Final IP PPS Rule 2014 Medicare DSH

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Objectives

- Medicare DSH Background
- PPACA revisions to Medicare DSH
- Proposed IP PPS Rule (April 26, 2013) to implement "New" DSH
- Case Study – Dollar impact of "New" DSH
- Final IP PPS Rule (August 2, 2013)
- Recommendations
- Case Law Update

Disclaimer

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Medicare DSH Background

- Enacted by statute in 1986.
- Purpose is to provide additional reimbursement for hospitals that serve a disproportionate share of low income patients.
- Low income patients tend to have more health issues and do less health maintenance and thus increase the amount of resources required to serve their health needs.
- Medicare DSH reimbursement has increased significantly over the last ten years.

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Medicare DSH Reimbursement

Total federal spending: ($ billions)

• FY 2000	5.18	• FY 2007	9.40
• FY 2001	5.68	• FY 2008	10.12
• FY 2002	6.63	• FY 2009	10.42
• FY 2003	7.10	• FY 2010	10.83
• FY 2004	7.82	• FY 2011	11.59
• FY 2005	9.00	• FY 2012	11.93
• FY 2006	9.18		

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Medicare DSH Reimbursement

Percentage of Inpatient Hospitals that Qualify for Medicare DSH

• FY 2003:	63%	• FY 2008:	75%
• FY 2004:	67%	• FY 2009:	77%
• FY 2005:	71%	• FY 2010:	76%
• FY 2006:	73%	• FY 2011:	78%
• FY 2007:	75%	• FY 2012:	78%

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Medicare DSH Reimbursement

The DSH add-on is based on the sum of two fractions:

(1) Medicare / SSI Fraction

Days for patients entitled to Medicare Part A and entitled to SSI benefits

Divided By

Days for patients entitled to Medicare Part A

(2) Medicaid Fraction:

Days for patients eligible for Medicaid and not entitled to Medicare Part A

Divided By

Days for patients in acute care areas (including nursery)

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Medicare DSH "New" Methodology

Medicare DSH "New" Methodology

- Section 3133 of PPACA requires significant revisions to Medicare DSH.
- Effective FY 2014 beginning October 1, 2013.
- CMS issued proposed rule on April 26, 2013.
- CMS issued final rule on August 2, 2013.
- CMS issued correction notice on September 30, 2013.

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Medicare DSH "New" Methodology

- The "new" Medicare DSH will have two components:
  - Part I will be 25% of the amount determined using the current payment calculation
  - Part II will be an allocation of a pool of funds:
    - The pool will be based on the remaining 75%, adjusted downward by a factor estimating the change in the aggregate uninsured rate.
    - Each hospital's share of the pool will be based on the hospital's uncompensated care as a percentage of total uncompensated care for all hospitals sharing the pool.

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Medicare DSH Final Rule FFY 2014

- UCC portion of funds to be allocated based on 75% of what would have been paid for DSH under old rule less reduction in uninsured less statutory reduction.
- Source used for estimated DSH payments for 2014 under old rule – Office of Actuary.
- No change in Capital DSH.

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Medicare DSH Final Rule FFY 2014

- Factor 1 = DSH Payment under old rule = $12.772B, 75% = $9.579B (correction notice = $9.593B). This excludes Maryland hospitals and SCHs receiving HSP. Proposed rule amount was $9.25B.
- Factor 2 = Reduction applied to Factor 1 to account for decrease in uninsured. Uninsured percentages based on CBO estimates.
- Factor 3 = Allocation methodology (low income days).

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Medicare DSH Final Rule FFY 2014

- Factor 2: Uninsured for 2013 published in 2010 = 18%, estimate for 2014 published in Feb 2013 = 16%, weighted for FFY = 17%
- Factor 2: 1-[(.17-.18)/.18] = 1 - .056 = .944 less statutory reduction .001 = .943
- Proposed rule did not weight uninsured percentage. Changed due to comments. Increased DSH funds by $500M.
- $9.593B x .943 = $9.046B
- Total DSH funds for allocation of UCC (using Factor 3) = $9.046B.

