DIXON HUGHES GOODMAN LLP

Medicare DSH Reimbursement

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THE NATIONAL HEALTHCARE PRACTICE OF DIXON HUGHES GOODMAN LLP

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Overview

- Medicare DSH Background
- Medicare DSH Methodologies
- FFY 2017 Proposed Rule – Factor 3 & S-10 Conversion
- FFY 2017 Final Rule – DSH Amounts, Allocations & S-10
- FFY 2017 Final Rule – Comments/Responses related to S-10 Conversion
- Medicare DSH Impact – Medicaid Days vs S-10
- OP PPS Final Rule – Changes to Appeal Rights

Medicare DSH Background

- Enacted by statute in 1986.
- Original intent was to provide additional reimbursement under PPS for hospitals that incur higher-than-average costs per case because they serve a disproportionate share of low income patients.
  - Low income patients tend to have more health issues and are more costly to treat.
  - These hospitals tend to have higher operating costs overall.
- Medicare DSH reimbursement has increased significantly over the last ten years.

Medicare DSH "New" Methodology

- Section 3133 of PPACA requires significant revisions to Medicare DSH.
  - Effective for discharges on or after 10/1/13
  - Traditional Medicare DSH Payment is reduced by 75%
  - Establishes new DSH Payment for Uncompensated Care

Medicare DSH "New" Methodology

- The "new" Medicare DSH has two components:
  - Part One will be 25% of the amount determined using the traditional payment calculation ("Empirically Justified").
  - Part Two will be an allocation of a pool of funds:
    - The pool will be based on the remaining 75%
    - Reduced in proportion to reductions in the national uninsured rate.
    - The pool will be split based on the hospital's amount of uncompensated care as a percentage of total uncompensated care for all qualifying hospitals.

Medicare DSH

FY 2017 IPPS Proposed Rule

Medicare DSH Proposed Rule FFY 2017

- Factor 1 = DSH payment that would have otherwise been paid under old rules. Estimated by Office of Actuary. Excludes Maryland hospitals and SCH expected to be paid HSR. CMS estimated DSH Payment under old rule = $14.23B, 75% = $10.67B
- Factor 1 – Filed Cost Reports from FFY 2013. Update and case mix factors applied to update to FFY 2017.
- Factor 2 = Reduction applied to Factor 1 to account for an estimated decrease in uninsured. Uninsured percentages based on CBO estimates.
- Factor 3 = Allocation methodology (Medicaid and Medicare/SSI low income days).

Medicare DSH Proposed Rule FFY 2017

- Factor 2: Uninsured for 2013 published in 2010 = 18%, estimate for 2017 published in Feb 2013 = 10.25%
- Factor 2: 1-[(.1025 -.18)/.18] = 1 - .4306 = .5694 less statutory reduction .002 = .5674.
- $10.67B x .5674 = $6.05B
- Total DSH funds for allocation of UCC (using Factor 3) = $6.05B.

Medicare DSH Proposed Rule FFY 2017

- Hospitals expressed concern that using one cost report period was “a poor predictor of their future uncompensated care burden and results in inadequate payments”
- Using three periods for Factor 3 basis would best “stabilize” hospitals uncompensated care payments.
- Factor 3 will be based on Medicaid days and average of three cost report periods. The periods used will be cost reports beginning in 2011, 2012 and 2013.
- Factor 3 Medicare SSI days will also be based on a three year average. Years used will be 2012, 2013 & 2014.

Medicare DSH Proposed Rule FFY 2017

- Factor 3 Computation – compute the factor 3 times, then average it. Example: 2011 Medicaid days & 2012 SSI days divided by total DSH hospitals 2011 Medicaid days & 2012 SSI days.
- Factor 3 table published on CMS website.

Medicare DSH Proposed Rule FFY 2017

- CMS proposing to change Factor 3 to Worksheet S-10 for FFY 2018 with a three year phase in.
- CMS not proposing to use S-10 for FFY 2017 because they would be using cost reports prior to 2014. Hospitals were not aware at that time that S-10 could be used for DSH.
- CMS contracted with consulting firm to evaluate the stability and consistency of data on S-10.
- Evaluation was based on the charity and bad debt between IRS 990 and S-10. The correlation was .71 in 2010 and .80 in 2012.

