

Improvements to Medicare Disproportionate Share Hospital (DSH) Payments

Summary of Comments from National Provider Call

HHSM-500-2011-00014I; Task Order: HHSM-500-TO001

Dobson | DaVanzo



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Introduction

The purpose of the project is to provide technical assistance to the Centers for Medicare & Medicaid Services (CMS) as it implements a revised Inpatient Prospective Payment System (IPPS) Medicare DSH payment policy (DSH payments) as called for by Section 3133 of the Affordable Care Act of 2010 (ACA). ACA sets forth requirements intended to: 1) reduce overall Medicare DSH payments as the number of uninsured falls under the ACA, and 2) better target the remaining DSH payments to hospitals with higher levels of uncompensated care. These objectives reflect the fact that provisions in ACA should reduce the need for DSH payments with the expansion of insurance coverage and commensurate reductions in uncompensated care. Further, empirical findings demonstrate that existing Medicare DSH payments are too large in aggregate, and are not well-targeted at the individual hospital level.

The Dobson | DaVanzo Team – Dobson DaVanzo and Associates, LLC (Dobson | DaVanzo) and KNG Health Consulting, LLC (KNG Health) – was awarded a contract under HHSM-500-2011-00014; task order: HHSM-500-1001 to conduct this study. Dobson | DaVanzo has taken lead responsibility of the uncompensated care analyses and eventual micro-simulations, and KNG Health has taken lead responsibility for the uninsured analyses.

Since the start of the contract, the Dobson | DaVanzo Team has provided background information to help inform CMS as it drafts the Medicare DSH sections of the 2013 and 2014 IPPS NPRMs. The analyses conducted to date focused on our assessment of alternative definitions, measures, and data sources for 1) the rate of uninsured individuals under the age of 65 years, and 2) hospital-specific uncompensated care costs. The validity of our analyses has been informed through feedback from CMS, fact-finding interviews with Congressional Budget Office (CBO) and CMS Medicare cost report (MCR) Experts, and a series of interviews with stakeholders and survey experts.

The strengths and limitations of alternative definitions and data sources were presented to the public during a National Provider Call (NPC) on January 8, 2013. This NPC was an

opportunity for the public to provide comments to CMS on the definitions and data sources that should be considered as CMS drafts the relevant sections of the FY 2014 IPPS Proposed and Final Rules. Approximately 1,304 participants attended the NPC. Comments from approximately 64 organizations were then received either via a dedicated email box or provided during the live comment period during the NPC.¹ The Dobson | DaVanzo Team has reviewed all submitted comments as well as the NPC recording and transcript. The purpose of this report is to summarize the public's comments on how Section 3133 should be designed and implemented in FY 2014.

This report is separated into three chapters – comments received related to 1) measuring the change in the uninsured; 2) measuring uncompensated care; and 3) implementation questions for CMS to consider when developing the FY 2014 IPPS Proposed Rule. Within the first two sections, we summarize the comments related to definitional issues, data source-related issues, and impact analyses.

Importance of Medicare DSH Payments to Hospitals

Commenters have emphasized the important role of Medicare DSH payments to the stability and financial viability of the nation's hospitals. While DSH payments have been provided to hospitals since 1986, the role or intention of these payments has changed significantly over time. Initially, DSH payments were provided to hospitals to cover the additional Medicare case costs thought to be resulting from the share of the low income populations the hospital. Later, DSH payments were provided in order to cover the cost of uncompensated care. While covering unpaid hospital costs has remained the overall intention of the program, many hospitals now rely on DSH payments to maintain positive margins, regardless of the source of payment shortfalls.

Many commenters indicated that the DSH payments they currently receive represent a significant proportion of their total inpatient revenue. It is not only urban public hospitals that rely on these payments, but it is also teaching hospitals and not-for-profit hospitals. For example, the Association of American Medical Colleges (AAMC) noted that Medicare DSH payments represent 12 percent of major teaching IPPS payments and 20 percent of major teaching hospitals' total base DRG payment net of outliers, IME, and capital payments. Furthermore, the National Association of Public Hospitals and Health Systems (NAPH) reported that the country's 200 safety-net hospitals represent just 2 percent of acute care hospitals, but these hospitals provide over 20 percent of all uncompensated care across the country. Other commenters indicated that Medicare DSH payments represent upwards of 20 percent of their system's total IPPS payments.

