NAPH Summary of Proposed Medicare DSH Regulations

On Friday, April 26, the Centers for Medicare & Medicaid Services (CMS) released a proposed rule implementing the Medicare disproportionate share hospital (DSH) provisions under the Affordable Care Act (ACA) as part of the Medicare Inpatient Prospective Payment System (IPPS) proposed rule for fiscal year (FY) 2014. Medicare DSH payments are an important component of federal support for safety net providers, and NAPH is working to ensure that implementation of the Medicare DSH provisions preserves the remaining resources for those hospitals providing a disproportionate share of care to vulnerable patients. This summary is intended to provide:

1. background on the Medicare DSH program;
2. summary of the statutory requirements of the ACA;
3. details of CMS’ proposed rule; and
4. next steps for NAPH and its members.

Over the next few weeks, NAPH will undertake a significant analysis of the potential impact of CMS’ proposal and of alternative implementation proposals. We will provide opportunities for NAPH members to learn more about the rule and solicit members’ feedback on its impacts.

Background on Pre-ACA Medicare DSH Program

1) History of the Program

Congress established the Medicare DSH program payment formula in the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985. It became effective for discharges occurring on or after May 1, 1986. Under section 1886(d)(5)(F) of the Social Security Act, hospitals serving a significantly disproportionate number of low-income patients receive an add-on adjustment to their Medicare diagnosis related group (DRG) payments. According to the Medicare Payment Advisory Commission (MedPAC), “the original justification for the adjustment was that poor patients are more costly to treat, so that hospitals with substantial low-income patient loads would likely experience higher costs for their Medicare patients than otherwise similar institutions.”

Over the past decade, many observers, including MedPAC, have agreed that Medicare DSH payments have been viewed as a form of support to hospitals that serve low-income patients because of their higher non-Medicare uncompensated care burdens. However, as MedPAC has noted, and as NAPH has long argued, the “low-income share measure does not include care to all the poor; most notably, it omits uncompensated care.” MedPAC’s own analyses show that Medicare DSH payments are not well targeted at hospitals with high uncompensated care costs. MedPAC found that the 10 percent of hospitals furnishing the most uncompensated care (defined

1 See also 42 C.F.R. § 412.106.
as charity care and bad debt) provide 41 percent of all unpaid care but receive only about 10 percent of Medicare DSH payments. Moreover, “hospitals’ uncompensated care burdens tend to be greater where Medicaid eligibility and coverage are limited. Thus, the omission of uncompensated care from the current measure has kept some of the most financially stressed hospitals from receiving the most help from the DSH adjustment.”

As a result, MedPAC has repeatedly recommended to Congress that the measure of low-income patient share should include poor Medicare patients, patients covered by any indigent care program, and uninsured patients.

2) Eligible Hospitals

To be eligible for the Medicare DSH add-on adjustment, hospitals either must meet a low-income share threshold (based on the DSH patient percentage or DPP) or be a Pickle hospital (i.e., an urban hospital with at least 100 beds that receives more than 30 percent of net inpatient care revenue from state or local government entities for the inpatient care of low-income patients not reimbursed by Medicare or Medicaid).

DPP is the sum of two ratios. The first ratio represents Medicare supplemental security income (SSI) days as a percent of total Medicare days. The second ratio represents Medicaid days as a percent of total days.

3) Medicare DSH Payments

Eligible hospitals receive Medicare DSH payments on a per-discharge basis. Because the add-on payment is an adjustment to each DRG payment, a hospital’s Medicare DSH payments are tied to its volume and mix of Medicare inpatient cases. Other than Pickle hospitals, eligible hospitals’ DPP level, urban or rural location, number of beds, and status as a rural referral center or sole community hospital determine the exact amount of the DSH adjustment. Pickle hospitals receive a 35 percent adjustment. In 2011, the federal government made roughly $11 billion in Medicare DSH payments.

Congressional Intent Behind the ACA Medicare DSH Provision

While there is limited legislative history on the ACA, reports from the committees of jurisdiction expressed that the intent of the Medicare DSH reforms was to maintain the adjustment, but only at the empirically justified level, and then make an “additional hospital payment . . . based on the estimated amount of uncompensated care, excluding bad debt, provided by the hospital.”