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Medicare DSH Final Rule FFY 2014

- Total DSH funds for allocation of UCC = $9.046B.
- How will these funds be allocated? Months of speculation in the industry. Most believed the source would be cost report Worksheet S-10.
- CMS proposed use of a proxy to estimate UCC. Proxy is Medicaid days plus Medicare SSI days.

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Comments to Proposed Rule

- Factor 1 – 75% of what would have been paid under old DSH rules for FFY 2014.
- The amount used for Factor 1 of $12.34B could be significantly understated. If the Secretary continues to lose in court related to including Part C days in the Medicaid fraction (Allina v HHS), then the amount for Factor 1 should be much higher. The fact that the proposed rule states that the CMS position is this amount will never be reconciled, makes the potential understatement even more problematic.

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CMS Response

"We continue to believe that *Allina* was wrongly decided and have appealed the decision." They also reference that they are "readopting" their policy of including Medicare Advantage (MA) days in the SSI fraction.

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Comments to Proposed Rule

- Filed cost reports from 2010 appear to be the basis for Factor 1. These filed reports could be understated due to retroactive eligibility that is not reflected in total Medicaid days. The appropriate inclusion of these days in the Medicare DSH calculation could significantly increase the amount for Factor 1.
  - CMS Response - "We do not believe that we should employ a cost reporting period for which cost report data have all been audited because doing so would require using much earlier data as the basis for the projection."

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Comments to Proposed Rule

- Medicaid expansion will increase the number of Medicaid days in FFY 2014 which will increase provider DSH payments. This increase should be accounted for in Factor 1.
  - CMS Response - We have "included an estimate of the impact of the Medicaid expansion in our projection of Factor 1 for this final rule." Spreadsheet is on the website. Impact must be in "other" column. There is no detail of the "other" computation in the DSH spreadsheet from the CMS web site.

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Comments to Proposed Rule

- A complete and accurate reconciliation should be done to ensure each provider receives the appropriate allocation. This reconciliation should include a retroactive settlement. The reconciliation should include a reconciliation of total funds (currently proposed at $12.34B) and a reconciliation of each provider's Factor 3. The amounts used for Factor 3 could change due to audit adjustments to Medicaid days as well as SCHs reimbursed the hospital specific rate. The proposed rule states that CMS does not intend to reconcile because "applying our best estimates prospectively would be most conducive to administrative efficiency, finality, and predictability in payments."

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Comments to Proposed Rule

We do not believe this reason justifies the lack of a reconciliation. Other payment programs are reconciled (wage index, Medicaid DSH) so we see no reason why DSH cannot be reconciled. Finality & predictability should not override obtaining the correct answer. We became impatient with the delay in SSI percentages but understood that they had to be incorporated in order to calculate the correct DSH amount for that time period. The process of cost report settlements with final SSI percentages was hardly final or predictable.

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CMS Response

"The statute gives us authority to estimate this amount." If we don't estimate, "final settlement of these payments could be delayed as much as 6 years or more." They cite example of outliers being based on estimates.

Comments to Proposed Rule

- The calculation of Factor 2 appears arbitrary. A two percent decrease in the percentage of uninsured does not seem reasonable based on economic conditions. The ACA has not been implemented so such a large decrease in uninsured is very speculative. There are no insurance exchanges established and this measure has no historical data. We understand that estimates must be used for interim payments. We maintain that this is another reason that a complete reconciliation of the allocation should be done. Upon reconciliation, more accurate numbers for uninsured for 2013 and 2014 should be available based on actual data.

CMS Response

"We continue to believe that the CBO projections of insurance coverage in 2014 and subsequent years are the most reliable and consistent basis on which to calculate Factor 2." Reconciliation would "impose an unacceptable delay in the final determination of uncompensated care payments."

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Medicare DSH Final Rule FFY 2014

- Why was S-10 not used as the source for Factor 3?
- Proposed rule discusses in some length.
- S-10 is "a new data source" and has been "used for specific payment purposes only in relatively restricted ways" (EHR).
- S-10 has not been subject to audit other than related to EHR.
- CMS believes that when information requested drives payment, it is more likely to be accurate.

