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## the new Medicare DSH payment what's baked into the pie—and how it's sliced

The Medicare program's new method for calculating disproportionate share hospital (DSH) payments reduces DSH payments to all qualifying hospitals—possibly to a greater extent than Congress had intended in the Affordable Care Act.

### AT A GLANCE

Medicare's new disproportionate share hospital (DSH) payment method combines a payment amounting to 25 percent of what a hospital would have traditionally received with an additional amount that is the product of three factors:

- > An estimate of the aggregate amount of DSH payments that the Medicare program would have paid in FFY14 under the traditional payment method
- > An adjustment to that figure to account for an estimated percentage change in the national uninsured rate between FFY13 and FFY14
- > Each hospital's estimated percentage of the total uncompensated care costs incurred by all hospitals that are expected to qualify for DSH payments

On Aug. 19, 2013, the Centers for Medicare & Medicaid Services (CMS) published a final rule implementing a new payment method for Medicare disproportionate share hospital (DSH) payments for FFY14 and beyond.<sup>a</sup> This new method, under the mandate of the Affordable Care Act (ACA), substantially reduces aggregate DSH payments and redistributes DSH payments among hospitals in unexpected ways that hospital finance officers should understand.

In enacting the new DSH methodology, Congress intended to reduce DSH payments as healthcare coverage expands under other provisions of the ACA, and to begin distributing the payments based in large part on uncompensated costs incurred by hospitals in caring for uninsured patients. The Congressional Budget Office (CBO) and the CMS actuary estimated when the ACA was enacted that aggregate DSH payments might be reduced by \$25 billion to \$50 billion over 10 years.<sup>b</sup> The actual 10-year payment impact of the new regime may vary considerably from those estimates, however, based on CMS's implementation of the statute.

Congress left CMS broad discretion to fill in the blanks in the statute with estimates as to many of the major aspects of the new DSH payment system. Congress also included a statutory provision that could potentially preclude a court or administrative tribunal from reviewing some major aspects of the agency's

a. The DSH payment final rule was published in the *Federal Register* as part of the final rule for the hospital inpatient prospective payment system.

b. See memorandum from Richard Foster, chief actuary, CMS, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended," April 22, 2010, ([graphics8.nytimes.com/packages/pdf/health/oactmemo1.pdf](http://graphics8.nytimes.com/packages/pdf/health/oactmemo1.pdf)), and Letter to Honorable Harry Reid, from Douglas W. Elmendorf, director, CBO, "Table 1: Estimate of the Effects on Direct Spending and Revenues for Non-Coverage Provisions of H.R. 3590, the Patient Protection and Affordable Care Act, as Passed By the Senate" ([http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/113xx/doc11307/reid\\_letter\\_hr3590.pdf](http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/113xx/doc11307/reid_letter_hr3590.pdf)).

implementation of the statute—a move that appears to run counter to the constitutional framework of checks and balances. Whether and to what extent CMS actually has unbridled power to implement this new methodology have not yet been tested, but in any event, it seems likely that DSH payment reductions may exceed what Congress and stakeholders might have expected when the ACA was enacted.

### The Traditional DSH Payment

Since 1986, the DSH payment has been one of the percentage add-ons to the base payment rate per discharge under the hospital inpatient prospective payment system (IPPS). In enacting the original DSH payment provisions, Congress determined that hospitals that serve a disproportionate share of low-income patients tend to incur higher-than-average costs per Medicare case for two reasons:

- > Low-income Medicare patients tend to be sicker and more costly to treat than other patients within a given DRG.
- > Hospitals that treat a large proportion of low-income patients overall tend to have certain characteristics, including utilization and staffing patterns, that cause them to reasonably incur higher operating costs for all cases.

Those two considerations are represented in two proxy measures used to calculate the DSH payment adjustment percentage for all but a handful of hospitals that qualify for DSH payment.<sup>c</sup> The DSH adjustment percentage is calculated based on a hospital's "disproportionate patient percentage" for a cost reporting period. The disproportionate patient percentage is the sum of two fractions, referred to as the "Medicare Part A/Supplemental Security Income (SSI) fraction" and the "Medicaid fraction."

The Medicare Part A/SSI fraction counts a hospital's number of patient days for patients who were entitled to benefits under both Medicare Part A and the Federal SSI program and divides that number by the hospital's total number of patient

c. Under the so-called "Pickle method," a few urban hospitals with at least 100 beds qualify for a 30 percent DSH payment add-on based on their percentage of net inpatient care revenues consisting of state and local government payments (other than Medicaid payments) for indigent care.

days for patients who were entitled to benefits under Medicare Part A. The Medicaid fraction counts a hospital's number of patient days attributable to patients who were eligible for Medicaid but not entitled to Medicare Part A and divides that number by the hospital's total number of patient days for a cost-reporting period.