Medicare DSH Proposed Rule FFY 2017

- MedPac has found that S-10 is a better proxy than low income insured days. Correlation between audited uncompensated care cost and S-10 was .80 compared to .50 for Medicaid/SSI days.
- Based on these analyses, CMS proposes to use S-10 for Factor 3.
- Three year phase in of S-10 so that Factor 3 would be based only on S-10 for FFY 2020 and subsequent years.
- CMS encourages providers to amend cost reports for Worksheet S-10 as soon as possible. It then issued billing transmittal in July that any 2014 amended cost reports for S-10 must be completed by September 30, 2016.

Medicare DSH Proposed Rule FFY 2017

- Example calculation of Factor 3 for FFY 2018:
  1) (2012 Medicaid days + 2014 SSI days) divided by all DSH hospitals (2012 Medicaid days + 2014 SSI days).
  2) (2013 Medicaid days + 2015 SSI days) divided by all DSH hospitals (2013 Medicaid days + 2015 SSI days).
  3) 2014 Worksheet S-10 divided by all DSH hospitals 2014 S-10.
  4) Sum 1-3 and divide by number of cost report periods.

Medicare DSH Proposed Rule FFY 2017

- Calculation of Factor 3 for FFY 2019
  1) 2013 Medicaid days + 2015 SSI days
  2) 2014 Worksheet S-10
  3) 2015 Worksheet S-10

- Calculation of Factor 3 for FFY 2020
  1) 2014 Worksheet S-10
  2) 2015 Worksheet S-10
  3) 2016 Worksheet S-10

Medicare DSH Proposed Rule FFY 2017

- CMS considered 3 definitions for uncompensated Care Costs – (1) charity (2) charity & bad debts (3) charity, bad debts & Medicaid shortfall.
- Most common definition in industry is charity & bad debts. Therefore, proposing to use line 30 of Worksheet S-10.
- Several hospital associations have advocated for inclusion of Medicaid shortfalls. Others have advocated to exclude Medicaid.
- CMS proposes to exclude Medicaid shortfalls from uncompensated care costs and invites comments.

Medicare DSH Proposed Rule FFY 2017

- Concerns related to charity care provided in cost report period. CMS plans to revise instructions to report charity on write off date instead of service date.
- Concerns related to exclusion of medical education costs on Worksheet S-10.
- CMS did an analysis of the impact of medical educations costs. This analysis is published in the proposed rule tables.
- CMS found that of over 1,000 teaching hospitals, 830 had an increase in CCR of less than 5%.
- CMS proposes to continue to exclude education costs. DSH is meant to reimburse the cost of uninsured "not for the costs incurred in training residents."

Medicare DSH Final Rule FFY 2017

- Finalizing the policy of using low-income insured days as proxy for uncompensated care. The utilization of S-10 will be delayed until no later than FY 2021.
- Continue to work on "accuracy and consistency" of S-10.
- Finalizing the use of three year average as the basis for Factor 3.
- Final DSH Amount = $14.40B x 75% = $10.80B (Proposed Rule = $10.67B).
- Final DSH Amount for UCC Distribution = $5.98B (Proposed = $6.05B).

Medicare DSH Final Rule FFY 2017

Comments

- CMS should be more transparent in calculations of Factor 1. Medicaid expansion impact on future DSH payments has not been calculated correctly.
- Flawed methodology to assume Medicaid expansion patients will be healthier than existing Medicaid patients.
- CMS should do a reconciliation of Factor 1.
- Significant modifications should be made to the form and instructions for S-10.
- Due to zero sum nature, if hospitals overstate uncompensated care, they benefit financially from doing so, while those that do not aggressively report suffer financial harm.

Medicare DSH Final Rule FFY 2017

Comments

- There must be a strict auditing process for S-10 before it is used for Factor 3.
- Audit process must be consistent and instructions should be made public.
- Set up audit process similar to wage index.
- FY 18 would not provide sufficient time for hospitals to improve their worksheet S-10 reporting.
- Three year phase in is not long enough. Cited 10 year capital as example.
- Use a stop/loss policy to mitigate gains and losses.

