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SIGNIFICANT CHANGES TO DSH UNDER PROPOSED 2014 IPPS RULES

EXECUTIVE SUMMARY

On April 26, 2013 CMS released proposed rules for implementing Section 3133 of the Affordable Care Act ("ACA"). Starting in 2014, these proposed rules will begin a series of substantial reductions in Disproportionate Share Hospital ("DSH") payments to hospitals. Most payments under the new DSH program will be from a set pool of funds that the statute suggests will be distributed to hospitals on a pro rata basis of each hospital's share of uncompensated care as compared to uncompensated care for all hospitals receiving DSH payments. However, for 2014, CMS has proposed to use proxies related to low paying insured patients (Medicaid and Medicare SSI patients) rather than any measure of uncompensated care. If this proposed rule is implemented, it will adversely affect hospitals in states who have opted out of the Medicaid expansion under the ACA.

DISCUSSION

Section 3133 of the ACA contains major reform of the DSH program. Starting in FFY 2014, this reform shall substantially reduce DSH payments to hospitals, and this was part of its purpose. Some of the rationale is that with Medicaid expanded, and more patients insured under the individual mandate, there will be less need for DSH payments. The ACA shifts DSH from a program compensating hospitals for the additional costs associated with treating poor people covered by Medicare towards reimbursing hospitals for uncompensated services furnished primarily to patients not covered by Medicare.

As explained below, the Secretary is permitted to make determinations of DSH eligibility and payments from "estimates" that are not subject to administrative or judicial review.

EMPIRICALLY JUSTIFIED DSH PAYMENTS

Under the first section of Section 3133, these DSH payments are 25% of what the hospital would have been paid had the DSH rules not been changed. It appears that administrative and judicial review of this aspect of the payment is still permitted, though obviously the stakes will be substantially lower. This amount is added to the payment for uncompensated care discussed below. CMS expects that the total amount of DSH payments in 2014 would have been $12.338 billion had the law not been changed. Thus, CMS expects to spend about $3.084 billion in empirically justified DSH payments.

PAYMENT FOR UNCOMPENSATED CARE

This is described as an "additional amount" for hospitals who qualify for the empirically justified 25% DSH payments discussed above. Thus, if you do not qualify for the 25% portion, then you will not receive this additional payment. This payment is the product of three factors. The first two factors set the size of the uncompensated payment pool while the third factor distributes that set pool to the hospitals on a pro rata share basis of their uncompensated care.

Factor 1. The first factor in establishing the pool for uncompensated care is to multiply the estimated DSH payments that would have been made to all hospitals had the program not been changed by 75%. This complements the reserve of 25% for the empirically justified DSH payments. The CMS actuary estimates that $12.338 billion would have been paid in DSH had the law not been changed, so that is multiplied 75% for $9.2535 billion. Thus, prior to application of the second factor, the uncompensated care pool for 2014 is $9.2535 billion.

Factor 2. The second factor is more complex and reflects the notion that as a higher percentage of Americans become insured, there should be less need for DSH payments. For 2014, the formula is 1 minus the percent change in uninsured individuals from the percentage of uninsured in 2013 minus 0.1%[1].

This factor first requires determining the percentage of uninsured Americans in 2013 (the year before implementation of expanded coverage under the ACA). For this, CMS proposes using a March 20, 2010 CBO Report, which estimated the number of Americans who would be uninsured in 2013 at 18% and 16% in 2014.

With these two variables, CMS calculates Factor 2 for 2014 as 0.888 as follows:

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Step 1: The Percent Reduction in Uninsured = (.16 - .18)/.18 = 0.111.

Step 2: 1 - 0.111 = 0.889

Step 3: $.889 - .001^2 = 0.888$

The uncompensated care payment pool for 2014 is then calculated by multiplying Factor 2 by the funds from Factor 1 as calculated above.

Uncompensated Care Payment Pool = 0.888 X $9.2535 billion = $8.217 billion.

Notably, this means total DSH payments (adding in the $3.084 billion for the empirically justified DSH payments discussed above) would be about $11.301 billion or about $1 billion less than would have been received by hospitals had the law not been changed. This reduction in DSH shall presumably increase as the "estimated" percentage of uninsured continues to decrease.