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Medicare DSH Final Rule FFY 2014

- CMS uses wage index as example that information must be audited to be used for payment purposes.
- Hospitals expressed concern that they have not had enough time to learn how to submit accurate and consistent data on Worksheet S-10.
- S-10 instructions still require clarification to ensure consistency.
- May propose to use S-10 in the future “once hospitals are submitting accurate and consistent data”. Final rule states “It is our intention to propose introducing use of the Worksheet S-10 to determine Factor 3 within a reasonable amount of time.”

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Medicare DSH Final Rule FFY 2014

- Medicaid days have been the driver of the DSH payment since the inception of the DSH regulation. They have also been subject to audit.
- Many providers contacted CMS to voice concerns over issues with using S-10.
- CMS requested comments from the proposed rule related to S-10.

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Worksheet S-10

- Initial discussions indicated Worksheet S-10 line 31 might be used to determine “uncompensated care”
- Line 31 comprised of:
  - Uncovered costs for
    - Medicaid (Line 8)
    - SCHIP (Line 12)
    - Other state and local (Line 16)
  - “Costs” of charity care (Line 23)
  - “Costs” of Non-Medicare and non-reimbursable Medicare bad debts
- “Costs” computed using overall cost-to-charge ratio (including HHA, SNF and subproviders)

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Worksheet S-10

- Uncovered costs
  - Per instructions Medicaid revenues reported as “the amount received or expected for the cost reporting period, net of associated provider taxes or assessments.”
  - Charges should relate to patient identifiable services for which the payments were reported on lines 2, 9, and 13.
- Costs of charity care computed on line 20 by applying the cost to charge ratio to the initial payment obligation for patient identified as charity.
  - “Partial” charity patients
- Bad Debt “Costs” computed on line 29 by applying the cost to charge the ratio to bad debt amounts
  - Bad debt written off at discount
  - Potential for bad debt also reported as uncompensated care
  - Bad debts are deductibles/coinsurance, not total charges

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Comments to Proposed Rule

- We agree that Worksheet S-10 would not currently provide a consistent allocation for DSH. If S-10 is to be considered in the future for this allocation, then the instructions need clarification and the Medicare Contractors must apply consistent audit procedures to the amounts reported.
- Worksheet S-10 may need to be expanded to more accurately calculate cost. The current forms use only an overall cost-to-charge ratio. We believe utilizing a cost-to-charge ratio by cost center similar to other worksheets in the cost report would provide a more accurate cost calculation.

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Comments to Proposed Rule

- Worksheet S-10 includes amounts for charity and bad debts. Since the year end cost report must be filed at the end of the fifth month after year end, that is not sufficient time to identify all charity and bad debt patients for the fiscal year. If S-10 is considered in the future, then we request that there be a reasonable amount of time to "refresh" the data in the worksheet similar to the process for wage index.

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Comments to Proposed Rule

- We have a recommendation for data to accumulate on Worksheet S-10. This worksheet could be revised to include days for charity and uninsured patients. The definition of uninsured would be per the Medicaid DSH audit rule published in the December 19, 2008 Federal Register. These days could then be used as the basis for Factor 3. This would provide a basis for Factor 3 based on uncompensated care and it would be easier for providers to accumulate this data as opposed to cost and charge calculations. This method would also provide a basis that can be audited by MACs in a more consistent fashion.

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Comments to Proposed Rule

- If Worksheet S-10 is considered in the future, one data inconsistency that would skew the DSH allocation using this worksheet is the treatment of uninsured patients that do not meet the provider charity care criteria. Currently charity care charges are included at 100% of gross charges. Charges for patients that are uninsured but do not qualify for charity are included net of any courtesy discount. Therefore, each provider's charity care policy could have a significant impact on the cost calculated on S-10.

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CMS Response

"We remain convinced that the Worksheet S-10 could ultimately serve as an appropriate source of more direct data regarding uncompensated care costs." We will review S-10 for "clarifications so it can yield accurate and consistent data. We will consider the commenters' specific recommendations for such revisions and clarifications as we do so. It is our intention to propose introducing use of the Worksheet S-10 to determine Factor 3 within a reasonable amount of time."

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Medicare DSH Final Rule FFY 2014

- Same rules apply for counting Medicaid days.
- Source for Medicaid days – "most recent available filed cost report."
- Source for Medicare SSI days – "most recent available SSI ratios."
- Table published that includes Medicaid and Medicare SSI days and hospital percentages for allocation.

