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**SMD# 21-xxx**

**RE: New Supplemental Payment Reporting and Medicaid Disproportionate Share Hospital Requirements under the Consolidated Appropriations Act, 2021**

Dear State Medicaid Director:

The Consolidated Appropriations Act, 2021 (CAA) was enacted on December 27, 2020.<sup>1</sup> It established a number of new requirements for state Medicaid programs, including, in Division CC, Title II, Section 202 (section 202), the addition of section 1903(bb) of the Social Security Act (the Act) to specify new supplemental payment reporting requirements. As defined in section 1903(bb) (2) of the Act, supplemental payments are payments to providers that are in addition to any base payment made to the provider under the state plan or demonstration authority, not including disproportionate share hospital (DSH) payments under section 1923 of the Act. The CAA also amended section 1923(g) of the Act, which describes the methodology for calculating hospital-specific Medicaid DSH limits, in Division CC, Title II, Section 203 of the CAA (section 203). This letter discusses new requirements related to supplemental payments, as well as new requirements for DSH.

This guidance discusses new statutory supplemental payments reporting provisions, describing new requirements in section 1903(bb) of the Act in the context of existing requirements for a state plan amendment (SPA) that would provide for supplemental payments, upper payment limit (UPL) demonstrations, and claiming Medicaid expenditures for federal financial participation, as well as the Secretary's authority to require reports under section 1902(a)(6) of the Act and 42 C.F.R. § 431.16, in the form and containing such information as the Secretary may require. This letter presents general information on the new statutory requirements, describes processes available to states to comply, and provides technical information to facilitate states' compliance with the statute. CMS may provide additional guidance on these requirements in the future. As indicated below, CMS intends to undergo notice-and-comment rulemaking to update the regulatory reporting requirements for Medicaid DSH payments to reflect the statutory changes to section 1923(g) of the Act.

**Section 1. New Supplemental Payment Reporting under Section 1903(bb) of the Act**

Through passage of Division CC, Title II, Section 202 of the CAA, Congress added subsection (bb) to section 1903 of the Act, which requires the Secretary of Health and Human Services to establish a system for states to submit reports on supplemental payments as defined in section 1903(bb)(2) of the Act, no later than October 1, 2021. States are required to submit "reports, as determined appropriate by the Secretary, on supplemental payments data, as a requirement for a State plan or State plan amendment [SPA] that would provide for a supplemental payment" as required by section 1903(bb)

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<sup>1</sup> P.L. 116-260.

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(1) of the Act. Since all states currently have an approved state plan, we interpret this requirement to apply both with respect to “a State plan” that currently provides for supplemental payments, as well as to SPAs that states may request that would provide for supplemental payments, if approved. We further interpret this requirement to apply with respect to all “supplemental payments data” as “supplemental payment” is defined in section 1903(bb)(2)(A) of the Act, to include all payments to providers in addition to any base payment (except DSH payments), whether under state plan or demonstration authority. Information about all supplemental payments under the state plan and under demonstration authority is necessary to provide a full picture of Medicaid payments. Furthermore, comprehensive information about all supplemental payments generally will be necessary for states to submit the information required under section 1903(bb)(1)(B)(i) of the Act, which requires an explanation of how state plan payments are consistent with section 1902(a)(30)(A) of the Act, as discussed further below.<sup>2</sup>

With regard to base payments, state payment methodologies typically provide for a standard payment to the provider on a per-claim basis for services rendered to a Medicaid beneficiary in a fee-for-service environment. We interpret “base payment,” as used in the definition of “supplemental payment” in section 1903(bb)(2)(A) of the Act, to refer to these payments, including any payment adjustments, add-ons, or other additional payments received by the provider that can be attributed to services identifiable as having been provided to an individual beneficiary, including those that are made to account for a higher level of care or complexity or intensity of services provided to an individual beneficiary.<sup>3</sup> Notably, CMS has long considered final reconciliation payments made under a cost reconciliation methodology where the state has established an interim payment methodology and then reconciles a provider’s interim payments to its actual costs in a final cost reconciliation as not being supplemental payments.<sup>4</sup>