Medicare DSH Final Rule FFY 2017

Comments

- Use discharges for uninsured patients for Factor 3. This would create a single auditable source of data for Factor 3.
- Medicaid shortfall should be included/excluded.
- Charity should not include indigent patients if those patients are then funded by a Medicaid DSH program.
- Applying a CCR to bad debt amount is not appropriate because the bad debt is deductible/coinsurance.
- Add a line on S-10 to capture bad debt for insured patients that cannot afford high deductibles.

Medicare DSH Final Rule FFY 2017

Responses

- Computations for Factor 1 are based on actuarial assumptions and the President's budget.
- No reconciliation of DSH amounts. Estimate is most conducive to administrative efficiency, finality and predictability.
- CMS believes it needs to "institute certain additional quality control and data improvement measures prior to moving forward" with S-10.
- After additional measures are in place, planning to use S-10 "no later than FY 2021."
- CMS will issue FAQs and host seminars on S-10 consistency.

Medicare DSH Final Rule FFY 2017

Responses

- Substantive cost report changes could not be made in time for a FY 2018 implementation.
- Typically, there is a 3-4 year time lag in information on the cost report and rate setting. (Example: wage index). Accordingly, cost report periods beginning in FY 2017 would be the first cost reports used for S-10.
- CMS will consider whether S-10 or a proxy should be used for Factor 3 between FY 2017 and FY 2021.
- Plan to instruct MACs to audit providers with the highest uncompensated amounts and sample others randomly.

Medicare DSH Final Rule FFY 2017

Responses

- Audit protocols will not be made public. All CMS & MAC audit procedures and protocols are confidential.
- Plans to issue more detailed instructions for S-10.
- Plans to continue to use three cost report periods as the basis for Factor 3.
- CMS plans to use a three year phase in. A longer period will not be necessary.
- Intend to use charity care and bad debts and to exclude Medicaid when S-10 conversion occurs.

Medicare DSH Final Rule FFY 2017

Responses

- CMS will consider these recommendations to S-10 as it makes revisions to the worksheet in the future.
- Adopted proposal to exclude teaching costs from CCR on S-10.
- Charity Care will be changed to report on write off date vs service date for cost reports beginning on or after October 1, 2016.

Medicare DSH Final Rule FFY 2017

Comments Related to Redistribution:

- Implementing S-10 as the basis for Factor 3 results in "massive funding redistributions" and could not have been predicted or intended by Congress.
- States that will gain the most from conversion to S-10 are states that did not expand Medicaid. States that rejected the expansion should not be rewarded.
- "Under CMS's proposed rule, this would result in lower uncompensated care distributions to Medicaid expansion states and would reward non-expansion states with higher uncompensated care distributions. This appears to be adverse to the principles of the Affordable Care Act, sending more dollars to states that have chosen voluntarily to have a higher share of uninsured patients". Comment was not in the Final Rule but was in Modern Healthcare, August 2, 2016.

Medicare DSH Final Rule FFY 2017

Comments Related to Redistribution:

- Exclusion of courtesy discounts means that hospitals with no discount policy will have more uncompensated care costs than those hospitals that do offer discounts. This creates a "disincentive for hospitals to maintain generous uninsured discount programs."

Medicare DSH Final Rule FFY 2017

Responses Related to Redistribution:

- We will address in future rulemaking.
- Medicaid expansion occurred after the cost report periods used for Factor 3.
- Hospitals can design charity care policy as appropriate and may include discounts offered to uninsured patients as charity care. We will consider any potential disincentives and may revise instructions.

Medicare DSH Uncompensated Care Cost (UCC)

Modeling Factor 3 Based on Worksheet S-10

- Used Hospital FY 2014 to obtain S-10 information from HCRIS.
- Allocation is based on Final FFY 2016 DSH.
- 103 DSH providers did not complete S-10 or have negative amounts for cost. Those providers would lose $102M combined.
- S-10, line 30 is used for UCC cost (Medicaid is excluded).
- State Redistribution – losers (1) NY $281M (2) PA $103M, winners (1) TX $363M (2) NJ $85M.