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- Table is on CMS web page: www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteinpatientPPS/FY-2014-IPPS-Final-Rule-Home-Page-Items/FY-2014-IPPS-Final-Rule-CMS-1599-F-Data-Files.html
- Most provider Medicaid days data appears to be based on cost report period beginning in FFY 2011.
- If amended cost report was processed by MAC before March 2013, those appear to be included. If additional Medicaid days included for audit, those are not included in Table because final settlement is not complete.

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Medicare DSH Final Rule FFY 2014

- SSI days were updated to 2011 published file. Proposed rule was based on 2010.
- Medicaid days are from the March 2013 HCRIS data. The proposed rule used December 2012.
- No change can be made to Medicaid days. Several commenters requested change.
- Correction notice on September 20, 2013 added Indian Health Services to Factor 1 and Factor 3.
- ACA prescribes that the estimates used by the Secretary are not subject to judicial review. Estimates include the factors used as well as the time period used.

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Medicare DSH Final Rule FFY 2014

- UCC payments will be made prospectively based on the average Medicare discharges for the provider from 2010-2012. The UCC payments will be settled on the filed cost report.
  - Proposed rule stated that UCC payments would be made on a periodic basis rather than per discharge.
  - Many commenters objected to periodic payments since those would not be included in the Pricer.

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CMS Response

"While we acknowledge that many MA plans use this tool to estimate fee for service payments, we note that there is no official CMS requirement that MA plans use this specific tool."

"MA organizations should be required to include amounts representing these uncompensated care payments in their payments for inpatient services furnished to their MA plan enrollees. It was not our intention to suggest otherwise in the proposed rule."

"We believe that distributing these payments on a per-discharge basis would make it easier for MA organizations to take these payments into account when making payments to non-contracting hospitals."

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Medicare DSH Final Rule FFY 2014

- Hospitals with DSH capped at 12% – cap not addressed at all in proposed rule.
- Many commenters requested clarification as to whether the cap would apply to the UCC allocation.
  - CMS Response - Cap applies only to the "empirical" DSH formula or the 25% portion. The cap does not apply to the UCC payment allocation.

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Medicare DSH Final Rule FFY 2014

- SCH – whether or not they will participate in the interim DSH pool will be estimated. If the estimate is incorrect, adjustment will be made at cost report settlement.
- SCHs should check their status on the Table.
- SCH comparison for Inpatient HSP reimbursement now includes the 75% UCC component.
- Proposed rule was to exclude the 75% UCC portion because it was to be paid on a period basis.
- CMS changed policy in the final rule due to comments. They stated it was not their intent to force SCHs to accept a reduction in DSH reimbursement.

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CMS Response

"We believe that it is appropriate for the uncompensated care payment to be considered as part of an SCH's payment under the Federal rate. For this and other reasons which we discuss later in this preamble, we have decided not to finalize our proposed policy to make interim uncompensated care payments on a periodic basis rather than a per-discharge basis for FY 2014."

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Medicare DSH Final Rule FFY 2014

- No redistribution per proposed rule! If SCH received allocation and should not have, no retroactive change to other hospital percentages.
- No reconciliation of the total DSH funds that would otherwise have been paid for DSH (denominator / $9.046B).

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Medicare DSH Final Rule FFY 2014

- Reason provided in proposed rule – this is "inherent use of estimates". (CMS) "does not know of any reason to believe there will be a bias toward systematic overpayment or underpayment."
- Is there any other Medicare/Medicaid reimbursement system that is not reconciled?

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Comments to Proposed Rule

- There should be a reconciliation of Factor 3 to account for the total DSH that would have been paid under the old rules, any change in the proxy after the published estimates and for the inclusion/exclusion of Sole Community Hospitals. The reconciliation may result in settlements for providers but that is necessary to allocate the funds on accurate, audited numbers for the fiscal year. The reconciliation for FFY 2014 should be done after audited information is available for FFY 2014.

