Medicare Disproportionate Share Reimbursement

Under the Affordable Care Act

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November 1, 2013
BACKGROUND ON DSH

Medicare Disproportionate Share Payments (DSH) were enacted by Congress in 1985 and designed to compensate hospitals for the additional cost associated with treating low-income Medicare patients. Qualification and payments are principally based on a formula comprised of the sum of two fractions:

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\frac{\text{Medicaid Eligible Days}}{\text{Total Days}} + \frac{\text{SSI Days}}{\text{Medicare Eligible Days}}
\]

The resulting sum of these two fractions determines whether a hospital qualifies for DSH reimbursement and how much funding it would receive. In fiscal year 2000, the Medicare program expended $5.18 billion in DSH payments to hospitals and by 2012, DSH payments totaled $11.93 billion with 78% of hospitals nationally qualifying for these payments.

AFFORDABLE CARE ACT CHANGES

Policymakers generally considered DSH payments as Medicare’s contribution in supporting uncompensated care and to ensure access to care for Medicare beneficiaries. However, the Medicare Payment Advisory Committee (MedPAC) and others argued that the low-income share measure does not include uncompensated care and DSH payments are not well targeted. MedPAC reported that “Because at most 25 percent of DSH payments were empirically justified as covering higher Medicare costs and DSH payments were poorly targeted at hospitals with high uncompensated care costs, Congress made several changes in the DSH payments as part of PPACA.” Therefore, for discharges on or after October 1, 2014 eligible hospitals will receive (1) 25% of DSH calculated under the pre-ACA methodology for their hospital, and (2) a pro-rata share of the remaining 75% after adjustments for the change in the national uninsured rate and other statutory adjustments. The distribution formula for allocating the “75% pool” should be based on each hospitals level of uncompensated care.

A number of issues surfaced during the agencies implementation of the new payment methodology, which were raised during the rulemaking process but largely ignored by CMS. The issues raised include:

1. This calculation is the source of ongoing litigation and while providers do not agree with CMS’ interpretation, CMS currently uses Medicare Part A and Part C eligible days
2. There are other determining factors such as bed size, hospital designation, etc. that impact qualification and payment, however, the details of those other factors are not relevant to overall background summary.
3. Source: CMS Office of the Actuary
1. ESTIMATES VERSUS BEST AVAILABLE DATA: In its Notice of Proposed Rulemaking CMS stated that “we believe that applying our best estimates prospectively would be most conducive to administrative efficiency, finality, and predictability”. SCA’s reply to that statement was our belief that while those are worthwhile objectives that might be achievable in the future; the primary objective should be accurate and adequate payments to hospitals. SCA does not believe that accurate and adequate payments to hospitals can be achieved via estimates, which are never trued-up, and that are solely drawn from assumptions being made for the implementation of a program in which no real historical experience is available. In addition, the validity of the assumptions being used by CMS to derive the estimates does not reflect the reality of what has transpired since the estimates were made. For example:

The Congressional Budget Office projected that the number of uninsured between 2013 and 2014 would drop by 11.2%. That decline in part is due to the assumed expansion of Medicaid by an estimated 9,000,000 new recipients. This assumption impacts hospitals in multiple ways:

a. First, the amount of projected 2014 DSH payments used to determine the size of the Uncompensated Care Pool should reflect assumed additional Medicare DSH payments due to the expansion of Medicaid commensurate with the reduction in the uninsured population of equal amount. However, it is not transparent from CMS’ estimates that the 2014 projections include a reasonable estimate of additional assumed DSH payments in 2014 resulting from the expansion, which SCA estimated would be approximately $2.8B. In response to our comment on this point CMS stated “we have included an estimate of the Medicaid expansion in our projection”, however, no details were provided by CMS that hospitals could use to evaluate the adequacy of CMS’ estimate.

b. Second, the assumed 9,000,000 new recipients is a large component of the calculated 11.2% decline in the number of uninsured in 2014. The decline in the number of uninsured that CMS is using is derived from CBO estimates. If those estimates are overstated by just 20%, that would result in the reduction of the uninsured share of 1%, which translates into an estimated $700M negative impact to
hospitals that cannot be recovered because there is no mechanism for the estimates to be trued-up with actual data.

This is an important point in light of the fact that there has been so much controversy around and resistance to Medicaid expansion by a number of states, many of which are in the top ten of states with the highest uninsured rates; Texas being one and Florida being another. While the CBO did make an effort to revise the projections based on the Supreme Court decision regarding mandatory Medicaid expansion, its downward adjustment of 1,000,000 recipients appears understated in light of the fact that the Urban Institute estimated that there are 5.7 million uninsured adults below the poverty level in the states that are not expanding Medicaid.

Additionally, in an issue brief published by the Department of Health and Human Services (HHS) on March 16, 2012, HHS acknowledged that it may take several years to reach full implementation, however, based on CBO estimates 70% of the total assumed Medicaid expansion will be achieved in year-one of the program.

c. Lastly on this point, we have all witnessed the plagued rollout of healthcare.gov that will undoubtedly slow enrollment in various insurance plans. This may also lead to a short term rise in the uninsured as many individuals are dropped from their current insurance plan and seek options in the uncertain environment. None of these problems or their resulting implications were considered as HHS forecasted the change in insured/uninsured. The result is likely to further widen the gap between projected changes in the insured and uninsured, and reality.