¹ Those who provided comments during the NPC call without identifying their affiliation may be double counted if they also provided comments via email.

Introduction

Commenters noted that any significant revisions to the way Medicare DSH payments are calculated could produce sizeable distributional impacts across hospitals. Since the pool of available DSH payments is a fixed amount based on the national change in the uninsured, an increase in Medicare DSH payments for some hospitals would produce decreases in Medicare DSH payments for others. Therefore, revisions to the program must be carefully considered, analyzed, and implemented, as these payments often ensure the financial stability of hospitals that serve the country's most vulnerable populations.

Comments on Uninsured Rates

Introduction

In this chapter, we review comments related to the definition of and data sources for the uninsured to be used in the implementation of Section 3133. We provide the estimated number of comments submitted on each topic. For many comments, we provide specific references to indicate which organization submitted the comment. Our review is separated into four areas:

- Interpretation of Section 3133
- Definitions and populations covered
- Data quality and validity
- Transparency and clarity

Interpretation of Section 3133

Several organizations submitted comments pertaining to how CMS is interpreting Section 3133 in terms of the data sources to be used at various points in time.² Among these comments, the range of interpretations of the statute indicates that some confusion exists as to which specific CBO estimates are to be used and for which years, based on the legislation. Some commenters also questioned the need for designating the data source for 2018 at this time.

The Dobson | DaVanzo Team's interpretation of Section 3133 is that the legislation is ambiguous as to whether the measure of the uninsured relates to fiscal year or calendar year. This is of importance in the first year of the coverage expansion; although not explicitly argued in the comments received to date. The number of uninsured during

² Federation of American Hospitals, the Florida Hospital Association, the Greater New York Hospital Association, Catholic Health East, and the Adventist Health Policy Association

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calendar year 2014 should be lower than during FY2014, which includes the last 3 months of calendar year 2013 (prior to the expansion).

We present these comments in three subcategories:

- Data source for 2013
- Data sources for 2014- 2017
- Data sources for 2018 onwards

DATA SOURCE FOR 2013

With respect to 2013, one commenter is interpreting the source of the data to be CBO's March 20, 2010 letter to Nancy Pelosi.³ A second commenter believes that CMS will use the 2013 estimate from the CBO's March 2010 letter, but they question the use of that estimate, given the subsequent Supreme Court decision.⁴ The estimate of the number of uninsured in 2013, however, would seem to be unaffected by the Supreme Court decision as it impacts states' expansion of Medicaid beginning in 2014. We do note that the CBO estimates of the uninsured are based on calendar year, although their budget impact estimates are based on fiscal years. The Dobson | DaVanzo Team believes the statute calls for the use of the CBO's March 2010 letter to Nancy Pelosi for the 2013 baseline.

DATA SOURCES FOR 2014 TO 2017

With respect to 2014 to 2017, two commenters are interpreting the legislation to mean that CBO will be the source of uninsured data for those years, though they expressed some confusion about the CBO estimates for those years. For example, two commenters expressed the concern that CBO will not have 2014 uninsured data available at the start of 2014, though CBO has already released projections of uninsured rates up to 2019.⁵ Another commenter requested clarification as to which specific CBO estimates would be used for the comparison estimates for 2014- 2017 and what calculations might be made with those estimates.⁶

Another commenter does not interpret the statutory language to mean that estimates from 2014 to 2017 must come from CBO and would like CMS to provide an explanation as to why CMS interprets Section 3133 in this manner.⁷ They question CMS's interpretation of the use of CBO estimates because of the phrase "based on" in Section 3133. In the statute, when describing the source of the uninsured data for 2013, the legislative language includes this parenthetical phrase: "(as calculated by the Secretary based on the most recent estimates available from the Director of the Congressional Budget Office