Factor 3. Unlike the first two factors, this one is budget neutral. It simply determines how the set pool for uncompensated care (proposed $8.217 billion for FFY 2014) shall be divided among hospitals. The statute and regulation essentially provide that each hospital shall receive a pro rata share of the uncompensated care pool based on their share of uncompensated care as compared to the total of uncompensated care for all hospitals nationwide. The formal statement of the formula in the statute can be summarized as follows:

$$\frac{\text{The amount of uncompensated care for the hospital as estimated by CMS}}{\text{The amount of uncompensated care for all DSH hospitals as estimated by CMS}}$$

THE CONVERSION OF FACTOR 3 TO LOW COMPENSATION INSURED PROXIES

In what may be the most controversial aspect of this proposed rule, CMS proposes to not measure uncompensated care for hospitals. Rather, CMS will use the "proxies" of insured low-income patients available from long existing DSH data for Medicaid patients plus Medicare SSI patients. CMS presents this decision as one made reluctantly after long consideration that initially favored using the measures of "charity care" and "bad debts" on lines 23 and 29 of Cost Report Worksheet S-10. However, CMS presents two reasons for rejecting this approach:

1. CMS sought to avoid a policy that would penalize states expanding Medicaid under the statute. The aspects of the ACA the U.S. Supreme Court declared unconstitutional were those penalizing states that refuse to expand Medicaid, effectively allowing states to opt out of said expansion. Many states have indicated they will opt out of Medicaid expansion. Under the statutory expression of Factor 3, such states would presumably benefit because without expanded Medicaid, hospitals in such states would tend to have higher rates of uncompensated care than hospitals in states with expanded Medicaid. However, this will not be true under the proxies CMS proposes to substitute for uncompensated care costs.

2. CMS claims the Worksheet S-10 methodology is unreliable because it is a new data source and that hospitals have not yet learned to submit accurate and consistent data. 2014 Factor 3 determinations would require using S-10 data from the very first year the form was used, and CMS believes this is unreliable.

CMS acknowledges that Worksheet S-10 "would otherwise be an appropriate data source to determine uncompensated care costs" and that CMS does "expect reporting on Worksheet S-10 to improve over time." Accordingly, CMS leaves open the possibility that it may use Worksheet S-10 data to determine uncompensated care costs in the future.

However, for 2014, CMS believes that "data on utilization for insured low-income patients can be a reasonable proxy for the treatment costs of uninsured patients." Accordingly, CMS proposes to use inpatient Medicaid days and Medicare SSI patient days. These days will be calculated under the Administrator's current methodology for DSH issues as stated in 42 C.F.R. §§ 412.106(b)(4) and (b)(2)(i).

Accordingly, for FFY 2014 the CMS proposes to convert Factor 3 from this:

$$\frac{\text{The amount of uncompensated care for the hospital as estimated by CMS}}{\text{The amount of uncompensated care for all DSH hospitals as estimated by CMS}}$$

To this:

$$\frac{\text{The number of Medicaid patient days + Medicare SSI days for the hospital as estimated by CMS}}{}$$

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The number of Medicaid patient days + Medicare SSI days for all hospitals as estimated by CMS

While this may seem a corruption of the statute, there are two significant barriers to appeal. First, the statute expressly allows using proxies when the Secretary determines proxies will better measure uninsured care costs. Second, the statute expressly bars administrative and judicial review of the estimates used to develop the three Factors discussed above.

This change will likely substantially penalize hospitals in states that opt out of Medicaid expansion. Such hospitals would have benefited from an approach rewarding uncompensated care because non-participation in Medicaid expansion would maintain their level of uncompensated care at a higher comparative level vs. hospitals in states expanding Medicaid. Instead, under these proxies, hospitals' states opting in to Medicaid expansion will comparatively benefit because the measures now include counting those expanded Medicaid program days.

Hospitals affected by this may desire to:

1. Support efforts to comment on the proposed rule objecting to the proxy methodology for 2014 outlined for Factor 3 in the proposed rules.
2. Lobby their state government that has chosen to opt out of Medicaid expansion to reverse that decision.
3. Seek clarification, through comments, that "no review" of CMS estimates does not extend to the numbers submitted by hospitals on their cost reports, which ironically are the same numbers, i.e., Medicaid eligible days used for the 25% portion of DSH just as has always occurred.

PRACTICAL TAKEAWAYS

- DSH payments to hospitals will decline starting in FFY 2014. For that first year, the decline will average about 10%. Hospitals should plan their budgets accordingly.
- DSH payments in 2014 will likely decline by more than the average for hospitals in states not participating in Medicaid expansion.
- Because CMS may use Worksheet S-10 data to calculate hospital DSH payments in years after FFY 2014, hospitals should make sure that Worksheet S-10 data relating to bad debts and charity care is complete and accurate.
- Starting in FFY 2014, many DSH issues are not subject to administrative or judicial review.

Comments on the Proposed Rule are due on June 25, 2013. If you have interest in making comments please contact us.

If you have any questions, please contact Keith D. Barber at 317-977-1428 or kbarber@hallrender.com, Maureen O'Brien Griffin at 317-977-1429 or mgriffin@hallrender.com or your regular Hall Render attorney.

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