



Disparities in Healthcare

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The Calculation of Uncompensated Care Costs in Medicaid DSH Audits: Where Do We Stand?



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The Medicaid program requires states to ensure that payments to hospitals “take into account...the situation of hospitals which serve a disproportionate number of low-income patients with special needs.”¹ Accordingly, any hospital that treats a disproportionate share of Medicaid patients is entitled to certain “payment adjustment(s).”² These payment adjustments are ordinarily referred to as disproportionate share hospital (“DSH”) payments.

However, the amount of DSH payments a hospital is entitled to is not unlimited. Rather, the Medicaid Act sets a hospital-specific limit (“HSL”) for DSH payments defined as “the costs incurred during the year of furnishing hospital services” to Medicaid-eligible individuals “as determined by the Secretary and net of payments” under the Medicaid Act.³

To ensure compliance with statutory requirements the Medicaid Act requires each state to perform an audit and provide an annual report of its DSH program.⁴ The audit must confirm, among other things, that: (1) only the uncompensated costs of providing care to Medicaid-eligible and uninsured patients is included in the calculation of the HSL; (2) the state included all Medicaid payments, including supplemental payments, in the calculation of the HSL; and (3) the state has separately documented and retained records of all Medicaid and uninsured costs and expenditures used in determining payment adjustments.⁵

To implement the auditing and reporting requirements, on December 9, 2008, the Centers for Medicare and Medicaid Services (“CMS”) issued a Final Rule that made two changes to the previously existing regulations (the “2008 Rule”).⁶ First, the 2008 Rule required states to submit on an annual basis certain information “for each DSH hospital to which the state made a DSH payment in order to permit verification of the appropriateness of such payments.”⁷ This information includes the hospital’s “total annual uncompensated care costs” which is defined as:

“...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 regular Medicaid rate payments, Medicaid managed care organization payments, supplemental/enhance Medicaid payments, uninsured revenues, and Section 1011 payments for inpatient and outpatient hospital services.”⁸

Second, the 2008 Rule required the annual audit to verify, among other things, that:

“[O]nly uncompensated care costs of furnishing inpatient and outpatient hospital services to Medicaid-eligible individuals and individuals with no third-party coverage for the inpatient and outpatient hospital services they received as described in Section 1923(g)(1)(A) of the Act are eligible for inclusion in the calculation of the hospital-specific disproportionate share ... payment limit.”⁹

Subsequent to the adoption of the 2008 Rule, on January 10, 2010, CMS posted answers to “frequently asked questions” (“FAQ”) regarding DSH audit reporting requirements on its website. FAQ 33 asked whether “days, costs and revenues associated with patients that have both Medicaid and private insurance coverage” would be included when calculating the DSH limit. In response CMS stated that “days, costs and revenues associated with patients that are eligible for Medicaid and also have private insurance should be included in the calculation of the hospital-specific DSH limit.” Similarly, FAQ 34 asked “[u]nder what circumstances should [hospitals] include Medicare payments” for dual eligible patients in the calculation of uncompensated care costs. CMS’s answer indicated that hospitals must “take into account...all Medicare and Medicaid payments made on behalf of dual eligibles” when calculating uncompensated care costs.

Thereafter, numerous hospitals asserted challenges, in various courts across the nation, asserting that FAQs 33 and 34 were unlawful amendments to the 2008 Rule, which made no reference to the inclusion of Medicare and private insurance payments in the calculation of uncompensated care costs. Each court that has addressed the issue has found the FAQs invalid, and issued either preliminary or permanent injunctions pro-

hibiting their enforcement, on the basis that CMS violated the Administrative Procedure Act (“APA”) by failing to properly adopt the policies embodied therein in accordance with the notice and comment provisions of the APA.¹⁰

In response to the challenges to the manner in which CMS adopted the policies, on August 15, 2016, CMS published a notice of proposed rulemaking, which was intended to “make clearer . . . an existing interpretation,” as embodied in FAQs 33 and 34, that “uncompensated care costs include only those costs for Medicaid individuals that remain after accounting for payments received by hospitals by or on behalf of Medicaid-eligible individuals, including Medicare and other third-party payments that compensate the hospitals for care furnished to such individuals.”¹¹

On April 3, 2017, after receiving 161 comments to the proposed rulemaking, CMS published the Final Rule entitled “Medicaid Program: Disproportionate Share Hospital Payments – Treatment of Third-Party Payers in Calculating Uncompensated Care Costs” (the “2017 Rule”).¹² The 2017 Rule, which became effective June 2, 2017, provides that uncompensated care costs “[a]re defined as costs net of third-party payments including, but not limited to, payments by Medicare and private insurance.”¹³

