PUBLICATION

CMS Provides More Information on New Medicare DSH Payment Calculations [Ober|Kaler]

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In the proposed federal fiscal year (FY) 2014 inpatient prospective payment system (IPPS) rule, CMS provided added details on the new Medicare disproportionate share hospital (DSH) calculation methodology. The provisions of the proposed rule addressing the changes to DSH can be found here. Providers have until June 25, 2013, to provide comments to the rule and to review the list of hospitals for which CMS has calculated a component of the DSH/uncompensated care calculation, as discussed more fully below.

As we reported in our earlier article, "The New DSH - Are You Supplying The Correct Data That Will Drive Your Payments," beginning in FY 2014, CMS will be calculating and paying DSH very differently. Under the new rules, 25 percent of the payment will be calculated using the current DSH methodology, which CMS refers to as the "empirically justified Medicare DSH payment." The remaining 75 percent will use a completely new methodology. That new methodology will be calculated by: (1) taking 75% of the DSH payments, as estimated by the Secretary of Health and Human Services, that would have been paid to hospitals under the current system, (2) adjusting it by a factor representing the percent change since 2013 in the uninsured percentage of the population, and then (3) determining each hospital's percentage share of that amount based on the hospital's relative share of total uncompensated care. CMS refers to the new payment amount as the "uncompensated care payment."

In the FY 2014 proposed rule, CMS supplied additional guidance. CMS proposed to add language to the regulation, clarifying that only hospitals that qualify for the empirically justified Medicare DSH payment will be eligible to receive the uncompensated care payment. CMS also provided additional guidance on calculating Factor 3 of the uncompensated care payment, i.e., a hospital's relative share of total uncompensated care. CMS stated that uncompensated care includes both charity care and bad debt, and that charity care reflects only the uncompensated portion of the charity care.

With regard to the data source it would use to determine Factor 3, CMS had earlier proposed to use data from Worksheet S-10 of the cost report. The Worksheet S-10 that would be used initially would have come from the first year that data was included on that worksheet, which was for the 2010 and 2011 cost reports. Due to stakeholder concerns about the standardization and completeness of the Worksheet S-10 data, as well as CMS's belief that the data used should be historically publicly available, subject to audit and used for payment purposes (or the public believes will be used for payment purposes), CMS determined not to use the Worksheet S-10 data at this time. In seeking to find an alternative data source, CMS proposed using the utilization of insured low-income patients, defined as inpatient days of Medicaid patients plus inpatient days of Medicare Supplementary Security Income (SSI) patients, to determine Factor 3. CMS acknowledged that although a more accurate estimate of Factor 3 would include an element measuring the cost associated with these patients, it asserted it does not have that data available to it. CMS thus proposed to use Worksheet S-3, Part I of the CMS-2552-96 version of the Medicare cost report and Worksheet S-2, Part I of the CMS 2552-10 version of the Medicare cost report and data that are used to update the SSI ratios on Worksheet E, Part A as the source of the alternative data to determine Factor 3 for FY 2014. CMS stated it may propose to use Worksheet S-10 data in the future.

For FY 2014, CMS intends to use FY 2010/2011 cost report data to establish Medicaid days and to use FY 2011 SSI ratios for the Medicare SSI days. CMS has asked for comments on: (1) the quality of the Worksheet S-10 data and whether it alone or in combination with other data would be sufficient to determine uncompensated care for FY 2014, and (2) how fast a transition to the use of Worksheet S-10 data could occur based upon increased reliability over time.

Since DSH payments are initially made on an interim basis, then subsequently finalized with settlement of the cost report, CMS has published a list of tables of Factor 3 for hospitals that it estimates will receive Medicare DSH payments at www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/dsh.html, to be used for interim payment purposes. Hospitals have 60 days from display of the proposed rule, i.e, until **June 25**, to review the tables and notify CMS in writing of a change in the hospital's subsection (d) status. CMS proposes that it will not recalculate the denominator in Factor 3 after publication of the final IPPS rule.

The estimates indicate that 2,349 (or 68 percent) of all applicable hospitals would be eligible for DSH payments in FY 2014. CMS intends to update its list of eligible hospitals and Factor 3 data in the final IPPS rule. CMS has asked for comments on whether it is appropriate to revise its determination of whether a hospital is entitled to DSH payment and the value of the hospital's Factor 3, at the time the hospital's cost report is settled.

Comments

The Patient Protection and Affordable Care Act requires implementation of the new methodology for determining DSH payments beginning in FY 2014. The problem CMS has encountered is finding the best data to use to implement the new methodology in FY 2014 and later years. Hospitals should consider CMS's proposed methodology and carefully review the list of hospitals included in the Factor 3 tables. **Comments are due to CMS by June 25, 2013.**