

## HEALTH INDUSTRY ALERT

### CMS ONCE AGAIN SIDESTEPS A CONGRESSIONAL DIRECTIVE REGARDING THE MEDICARE DSH ADJUSTMENT



Section 951 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. No. 108-173 (MMA), provides that the Centers for Medicare & Medicaid Services (CMS) “shall arrange to furnish...hospitals...the data necessary for such hospitals to compute the number of patient days used in computing the disproportionate patient percentage...for that hospital for the current cost reporting year.” Congress is clearly attempting to bring order to the complicated and often messy process of calculating and verifying a hospital’s Medicare disproportionate share hospital (DSH) adjustment, which is provided to hospitals that treat a disproportionate number of low-income patients.

Unfortunately, as made evident in its recent FY 2006 Medicare hospital inpatient prospective payment system final rulemaking, *see* 70 Fed. Reg. 47,278, 47,438-43 (Aug. 12, 2005), CMS has determined that, despite the straightforward language of Section 951, it would not comply with this congressional directive. The Medicare Program is once again preventing hospitals from receiving all appropriate DSH adjustment payments.

#### BACKGROUND

A hospital can qualify for a DSH adjustment under two distinct methods. Under the first method, the so-called “Pickle Method,” a hospital located in an urban area and having 100 or more beds may receive a DSH adjustment if 30 percent of its net inpatient care revenues are derived from state and local government payments for care furnished to indigent patients. Under the second method, which is by far the most prevalent method, a hospital’s qualification for a DSH adjustment, and the amount of that adjustment, is based upon the hospital’s disproportionate patient percentage, which is the sum of two fractions – the “Medicare fraction” and the “Medicaid fraction.”

The Medicare fraction is computed by dividing the number of patient days that are furnished to patients who were entitled to both Medicare Part A and Supplemental Security Income (SSI) benefits by the total number of patient days furnished to patients entitled to benefits under Medicare Part A. The Medicaid fraction is computed by dividing the number of patient days furnished to patients who, for those days, were eligible for Medicaid but were not entitled to benefits under Medicare Part A by the number of total hospital patient days.

Section 951 of the MMA requires CMS to furnish the personally identifiable information that would enable a hospital to compare and verify its records against CMS' records, in the case of the Medicare fraction, or against the state Medicaid agency's records, in the case of the Medicaid fraction. In other words, by its very terms, Congress is directing CMS to provide to hospitals the data used to determine the numbers of patient days to be utilized in the DSH adjustment calculations.

### **THE MEDICARE FRACTION: SOME GOOD NEWS**

In order to determine the numerator of the Medicare fraction for each hospital, CMS obtains an SSI data file from the Social Security Administration (SSA) and matches the personally identifiable information from that file against the Medicare Part A entitlement information for the fiscal year to determine the number of Medicare/SSI days for each hospital. These data are maintained in the MedPAR Limited Data Set (LDS).

Under the previous rules, a hospital could ask to have its Medicare fraction recomputed based on its cost reporting year, if that year differed from the federal fiscal year. The regulations limited this request, however, to once per cost reporting period and the hospital was forced to accept the resulting DSH percentage even if it was less favorable. Moreover, due to Privacy Act and HIPAA concerns, CMS only allowed the disclosure of the MedPAR LDS without an individual's consent if the information was to be used for a purpose that was compatible with the purpose for which the information was collected. Previously, a hospital only qualified for such a "routine use" disclosure if it had an appeal of its DSH adjustment pending before the Provider Reimbursement Review Board (PRRB) and paid a fee (\$900 or \$1,200, depending upon the year at issue) for such data.

Beginning with cost reporting periods that include December 8, 2004, upon request, CMS will now arrange to furnish the MedPAR LDS data for a hospital's Medicare/SSI patients regardless of whether it has a properly pending appeal before the PRRB. This data will be available free of charge. Stay tuned for further rulemaking regarding this process.

A hospital will theoretically be able to use this data to calculate and verify its Medicare fraction before saying that it prefers to have the Medicare fraction determined on the basis of its own cost reporting year, rather than on the federal fiscal year. The resulting fraction will be the hospital's official Medicare fraction, and will be binding on the hospital for that cost reporting period. A separate request will need to be made for each year.

Unfortunately, however, this does not apply to cost reporting periods prior to December 8, 2004, and this data will not be provided unless a hospital submits a written request (now through its fiscal intermediary) and completes a detailed Data Use Agreement with CMS. Finally, other than through an appeal to the PRRB, CMS has declined to establish a process by which a hospital can challenge the accuracy of the days included in the Medicare fraction or otherwise confirm that all appropriate days were included in the fraction (such as dual eligible, exhausted benefit and third-party payer days). At least hospitals no longer have to pay for the opportunity to obtain potentially incomplete Medicare/SSI data from CMS.

### **THE MEDICAID FRACTION: NOTHING HAS CHANGED**

The numerator of the Medicaid fraction includes hospital inpatient days that are furnished to patients who, for those days, were eligible for Medicaid but were not entitled to benefits under Medicare Part A. The number of Medicaid, non-Medicare days is divided by the hospital's total number of inpatient days in the same period. Since congressional directives do not mean much to CMS where the DSH adjustment is concerned, CMS has flatly decided to disregard the MMA with regard to the provision of data supporting these days.

Notably, CMS acknowledges that there is "no uniform national method for hospitals to verify Medicaid eligibility for a specific patient on a specific day" and that at least one state is reportedly not providing hospitals with proof of Medicaid eligibility. CMS has amazingly determined that, even though Congress has found otherwise, "it is reasonable to continue to place the burden of furnishing the data adequate to prove eligibility for each Medicaid patient day claimed for DSH percentage calculation purposes on the hospitals." Moreover, CMS stated in the rulemaking that "there is no need to modify the Medicaid State plan regulations to require that State plans verify Medicaid eligibility for hospitals." CMS also does not believe that it can direct states to provide eligibility information (when they decide to do so) free of charge.

CMS does magnanimously provide that it will "continue to work with State Medicaid agencies to ensure that Medicaid eligibility information (including "historical" data) is made available to hospitals" and that states do not impose "unreasonable fees" for this eligibility data. However, if hospitals believe there are problems with the data, CMS simply suggests that hospitals "work with their fiscal intermediaries and State Medicaid agency to address the specific problems the hospital is encountering."

Through Section 951 of the MMA, Congress intended to establish a process by which hospitals could verify the accuracy of their DSH adjustment calculations. If CMS had implemented this congressional mandate, it is quite possible that decades of confusion and litigation involving the DSH adjustment would have come to an end. Sadly, that is not to be the case.

## CONTACT INFORMATION

If you have any questions about this rulemaking, need assistance with general Medicare DSH adjustment payment questions, or require counsel regarding associated Medicare appeals, please contact:

John R. Jacob .....202.887.4582 .....jjacob@akingump.com ..... Washington

Elizabeth H. Goldman .....202.887.4423 .....egoldman@akingump.com ..... Washington

Jamie L. Anderson .....202.887.4033 .....jlanderson@akingump.com ..... Washington

Austin	Brussels	Dallas	Houston	London	Los Angeles	Moscow
New York	Philadelphia	Riyadh (Affiliate)	San Antonio	San Francisco	Silicon Valley	Washington, D.C.