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<sup>2</sup> Some states make supplemental payments to providers of home and community-based services (HCBS) through waivers under section 1915(c) of the Act. Because section 1903(bb)(2) specifically defined “supplemental payment” to include payments under the state plan or under demonstration authority, without referring to waivers, we currently do not interpret the term to include supplemental payments under 1915(c) HCBS waivers or any other “waiver” authority, other than in the context of a demonstration under section 1115 of the Act. While we frequently have interpreted legislative references to “waiver” authority to include reference to section 1115 demonstrations (including those implemented under section 1115(a)(2) expenditure authority, regardless of whether a section 1115(a)(1) waiver is involved), it is not clear that Congress intended the term “demonstration authority” as used in section 1903(bb)(2)(A) to include waivers other than in a section 1115 demonstration. However, we do not believe this limitation will compromise states’ and our ability to ensure that payments for 1915(c) HCBS waiver services are consistent with efficiency and economy as required under section 1902(a)(30)(A) of the Act and as explanatory reporting is required under section 1903(bb)(1)(B)(i) of the Act, because payments for these services in the case of a state with a 1915(c) HCBS waiver generally are made exclusively under the waiver, and comprehensive review of the state’s payments for those services can be accomplished through the applicable waiver review process. Although we are not currently interpreting the supplemental payments data reporting requirements under section 1903(bb) of the Act to extend to supplemental payments authorized under a waiver authority other than a section 1115 demonstration, we may revisit this question in the future.

<sup>3</sup> For example, a state establishes a base per diem payment amount for nursing facilities and calculates an additional payment add-on for facilities located in rural areas. So long as the add-on amount is paid on the initial claim for services or is included in a single base payment amount that includes the regular service payment plus the regional adjustment amount, then that total payment constitutes the full base payment amount.

<sup>4</sup> The reason for this is twofold. First, reconciled cost is the base reimbursement methodology for all services provided by a given provider or facility under a cost-reconciled interim payment methodology. Second, cost reconciliation may include either an additional payment to the provider or a return of funds to the state, if the provider received aggregate interim payments that are greater than the sum of its costs. This potential for return of funds to the state is characteristic of a base payment methodology that uses interim payments reconciled to final cost, but is not characteristic of supplemental payments, which may be intended to increase a provider’s base payment.

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As a condition of approval for a state plan or SPA that would provide for a supplemental payment, states must report the below-described required information through the CMS-designated reporting system, beginning with supplemental payments data about payments made on or after October 1, 2021. The data submitted must include both narrative information as well as quantitative, provider-specific data on supplemental payments, as discussed below. With this information, CMS will better be able to review and provide oversight of Medicaid supplemental payments paid to individual providers under the state plan or demonstration authority. Further, the information will provide CMS more complete information when evaluating, developing, and implementing possible changes to Medicaid payment policy and fiscal integrity policy. As required by section 1903(bb)(1)(C) of the Act, CMS will make the state-reported supplemental payment information publicly available.

By not later than October 1, 2021, section 1903(bb)(1) of the Act requires CMS to establish a system through which states making or wishing to make supplemental payments must report specified information, including:

- An explanation of how supplemental payments made under the state plan or a state plan amendment will result in payments that are consistent with section 1902(a)(30)(A) of the Act, including standards with respect to efficiency, economy, quality of care, and access, along with the stated purpose and intended effects of the supplemental payment.
- The criteria used to determine which providers are eligible to receive the supplemental payment.
- A comprehensive description of the methodology used to calculate the amount of, and distribute, the supplemental payment to each eligible provider, including:
  - data on the amount of the supplemental payment made to each eligible provider, if known, or if the total amount is distributed using a formula for one or more fiscal years, data on the total amount of supplemental payments for the fiscal year(s) available to all providers eligible to receive a supplemental payment;
  - if applicable, the specific criteria with respect to Medicaid service, utilization, or cost data to be used as the basis for calculations regarding the amount or distribution of the supplemental payment; and
  - the timing of the supplemental payment made to each eligible provider.
- An assurance that the total Medicaid payments made to an inpatient hospital provider, including the supplemental payment, will not exceed upper payment limits, as applicable.
- If not already submitted, a UPL demonstration under 42 C.F.R. § 447.272, as applicable.

### **Existing Supplemental Payment Reporting and State Plan Processes**

Under the current state plan requirements and the SPA process, states have been required to provide information that is generally consistent with the data reporting elements included in section 1903(bb)(1)(B) of the Act, and listed above, to meet the requirements of 42 C.F.R. § 430.10, including that the state plan must give “assurance that it will be administered in conformity with the specific requirements of title XIX” of the Act and its implementing regulations, and that it contain “all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program.” The new reporting requirements in section 1903(bb)(1)(B) of the Act notably expand on the information CMS heretofore has required as part of the usual SPA process by including, in section 1903(bb)(1)(B)(iii)(I) of the Act, “data on the amount of the supplemental payment made to each eligible provider, if known[.]” Our practice has not been generally to require this provider-specific payment information, except in cases where this

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information was needed as part of a UPL demonstration for the state to show compliance with an applicable Medicaid UPL for the specific service.