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Comments to Proposed Rule

- Considering the significant amount of changes to the DSH methodology, the material impact to many providers and the proposal by CMS to not reconcile the amounts in any of the Factors, we suggest that the implementation of the new DSH rule be "phased in" over a four-year period. This would mean that for FFY 2014 25% of the DSH amount would be subject to the new methodology based on this proposed rule and 75% of DSH would continue to be based on the current methodology. This "phase in" would lessen the immediate financial impact of the DSH changes and would give providers time to prepare and forecast the large financial gains and losses.

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Comments to Proposed Rule

The "phase in" is consistent with significant changes made by the Secretary in the past. An example of this application is the change in reimbursement for Psych to PPS.

- Other commenters suggested a stop-loss/stop-gain policy to minimize the impact by no more than 2% per provider. Others commented that the new DSH method results in a "redistribution" and therefore should be delayed.
  - CMS Response – We do not have statutory authority to delay or phase-in. The new methodology "was designed to have redistributive effects."

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Medicare DSH Final Rule FFY 2014

- Commenters stated that the proposed proxy unfairly rewards providers in states that elect to expand Medicaid. The commenters also believe that the proxy is not an appropriate estimate of uninsured since the proxy is for insured patients.
  - CMS Response - We disagree that states that expand Medicaid are inappropriately rewarded. "It is possible for hospitals in states that choose to expand Medicaid to receive lower UCC payments." We believe this is the best proxy currently available.

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Medicare DSH Final Rule FFY 2014

Implications of Medicaid Days as Proxy (From Proposed Rule Presentation)

- ACA Medicaid expansion
- Current Medicaid eligibility/FPL
- Redistribution of DSH reimbursement
- Is Proxy a fair estimate of uncompensated care?

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CMS Table FFY 2014 Medicaid Days + Medicare SSI Days

Factor 3 – Top 30 Hospitals

FY 2014 IPPS Final Rule: Implementation of Section 3133 of the Affordable Care Act - Medicare DSH - Supplemental Data

PRO	Name	Sept 2013 Medicaid Days	Sept 2013 SSI Days	Sept 2013 Insured Low Income Days	Sept 2013 Factor 3	Sept 2013 Total Uncompensated Care Payment Amount	Sept 2013 Estimated Per Claim Amount	Sept 2013 Claims Averag	Projected to Receive DSH for FY 2014
330059	MONTEFIORE MEDICAL CENTER	185,096	41,265	226,361	0.621363%	$ 56,210,866.78	$ 3,278.62	17,145	Y
100022	JACKSON HEALTH SYSTEM	195,957	22,380	218,337	0.599337%	$ 54,218,315.08	$ 6,940.39	7,812	Y
330101	NEW YORK-PRESBYTERIAN HOSPITAL	168,017	38,429	206,446	0.566696%	$ 51,265,494.51	$ 1,862.24	27,529	Y
100006	ORLANDO REGIONAL HEALTHCARE	138,508	13,037	151,545	0.415992%	$ 37,632,259.12	$ 2,498.05	15,065	Y
450015	PARKLAND HEALTH AND HOSPITAL SYSTEM	137,560	4,003	141,563	0.388592%	$ 35,153,489.05	$ 10,446.80	3,365	Y
150056	INDIANA UNIVERSITY HEALTH	127,778	10,140	137,918	0.378586%	$ 34,248,348.10	$ 2,231.65	15,347	Y
100007	FLORIDA HOSPITAL	114,674	23,019	137,693	0.377969%	$ 34,192,475.21	$ 916.99	37,288	Y
330169	BETH ISRAEL MEDICAL CENTER	87,384	32,052	119,436	0.327853%	$ 29,658,824.11	$ 2,041.21	14,530	Y
180088	NORTON HOSPITALS, INC	107,995	10,521	118,516	0.325328%	$ 29,430,366.04	$ 1,689.01	17,425	Y
450388	METHODIST HOSPITAL	98,256	20,205	118,461	0.325177%	$ 29,416,708.22	$ 1,316.48	22,345	Y
330024	MOUNT SINAI HOSPITAL	88,121	23,794	111,915	0.307208%	$ 27,791,179.38	$ 1,640.73	16,938	Y
440049	METHODIST HEALTHCARE MEMPHIS HOSPIT	91,065	18,299	109,364	0.300205%	$ 27,157,704.88	$ 1,396.00	19,454	Y
450289	HARRIS COUNTY HOSPITAL DISTRICT	105,922	3,233	109,155	0.299632%	$ 27,105,805.17	$ 14,078.50	1,925	Y
330009	BRONX-LEBANON HOSPITAL CENTER	92,214	16,811	109,025	0.299275%	$ 27,073,523.05	$ 10,080.75	2,686	Y
330194	MAIMONIDES MEDICAL CENTER	82,170	26,571	108,741	0.298495%	$ 27,002,999.04	$ 2,523.64	10,700	Y