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5 Id.
MedPAC also described its understanding of Congress’ purpose in enacting this provision as consistent with its recommendation to account for care provided to all patients, including those with no ability to pay, and for uncompensated care in the DSH formula. “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, the Congress made several changes in the DSH payments as part of PPACA…. We expect CMS to define uncompensated care as non-Medicare bad debts and charity care, as in current Medicare cost reports.”

ACA Statutory Framework for Medicare DSH Reductions and New Payment Methodology

Section 3133 of the ACA amends the Medicare DSH adjustment provision under section 1886(d) (5) (F) of the Act to reduce Medicare DSH adjustment payments beginning with discharges in FY 2014 (beginning Oct. 1, 2013). In addition, it establishes Section 1886(r), which provides for an additional payment for a hospital’s uncompensated care. The Congressional Budget Office has estimated that the net reduction in DSH payments will be $22.1 billion over 10 years.

For discharges on or after FY 2014, hospitals that are eligible to receive Medicare DSH payments will receive only 25 percent of the add-on adjustment amount they would have received under the current formula. CMS refers to this amount as the “empirically justified Medicare DSH payment.” The uncompensated care portion of the payment would be derived from three factors. The remaining 75 percent of how much these hospitals would have received (Factor 1) would be (1) aggregated; (2) reduced by the percentage change in the national uninsurance rate for the nonelderly as compared with FY 2013, plus an additional statutory reduction amount of 0.001 for FY 2014 (Factor 2); and (3) distributed among all DSH eligible hospitals based on each hospital’s relative level of uncompensated care (Factor 3). CMS refers to this payment as the “uncompensated care amount.”

CMS’ Proposed Changes to Medicare DSH

Hospitals that qualify for Medicare DSH payments, either based on DPP or by qualifying as a Pickle hospital, will receive their FY 2014 Medicare DSH payments based on the changes mandated by the ACA.


9 See CBO, Cost Estimate, H.R. 4872, Reconciliation Act of 2010 (Final Health Care Legislation), March 20, 2010. Estimates of future Medicare DSH spending have since been revised to reflect lower coverage projections as a result of the Supreme Court decision making the Medicaid expansion under the ACA voluntary.

10 ACA Medicare DSH provisions apply to PPS hospitals, including hospitals in Puerto Rico and hospitals participating in the Bundled Payment for Care Improvement Initiative. The provisions do not apply to Maryland hospitals, sole community hospitals, and hospitals participating in the Rural Community Hospital Demonstration.
Pickle hospitals would receive 25 percent of the 35 percent add-on adjustment for which they would otherwise qualify. Along with all other DSH eligible hospitals, Pickle hospitals will be able to qualify for uncompensated care-related DSH payments, based on their uncompensated care.

Eligibility for empirically justified Medicare DSH payments remains unchanged. Only hospitals eligible for the empirically justified Medicare DSH payments will qualify for uncompensated care-based Medicare DSH payments. CMS proposes to make a determination concerning eligibility for interim uncompensated care payments based on each hospital’s estimated DSH status for FY 2014 using the most recent data available. CMS proposes to base its final determination of a hospital’s eligibility for uncompensated care payments on the hospital’s actual DSH status on the cost report for that payment year.

Proposed Medicare Changes at a Glance

a) Total Medicare DSH payments without regard to ACA: $12.338 billion
b) 25% will continue to be paid based on existing methodology: $3.084 billion
c) Uncompensated care payments
   i) Calculation
      (1) Aggregate amount available for uncompensated care payment = Factor 1 x Factor 2 ($8.217 billion)
         (a) Factor 1 – 75% of how much DSH would have paid ($9.2535 billion)
         (b) Factor 2 – percentage change in estimated uninsurance rate plus 0.001 (88.8%)
      (2) Eligible hospitals’ share of uncompensated care payments = Factor 3 x aggregate amount available
         (a) Factor 3 – hospital low-income days as a percent of all eligible hospitals’ low-income days

