Medicare DSH: What is in the Proposed Rule and What it Means for Hospitals

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Overview

- Pre-ACA Medicare DSH Program
- ACA Medicare DSH Reduction and Revised Methodology
- CMS’ Proposal
- Next Steps for NAPH Members
Pre-ACA Medicare DSH Program
History of Medicare DSH

- Established in 1985

- “Poor patients are more costly to treat...hospitals with substantial low-income patient loads would likely experience higher costs for their Medicare patients than otherwise similar institutions.”

- CMS made $10.8b in Medicare DSH payments to hospitals in FY 2010
Eligible Hospitals and Medicare DSH Payments

- Hospitals eligible for Medicare DSH based on disproportionate patient percentage (DPP) threshold or Pickle hospital status

- Eligible hospitals receive a percentage add-on to each Medicare DRG payment

- Thus, hospitals with high levels of Medicaid and Medicare inpatients receive the most Medicare DSH payments under pre-ACA formula
Pre-ACA Medicare DSH Payment In Detail

- Determine DPP

\[
\left( \frac{\text{Medicare SSI Days}}{\text{Total Medicare Days}} \right) + \left( \frac{\text{Medicaid, non-Medicare Days}}{\text{Total Patient Days}} \right)
\]

- Based on a hospital’s urban/rural status and number of beds, apply complex rules to DPP to determine hospital’s DSH adjustment percentage
Pre-ACA Medicare DSH Payments in Detail

- Medicare DSH payments are poorly targeted

- “[T]he current low-income share measure does not include care to all the poor; most notably, it omits uncompensated care.”
  
  – MedPAC

- Top 10 percent of the hospitals providing 41 percent of all unpaid care receive only about 10 percent of Medicare DSH payments
Medicare DSH in the ACA
Medicare DSH in the ACA

- $22.1 billion in Medicare DSH cuts in FYs 2014-2019 (pre-Supreme Court decision)

- Effective for FY 2014, eligible hospitals will receive 25 percent of what they would have received as an add-on payment to each DRG

  CMS calls this the empirically justified payment
Medicare DSH in the ACA

- The remaining portion will be:
  - reduced to reflect change in national uninsurance rate as compared to FY 2013
  - distributed based on hospitals’ relative levels of uncompensated care costs (UCC)

- Thus, hospitals with higher UCC would receive more Medicare DSH payments under the ACA formula
ACA Changes

Old formula benefits high Medicaid & Medicare

Medicare DSH

Old Formula (25%)

(Medicaid expansion = increased utilization)

New Formula

75% of old amounts

Reduced as uninsured rate decreases

New formula benefits high UCC
UCC-based Medicare DSH Payment

- Separate payment from per-discharge add-on

- Each hospital’s share = ratio of hospital UCC to all hospitals’ UCC

- CMS may use “alternative data … which is a better proxy for the costs … for treating the uninsured.”
CMS’ Proposal
Proposed Changes at a Glance

- Total Medicare DSH payments without regard to ACA: $12.338 billion
  - $3.084 billion will continue to be paid as add-on payments to each DRG
  - $9.254 billion as starting point for determining UCC-based Medicare DSH payments
Eligibility for Medicare DSH payments

- For empirically justified payments: unchanged (DPP or Pickle)
- For UCC-based payments: must already be eligible for empirically justified payments
  - CMS will make initial determination prior to fiscal year
    - Action: confirm CMS’ posted data
  - Final eligibility based on actual DSH status on the cost report
Empirically Justified Payments

- Continue to be paid as per-discharge add-on
- Reduced to 25% of adjustment
- CMS estimates $3.084 billion for FY2014
- Subject to same cost report settlement process
- Could see adjustment increase if Medicaid utilization increases
UCC-based Medicare DSH Payments

- Paid as a lump sum amount
- on an “interim, periodic basis”
- No administrative or judicial review
Determining UCC-based Medicare DSH Payments

Factor 1
75% of $12.338b (what would otherwise be paid)