Medicare DSH Uncompensated Care Cost (UCC)

- Observations from Scenario using only charity & bad debts (S-10 line 30).
  - Redistribution – Fixed Pool $! Total UCC pool for FFY 2016 = $6.4B, FY 2017 = $5.97B.
  - Notable hospital in NY is biggest loser at almost $41M. Probably because they have a huge amount of Medicaid days.
  - Top 8 losers, 5 are NY hospitals.
  - Top 30 winners combined impact is almost $1B.
  - Top winner is a rehab hospital with $144M gain. Total UCC Cost is $737M, total Worksheet A expenses are $269M.

Medicare DSH Uncompensated Care Cost (UCC)

Example 1: Gain (Loss) on Factor 3 conversion to S-10

Medicare Days	202,154	42.96%
Medicaid Days	221,549	47.08%
Other Payors/Uninsured	46,884	9.96%
Total Days	470,587	100%

- Uncompensated Care Cost: $138,000,000
- Loss on Conversion to S-10: $34,000,000 (Based on FFY 2015 Final Rule)
- Mean Medicaid days in pool: 10,876 (20 x mean)
- Mean UCC in pool: $13,403,000 (10 x mean)

Medicare DSH Uncompensated Care Cost (UCC)

Example 2: Gain (Loss) on Factor 3 conversion to S-10

Medicare Days	13,000	11.05%
Medicaid Days	53,761	45.71%
Other Payors/Uninsured	50,843	43.24%
Total Days	117,604	100%

- Uncompensated Care Cost: $344,000,000
- Gain on conversion to S-10: $45,000,000 (Based on FFY 2015 Final Rule)
- Mean Medicaid days in pool: 10,876 (4.9 x mean)
- Mean UCC in pool: 13,403,000 (25 x mean)

Medicare DSH Uncompensated Care Cost (UCC)

- Evaluate current year Worksheet S-10 for accuracy and completeness.
- Prepare current cost report Worksheet S-10 as if DSH UCC allocation will be using it as basis for Factor 3.
- Monitor news and publications for changes to S-10 and any education offered by CMS.
- Continued diligence and focus on reporting of Medicaid days on Worksheets S-2 and S-3.
- Consider outside assistance and analysis of current or prior years S-10.
- Monitor proposed rule in April 2017 for conversion timeline update.
- Verify Medicaid days used in the proposal and final rule within the dates prescribed by CMS.

Final Rule - Appeals

- Included in Outpatient PPS Final Rule – November 2015
- Effective for cost report periods beginning on or after January 1, 2016.
- Provider must "include an appropriate claim for a specific item in its Medicare cost report in order to receive or potentially qualify for Medicare payment for the specific item."
- If the item is not included in the cost report (either affirmative claim for payment or protest), the item will not be included in NPR and no payment may be made pursuant to any order by a reviewing entity in an administrative appeal.

Final Rule - Appeals

- An amended cost report accepted by the Contractor (MAC) qualifies as a request for payment under this rule. "Contractor has discretion whether to accept an amended cost report."
- Reopening of a cost report also qualifies as a request for payment. Reopening is also at discretion of MAC.
- Continues CMS focus that all claims for reimbursement, including protests as to disputed issues, should be included in initial filed cost report.
- Including the claim in the initial filed cost report gives the MAC an opportunity to review and audit the claim and include payment in the NPR.

Final Rule - Appeals

- Inefficient use of resources to use PRRB for issues that are "clearly allowable."
- Providers should know what items to include in the initial cost report and have 5 months to prepare the report. One exception is provided related to Medicaid eligible days.
- CMS instructs the MACs they must accept "one amended cost report submitted within a 12-month period after the hospital's cost report due date, solely for the specific purpose of revising a claim for DSH by using updated Medicaid eligible patient days."
- For situations where a provider may be unaware of a payment error, CMS believes there is ample opportunity to meet the requirement of an appropriate cost report claim.

Questions?

THOUGHTS?

COMMENTS?

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