Factor 3 – Top 30 Hospitals

FY 2014 IPPS Final Rule: Implementation of Section 3133 of the Affordable Care Act - Medicare DSH - Supplemental Data									
PRO	Name	Sept 2013 Medicaid Days	Sept 2013 SSI Days	Sept 2013 Insured Low Income Days	Sept 2013 Factor 3	Sept 2013 Total Uncompensated Care Payment Amount	Sept 2013 Estimated Per Claim Amount	Sept 2013 Claims Averag	Projected to Receive DSH for FY 2014
050373	LAC+USC MEDICAL CENTER	101,407	4,132	105,539	0.289706%	$ 26,207,865.62	$ 19,543.52	1,341	Y
050327	LOMA LINDA UNIVERSITY MEDICAL CENTE	93,585	6,707	100,292	0.275302%	$ 24,904,909.64	$ 4,515.85	5,515	Y
250001	UNIVERSITY OF MISSISSIPPI MED CENTE	92,913	7,249	100,162	0.274946%	$ 24,872,627.52	$ 4,327.68	5,747	Y
340113	CAROLINAS MEDICAL CENTER/BEHAV HEAL	89,969	6,744	96,713	0.265478%	$ 24,016,158.08	$ 1,925.81	12,471	Y
070022	YALE-NEW HAVEN HOSPITAL	86,993	7,503	94,496	0.259392%	$ 23,465,623.79	$ 1,716.37	13,672	Y
330046	ST LUKE'S ROOSEVELT HOSPITAL	75,644	18,762	94,406	0.259145%	$ 23,443,274.63	$ 2,755.22	8,509	Y
050060	COMMUNITY REGIONAL MEDICAL CENTER	81,897	11,361	93,258	0.255994%	$ 23,158,198.69	$ 3,165.71	7,315	Y
100128	TAMPA GENERAL HOSPITAL	81,459	10,137	91,596	0.251432%	$ 22,745,484.22	$ 2,411.01	9,434	Y
100075	ST JOSEPH'S HOSPITAL	77,858	12,945	90,803	0.249255%	$ 22,548,563.30	$ 2,291.29	9,841	Y
230038	SPECTRUM HEALTH - BUTTERWORTH CAMPU	82,423	7,399	89,822	0.246562%	$ 22,304,957.46	$ 1,498.52	14,885	Y
010033	UNIVERSITY OF ALABAMA HOSPITAL	77,590	10,717	88,307	0.242404%	$ 21,928,746.62	$ 1,899.85	11,542	Y
450068	MEMORIAL HERMANN TEXAS MEDICAL CENT	78,339	8,054	86,393	0.237150%	$ 21,453,454.50	$ 3,585.34	5,984	Y
370093	O U MEDICAL CENTER	82,149	3,680	85,829	0.235601%	$ 21,313,399.77	$ 4,630.33	4,603	Y
100113	SHANDS HOSPITAL AT THE UNIVERSITY O	76,629	8,759	85,388	0.234391%	$ 21,203,888.89	$ 1,971.66	10,754	Y
440039	VANDERBILT UNIVERSITY HOSPITAL	79,199	5,095	84,294	0.231388%	$ 20,932,222.44	$ 2,078.67	10,070	Y

