

## ADVISORY | States

January 17, 2012

### CMS PROPOSED REGULATION TO BROADEN THE DEFINITION OF UNCOMPENSATED COSTS

In a welcome move, the Centers for Medicare & Medicaid Services (CMS) recently released for publication in the Federal Register a proposed rule that broadens the definition of “uninsured” for purposes of calculating costs reimbursable under the disproportionate share hospital (DSH) program. It is expected to be published in the Federal Register on January 18th. A copy of the proposed rule is available [here](#).

#### BACKGROUND

Since 1993, the Medicaid statute has limited DSH payments for any hospital to 100 percent of the cost during a year of furnishing hospital services (net of other Medicaid payments) to persons who either were Medicaid-eligible or had no health insurance or other source of third party coverage for services provided during the year. Social Security Act, § 1923(g). In 1994, HCFA, the predecessor agency to CMS, issued guidance confirming that a patient was not considered insured if he/she did not have insurance for the service provided. That remained the accepted definition until December 2008, when CMS issued its regulations to implement the DSH auditing and reporting requirements authorized by Congress in 2003. In the preamble discussing and explaining these regulations CMS altered its definition of “insured” to mean anyone with health insurance (creditable coverage) or other source of third party coverage, whether or not it covered the service actually provided. See 73 Fed. Reg. 77904 (December 19, 2008).

The change in the definition of “insured” came as a surprise, for it was not set forth in the proposed DSH audit and reporting regulations nor mentioned in the preamble to the proposed regulations. Moreover, the change was not reflected in the final regulations themselves, which defined “uncompensated care costs” as those for furnishing services to individuals with “no source of third party coverage for the hospitals services they receive.” 42 C.F.R. § 447.299(c)(16). Nonetheless, CMS had advised states that the definition set forth in the preamble represented its current application of the provision limiting DSH payments to no more than uncompensated costs.

States have remonstrated with CMS, contending that the new, more restrictive, definition was not consistent with the statute, which refers to insurance “for services provided,” nor with the purpose of the DSH provisions to assist hospitals that provide care for which they are not paid. CMS has now responded by issuing a proposal to modify its DSH regulations to incorporate the original definition of “insured” as meaning coverage for the service actually provided by the hospital.

#### PROPOSED RULE

The proposal would modify 42 C.F.R. Part 447 by adding a new section 447.295 that defines persons with no health insurance (or other source of third party coverage) to mean those who have “no source of third party coverage for the specific inpatient hospital or outpatient hospital service

furnished by the hospital.” This means that even if an individual has some health insurance, he/she will be considered uninsured with respect to a hospital service that is not covered by the insurance policy. The definition goes on to explain that where there are lifetime or annual coverage limits imposed by the insurer (or other third party payer) services “beyond the limit” would not be considered to be covered by insurance, and thus could be included in the calculation of uncompensated costs. For Native Americans, Indian Health Service and tribal coverage is considered to be third party coverage only when services are provided directly or when they are authorized for coverage through contract health service programs.

The preamble to the proposed rule confirms that bad debt, or unpaid co-payments and deductibles, or payer discounts may not be included in the calculation of uncompensated costs. This has been the consistent CMS position.

The proposal will have a particular salutary effect on psychiatric hospitals. Under the rules currently in place, CMS does not permit a hospital to treat Medicare patients as “uninsured,” even if they have exhausted annual and lifetime limits. Under the current rules, only the costs of dually-eligible Medicare patients may be counted, because they are considered unreimbursed “Medicaid” (not uninsured) costs. The proposal would permit a psychiatric hospitals to treat Medicare patients as uninsured once their Medicare benefits are exhausted.

## PRISONER CARE

The proposed rule also deals with the treatment of prisoners, defined as those involuntarily in “secure custody as a result of criminal charges,” or inmates in public institutions. They are considered to have a source of third party coverage, based on the asserted obligation of the custodial agency to provide for their care. Costs associated with hospital services to persons in these categories are not to be included in calculating the hospital-specific DSH limits. This position is consistent with guidance provided by CMS in 2002 (State Medicaid Director Letter #02-013, August 16, 2002). While CMS confirms their position that prisoners may not be considered “uninsured” for DSH purposes, historically it has permitted Medicaid to pay for inpatient care provided to Medicaid-eligible prisoners (provided that the prisoner is transferred out of the prison to the hospital). We do not believe the current proposal would preclude a State from reimbursing unreimbursed Medicaid (not uninsured) costs in this situation.

## EFFECTIVE DATE

The preamble states that the proposed clarification would be effective for DSH audits and reports submitted following the effective date of the rule. It states that this will avoid “unintended, and potentially significant, financial impact resulting from the 2008 DSH final rule.” Under that rule, DSH audits would not be “given weight” for Medicaid state plan years prior to 2011. This has been understood to mean that the audits would not be used to adjust (lower) federal participation in DSH payments prior to 2011 that were based on state prospective estimates of hospitals’ uncompensated costs. The audit reports for 2011, the first year that such adjustments would be made, will not be due until 2014. We take the statement in the proposed regulation to mean that the final regulation will be issued prior to the due date for the 2011 audits, and that the new definition of “uninsured” would apply to the audits for that year and the years to follow.

## COMMENTS

CMS’s acknowledgement that the 2008 narrowing of the definition of uncompensated costs was unwarranted and its willingness to amend its regulation to enshrine the previous definition is most

welcome. Comments on the proposal will be due 30 days after Federal Register publication, and we believe that state Medicaid agencies should support the proposal. To that end, we will circulate shortly a brief comment document that urges immediate adoption of the proposed regulation, and seeks confirmation of our understanding that the soon-to-be-superseded definition will not have any adverse financial consequences for states.

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