Under the current state plan requirements and the SPA process, when a state adds a new, or modifies an existing base or supplemental payment through a SPA, or submits a new or updated UPL demonstration, CMS requests certain information documenting compliance with applicable statutory and regulatory requirements. For example, any SPA that proposes a supplemental payment must describe how the proposed supplemental payment methodology is consistent with economy and efficiency as required under section 1902(a)(30)(A) of the Act, as well as the criteria used to determine which providers are eligible for a supplemental payment and the distribution methodology for the payment. For supplemental payments within a class of services subject to an UPL, CMS also requires annual UPL demonstration submissions describing the UPL methodology and including supporting documentation showing which providers are eligible for the supplemental payment and the estimated total amounts they will be paid, including base and supplemental payments; and the aggregate amount of these payment totals for all providers of the class of services is then compared to the UPL.<sup>5</sup> For information submitted by a state as part of a SPA request, including UPL demonstrations and supporting documentation, where required, we have maintained the information as part of the administrative record of the state plan but have not appended the supporting documentation to the state plan itself. This supporting information has been documented and archived in our state plan records, but it has not, to date, been housed within a specified reporting system amenable to quick information retrieval and public reporting.

States are also required to keep detailed records related to their claims for FFP, including documentation that details the amounts paid to providers under the state plan or demonstration authority, as applicable. The amounts reported on the Form CMS-64 and its attachments must represent actual expenditures and credits for which all supporting documentation, in readily reviewable form, has been compiled and is available at the time the claim is filed.<sup>6</sup> Currently, states report aggregate expenditures associated with supplemental payments for five categories of services on the Form CMS-64 on a quarterly basis. As part of its oversight activities to determine the allowability of the state's claimed expenditures, CMS occasionally requests supporting documentation from the state detailing provider-specific base and supplemental payment amounts. States must have this information available in case CMS requires the information to establish that all applicable requirements for FFP are met, including that the claim for FFP represents actual expenditures and that the UPL, if applicable, is not exceeded. CMS's expectation is that the states already have access to provider-specific supplemental payment information described in section 1903(bb)(1)(B) of the Act because this information is necessary to comply with the existing SPA review and the CMS-64 claiming processes.

### **Reporting System for Information Required Under Section 1903(bb) of the Act**

Pursuant to section 1903(bb)(1)(A) of the Act, we are initially designating the Medicaid Budget and Expenditure System (MBES) as the system established for states to submit the reporting information required under section 1903(bb)(1) of the Act. Certain information that is typically generated and maintained by states, and sometimes provided to CMS, as part of the SPA submission and the Form

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<sup>5</sup> This example is illustrative only; we note that the reporting requirements under section 1903(bb) are not limited to supplemental payments for services that are subject to a UPL.

<sup>6</sup> 42 C.F.R. § 430.30(c) and the CMS State Medicaid Manual, Chapter 2, § 2500.2, available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927>

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CMS-64 expenditure reporting processes will now also be collected through a supplemental reporting form within MBES, which will reflect the entire set of data reporting elements required under section 1903(bb)(1)(B) of the Act. Our centralized collection of all supplemental payments data required under section 1903(bb) of the Act through the MBES, which is already familiar to states, will facilitate the uniform collection of all data elements required under section 1903(bb)(1)(B) of the Act, and their public reporting, as required under section 1903(bb)(1)(C) of the Act. As noted above, CMS anticipates that the states already will have the required information readily available, as this information is necessary to support SPA submissions, UPL demonstrations, and aggregate-level supplemental payment data already reported on the CMS-64. We will issue further technical instructions to states regarding the lines and supplemental forms on which to enter the reporting information required under section 1903(bb)(1)(B). CMS is actively working to modify the MBES to reflect the new reporting requirements and to facilitate states' entry of the necessary information while minimizing administrative burden; any changes to MBES reporting forms will be submitted through the Paperwork Reduction Act of 1995 (PRA) review process and approved by the Office of Management and Budget.