Nevertheless, the adoption of the 2017 Rule has not stopped challenges to CMS’s policy. Since the adoption of the 2017 Rule, two additional courts, the United States District Court for the Western District of Missouri in *Missouri Hospital Ass’n v. Hargan* and the United States District Court for the District of Columbia in *Children’s Hosp. Ass’n of Texas v. Azar*, have addressed the calculation of uncompensated care costs. Consistent with earlier decisions, both courts found that CMS violated the APA by failing to adopt the policies embodied in the FAQs in accordance with the notice and comment provisions of the APA.¹⁴

Both of these courts went a step further and also held the 2017 Rule invalid because it contradicts the plain language of the Medicaid Statute, which states that DSH payments cannot exceed:

“[T]he costs incurred during the year of furnishing hospital services (as determined by the Secretary and net of payments under this subchapter, other than under this section, and by uninsured patients) by the hospital to individuals who either are eligible for medical assistance under the state plan or have no health insurance (or other source of third-party coverage) for services provided during the year.”¹⁵

Specifically, the courts found this language unambiguously indicates which payments can be subtracted from total costs incurred during the year by hospitals: (1) “payments under this subchapter,” which the courts found to refer specifically to payments made by Medicaid; and (2) payments made by uninsured patients. Because the Medicaid statute makes no reference to subtracting other third-party payments made on behalf of Medicaid-eligible patients from the total costs incurred, the

courts concluded that CMS exceeded its authority in adopting the 2017 Rule.¹⁶ Accordingly, the *Missouri Hospital Ass’n* court enjoined the enforcement of the 2017 Rule, and the *Children’s Hosp. Ass’n of Texas* court vacated the 2017 Rule in its entirety.¹⁷

In light of these court decisions, as of December 30, 2018, CMS has withdrawn FAQs 33 and 34 from its January 10, 2010 Medicaid DSH guidance. As a result, FAQs 33 and 34 are no longer in effect and CMS will accept revised DSH audits that cover hospital services furnished before June 2, 2017, when the 2017 Rule was adopted. CMS maintains that hospital services performed after June 2, 2017 are still governed by the 2017 Rule; however, CMS has indicated that it will not enforce the 2017 Rule as long as the decision in *Children’s Hospital Ass’n of Texas* remains in effect. That decision is currently pending appeal before the United States Court of Appeals for the D.C. Circuit. Accordingly, at this time CMS is not requiring the inclusion of private insurance and Medicare payments in the calculation of uncompensated care costs, but nevertheless will require it for hospital services performed post June 2, 2017 if it is successful on appeal.

Given the number of courts that have considered this issue, and the impact of the decision on hospital reimbursement nationwide, it appears likely this dispute will ultimately need to be resolved by the Supreme Court of the United States. However, providers can expect there to likely be several other lower court decisions before the issue is finally addressed by the Supreme Court.

About the author

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Footnotes

¹42 U.S.C. § 1396a(13)(A)(iv).

²*Id.* § 1396r-4(b) and (c).

³*Id.* § 1396r-4(g)(1)(A).

⁴*Id.* § 1396r-4(g)(1)(A).

⁵*Id.* § 1396r-4(g)(1)(A).

⁶See 73 Fed. Reg. 77904 (Dec. 19, 2008).

⁷*Id.* at 77950.

⁸*Id.* at 77950; 42 C.F.R. § 447.229(c)(16).

⁹73 Fed. Reg. at 77951; 42 C.F.R. § 445.304.

¹⁰See *Texas Children’s Hospital v. Burwell*, 76 F. Supp.3d 224 (D.D.C. 2014); *New Hampshire Hospital Ass’n v. Burwell*, 2017 WL 822094 (D.N.H. Mar. 2, 2017); *Children’s Hosp. of the King’s Daughters, Inc. v. Price*, 258 F.Supp.3d 672 (E.D. Va. 2017); *Tennessee Hosp. Ass’n v. Price*, 2017 WL 2703540 (M.D. Tenn. June 21, 2017); *Children’s Health Care v. Centers for Medicare & Medicaid Servs.*, 2017 WL 366758 (D. Minn. June 26, 2017).

¹¹81 Fed. Reg. 53980, 53981 (Aug. 15, 2016).

¹²82 Fed. Reg. 16114-02, 16117 (Apr. 3, 2017).

¹³42 C.F.R. § 447.229(c)(10)(i).

¹⁴See *Missouri Hospital Ass’n v. Hargan*, 2018 WL 814589 (W.D. Mo. Feb. 9, 2018); *Children’s Hosp. Ass’n of Texas v. Azar*, 300 F. Supp.3d 190 (D. D.C. 2018).

¹⁵42 U.S.C. § 1396f-5(g)(1)(A).

¹⁶*Missouri Hospital Ass’n*, 2018 WL at *10-12; *Children’s Hosp. Ass’n of Texas*, 300 F. Supp.3d at 205-210.

¹⁷*Missouri Hospital Ass’n*, 2018 WL at *13; *Children’s Hosp. Ass’n of Texas*, 300 F. Supp.3d at 210-211.