determine any associated overpayment amount.

On the other hand, CMS acknowledges that even where state contracts with auditors require the auditor to quantify the actual or estimated financial impact of any findings, there are rare circumstances where the financial impact of an identified issue cannot be quantified. CMS would allow the auditor to submit an estimated impact in these expectedly rare circumstances. In that case, CMS would not require states to treat the estimate an auditor produces as a determination of an overpayment amount. Consistent with the characterization of overpayments in §433.316(c)(1) through (3), an estimate would reflect an inability to calculate a specific amount and would not represent a quantified overpayment. It is CMS' expectation that more auditors, by employing appropriate methods at their professional discretion, have the ability to quantify these amounts than are currently being required to do so under their contracts with states. If an auditor is truly unable to quantify a finding or caveat using its best professional efforts, the auditor should recommend specific corrective action in its audit report, and CMS expects states to submit a corrective action plan as part of the final audit report for CMS approval.

A few commenters express concern regarding burden and auditors' ability to quantify data caveats, recommending instead that CMS target states with the highest DSH allotments for this new requirement or that CMS hire a vendor to perform all audits. Another commenter said CMS lacked data supporting the assertion that auditors could easily quantify their findings, or that it would be rare for an auditor to need to provide an estimate.

The agency disagrees that this new requirement will constitute a significant burden increase. If an auditor is already completing a full review of DSH documentation, then the information needed to calculate amounts should be readily available. CMS says that if a state finds there is a significant change in effort to meet this additional requirement, it could be an indication that previous audit contracts were too limited. The agency also notes that DSH audits are statutorily required under section 1923(j) of the SSA for states to perform the audit and submit an independent certified audit. Lastly, regarding the comment stating CMS lacked data supporting the assertion auditors could easily quantify their findings, the agency said it has heard from various auditors directly that they can provide more data but are not presently being requested by states to do so and is why CMS is confident it would be unlikely that an auditor would need to provide an estimated financial impact amount in more than rare circumstances.

F. Definitions (§455.301)

CMS finalizes what amounts to a conforming change to the current definition of the "independent certified audit" to include the requirement for auditors to quantify the financial impact of each audit finding, or caveat, on an individual basis, for each hospital, per the proposed new reporting requirement in §447.299(c)(21), described above. CMS did not receive comments on this provision.

G. Condition for Federal Financial Participation (FFP) (§455.304)

CMS finalizes conforming changes to the requirements for independent certified audit verifications to reflect revisions finalized to the independent certified data elements at §447.299(c)(6), (7), (10), and (16) (described in section II.E.1. above). The modifications to clauses (1), (3), (4), and (6) of §455.304(d) reflect the statutory changes made by section 203 of

the CAA 2021 updating the independent certified audit verifications as they relate to the treatment of Medicaid eligibles and third-party payers.

Essentially, the changes remove the reference in these clauses to Medicaid eligible individuals and update the text to indicate that only payments or costs, as the case may be, are determined in accordance with §447.295(d) (see section II.E. above). Thus, the changes made by section 203 of the CAA 2021 (that is, only including costs for which Medicaid is the primary payer and the 97th percentile hospital exception described above) would be incorporated into the requirements for independent certified audit reports.

These changes are applicable to fiscal years beginning on or after October 1, 2021, aligning with the effective date of the CAA 2021. CMS did not receive comments on this provision.

H. Process and Calculation of CHIP Allotments for FYs after FY 2008 (§457.609)

Current regulations at §457.609(h) give CMS the option to publish CHIP allotments in the Federal Register. It has not done so since the FY 2013 CHIP allotments. Instead, CMS notifies states of their CHIP allotments through email notifications or MBES/CBES. It finalizes striking from §457.609(h) the option to publish in the Federal Register the national CHIP allotment amounts and to instead post CHIP allotments in the MBES/CBES and at Medicaid.gov (or similar successor systems or websites) annually.

Selected Comments/Responses: Several commenters cited concerns about the lack of transparency of MBES/CBES publications, since they are not available to the public, as raised in the comments regarding DSH allotment publication in section II.C. above. CMS notes that, unlike the DSH allotment publication, current regulations give CMS the option to publish the CHIP allotments in the Federal Register. The new regulation commits CMS to publish final CHIP allotments on
Medicaid.gov, which is not currently done, thus increasing transparency for CHIP allotments. CMS finalizes its proposal without modification.