1) Empirically Justified Medicare DSH Payment

The proposed rule specifies that the empirically justified Medicare DSH payment will continue to be paid to DSH eligible hospitals as a percentage add-on payment. The amount of the add-on payment continues to depend on a hospital’s DPP or Pickle status, but will be reduced to 25 percent of what would otherwise have been paid. Hospitals will continue to receive the add-on payment for each claim as a per-discharge, interim payment based on the best available data concerning each hospital’s eligibility for and amount of DSH payment. Final eligibility and amount of the add-on payments will be determined at the time of cost report settlement. CMS proposes to make changes to the cost report so that the empirically justified Medicare DSH payment can be settled at the appropriate level. The agency said it will release detailed operational instructions and cost report instructions after the issuance of the final rule.
CMS estimates the total amount of empirically justified Medicare DSH payments for FY 2014 to be $3.084 billion. This total represents 25 percent of $12.338 billion, an amount the CMS Office of the Actuary (OACT) \(^{11}\) estimated in February 2013 to be the amount of Medicare DSH payments that otherwise would have been paid to DSH-eligible hospitals without regard to the ACA’s Medicare DSH provision. Citing the need to create predictability and finality, and administrative efficiency, CMS proposes to finalize both the total amount of Medicare DSH payments that otherwise would have been paid and the total amount of empirically justified Medicare DSH payments using the most recent OACT projections available prior to the issuance of the final rule. If this proposal if finalized, CMS plans to use OACT’s July 2013 Medicare DSH estimates. CMS does not plan to revise or update these estimates.

OACT uses the most recently submitted cost report to identify current Medicare DSH payments and the most recent DSH payment adjustments in the IPPS impact file, and applies inflation updates and assumptions for future changes in utilization and case mix to estimate Medicare DSH payments for the upcoming fiscal year.

2) Uncompensated Care-based Medicare DSH Payment

To determine the amount of each hospital’s uncompensated care-based Medicare DSH payment, the ACA directs CMS to calculate Factors 1, 2, and 3. The product of the first two factors produces the total amount available to be distributed. The formula for the third factor produces each hospital’s relative share of total hospital uncompensated care. Factor 3 applied to the product of Factors 1 and 2 would produce each hospital’s uncompensated care-based Medicare DSH payment.

a. Aggregate Amount Available for Uncompensated Care-based Medicare DSH Payment (Factor 1 x Factor 2)

To determine the aggregate amount available for uncompensated care-based Medicare DSH payments, CMS proposes to reduce Factor 1 by the percentage change in the national uninsurance rate and a statutory reduction amount of 0.001 for FY 2014 (Factor 2).

i. Factor 1

Factor 1 ($\text{9.2535 billion}$) is the difference between the total amount of Medicare DSH payments that otherwise would have been paid ($\text{12.338 billion}$) and the total amount of empirically justified Medicare DSH payments ($\text{3.084 billion}$).

\(^{11}\) OACT projects Medicare DSH payments on a biannual basis, typically in February and July of each year. The February estimate is based on data from December of the previous year and the July estimate is based on data from June. Each estimate is based on the most recently filed Medicare hospital cost report with Medicare DSH payment information and the most recent Medicare DSH patient percentages and Medicare DSH payment adjustments provided in the IPPS Impact File.
Factor 2 equals the sum of the percentage change in the national uninsurance rate and a statutory reduction amount of 0.1 percent for FY 2014. For FYs 2015-2017, the statutory reduction amount increases to 0.2 percent.

To determine the percentage change in the national uninsurance rate for FYs 2014-2017, CMS proposes to use the Congressional Budget Office’s (CBO’s) estimate from March 20, 2010, as the national uninsurance rate for FY 2013, the baseline. Using this source, the uninsurance rate for FY 2013 is 18 percent. This CBO estimate includes all residents younger than 65, including undocumented immigrants. CMS notes that the ACA does not permit CMS to exclude anyone other than those who are at least 65 years old.

For FY 2014’s uninsurance rate, CMS proposes to use similar data from the most recent available CBO estimate of the percentage of uninsured individuals. As CMS noted, using updated CBO estimates would account for changes in the environment that can impact insurance rates, such as more recent economic conditions and impact of state decisions with respect to Medicaid expansion in light of the Supreme Court’s decision in the National Federation of Independent Business v. Sebelius case. At the time of publication of the proposed rule, the Feb. 5, 2013, CBO estimate of uninsurance for all residents is the most recently available. In this estimate, CBO projects the national uninsurance rate for FY 2014 to be 16 percent. CMS proposes to update the uninsurance rate if CBO releases a more up-to-date estimate prior to publication of the FY 2014 IPPS final rule. CMS will not retroactively adjust the uninsurance rate to account for estimates that become available after publication of the final rule.