³ Adventist Health Policy Association

⁴ The Federation of American Hospitals

⁵ Catholic Health East and Mercy Health

⁶ Southwest Consulting Associates

⁷ The Federation of American Hospitals

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before a vote in either House on the Health Care and Education Reconciliation Act of 2010...).” In describing the source of data for 2014 to 2017, it states that the Secretary should use “the most recent period for which data is available.” The commenter notes that, in *Paladin Community Medical Center v. Sebelius*, CMS successfully argued in Court that the statutory term “based on” does not equate with “based exclusively on,” which would imply that CMS has the discretion to choose a non-CBO source for 2014 to 2017. If ambiguity does exist, the commenter suggests using a source other than CBO, because CBO data are based on micro-data from the Survey of Income and Program Participation. We note that this data source was not rated as a reliable source for national uninsured estimates by the Dobson | DaVanzo Team in the NPC. While this point is addressed in a later section of this report devoted to the evaluation of data sources, the larger point to recognize (which likely underlies all the comments) is that the use of CBO estimates likely ensures a reduction in DSH payment in 2014 because estimates (projections) of the uninsured in 2014 are already being made available by CBO. On the other hand, the most recently available data from non-CBO sources (such as the National Health Interview Survey) at the time the IPPS rule is finalized would be from 2013.)

DATA SOURCES FOR 2018 AND BEYOND

Some commenters also questioned why CMS needs to identify a data source for 2018 and beyond at this time. In particular, a survey source that may be available now may not be available or appropriate in 2018, thus it seems premature to consider these sources now.⁸

Definitions and Populations Covered

Numerous comments raised questions about the definition of the uninsured and the populations that are covered by the measures under consideration. The specific sub-topics are listed below:

- Definitions
 - Patients who have insurance but do not have coverage for all services
 - Defining uninsured at the hospital level
- Populations covered
 - Undocumented immigrants
 - Elderly

DEFINITIONS

INSURED PATIENTS WITH UNCOVERED SERVICES: One commenter⁹ mentioned that insured patients with uncovered (underinsured) services should be counted as uninsured and that the value of those services should be included as charity care if they are not paid. Another commenter questioned whether individuals with a catastrophic or high-

⁸ Southwest Consulting Associates, The Federation of American Hospitals

⁹ National Association of Public Hospitals and Health Systems

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deductible policy are considered to be insured.¹⁰ We note that the five national surveys include questions designed to identify whether respondents have “comprehensive” insurance that covers most health care services and hospitalizations. For example, persons with only dental or vision insurance or who receive insurance associated with a particular disease are not counted as having insurance. However, these surveys do not typically ask about specific services in order to determine whether a respondent is insured, underinsured, or not insured.

DEFINING UNINSURED AT THE HOSPITAL LEVEL: Some commenters proposed that, for the purposes of Section 3133, “uninsured” should be defined at the hospital level.¹¹ National-level measures of the uninsured do not provide insight into the specific populations that are seeking care at hospitals. Some of those individuals, as described in the previous paragraph, may have some form of health insurance, but little or no coverage for the services they are seeking at the hospital.¹² Another commenter mentioned that having more people insured in a community does not necessarily mean that the hospitals in that community will be seeing fewer uninsured patients.¹³ The same commenter raises the concern that the uninsured rate may not decrease and may actually rise in certain states, depending on how that state proceeds with its Medicaid expansion. They propose that any change in DSH payments should be tied directly to uncompensated care, regardless of the change in the uninsured rate. We note that the use of the hospital’s share of the national uncompensated care pool is meant to compensate for local differences in the uninsured and hospital-specific exposure to the uninsured.

POPULATIONS COVERED

UNDOCUMENTED IMMIGRANTS: The coverage of undocumented immigrants was cited frequently as a necessary component of the definition of the uninsured, as many hospitals in certain parts of the country serve large numbers of undocumented individuals through their emergency room and clinics.¹⁴ Unable to qualify for Medicaid or to access coverage through the state exchanges, these individuals will continue to be uninsured.

As discussed during the NPC, each of the surveys that we examined develops its sampling plan using household addresses and does not utilize any information related to citizenship status. Thus, undocumented immigrants are eligible to participate in the survey. But they may not choose to participate, fearing that their immigration status will be revealed. So the exact coverage of surveys of undocumented immigrants is not specifically known.