### Impetus for the New Method

In March 2007, the Medicare Payment Advisory Commission (MedPAC) issued a report to Congress asserting that about 75 percent of the traditional DSH payment to hospitals was not "empirically justified" by higher costs per case. The report observed that a portion of the DSH payment could be redirected as a means of offsetting a portion of hospitals' costs of uncompensated care by breaking the link to per-case payments and distributing those funds based on each hospital's uncompensated care costs. In that regard, the report asserted that existing DSH payments, based on Medicaid and low-income Medicare Part A patient days, are "poorly targeted to hospitals' shares of uncompensated care," and that "hospitals most involved in teaching and in treating Medicaid and low-income Medicare patients are not, by and large, the ones that devote the most resources to treating patients who are unable to pay their bills." The report recommended that CMS improve its existing Medicare cost report form for reporting costs of uncompensated care and other forms of indigent patient care (S-10) and its accompanying instructions to address widely acknowledged inaccurate and inconsistent reporting due to insufficient program guidance as to what should be reported on S-10.

### The New DSH Payment

The new DSH payment methodology expressly responds to MedPAC's 2007 report. The new payment method became effective on Oct. 1, 2013, for operating DSH (not capital DSH), and will apply to all discharges at qualifying hospitals on or after Oct. 1, 2013. There will be no delay in the effective date or transition period and no stop-loss or stop-gain caps on payments under the new system, as was suggested in some comments.

The new payment method applies to all general acute care hospitals that are paid under the IPPS—referred to here as *subsection (d) hospitals*—and that qualify for the traditional DSH based on their “disproportionate patient percentage” or under the Pickle method. The new DSH payment does not apply to:

- > Sole community hospitals that are paid on the basis of their own hospital-specific payment rate per discharge
- > Maryland hospitals that are paid under a Medicare waiver
- > Hospitals participating in the Rural Community Hospital Demonstration Program
- > Critical access hospitals that are paid on reasonable cost basis<sup>d</sup>

When CMS put the final IPPS rule on display, it posted a DSH Supplemental Data File listing IPPS hospitals that are expected to qualify for DSH in FFY14 (based on prior-period data) and the agency’s calculation of the amount of the additional payment that will be made to each of those hospitals for discharges in FFY14.<sup>e</sup> The final rule provides that those amounts will not change. The only thing that could change is whether the hospital receives those amounts, which could occur in two circumstances:

- > When a hospital that is expected to qualify for the traditional DSH payment does not in fact qualify based on its disproportionate patient percentage for the current cost year (in which case, interim payments made for traditional DSH and uncompensated care costs will have to be repaid at cost report settlement)
- > When a hospital that is not expected to qualify for the traditional DSH payment does in fact qualify based on its disproportionate patient

d. Sole community hospitals are paid the higher of the standard IPPS payment methodology (including DSH) or their own hospital-specific rate per discharge derived from one of several potential base periods. In a change from the proposed rule, the final IPPS rule confirms that CMS will account for the additional payment for uncompensated care costs in determining the higher of the hospital-specific and the IPPS federal rate.

e. “FY 2014 IPPS Final Rule Data Files,” CMS, [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](http://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).

percentage for the current cost year (in which case, the hospital will receive the DSH payment as calculated using the new DSH payment methodology)

### Payment Components

The new DSH payment regime comprises two components.

The first component is a payment equal to 25 percent of the amount that a hospital would have been paid under the traditional DSH payment method, based on the disproportionate patient percentage. But for the 75 percent reduction, that payment will be calculated and paid the same way as always.

The second component is an additional payment amount for uncompensated care costs. This additional payment amount is listed for each hospital that is expected to qualify for DSH in a Supplemental Data File that CMS posted to its website when it put the final IPPS rule on display. That amount is the product of three factors.

**Factor 1.** To calculate payment for uncompensated care, CMS first must estimate the amount equal to 75 percent of the aggregate amount of DSH that would have been paid to all hospitals for discharges in FFY14 under the traditional payment calculation had the new payment method not been prescribed in the ACA. Under the proposed IPPS rule, CMS would have calculated this factor using an estimate from its actuary, which started with DSH payments made in 2009 and applied certain update factors to project the calculation forward to 2014.

That original estimate did not account for the effect, under the traditional DSH payment calculation, of any anticipated expansion of Medicaid coverage in 2014, under the ACA. And the fact that traditional DSH payment tended to increase with increasing Medicaid patient days suggests that the projection of traditional DSH payments made for 2014 should account for projected increases in Medicaid coverage.

The final IPPS rule calls for CMS to adjust the Factor 1 estimate to account for Medicaid expansion. The rule itself does not identify the magnitude of the Medicaid expansion estimated by CMS for this purpose or the approach CMS used to revise the Factor 1 estimate to account for that expansion. However, the Factor 1 estimate indicated in the final rule (\$9.58 billion) is about 3.6 percent greater than that indicated in the proposed rule (\$9.25 billion).