Final Rule DSH Impact
State Winners & Losers

States with Largest Gains	Amount		States with Largest Losses	Amount
Indiana	32,557,504		Montana	(453,964)
Tennessee	34,871,597		Vermont	(660,498)
Georgia	46,250,813		Delaware	(876,483)
Arizona	54,638,468		North Carolina	(1,066,782)
Ohio	70,085,677		Maine	(1,878,917)
Puerto Rico	89,054,341		Mississippi	(3,170,972)
Texas	101,165,012		District of Columbia	(5,281,507)
Pennsylvania	115,323,995		Washington	(7,271,869)
Florida	142,346,879		Massachusetts	(20,697,902)
New York	181,339,820		California	(157,078,880)

Case Study

- Generally, winners appear to be those hospitals with high Medicaid + low Medicare.
- Generally, losers appear to be those hospitals with low Medicaid + high Medicare.
- Examples

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FY 2014 IPPS Final Rule: Implementation of Section 3133 of the Affordable Care Act - Medicare DSH - Supplemental Data							
PROV	NAME	Medicaid Days	Medicare SSI Days	Insured Low Income Days	Factor 3	Projected to Receive DSH for FY 2014	Pool amount
100022	JACKSON HEALTH SYSTEM	195,957	22,380	218,337	0.599337%	Y	54,218,315

2011 Medicare DSH Amount	41,377,286
	x 25%
	10,344,321
UCC portion of DSH based on CMS table	54,218,315
Total DSH Estimate for 2014	**64,562,636**
Total DSH for 2011	**41,377,286**
Increase	**23,185,350**

Days Utilization – 2011 Cost Report

Medicare	22%
Medicaid	52%
All Others	26%
	100%

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FY 2014 IPPS Final Rule: Implementation of Section 3133 of the Affordable Care Act - Medicare DSH - Supplemental Data							
PROV	NAME	Medicaid Days	Medicare SSI Days	Insured Low Income Days	Factor 3	Projected to Receive DSH for FY 2014	Pool amount
140124	JOHN H STROGER HOSPITAL	51,400	1,728	53,128	0.145837%	Y	13,192,957

2011 Medicare DSH Amount	5,877,328
	x 25%
	1,469,332
UCC portion of DSH based on CMS table	13,192,957
Total DSH Estimate for 2014	**14,662,289**
Total DSH for 2011	**5,877,328**
Increase	**8,784,961**

Days Utilization – 2011 Cost Report

Medicare	11%
Medicaid	44%
All Others	45%
	100%

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FY 2014 IPPS Final Rule: Implementation of Section 3133 of the Affordable Care Act - Medicare DSH - Supplemental Data							
PROV	NAME	Medicaid Days	Medicare SSI Days	Insured Low Income Days	Factor 3	Projected to Receive DSH for FY 2014	Pool amount
010092	D C H REGIONAL MEDICAL CTR	28,516	8,084	36,600	.100467%	Y	9,088,658

2011 Medicare DSH Amount	14,555,978
	x 25%
	3,638,995
UCC portion of DSH based on CMS table	9,088,658
Total DSH Estimate for 2014	**12,727,653**
Total DSH for 2011	**14,555,978**
Decrease	**(1,828,325)**

Days Utilization – 2011 Cost Report

Medicare	63%
Medicaid	22%
All Others	15%
	100%

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FY 2014 IPPS Final Rule: Implementation of Section 3133 of the Affordable Care Act - Medicare DSH - Supplemental Data							
PROV	NAME	Medicaid Days	Medicare SSI Days	Insured Low Income Days	Factor 3	Projected to Receive DSH for FY 2014	Pool amount
050739	CENTINELA HOSPITAL MED CTR	24,784	8,958	33,742	0.092622%	Y	8,378,948

2011 Medicare DSH Amount	26,865,088
	x 25%
	6,716,272
UCC portion of DSH based on CMS table	8,378,948
Total DSH Estimate for 2014	**15,095,220**
Total DSH for 2011	**26,865,087**
Decrease	**(11,769,867)**

Days Utilization – 2011 Cost Report

Medicare	49%
Medicaid	33%
All Others	18%
	100%

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Medicare DSH "New" Methodology

Recommendations

- Verify numbers used in Final Rule Table.
- Verify status of qualifying for DSH in Table.
- Include all appropriate Medicaid days in future filed cost reports. Depending on timing, amendments may not be included in the allocation.