2. UNRESOLVED LITIGATION RELATED TO MEDICARE DSH: There has been ongoing litigation regarding aspects of the Medicare DSH payment formula for many years, some of which has been resolved and presumably incorporated into CMS’ projections for 2014. However, there are other issues that have been resolved that have not been incorporated into CMS’ projections as well as unresolved issues with national implications that are approaching resolution that also has not been incorporated into CMS’ projections.
a. CMS acquiesced to the court’s decision in Baystate v. Sebelius and revised its process for computing the SSI Ratio portion of the Medicare DSH payment calculation. However, since the data CMS is using to project Medicare DSH payments in 2014 does not fully reflect the results of that acquiescence, the 2014 projection is likely understated. It is anticipated that the cost reports used as the basis for the 2014 projections will be final settled within the next 6-9 months, therefore, more accurate data will be available for CMS’ projections.

b. One remaining issue currently being litigated relates to the treatment of Medicaid eligible recipients that also are enrolled in a Medicare Advantage plan in Allina v. Sebelius. CMS’ interpretation is that these days should be excluded from the Medicaid fraction of the DSH payment calculation and included in the SSI Ratio calculation. Hospitals advocate the opposite treatment. To date, the Federal District Court in DC has ruled in favor of the hospitals and went so far as to vacate the portion of the rule supporting CMS’ interpretation (although the vacature ruling has been stayed pending the appeal of this case). HHS has appealed the district court’s ruling and the case is pending before the DC Circuit Court of Appeals.

In addition, the Administration in its 2014 budget request included a legislative objective that will request that Congress “clarify that individuals who have exhausted inpatient benefits under Part A or who have elected to enroll in Part C plan should be included in the calculation of the Medicare fraction of the hospital’s Disproportionate Share Hospital (DSH) patient Percentage”. Prior to 2004 CMS didn’t interpret the statute this way and in fact the DC District Court ruled that CMS’ policy was to include these days in the Medicaid fraction. CMS attempted an about face in a 2004 rulemaking that has been struck down by the DC District court so it now appears that the Administration will be looking to Congress to circumvent the courts rulings.

It is likely that a final decision related to this issue will be reached in the next 12-18 months. SCA estimates that CMS’ 2014 projections are understated by $1.1B, funding that hospitals will not be able to recover if the
ACA DSH program is not delayed and hospitals ultimately prevail in this litigation.

HOSPITAL PRIORITIES

1. In the near term, strong focus should be on reported Medicaid days in the as-filed cost report.
   
   i. Due to the timing of computing the “estimates” to be used for publication in the proposed and final rules, as-filed cost report data is being utilized for factor 3.

   ii. Hospitals cannot count on the fact that a revised DSH analysis will be used, even if submitted in an amended cost report.
       - First, depending on the timing of the amended cost report, it may not even be accepted by the hospitals MAC.
       - Second, even if accepted, it may not have been submitted in time to be used.

   ACTION ITEM: (1) Invest the appropriate resources in the as-filed cost report process. While hospitals are accustomed to Medicaid days somewhat tracking up and down with total days, thus not necessarily resulting in a material change in DSH, a downward trend in Medicaid days will typically have a material negative impact in the UC allocation. (2) Time a revised analysis such that the hospital has a greater chance of their MAC accepting an amended cost report.

2. Intermediate/Longer Term: Hospitals need to begin to turn their attention to data reported on worksheet S-10.
   
   i. Timing presumably will continue to be an issue therefore it is expected that as-filed S-10 data will be used.

   ii. Since changes in S-10 data will not necessarily drive a change in the cost report settlement amount, amended cost report filings to update S-10 data may not be accepted regardless of when submitted.

   iii. It is anticipated that revised reporting instructions will be issued and a cycle of reporting completed under the new instructions before S-10 data will be used.
**ACTION ITEM:** Hospitals should be focused on reporting S-10 in accordance with current instructions. Hospitals should also be documenting its current process of accumulating the data to report on S-10 to facilitate a smoother transition to the expected new instructions. Hospitals should also be evaluating applicable policies and procedures that effect the reporting of data on worksheet S-10.

**CONCLUSION**

The Medicare DSH / Uncompensated Care (S-10) program, which determines / will determine the allocation of billions of dollars in critical reimbursement to hospitals in North Texas and across the country, is at a critical juncture. The timeliness of preparing a cost report which claims all reimbursement a hospital is due under the Medicare program, while maintaining a claim compliant with Medicare rules and regulations, is becoming increasingly difficult. We recommend that all hospitals review the use of their resources in these areas, or engage a third party to help navigate the next few years of change. SCA believes that with its depth of experience in these matters, we are best equipped to assist hospitals in this regard. However, if not SCA, we encourage hospitals to engage outside help at this critical time.