$9.254b

Factor 2
Change in uninsurance rate and 0.001

88.8%

Factor 3
Hospital’s share of UCC

$8.217b
Determining Factor 3

- ACA definition of Factor 3:

  “the amount of uncompensated care for such hospital for a period selected by the Secretary (as estimated by the Secretary, based on appropriate data (including, in the case where the Secretary determines that alternative data is available which is a better proxy for the costs of subsection (d) hospitals for treating the uninsured, the use of such alternative data.))”
CMS Proposes a Proxy for UCC

- Notes that almost all definitions of UCC include charity care + bad debt
- However, due to shortcomings of Worksheet S-10 data, CMS opts for Medicare SSI days and Medicaid days
- Which are already used to determine DPP, which in turn determines hospitals’ empirically justified payments
Determining Factor 3

(Hospital’s Medicare SSI Days + Medicaid Days)

(Medicare SSI Days + Medicaid Days for All DSH Hospitals)
Determining UCC-based Medicare DSH Payments

\[
8.217 \text{ billion} \times \left( \frac{\text{Factor 1}}{\text{Factor 2}} \right) \times \text{Factor 3}
\]

- Factor 3: Hospital’s share of UCC
Alternative UCC Definitions Considered

- Notes that only some definitions include Medicaid shortfall
- Does not appear to favor inclusion of Medicaid shortfall in UCC definition
- Plans to monitor effects of different UCC definitions on measures designed to expand coverage under the ACA
Sources of UCC Data Considered

- Worksheet S-10 (Medicare cost report) could “potentially provide the most complete data”, includes:
  - Charity care and bad debt
  - Medicaid/CHIP Shortfall
    - Offset by provider taxes but not IGTs/CPEs
    - State/Local Program Shortfall

- Medicaid DSH audit data on UCC not available for all hospitals
Shortcomings of S-10 Data Discussed

- Concern regarding accuracy and consistency of S-10 data
  - But is using S-10 charity care data to determine meaningful use incentives

- S-10 data have not been publicly available, subject to audit, and used for payment purposes

- Will reconsider in future years
Also...

- 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 and later
Implications of Changes to Medicare DSH Payments

- ACA change to Medicare DSH breaks the link to Medicare discharges
  - Benefits hospitals with relatively fewer Medicare patients

- CMS’ proxy is less redistributive than anticipated
  - Not based on actual UCC
  - Does not capture uninsured UCC

- Not clear how long CMS will use proxy
Would an Alternative Proxy be Preferable?

- Use of inpatient days does not reflect:
  - Complete picture of hospital’s low-income patient population
  - Volume of outpatient care provided
  - Relative resource intensity of care provided

- S-10 UCC data vs. proposed low-income days?
- Proposed low-income days, adjusted to overcome the shortcomings noted above?

- NAPH is undertaking significant data analysis and wants to hear from you
Factors Affecting Relative Impact on Your Hospital

- Hospital patient mix
- Medicaid expansion*
- Inpatient vs. outpatient utilization
- Financing of Medicaid payments
- Hospital case mix
- Others?

*Lag in data means no impact reflecting expansion for several years
Calculate Your Estimated FY 2014 DSH Payments

- Download Medicare DSH supplemental file at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.html
- Locate hospital’s UCC share in “Proposed Factor 3” column
- Take UCC share and multiple by $8.217 billion
- Add result to 25% of your current total DSH payments
Considerations for Members

- Is my FY 2014 DSH payment under CMS’ proposal:
  - More or less than FY 2013 DSH payment?
  - More or less than it would be under an alternative proxy for UCC?
- How will my hospital be impacted in future years when Factor 2 decreases and aggregate amount available for UCC payments decrease?
- Am I accurately completing the S-10?
Next Steps for Members

- Review the hospital-specific data posted by CMS
  - Verify eligibility and low-income days before June 25
- Share insight on proposal and alternatives with NAPH
- Attend annual conference session
- Comments due to CMS on June 25
Questions?

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