Once modified, the updated MBES reporting will capture all of the narrative and quantitative data required under section 1903(bb)(1)(B), including data on the amount of the supplemental payments made to each provider under both the state plan and demonstration authorities consistent with section 1902(a)(30)(A) of the Act, when FFP in such payments is claimed. In addition to the state's quarterly expenditure report on the CMS-64, a state will also report provider-specific base and supplemental payment amount information, which will support the CMS-64 claim submitted through the MBES. We have elected to use MBES as the designated reporting system under section 1903(bb)(1)(A) in part so that provider-level payment data required to be reported under section 1903(bb)(1)(B)(iii)(I) readily can be reviewed in the context of actual state expenditures for Medicaid provider payments.<sup>7</sup> Additionally, this reporting will help ensure the correctness and verification of the information states submit through the SPA process to request a new supplemental payment, which includes a comprehensive description of the methodology, timing, and the formula for the distribution of payments to providers, and, if necessary, a revised UPL demonstration including estimated base and supplemental payment amounts to the eligible providers to demonstrate that there is adequate room under the state's UPL to support the proposed supplemental payments. As noted earlier, CMS expects that states will have in their possession all of the information required, including the provider-specific payment amounts when approved supplemental payments are actually made and claimed for FFP, as the aggregate expenditures reported on the CMS-64 comprise the individual, provider-specific payment amounts.

Given the statutory requirement in section 1903(bb)(1)(A) of the Act that we establish a system to collect the required supplemental payments data by not later than October 1, 2021, which is the first day of the first quarter of federal fiscal year (FY) 2022, we believe Congress intended CMS to begin collecting the information specified in section 1903(bb)(1)(B), beginning with information about FY 2022. Accordingly, states will be required to begin reporting the data required under section 1903(bb)(1)(B) when claiming FFP in currently approved supplemental payments on the CMS-64 for payments made to providers in the quarter beginning October 1, 2021, and when requesting a SPA

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<sup>7</sup> In addition to section 1903(bb) of the Act, requesting provider-specific payment information through MBES is supported by the requirement under section 1902(a)(6) of the Act that the state must "make reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports," including to ensure the correctness and verification of the aggregate claimed expenditure reporting on the CMS-64.

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that would provide for a new, renewed, or modified supplemental payment beginning on or after that date. We do not interpret the new reporting requirements under section 1903(bb) of the Act to extend to supplemental payments made by the state before October 1, 2021, although, as discussed above, states generally are expected to have and maintain this information pursuant to separate federal requirements, including to support claims for FFP.

Consistent with the requirement under section 1903(bb)(1) of the Act that states submit reports, “as determined appropriate by the Secretary, on supplemental payments data” as that term is defined in section 1903(bb)(2) to include payments under the state plan or under demonstration authority, and consistent with the requirement under section 1903(bb)(1)(B)(i) that the state’s reporting must explain how payments will remain consistent with efficiency and economy as required under section 1902(a)(30)(A) of the Act, supplemental payments made under demonstration authority will also be included in the reporting. This includes uncompensated care (UC) pool payments, delivery system reform incentive payments (DSRIP), and possibly designated state health program (DSHP) payments to the extent that such payments meet the definition of supplemental payment as specified in section 1903(bb)(2) of the Act. We are available to provide technical assistance to states in determining whether the state’s DSHP payments qualify as supplemental payments within the meaning of section 1903(bb)(2) of the Act. States’ reporting must include required information for supplemental payments regardless of whether the supplemental payments are subject to a UPL, because the statutory definition of supplemental payments is not limited to those for services to which a UPL applies. Therefore, information about supplemental payments that are not subject to a regulatory UPL, such as supplemental payments for physicians or other Medicaid practitioners, must be reported.

The new reporting requirements under section 1903(bb) of the Act supplement the information states are required to submit during the review process for certain SPAs, section 1115 demonstration requests, and annual UPL demonstrations. CMS will continue to require states to document statutory and regulatory compliance as part of our approval and oversight procedures, including these routine SPA, section 1115 demonstration, and UPL review processes. While the information received through SPA and section 1115 demonstration approval procedures and the annual UPL reporting process document consistency with statutory and regulatory requirements at the time of approval and, annually in the case of UPL demonstrations, the new collection of reporting information required under section 1903(bb) of the Act through the MBES will enable improved, ongoing oversight of Medicaid payments to better ensure continuing compliance with all applicable statutory and regulatory requirements.