III. Retroactive Application of the Rule

As it has noted throughout the preamble, CMS reiterates that section 203 of the CAA 2021 requires that changes to the calculations of Medicaid hospital-specific DSH limits take effect on October 1, 2021, and apply to payment adjustments made under section 1923 of the SSA during fiscal years beginning on or after that date. Thus, these provisions of this rule apply retroactively.

IV. Information Collection Requirements

The rule establishes a new mandatory reporting requirement and modifies some existing DSH audit requirements (§447.299). The requirements would create a total annual burden of 150 hours at a cost of $14,976 and an average per state burden of 3 hours (150 hr / 50 states) and approximately $300 per state ($14,976 / 50 states).[14]

[14] The 50 states includes the District of Columbia but excludes Massachusetts, which does not complete DSH audits because its entire DSH allotment amount is diverted for payments under a section 1115 demonstration project.

V. Regulatory Impact Analysis

CMS examined the impacts of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96-354), section 1102(b) of the SSA, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995; Pub. L. 104-4), Executive Order 13132 on Federalism (August 4, 1999), and the Congressional Review Act (5 U.S.C. 804(2)).

Based on its estimates using a "no action" baseline, OMB's Office of Information and Regulatory Affairs has determined that this rulemaking is "significant." This "no action" baseline incorporates the statutory changes made by the CAA 2021 that do not require rulemaking to be in effect, such as the change to the definition of Medicaid shortfall. Additionally, the rule is not expected to have a significant economic impact on a substantial number of small entities.

CMS estimates the overall burden of adding the requirement for the calculation of the hospital-specific DSH limit for hospitals meeting the exception for 97th percentile hospitals as follows.

For states to assess which hospitals meet the exception, CMS estimates approximately 2 hours—that is, 1 hour at $80.36/hr for a financial specialist to prepare a spreadsheet report, and 1 hour at $135.76/hr for management and professional staff to review the report. In the aggregate, CMS estimates an ongoing annual burden of 100 hours (50 states x 2 hr/response x 1 response/year) at a cost of $10,806. Additionally, state auditors would spend an additional hour verifying the hospital-specific DSH limits for hospitals meeting the exception for 97th percentile hospitals. The estimated annual burden would be 1 hour per state (50 states x 1 hour) 50 hours x $83.40/hr for auditors to complete the audit at a cost of $4,170 per year. The total cost of this provision would be $14,976 ($10,806 + $4,170) and 150 hours, or $299.52 and 3 hours per state.

The additional DSH audit data reporting element creates a burden of 150 hours at a cost of $14,976, with an average of 3 hours, at a cost of $299.52 per state Medicaid agency per year.

CMS did not estimate any cost impact related to the DHRM BNF proposal because it merely clarifies how amounts are determined; the impact of the policy itself was accounted for in the 2019 final rule that finalized the factor amounts. Similarly, no cost impact is estimated for the policies to publish DSH and CHIP allotments through an alternative means.

CMS says the benefits of the rule include enhanced federal oversight of the Medicaid DSH program, improved accuracy of DSH audit overpayments identified through and collected as a result of annual DSH audits, clarity on certain existing Medicaid DSH policies, and reduced administrative burden.

CMS notes that this rule's policies will affect the calculation of the hospital-specific DSH limit established at section 1923(g) of the SSA, and some providers may see a decrease in their historic hospital-specific DSH limits. However, these effects are a direct result of statutory

changes rather than the regulatory ones. CMS observes that some providers may see an increase in their historic hospital-specific DSH limits, but this is again by reason of statutory rather than regulatory changes. It is also possible that lower hospital-specific DSH limits for some hospitals may result in states choosing to distribute higher DSH payments to hospitals that historically had not been paid at higher levels. CMS believes these changes will not affect the flexibility afforded states in setting DSH payment methodologies to the extent they are consistent with section 1923(c) of the SSA and all other applicable statutes and regulations.

CMS describes alternative policies it considered for the data sources used for purposes of determining whether a hospital qualifies as a 97th percentile hospital.