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overview

PROPOSED CHANGES TO THE DSH CALCULATION

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What is DSH?

- Enacted shortly after enactment of the DRG payment system to allow hospitals that take care of a disproportionate share of low income individuals to receive payment for their higher costs
  - Consists of two fractions, the Medicare Fraction and the Medicaid Fraction
  - Qualification for DSH payments requires exceeding a DPP threshold of 15%
  - Amount of payment varies depending upon whether a hospital is rural or urban, and its bed count
  - Is paid as a per-discharge, add-on
  - Approximately 80% of inpatient acute care facilities qualify for some DSH funding

ACA

- Section 3133 of the ACA (enacted on Mar. 23, 2010), effective beginning FFY 2014
- Overarching goal was to increase healthcare coverage for the uninsured
- Costs of increasing coverage required a number of payment reductions, including DSH

ACA *(cont.)*

- On the theory that DSH was a payment to compensate hospitals for care that was otherwise not compensated, payments are reduced in proportion to reductions in the uninsured population
  - Uses a 3-part formula
- Precludes judicial review of:
  - Secretary “estimates” (and everything is an estimate)
  - The period of time used to calculate the new DSH amounts

Supreme Court Decision

- National Federation of Independent Business v. Sebelius, __ U.S. __, 132 S. Ct. 2566 (2012)
- Upheld ACA, but struck down Medicaid expansion
- Has various implications for revisions to DSH calculation

CMS Proposed Rule

- 78 Fed. Reg. 27486, 27577-92 (May 10, 2013)
- Comments due June 25, 2013

CMS Proposed Rule *(cont.)*

- Payments only go to qualifying hospitals
  - Any "subsection (d)" hospital that otherwise qualifies for DSH
    - Decided on an interim basis, and then reconciled at cost report settlement
  - Includes Puerto Rico hospitals
  - Includes SCHs paid the Federal amount (and payments will not affect calculation of whether the Federal amount is payable)
  - Excludes Maryland hospitals
  - Excludes Rural Community Hospital Demonstration hospitals
  - Estimate that 2,349 hospitals will qualify

CMS Proposed Rule *(cont.)*

- CMS breaks down operating DSH payments into the "empirically justified Medicare DSH payment" and the "uncompensated care payment"
- For the Empirically Justified Medicare DSH Payment (the "legacy" DSH payment), CMS is proposing to effectuate two changes:
  - Reduce this factor by 75 percent
  - "Readopt" in light of the *Allina* decision (in an "abundance of caution") its rule that MA plan days are included in the Medicare Fraction.

CMS Proposed Rule *(cont.)*

- For the Uncompensated Care Payment, breaks down into three factors:
  - Estimate of DSH funding pool
  - Change in uninsured
  - Hospital-specific share

CMS Proposed Rule *(cont.)*

- Estimate of pool
  - Goal is to determine what the 75 percent reduction in the DSH funding would be
  - Use Office of the Actuary estimate from June
  - Excludes SCHs paid on an HSR
  - Tentative amount is $9.2535 billion

CMS Proposed Rule *(cont.)*

- Change in uninsured under 65
  - Goal is to assess the amount by which the uninsured population has been reduced
  - CMS asserts that, by statute, it must use the CBO March 20, 2010 letter to the Speaker of the House, which estimates that the uninsured rate for the nonelderly population including all residents (such as undocumented aliens) is 82 percent.
    - Figure remains in place from FYs 2014 through 2017.
    - In FYs 2018 forward, CMS has more discretion over the data sources it is allowed to use.

CMS Proposed Rule *(cont.)*

- Proposes to use the CBO *Budget and Economic Outlook*, dated Feb. 5, 2013 for the 2014 figure, which is 84 percent
- The second factor is thus 88.9 percent (1-[(0.18 – 0.16)/0.18]), reduced by the statutorily required additional 0.1 percent, to total **88.8** percent, or $8.217 billion.

CMS Proposed Rule *(cont.)*

- Hospital-specific share
  - Three factors:
    - Definition of “uncompensated care”
    - Data source
    - Timing and manner of computing

CMS Proposed Rule *(cont.)*

- Uncompensated care definition
  - Considered charity care, plus non-Medicare bad debt, plus non-reimbursed Medicare bad debt.
    - Charity care is based on hospital's individual criteria, and is net of partial payment.
    - Non-reimbursed Medicare bad debt is allowable bad debt not reimbursed by Medicare.
  - Would not include losses on Medicaid.

CMS Proposed Rule *(cont.)*

- Hospital-specific share *(cont.)*
  - Data source
    - S-10 deemed unreliable for now. But . . .
      - Possibly will use line 23, Column 3 (charity care at full charges), and line 20 (Non-Medicare and non-reimbursed Medicare bad debt) in the future.
    - Proposes to use Medicare and Medicaid Fraction numerators instead. The denominator will be all such days for all DSH hospitals.
    - Intends to use the 2010/2011 cost reports for Medicaid days and the 2011 cost report for the SSI ratio.
    - Seeks comment on the use of this data, standing alone or with other data, as well

CMS Proposed Rule *(cont.)*

- Payment Mechanics
  - CMS would make interim, but not per-discharge payments
  - Proposes to reconcile only whether payments are due, but not the amount of the payment, at the time of discharge
  - Seeks comments on whether Factor 3 should be recalculated

CMS Proposed Rule *(cont.)*

- Appeal Rights?
  - No judicial review of “estimates”
  - Question regarding Medicaid data under appeal, e.g., days still being processed
  - If move to the S-10, unclear whether adjustments could be appealed, even though effect would be entirely prospective and not used for payment in the current cost report

Accruing and Reporting Costs of Treating the Uninsured and the Underinsured

- The S-10 references a hospital's policy based on financial criteria. It does not include courtesy discounts or other price concessions given without meeting financial criteria.
- Assuming that the S-10 will be used going forward, hospitals should avoid using giving discounts without seeking to qualify a patient under the hospital's charity care policy.

Accruing and Reporting Costs of Treating the Uninsured and the Underinsured *(cont.)*

- OIG view on charity care policies:
  - Cannot have copay waivers serve as an inducement to Medicare beneficiaries to use services.
    - Can result in criminal or CMP liability.
  - Allowable if:
    - There is an individualized determination of financial need;
    - The determination is based on uniformly applied criteria;
    - The financial need criteria are reasonable; and
    - The policy is not advertised.

Accruing and Reporting Costs of Treating the Uninsured and the Underinsured *(cont.)*

- IRS view of charity care policies:
  - Must specify eligibility criteria
  - Must specify payment calculation
  - Must specify application process
  - Must specify billing and collection process (which requires that patients be allowed to apply for up to 240 days from the date of the first bill)
  - Must explain measures to widely publicize policy
  - Amounts are limited to either:
    - The average discount for the prior 12 month period; or
    - The expected Medicare payment

Accruing and Reporting Costs of Treating the Uninsured and the Underinsured *(cont.)*

- Tips on restructuring charity care and bad debt policies
  - Make sure criteria are clear and as granular as needed for the institution
  - Make sure that the system is designed to get patients under the charity care policy as early as possible
  - Make sure that gross charges are consistently recorded
  - Determine the most administratively convenient methodology for determining a compliant approach to setting the payment amount for patients under the policy
  - Make sure that bad debt policy is consistently applied, including to commercial pay patients

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