The approach for estimating Factor 1, described in the final rule, takes into account the effect of the CMS current policy on the counting of patient days for individuals who receive Medicare benefits through enrollment in a Medicare Advantage plan under Part C of the Medicare program. Several comments expressed objections to this aspect of the proposed rule, noting among other things that a federal district court decision in November of last year vacated the rulemaking in which CMS adopted that policy change.<sup>f</sup> In the final rule, CMS decided not to change this aspect of its method, stating that it has appealed the district court decision to the Court of Appeals for the District of Columbia.

Meanwhile, the final rule provides that CMS will not revise this estimate of Factor 1 for any reason, including any affirmation of the federal court decision vacating the rule in which the agency first adopted its current policy. (For an additional discussion of the treatment of Part C Medicare Advantage patient days, go to [hfma.org/hfm](http://hfma.org/hfm).) As a result, the Factor 1 estimate may be substantially understated. One consulting group commenting on the proposed rule estimated that the agency's projection of the vacated rule on Medicare Part C patient days had the effect of reducing the Factor 1 estimate by nearly 10 percent, which would translate to 10 percent payment reduction across-the-board to all hospitals under the new methodology.

CMS alleges that it is unable to quantify the impact of this issue on DSH payments, even as it purported

to have accounted for a 2014 expansion of Medicaid coverage in its Factor 1 estimate. But if the agency was able to account for an expansion of Medicaid eligibility in 2014 and estimate its impact in increasing DSH payments, then it certainly could estimate the DSH payment impact for 2014 of removing Part C patient days from Part A/SSI fraction and adding the Medicaid-eligible portion of those days to the Medicaid fraction numerator.

**Factor 2.** To arrive at the second factor, CMS must adjust the amount calculated under Factor 1 to account for the percentage change in the national uninsured rate from 2013 to 2014. In calculating this factor, CMS assumes a baseline uninsured rate of 18 percent for 2013, as estimated by CBO in a report prepared in 2010, prior to enactment of the ACA. In the final rule, CMS also uses a CBO report as a basis for estimating the uninsured rate for FFY14; however, in a significant change from the proposed rule, the final rule applies an estimate of the uninsured rate for FFY14 that was normalized using CBO estimates of the uninsured rates for calendar years 2013 and 2014. As a result, the final rule uses an estimated uninsured rate for FFY14 that is higher than that used in the proposed rule, resulting in a lower Factor 2 adjustment for the percentage change in the uninsured rate.

The adjusted "pool" for FFY14, after the application of Factors 1 and 2, will be about \$9.03 billion, which is nearly 10 percent greater than the pool that would have been calculated under the proposed rule. As noted above, however, CMS will not reconcile the final estimates of Factors 1 or 2 with actual data for FFY14 or later fiscal years.

**Factor 3.** The third factor represents each qualifying hospital's estimated percentage of the total uncompensated care costs incurred by all hospitals that are expected to qualify for the DSH payment. The ACA requires CMS to estimate this proportion "for a period selected by the Secretary," based on "appropriate data" or "alternative" available data that are a "better proxy" for the costs of subsection (d) hospitals for treating the uninsured.<sup>g</sup>

f. See *Allina Health Services v. Sebelius*, 904 F. Supp. 2d 75 (D.D.C. 2012).

g. Social Security Act § 1886(r)(2).

As discussed at some length in both the proposed and final rules, hospitals are required to report uncompensated care costs and other indigent patient care costs on worksheet S-10 of the hospital cost report form. Nevertheless, in the proposed and final rules, CMS determined to use “alternate” data to measure uncompensated care cost for FFY14, at least, and possibly for additional years (although the agency indicated that it will consider using S-10 data for later years).

For 2014, CMS has calculated Factor 3 using the Medicare/SSI patient days the agency had calculated for FFY11 and the Medicaid patient days reported in hospital cost reports for fiscal years ending in 2010 or 2011. In both the proposed and final rule, CMS asserts that the sum of Medicaid and Medicare/SSI patient days is a suitable proxy for a hospital’s uncompensated cost of care furnished to uninsured patients.

Ultimately, CMS stated that it grounded its decision to use Medicaid and low-income Medicare patient days on concerns about the standardization and completeness of the data reported on worksheet S-10 data. However, CMS also noted in the proposed rule: “[W]e wish to avoid creating a policy that would serve as a disincentive for states wishing to expand Medicaid.” Whatever the reasons for this decision, the final rule makes it clear that CMS that may use S-10 data to calculate Factor 3 for later fiscal years once hospitals have more experience reporting all of the data elements on worksheet S-10, and it reiterates the need to focus on S-10 data reporting.