Using FY 2013 as the baseline, CMS calculates the percentage reduction in the national uninsurance rate to be 11.1 percent for FY 2014 ((0.18 – 0.16) / 0.18). CMS then adds the additional statutory reduction amount of 0.1 percent for FY 2014 to the 11.1 percent to arrive at a total reduction factor of 11.2 percent. Following the statutory language for determining Factor 2, CMS calculates Factor 2 to be 88.8 percent (or 1 minus 11.2 percent).

Multiplying Factors 1 and 2, CMS determines the amount of Medicare DSH payments available for distribution based on uncompensated care to be $8.217 billion for FY 2014. This amount will change if the underlying data changes before publication of the final rule.

b) Eligible Hospitals’ Share of Total Hospital Uncompensated Care (Factor 3)

Factor 3 is a hospital-specific value that represents each hospital’s proportion of total hospital uncompensated care for all eligible hospitals. Applying each eligible hospital’s Factor 3 to the product of Factors 1 and 2 produces each hospital’s amount of uncompensated care-based Medicare DSH payment.

In considering various ways of defining uncompensated care and available data sources, CMS notes that almost all definitions of uncompensated care include both charity care and bad debt.

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\[12 \text{ $9.2535 \text{ billion} \times 88.8 \text{ percent} = $8.217 \text{ billion}}\]
CMS also notes that Worksheet S-10 of the Medicare cost report could potentially provide the most complete uncompensated care cost data for Medicare hospitals. However, for the following reasons, CMS ultimately proposes not to define uncompensated care in a way that would require use of Worksheet S-10 data:

- there is concern regarding the accuracy and consistency of Worksheet S-10 data;
- only data that have been publicly available, subject to audit, and used for payment purposes historically be used for determining payments;
- CMS does not want to create a disincentive for states that wish to expand their Medicaid programs; and
- data on uncompensated care costs that would reflect efforts to expand coverage would not be available until FY 2016 or later.

CMS expects reporting on Worksheet S-10 to improve over time and notes that it may proceed with a proposal to use Worksheet S-10 data to determine uncompensated care costs in the future. For these reasons, CMS proposes to use inpatient utilization by insured low-income patients as a proxy for uncompensated care. Specifically, CMS proposes to use inpatient days of Medicare SSI patients and inpatient days of Medicaid patients to determine Factor 3. A hospital’s insured low-income inpatient days would represent that hospital’s numerator for Factor 3. The sum of insured low-income inpatient days for all hospitals that CMS estimates would receive Medicare DSH payments for FY 2014 would represent the denominator of Factor 3. The resulting quotient is a hospital’s Factor 3. Although Medicare SSI and Medicaid days also are part of the calculation to determine the hospital DPP, CMS notes that use of these two data points for the uncompensated care-based Medicare DSH payment will lead to a different set of results because the DPP calculation subjects them to additional computations.

CMS proposes to use the cost report as the source for Medicare SSI and Medicaid days. For Medicare SSI days, CMS proposes to use data used to update the SSI ratio on Worksheet E, Part A (i.e., MEDPAR claims data). For Medicaid days, CMS proposes to use data from Worksheet S-2, Part I. For FY 2014, CMS proposes to use the FY 2011 SSI ratios for the Medicare-SSI days (or, if the FY 2011 SSI ratios are unavailable, the FY 2010 SSI ratios) and data from the 2010/2011 cost reports for Medicaid days.

CMS’ estimates of eligibility to receive FY 2014 Medicare DSH payments are based on the December 2012 update of the Provider Specific File that lists the most recently available DPP and DSH payment adjustments for hospitals that qualify to receive DSH payments. CMS estimates that 2,349 hospitals, or 68 percent of all applicable hospitals, would be eligible for DSH payments in FY 2014.

c) Further CMS Discussion Regarding Worksheet S-10 Data

Although CMS did not propose to use data from Worksheet S-10, the agency spent a considerable amount of time discussing uncompensated care cost data on Worksheet S-10. Specifically, CMS notes that almost all definitions of uncompensated care include both charity care and bad debt. CMS would define charity care to be cost of care for patients that meet hospitals’ individual criteria for charity care net of any partial payments received by the hospital.
from patients (as reported on line 23, column 3 of Worksheet S-10). CMS would define bad debt to include cost of non-Medicare bad debt and non-reimbursed Medicare bad debt (as reported on line 29 of Worksheet S-10). For non-Medicare bad debt, CMS would have included cost of hospital care for non-Medicare patients that have the financial capacity to pay, but are unwilling to settle the claim. For non-reimbursed Medicare bad debt, CMS would have included allowable coinsurance and deductibles for Medicare patients from whom the hospital has sought to collect payment through reasonable collection efforts.

