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Summary of Final Disproportionate Share Hospital (DSH) Third-Party Payer (TPP) Rule

Link to final rule: 2024-03542.pdf (govinfo.gov)
Link to proposed rule (from February 2023): 2023-03673.pdf (govinfo.gov)

Background

State Medicaid programs are required by federal law to make Medicaid Disproportionate Share Hospital (DSH) payments to eligible hospitals that serve a significant number of Medicaid and uninsured individuals. These payments are capped by the hospital specific DSH limit ("HSL"), which is the difference between the hospital's costs for providing inpatient and outpatient hospital services to Medicaid patients and the uninsured, and the payments received for those services.

CMS policy around DSH calculations has been the subject of years of litigation brought by hospitals. The hospitals first challenged CMS informal guidance --that in calculating HSLs, payments received by a hospital for Medicaid patients with other health care coverage, including Medicare, must be considered in determining the hospital's Medicaid costs -- and then challenged CMS' 2017 final rule to codify the guidance in regulation (see 42 C.F.R. § 447.299(c)(10)). After several federal appellate court decisions upheld the DSH methodology required by CMS' 2017 final rule, the Consolidated Appropriations Act (CAA) of 2021 modified the DSH methodology; effective October 1, 2021, only costs and payments for services furnished to beneficiaries for whom Medicaid is the primary payer for such services may be included in the calculation. As a result, costs and payments for services provided to Medicaid beneficiaries with other sources of coverage, including Medicare and commercial insurance, must be excluded from the HSL calculation. The CAA of 2021 also provided a limited exception to this methodology for certain hospitals ("97th percentile hospitals"), which is described below.

Following enactment of the CAA of 2021, CMS issued a State Medicaid Directors letter in December 2021 providing additional guidance and a proposed rule on February 24, 2023 to implement the CAA modifications. See 88 Fed. Reg. 11865 (Feb. 24, 2023). On February 23, 2024, CMS issued a final rule implementing the CAA of 2021 changes to the DSH methodology. *See* 89 Fed. Reg. 13916 (Feb. 23, 2024). In addition, CMS also included several other provisions in the final rule that are intended to mitigate Medicaid DSH overpayments and align with recommendations from MACPAC in 2019 to enhance administrative efficiencies, including new requirements around identifying and addressing DSH overpayments.

*****Note: This rule is separate from the proposed DSH allotment reductions of $8 billion that have been delayed as part of the Continuing Resolution, which runs through March 22, 2024*****

What key changes are included in the final DSH TPP rule?

Methodology for Calculating Hospital-Specific DSH Limits:

- This rule incorporates the CAA OF 2021 limitations on how the Medicaid portion of hospital specific DSH limits are calculated by requiring states to exclude from its Medicaid DSH shortfall calculations any costs and payments for services provided to Medicaid patients for whom Medicaid is not the primary payer. Under the previous policy, states determined hospitals' Medicaid shortfalls by including annual costs and payments for all Medicaid eligible patients including those with Medicare (i.e. dual eligibles) or with primary private health insurance coverage. The rule specifies that *"only costs and payments for inpatient and outpatient hospital services for which Medicaid is the primary payer* ***under a single, service-specific determination*** *can be included in Medicaid shortfall portion of hospital-specific DSH limit."* **The rule provides an exception to this DSH calculation limitation for hospitals defined as "97th Percentile Hospitals" which is discussed below.**

- DSH allotment amounts included in budget neutrality calculations in 1115 waivers approved after July 31, 2009 would also be subject to reduction based on new limit calculations using average Medicaid volume factor (HMF) and uncompensated care factor (HUF) reduction percentages.