### **Process and Timeframe for Data Reporting**

States will report all of the information required under section 1903(bb)(1)(B) of the Act through the MBES reporting system, as previously described. Once we have completed the intended modifications to MBES, the reporting form will allow states to enter narrative information, where appropriate, which will carry over on the form from one MBES submission to the next. This will reduce burden on states by not requiring them to duplicate narrative information that has not changed from one quarterly MBES submission to the next. When there is new or changed narrative information to provide, the state will be able to modify the carried-over content on the MBES form, such as when the state makes a change to any of its Medicaid supplemental payments or supplemental payment methodologies.

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Most of the data collected pursuant to section 1903(bb) of the Act will be collected as narrative responses and assurances from the state, similar to how much information and assurances of compliance with applicable requirements are collected from states during the SPA review process. The data element listed in section 1903(bb)(1)(B)(iii)(I) of the Act, however, will be collected as a list that will include quantitative data detailing the “the amount of the supplemental payment made to each eligible provider, if known,” which will require provider-specific reporting of payments amounts for currently approved supplemental payments as FFP in such payments is claimed on the CMS-64, and for proposed supplemental payments where the amount each qualifying provider is proposed to receive is known by the state. For supplemental payments where the provider-specific payment amount is not known, if the total amount is distributed using a formula based on data from one or more fiscal years, the MBES form will collect data on the total amount of the supplemental payments for the fiscal year or years available to all providers eligible to receive a supplemental payment. Consistent with section 1903(bb)(1)(B)(i) of the Act, states will also be required to include in this provider-specific reporting the amount of base payments made to the provider under state plan and/or demonstration authority, which is necessary to ensure that payments are consistent with section 1902(a)(30)(A) of the Act and to assure the correctness and verification of state assurances in this regard.

As discussed above, as a condition of approval for a state plan or SPA that would provide for a supplemental payment, states must report the information required under section 1903(bb)(1)(B) of the Act through the MBES, beginning with supplemental payments data about payments made on or after October 1, 2021. Thus, in alignment with the quarterly MBES reporting cycle, the first newly required reporting will be through the Form CMS-64 expenditure report for the quarter from October 1, 2021 to December 31, 2021. States will be expected to submit the required reports through MBES at the same time the state certifies the Form CMS-64 as a condition of approval for a newly requested supplemental payment and to support the state’s claim for FFP in expenditures for currently approved supplemental payments on the quarterly Form CMS-64. As noted above, we will be modifying the MBES to include new forms for states to report narrative and provider-specific, quantitative information for all supplemental payments under state plan and demonstration authority, as described in section 1903(bb) of the Act, beginning with the reporting period for the quarter beginning October 1, 2021.

## **Compliance and Enforcement**

Consistent with section 1903(a) of the Act and implementing regulations in 42 C.F.R. § 430.30, states must document expenditures to ensure a clear audit trail. CMS will conduct oversight to ensure that the state expenditures are allowable and accurate. CMS will view a lack of complete and accurate reporting of all information required under section 1903(bb)(1)(B) of the Act as possible grounds for disapproval of SPA requests that would provide for a new, renewed, or modified supplemental payment. In addition, we may take a state’s compliance with these statutory reporting requirements into account in determining whether to approve a section 1115 demonstration request for supplemental payment authority. Finally, incomplete or inaccurate reporting of required information concerning expenditures for supplemental payments claimed on the quarterly Form CMS-64 may result in deferral and/or disallowance of claimed amounts as provided in 42 C.F.R. §§ 430.40 and 430.42, respectively. However, in light of the short timeframe for commencing this newly required reporting, CMS understands that these new reporting requirements will require significant work with

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our state partners. CMS is committed to making every effort to work in good faith with states to assist them in meeting the requirements of the statute.

## **Section 2 - Medicaid Shortfall Calculations under Section 1923(g) of the Act**

Division CC, title II, section 203 of the CAA amended section 1923(g) of the Act, which describes the methodology for calculating hospital-specific Medicaid DSH limits, effective October 1, 2021. Under the amended provisions establishing hospital-specific limits, a hospital's DSH payment may not exceed the costs incurred by that hospital in furnishing services during the year to Medicaid beneficiaries for whom Medicaid is the primary payer and the uninsured, less other (non-DSH) Medicaid payments made to the hospital and payments made by uninsured patients.

