American Hospital Association™
Advancing Health in America

Special Bulletin

December 15, 2021

CMS Releases Medicaid Guidance to States on Supplemental Payment Reporting and DSH Requirements

The Centers for Medicare & Medicaid Services (CMS) in a Dec. 10 letter to state Medicaid directors provided state agencies with guidance pertaining to two provisions of the Consolidated Appropriations Act (CAA) of 2021. Section 202 of the CAA specified new state reporting requirements for non-disproportionate share hospital (DSH) supplemental payments. Section 203 addressed the method for calculating the hospital-specific Medicaid DSH limits. Both provisions have statutory effective dates of Oct. 1, 2021.

The guidance outlines CMS' plans to implement these new requirements while acknowledging this guidance is not complete. The agency notes that additional regulatory guidance will be needed, including further rulemaking for the Medicaid DSH hospital-specific limits provision.

The following is a summary of the guidance contained in the Dec. 10 letter.

New Supplemental Payment Reporting Requirements: Section 202 of the CCA instructed CMS to establish a new reporting system for state supplemental payments. The statute specifically requires states to report the following:

- An explanation of the purpose and intent for the supplement payment and how such payments are consistent with the Medicaid statute's "equal access" standard, which requires that provider payments are consistent with efficiency, economy, and quality of care objectives to ensure Medicaid beneficiary access to care;
- The criteria the state uses for determining eligible providers for supplemental payments;
- A description of the methodology to calculate the amount of supplemental payments and how they are to be distributed, including provider-specific level data;
- Assurance that total payments, including supplemental payments to an inpatient hospital, does not exceed the applicable Medicaid upper payment limits (UPL); and
- Submission of CMS' UPL demonstration documentation.

As CMS moves forward with implementing this new reporting requirement, the agency intends to build on current reporting and state plan amendment (SPA) submission requirements. According to CMS, while the new reporting requirements add provider-specific level data, states are curently required to have documentation on provider level

data available. The SPA process, UPL demonstration documentation, and the budget expenditure reporting through Form CMS-64 all requrie that states have appropriate documentation such as provider-specific level payment informaiton if requested by CMS. In addition, the agency is designating the Medicaid Budget and Expenditure System (MBES) as the system for which states will submit the newly required information. The MBES currently allows states to submit their Form CMS-64 electronically directly to the CMS Data Center. CMS is in the process of modifying the current MBES reporting system and will provide state Medicaid agencies with further instructions, as well as additional reporting forms. Finally, the agency plans to submit any new reporting forms through the Paperwork Reduction Act review process for approval by the Office of Management and Budget.

Most of the data collected to implement the new reporting requirements will be in the form of narratives and state assurances, which is similar to the current SPA review process. However, CMS plans to collect quantitative data detailing the amount designated for each provider approved to receive supplemental payments, as well as the amount designated for each provider that is proposed to receive supplemental payments where the state knows the amount. Where the amount is unknown by the state, the new MBES form will collect data on the total amount of the supplemental payments for the fiscal years available for the eligible providers receiving such supplemental payments.

States also will be required to submit the base rate in addition to the supplemental payments amounts, such that CMS can ensure that the state is meeting the “equal access” standard and verify state assurances with regard to this standard. Supplemental payments made under 1115 Medicaid waiver authority, including uncompensated care pool payments, delivery system reform incentive payments (DSRIP), and applicable designated state health program payments (DSHP), will be included in the reporting requirements. In addition, states will be required to report supplemental payments for which a regulatory UPL does not apply, such as supplemental payments for physicians or other Medicaid practitioners. The new reporting requirements, however, will not apply to Medicaid home and community-based waivers that permit supplemental payments made to providers for home and community-based services.

CMS expects states to begin reporting supplemental payment data for payments beginning Oct. 1 – the first quarter of the federal fiscal year 2022 – and for which the state is claiming federal matching dollars. The agency expects states to submit the required supplemental payment information during routine reviews for SPAs, 1115 waivers and UPL programs, and CMS will conduct oversight to ensure state Medicaid expenditures are allowable and accurate. However, the agency acknowledges that state Medicaid agencies face considerable work to comply with the reporting requirements, especially with the shortened time frame. As such, CMS commits to providing states with technical assitance and further guidance.

Changes to Medicaid Shortfall Calculations: Section 203 of the CAA made changes to the methodology for calculating hospital-specific Medicaid DSH limits. The hospital-specific DSH limit is based on a calulation of the hospital's Medicaid shortfall (Medicaid payments below the cost of providing care), the cost of care provided to the uninsured, and any payments received for that care. Specifically, the changes made by Section 203 address the method for calculating the Medicaid shortfall so that the calculation only includes the costs and payments for hospital services furnished to patients for whom Medicaid is the primary payer. Costs and payments associated with services provided Medicaid-eligible individuals for whom Medicaid is not the primary payer will be excluded. Those individuals include Medicare dually-eligible individuals or certain individuals with commercial coverage. Section 203 contains an exception for certain hospitals that provide a high volume of care to Medicare dually-eligible indiviudals. Hospitals are eligible for this exception if they are in the 97th percentile or above of all hospitals with respect to their proportion of Medicare supplemental security income (SSI) days. If a hospital meets the eligiblity threshold for this exception, the hospital will calculate their hospital-specific DSH limit using the higher of the method in place as of Jan. 1 2020 (proir to the passage of Section 203 in the CCA) or the method in effect as of Oct. 1, 2021.

The agency, however, notes that there is no readily available source of data to determine this exception. CMS points to several issues between the available Medicare SSI data (and the ratio that is calculated using this data) and the statutory requirements in Section 203. For example, current reporting on SSI days is used for purposes of determining a hospital's Medicare DSH threshold and that formula only takes into account SSI days for which the patient is also eligible for Medicare Part A. The data does not include the total days attributable to all patients with SSI, as would be needed to comply with Section 203. In addition, the SSI data is not reported for all hospitals that receive Medicaid DSH payments, such as critcal access hospitals and psychiatric hospitals. Lastly, the annually published SSI days are based on the federal fiscal year and not on the Medicare cost reporting periods; however, Section 203 requries that the exception be based on information from the hospitals' latest cost reporting period. Because of these data limitaitons, CMS intends to develop a data source to determine which hospitals would qualify for this exception and make that data source availble to states. As such, the agency plans to provide additional guidance, including through future rulemaking, to address this exception. CMS does underscore that the statutory changes are self implementing and encourages states to make appropriate changes to comply. However, the agency also notes that given the three-year data lag in state Medicaid DSH audit reporting, that audits affected by the statutory changes of Section 203 would not be due to CMS until the end of 2025.

NEXT STEPS

Further guidance on both of these statutory provisions is forthcoming from CMS. AHA will provide updates as they are made available. If you have questions, please contact AHA at 800-424-4301.