New Requirements Related to DSH Overpayments:

- States are required to submit an independent certified audit and an annual report to CMS containing specified information about DSH payments made to each DSH hospital. States currently have 3 years beyond the applicable FFY to submit DSH audits and 2 years following the identification of an overpayment to redistribute payments, as needed, under the State plan. This rule finalizes the date of discovery of a DSH overpayment as the date when the DSH audit is submitted to CMS.
- DSH auditors are now required to determine whether "the State made DSH payments that exceeded any hospital's hospital-specific DSH limit in the Medicaid State plan rate year under audit," and to quantify the financial impact of any finding on a hospital-specific basis, including impact of missing data, to limit the burden on States and CMS to perform follow-up reviews or audits. Currently, some state contracts with auditors do not require any quantifications of overpayments.
- Despite comments submitted on the proposed DSH TPP rule related to concerns around transparency and accessibility of information, CMS is eliminating the requirement to publish annual DSH allotments in the Federal Register and will instead be posting this information in Medicaid Budget and Expenditure System (MBES/CBES) and at Medicaid.gov.

Which hospitals are exempt from this new DSH limit methodology?

The rule provides an exception to the new DSH limit calculation for safety-net hospitals with the highest concentrations of low-income patients, defined as **those hospitals in the 97th percentile or above of all hospitals nationwide with respect to the number of inpatient days or percentage of total inpatient days,** for the hospital's most recent cost reporting period, made up of patients who, for such days, were entitled to benefits under Part A of Title XVIII and Supplemental Security Income (SSI) benefits under Title XVI (excluding any State supplementary benefits paid). For these hospitals, the hospital specific DSH limit is the higher of a limit calculated using costs and payments related to beneficiaries for whom Medicaid in the primary payer (the post-CAA required method) or a limit that includes all Medicaid eligibles, specifically those for whom Medicare or private insurance is the primary payer.

When does the new DSH limit calculation methodology take effect?

For any State Plan Rate Year (SPRY) beginning on or after October 1, 2021, states and hospitals must retrospectively comply with this new DSH calculation guidance. CMS does not have the statutory authority to apply the effective date of the amendments made by CAA 2021 to periods before Oct. 1, 2021. For all other provisions of the final rule, including those related to the treatment of quantified audit findings as overpayments, the effective date is April 23, 2024.
To identify the 97 percentile hospitals that are exempt, CMS will generate two lists based on Medicare cost reports and claims data: (1) one list based on total number of inpatient days for patients entitled to both Medicare Part A benefits and SSI benefits, and (2) a second list based on inpatient day percentage. Note that CMS will exclude hospitals with no Medicare cost report in HCRIS for the relevant reporting period. Data used to generate lists will also be shared on an annual basis, including SSI/Part A days, total inpatient days for each hospital and distinct psych/rehab units, if applicable.

- ***For State Plan Rate Years (SPRY) that began on or after October 1, 2021 through September 30, 2024:*** Exemptions will be applied retroactively and CMS will be releasing the exception lists as soon as possible, although CMS has not committed to a specific timeframe.
- ***For SPRYs beginning on or after October 1, 2024:*** CMS has committed to releasing the exception lists annually, on a prospective basis, sometime after March 31 of each year, in advance of the October 1 date**.**

What has the reaction been from hospital associations?

- In response to the proposed and final DSH rules, America's Essential Hospitals (AEH) and the American Hospital Association (AHA) have pressed CMS to share the hospital exception lists as soon as possible to allow adequate time to prepare for any repayments owed retrospectively for SPRYs prior to 2024. They included comments on the proposed DSH TPP rule in February 2023 requesting that CMS publish the exception lists at least 60 days prior to the October 1 date to which the exception lists will apply.
- Associations also noted disappointment with CMS' decision to limit exception eligibility to those hospitals that currently submit Medicare cost reports, as this lowers the number of hospitals that qualify for the exception and raises concerns about the impact of these DSH cuts on select hospitals' finances.

What are the potential implications?

- Select safety-net hospitals may receive lower Medicaid DSH payments. This regulation implies there will likely be cuts to DSH payments for those safety net hospitals that are not exempt and that had previously included Medicare costs and Medicare payments related to dual eligibles or other third-party payors in calculating their hospital specific DSH limits.
- Until specific hospital exception lists are made available by CMS, however, it is unclear what the total financial impact will be nor which hospitals will specifically be impacted.