

Allowable Uninsured Charges/Costs Defined

42 CFR Parts 447 and 455
[CMS-2198-F]
RIN 0938-AN09
Medicaid Program; Disproportionate
Share Hospital Payments

CMS issued a final rule regarding DSH audits in the December 19, 2008 Federal Register. The rule does not alter any fundamental requirements or distribution of DSH allotments. Rather, the purpose of the rule is to verify the data, related calculations and documentation used by the states in distribution and federal reporting of these funds from the 2005 SFY forward. Clifton-Gunderson will be the firm administering the audits. The final rule itself and an abbreviated version are available on their [website](#). Please recall that it is the hospital's responsibility to maintain the justification and documentation of all information provided by the provider.

CMS is allowing a transition period through the 2010 state plan year, therefore in 2011, these results will begin impacting the states DSH allotment. Current audits begin with SFY 2005. These findings may be used to redistribute hospital-specific allocations.

The CMS proposed DHS audit rule was very confusing regarding the use of the term "bad debt". Unfortunately, CMS' own definition of bad debt in the final rule further complicates the matter. The rule states that "*Bad debt arises when there is non-payment on behalf of an individual who has third party coverage*". This definition confused many commenters as it excludes uninsured charges that have also been written off as bad debt. Other commenters feared that once an uninsured account has been written off as bad debt, it cannot be used to calculate hospital-specific DSH. To clarify CMS wrote:

Per CMS, "the statutory definition of uncompensated care includes the costs of furnishing hospital services to uninsured patients, minus the payments actually received from those patients....As long as the costs are for services furnished to uninsured patients, they (uninsured accounts written off as bad debt) may be included in the calculation of the hospital-specific limit, regardless of whether the hospital treats the costs as bad debt on its own books."

Another subject of confusion throughout the document was the large self-pay balances created by high-deductible and limited coverage plans. CMS explained that costs for patients with any form of third party coverage at all should not be included in the calculation of the DSH limit. This includes covered charges denied in whole or in part by the carrier (to include Medicaid MCOs) for any reason. This includes denials due to improper billing (for example, lack of a precertification).

CMS verified that hospitals may claim total or gross uninsured charges even if discounts are given to the uninsured (charity or otherwise). Payments decrease the amount that can be claimed as eligible charges for an account Discounts do not.

Finally, in § 455.304 Condition for Federal financial participation (FFP), page 77951 CMS again verified that overages in traditional Medicaid and Medicaid MCO payments must be netted against the uninsured cost in the hospital-specific DSH distributions.

(4) Verification 4: For purposes of this hospital-specific limit calculation, any Medicaid payments (including regular Medicaid fee-for-service rate payments, supplemental/enhanced Medicaid payments, and Medicaid managed care organization payments) made to a disproportionate share hospital for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals, which are in excess of the Medicaid incurred costs of such services, are applied against the uncompensated care costs of furnishing inpatient hospital and outpatient hospital services to individuals with no source of third party coverage for such services.