CMS also notes that some definitions of uncompensated care include Medicaid shortfalls. However, CMS also notes that shortfalls are not unique to Medicaid and can occur with patients covered by commercial payers.

For the reasons stated above regarding Worksheet S-10 data, CMS decided not to define uncompensated care based on uncompensated care costs and plans to monitor the potential effects of different definitions of uncompensated care on measures designed to expand insurance coverage under the ACA.

3) How Will Payments Be Made?

To receive uncompensated care-based Medicare DSH payments, hospitals must be eligible to receive the empirically justified Medicare DSH payment. Payments will be determined prospectively prior to the payment year based on the methodology described above. CMS proposes to make payments on an interim, periodic basis, not on a per-discharge basis. (Note that for bad debt payments, this language means biweekly. CMS did not specify in the proposed rule how often Medicare DSH payments would be made.)

At cost report settlement, the fiscal intermediary/Medicare administrative contractor will make a final determination concerning whether each hospital is eligible for empirically justified Medicare DSH payments and, therefore, uncompensated care payments in FY 2014 and each subsequent year. However, CMS does not propose to re-estimate Factor 1, Factor 2, or Factor 3 in the reconciliation process. If a hospital is found to be ineligible at that time, the hospital will have to repay to CMS any Medicare DSH payments made thus far.

4) Administrative and Judicial Review

In accordance with the ACA, CMS notes that there will not be any administrative or judicial review of the estimates developed for purposes of applying the three factors used to determine uncompensated care-based Medicare DSH payments, or for the periods selected to develop the estimates.

5) Other Implications for Medicare Reimbursement

In the proposed rule, CMS notes that changes to the Medicare DSH program could impact other Medicare reimbursements. Specifically, CMS proposes to raise the outlier threshold (from $21,821 to $24,140) to account for the decrease in the DSH adjustments so that total outlier payments remain within CMS’ target of accounting for more than 5.1 percent of total operating
IPPS DRG payments. Moreover, because only the empirically justified DSH payment will continue to be paid on a per-discharge basis, only that portion will be reflected in the PPS pricer, which many Medicare Advantage (MA) plans use to pay hospitals. As proposed, uncompensated care-based Medicare DSH payments will not be included in the pricer. Providers that contract with MA plans for the “Medicare rate” could see lower payments.

Next Steps

NAPH encourages members to review the hospital-specific data posted by CMS to verify the Medicaid and Medicare SSI days to be used for the calculation of Factor 3. A link to the data can be found here: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.html, Downloads, Medicare DSH Supplemental File. Hospitals have until June 25, 2013, to inform CMS of any errors in this data. Since the ACA does not permit appeals of CMS’ calculations, this is your only opportunity to verify the accuracy of the data.

NAPH also encourages you to consider the impact of various alternative definitions for uncompensated care (e.g., a definition that reflects the cost of treating the uninsured, the amount of outpatient services provided to low-income patients, and/or the intensity of resources provided to medically-complex patients) on your facility, and share your insights with NAPH staff. We also encourage you to submit your own comment letters, and to use NAPH’s draft letter, which will be circulated to members in June, as appropriate.

On May 23, at 2 pm ET, NAPH will host a webinar on the details of the Medicare DSH provision in the FY 2014 IPPS proposed rule. Details will be sent via email. At the NAPH 2013 annual conference, in Hollywood, Fla., NAPH also will devote a session to discussion of both the Medicaid and Medicare DSH changes. Please look for emails from NAPH in the coming days and weeks for additional resources on this topic.

If you have questions or comments, please contact Xiaoyi Huang, assistant vice president for policy, at xhuang@naph.org or (202) 585-0127.