Effective October 1, 2021, the amendments to section 1923(g) of the Act made by section 203 change the methodology for calculating the Medicaid shortfall portion (Medicaid costs less Medicaid payments) of the hospital-specific DSH limit to only include costs and payments for hospital services furnished to beneficiaries for whom Medicaid is the primary payer. Costs and payments associated with services furnished to Medicaid-eligible individuals for whom Medicaid is not the primary payer are excluded from the calculation of the hospital-specific DSH limit. The calculations for the uninsured portion of the hospital-specific DSH limit are substantively unaffected by the amendments made by section 203, and continue to include payments made to the hospital by or on behalf of uninsured individuals (except for payments on behalf of indigent patients made by the state or unit of local government).

Section 1923(g)(2) of the Act, as amended, provides an exception for certain hospitals that are in the 97<sup>th</sup> percentile or above of all hospitals with respect to the number of Medicare supplemental security income (SSI) days (that is, inpatient days made up of patients who, for such days, were entitled to Medicare Part A benefits and to SSI benefits) or percentage of Medicare SSI days to total inpatient days. Hospitals to which this exception applies will calculate their hospital-specific DSH limit using the higher value of either the hospital-specific DSH limit calculation resulting from the methodology that was specified in section 1923(g)(1)(A) on January 1, 2020 (that is, the methodology that was in effect prior to the amendments made by section 203) or the methodology in effect as of October 1, 2021.

Currently, there is no readily available source of data available to determine the application of this exception. The [Medicare SSI days and ratio information](#) for use in the Medicare disproportionate share adjustment calculation for Inpatient Prospective Payment System (IPPS) DSH hospitals is not appropriate because the Medicare SSI ratio is determined using *total Medicare Part A days* in the denominator, while section 1923(g)(2)(B) of the Act specifies that a hospital must be at least in the 97<sup>th</sup> percentile of all hospitals with respect to its percentage of *total inpatient days* made up of patients who are both entitled to Medicare Part A and entitled to SSI benefits. In addition, the Medicare SSI days and ratio information does not include all hospitals that receive Medicaid DSH payments, including critical access, rehabilitation, and psychiatric hospitals. Finally, the Medicare SSI days and ratio data as published annually by Medicare is based on the latest available federal fiscal year, while the 97<sup>th</sup> percentile determination under section 1923(g)(2)(B) of the Act is based on the hospitals' latest cost reporting periods. As such, CMS intends to develop a data source to determine whether or not hospitals, ranked on a national level, qualify to meet the 97<sup>th</sup> percentile exception, consistent with section 1923(g)(2), as amended. CMS intends to make this source

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available to states for use in setting DSH payment methodologies. CMS also intends to release additional guidance and engage in future rulemaking as necessary to address this exception. CMS understands states and hospitals will be seeking this additional guidance to comply with the new requirements of 1923(g), and that CMCS is committed to issuing updates to states as soon as information is available about the updated data source.

### **DSH Audit Reporting and Timing for Section 1923 of the Act**

Section 1923(j) of the Act requires states to submit an independent certified audit and an annual report to the Secretary containing specified information about DSH payments made to each DSH hospital. The regulation at 42 C.F.R. § 455.304(b) requires that DSH audits be submitted to CMS no later than the last day of the calendar year ending three years from the end of the Medicaid state plan rate year (SPRY) under audit. The regulation at 42 C.F.R. § 447.299 further describes the data elements that must be reported as part of state audit submissions.

Generally, the DSH audits affected by the statutory changes to section 1923(g) of the Act will not be due to CMS until the end of 2025, given the three-year lag in DSH audit reporting. While CMS intends to undergo rulemaking to update the regulatory reporting requirements to reflect the statutory changes, states should note that the amendments to section 1923(g) of the Act are self-implementing and effective October 1, 2021. As such, states should make necessary system changes and update state plan methodologies, including DSH audit redistribution methodologies, to comply with statutory requirements for hospital-specific DSH limits. States should also consider amending their state plan to update any hospital-specific limit or Medicaid shortfall definition in cases where existing plan language may not be consistent with the amendments to section 1923(g). Any necessary SPA should be submitted by the last day of the SPRY to be effective for the associated SPRY. CMS is committed to providing technical assistance to aid states in determining whether the submission of a SPA is necessary.

We will continue to work with states to ensure the highest level of stewardship for the Medicaid program, and know that our state partners are equally committed to this goal. We expect that our further consultations with states and other stakeholders will lead to additional guidance on this topic this year.

Sincerely,

/s/

Daniel Tsai

Deputy Administrator and Director

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