The final rule also rejects suggestions advanced in some comments that Medicaid and Medicare/SSI days should be adjusted for different wage costs in different geographic areas or for differences in case mix adjustment. Under the final rule, the Medicaid and Medicare/SSI days included in the calculation do not include patient days in IPPS-exempt units of a hospital, although CMS indicates that it may consider a later change to the rule to include those days.

The numbers of prior-period patient days used to calculate Factor 3 are listed for each hospital in

the DSH Supplemental Data file posted on the agency website. The final rule provides that percentages calculated using those days will not change. CMS will not recalculate the percentages based on a hospital’s actual number of Medicaid and Medicare/SSI patient days in 2014 or on any later changes to its number of patient days for the prior period used to calculate the Factor 3 percentages under the final rule.

### Payment Mechanics and Logistics

The traditional DSH payment (reduced to 25 percent) will be calculated and paid as always on an interim basis, per discharge, subject to final reconciliation at cost report settlement. The payment process for the additional payment for uncompensated costs will be different.

Hospitals that are expected to qualify for the traditional DSH payment will also receive interim payments per discharge for the uncompensated care payment. The amounts of these interim payments are reflected in the DSH Supplemental Data file and represent the predetermined payment amounts for the whole FFY14, divided by the hospital’s expected number of discharges in that year, which CMS estimated using an average number of discharges by the hospital in a prior three-year period. The sum of those per-discharge payments will be reconciled with the predetermined aggregate amount due for the year at cost report settlement.

For example, assume that Hospital A has a Sept. 30 year-end and, according to CMS’s calculations, will likely qualify for the traditional DSH payment. If Hospital A’s uncompensated care payment, based upon the application of Factors 1-3, is \$3 million for FFY14, and its average number of discharges per year is 5,000, then Hospital A will receive an uncompensated care payment of \$600 for each discharge in its fiscal year beginning on Oct. 1, 2013 and ending on Sept. 30, 2014. If Hospital A ends up with greater or fewer than 5,000 discharges for that cost reporting period, then it may receive or owe payment at cost report settlement, so that the aggregate amount of the uncompensated care payment to Hospital A for the 2014 cost reporting period will equal \$3 million.

The final rule does not address the mechanics of this payment and reconciliation process for a hospital with a fiscal year that differs from the federal fiscal year. Presumably, the uncompensated care payment for FFY14 would be prorated to the portions of the cost reporting periods occurring in FFY14, but hospitals will have to await further instruction from CMS.

Hospitals that are not expected to qualify for the traditional DSH payment, as reflected in the DSH Supplemental Data file, will not receive any payment for uncompensated care costs on a per-discharge basis. If such hospitals ultimately do qualify for DSH, they will receive the payments at cost report settlement. The amount of the additional payment would be calculated using the Factor 3 percentage listed for that hospital in the Supplemental Data File.

### DSH Caps

The 12 percent DSH payment cap that applies to some small urban and rural hospitals under the traditional DSH payment method will continue to apply to the reduced traditional DSH payment that will be made under the new rules. The traditional DSH payment that will be made to these hospitals under the new law cannot exceed a 3 percent payment add-on. But the cap does not apply to the additional DSH payment for uncompensated care costs. Thus, in some circumstances, the combined total DSH payment made to these hospitals under the new law could exceed 12 percent of the base IPPS payment rate per discharge.

### Preclusion of Review

The final rule codifies in the regulations a statutory provision that could potentially preclude appeals, administratively or to a court, for review and correction of certain types of potential error in CMS's implementation of the statute. Although the ACA requires the agency to follow its broad parameters for the new methodology, it also provides that there will be no administrative or judicial review of any CMS "estimate" used to determine the three factors in the calculation of

the uncompensated care cost payment and any period selected by CMS for those purposes. Thus, Congress also may have shielded major aspects of the agency's implementation from review.

This preclusion of review is troubling in that it grants CMS a degree of power and control, with a potential lack of accountability, that could result in DSH payment cuts that are deeper than Congress intended. Given the amount of funding at stake for hospitals that depend on DSH to support their community support missions, it is surprising that the preclusion-of-review provisions governing the DSH payment changes and several other payment reforms under the ACA (e.g., value-based purchasing, readmissions penalties, hospital-acquired condition penalties) have not yet prompted political backlash.

### Conclusion

The new DSH payment method, effective Oct. 1, 2014, will substantially reduce and redistribute Medicare DSH payments. Although some hospitals may see a benefit, at least in the near term, aggregate payments to all hospitals are being reduced, and those payment reductions may exceed expectations based on the intent of the ACA. Hospital executives and financial officers should be aware of the changes and the immediate impact of those changes on Medicare payments to their institutions and plan accordingly. ●

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