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Medicare DSH "New" Methodology

Recommendations

- Amended Cost Report Example - we found $800,000 understatement in Factor 3 allocation because provider did not do Medicaid days analysis before cost report was filed.
- Hospitals that are capped for DSH should consider an analysis of Medicaid eligible days.
- Begin to evaluate information required to accurately complete Worksheet S-10

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DSH Appeal/Litigation Update

Medicare Advantage (MA) Days

- DSH regulation – exclude days from Medicaid fraction that are "entitled to benefits under Part A."
- If MA days meet this criteria, they should be in SSI fraction. If MA days do not meet this definition, they should be in the Medicaid fraction.

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Medicare Advantage (MA) Days

- *Northeast* case – related to discharges prior to 2004 rule. D.C. Circuit invalidated CMS application of rule to periods prior to rule change.
- *Allina* – related to discharges after 2004 rule. District Court vacated 2004 rule dealing with MA days. CMS has appealed to D.C. Circuit.
- CMS stated their position again in 2014 IP PPS proposed rule. Encouraged comments.

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Medicare Advantage (MA) Days

- CMS adopted the proposed rule – include MA days in the SSI fraction.
- Some commenters expressed support for CMS position.
- Most commenters disagreed with CMS and urged them to exclude MA days from the SSI fraction.
  - CMS Response – Patients enrolled in MA are entitled to Part A benefits. They reference their wins in Circuit Court in exhausted benefit cases (Metropolitan & CHI).

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Medicare Advantage (MA) Days

- Comments received that due to decision in Allina & Northeast, this is a change in CMS policy.
  - CMS Response – This is not a change in policy. We never had a policy of excluding MA days from SSI fraction. We are simply "readopting a policy that we finalized in the FY 2005 IPPS final rule."

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Other Dual Eligible Days

- Days where a patient is participating in Medicaid and Medicare Part A but no payments are made under Medicare Part A.
- Common Examples
  - Part A exhausted benefits (90 days per spell of illness + 60 lifetime reserve days)
  - Medicare Secondary Payor
  - Medical or technical denials
- The legal question –
  - Are individuals "entitled to benefits under Part A" for all of their inpatient days?

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Other Dual Eligible Days

- Legal question is same as MA.
- *Catholic Health* – relates to discharges prior to 2004. Provider won in District Court. CMS appealed and won in D.C. Circuit.
- *Metropolitan Health* – relates to discharges after 2004. Providers won in District Court. CMS appealed and won in Michigan Circuit Court.
- Appeals for exhausted benefit days will have a lower likelihood of success due to these Circuit Court decisions.
- Attorneys do not believe these cases have any impact on the *Allina* appeal.

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Other Dual Eligible Days

- NPRs are being issued again. They include SSI fractions that include MA days.
- MACs issuing simultaneous re-openings with NPR, pending outcome of *Allina.*
- Recommendation – Continue to appeal based on *Allina*.

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DSH Appeal Update

SSI Fraction

- Matching allegedly corrected but without detail, no way to document. Continue to appeal. *(Baystate).*
- Request SSI detail in Data Use Agreement (DUA). Long delays reported in receiving data.
- Allina Impact – Impact of removing MA days should be appealed.

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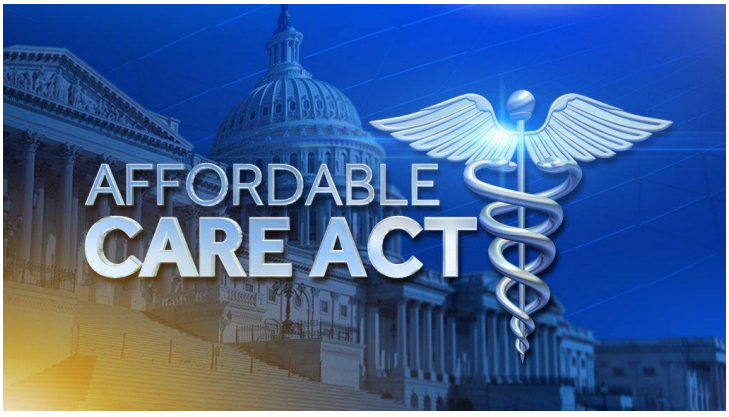
Questions / Comments



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