¹⁰ Carolinas Healthcare System

¹¹ Lutheran Medical Center, Adventist Health Policy Association, and the National Association of Public Hospitals and Health Systems

¹² National Association of Public Hospitals and Health Systems

¹³ Adventist Health Policy Association

¹⁴ BESLER Consulting, Carolinas Healthcare System, Safety Net Hospital Alliance of Florida, California Hospital Association, Healthcare Association of New York, and Dignity Health

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ELDERLY: One commenter, based in Florida, mentioned the elderly as a population that should be covered in any survey measuring the uninsured.¹⁵ We note that, like undocumented immigrants, the elderly are eligible to participate in all of the surveys, because the sampling plans are based on household addresses, not the composition of the households. However, all surveys provide estimates (or can be used to calculate) the number of uninsured for those under age 65, as required by the legislation.

DATA QUALITY AND VALIDITY

A significant number of comments raised questions about the quality of the estimates produced by the five surveys and by CBO. Several commenters emphasized that the uninsured measure that is ultimately adopted by CMS should be based on the best available data. We organize these comments into the following sub-topics:

- Sample size and representativeness
- Local/regional estimates vs. national estimates
- Variability of estimates
- Possible use of an algorithm or validation with IRS records
- Validity of CBO estimates

SAMPLE SIZE AND REPRESENTATIVENESS: The “smaller” sample sizes of some of the surveys (14,000 to 35,000 households) were of concern to some commenters.¹⁶ For example, one commenter cited the fact that we evaluated the National Health Interview Survey to be Excellent on different dimensions, though its sample size was 35,000 households and 87,500 individuals.¹⁷ They raised concerns about basing a national payment policy for hospitals on a survey with this sample size. As we described in our report and during the NPC, the sampling methodologies of the five surveys are designed to be representative of the national population being measured. While these samples may be too small for the development of regional or metropolitan-area estimates, they more than meet appropriate standards for the estimation of national uninsured rates. They have also been fine-tuned for representativeness over time.

LOCAL/REGIONAL ESTIMATES VS. NATIONAL ESTIMATES: Some commenters expressed the concern that national uninsured rates produced through the five surveys do not accurately depict uninsured trends at the regional or local level.¹⁸ Some suggest using some sort of regional measure or regional adjustment to the national rates. However, we believe that Factor 3 will account for higher uncompensated care associated with the uninsured on a hospital-by-hospital basis.

¹⁵ Safety Net Hospital Alliance of Florida

¹⁶ Catholic Health East, Mercy Health System of SEPA

¹⁷ Southwest Consulting Associates

¹⁸ Healthcare Management Solutions, Catholic Health East, Mercy Health System of SEPA

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VARIABILITY OF ESTIMATES: In addition to sample sizes, several commenters had concerns about the variability of the uninsured estimates from the five surveys.¹⁹ All the comments related to data quality and validity urge CMS to thoroughly review all of the data sources under consideration and examine the variability of the estimates produced by each source.

POSSIBLE USE OF AN ALGORITHM OR VALIDATION WITH IRS RECORDS: One commenter suggested creating an algorithm using data from several surveys to measure the national uninsured rate.²⁰ Another commenter questioned whether, as the IRS will implement the uninsured penalty in tax returns, there are any plans to use that data to validate the uninsured rates used to implement Section 3133.²¹ We note that, although we cannot ascertain, at this time, whether IRS records will provide a valid baseline, we feel that the idea is worth exploring. In addition, we note that other data sources may become available in the next few years, which raises, again, the question of whether a data source for FY 2018 and beyond must be established at this time.

VALIDITY OF CBO ESTIMATES: Two commenters raised doubts about the validity of CBO estimates, given that they are based on micro-data from the Survey of Income and Program Participation (SIPP), which, in the Dobson | DaVanzo Team's review, does not compare favorably against the other data sources under consideration for FY 2018 and beyond.²² We note that the CBO estimates are based on a model that makes use of SIPP microdata, not the final national-level estimates produced by the SIPP. The model assumptions and parameters can be updated as needed from year to year.

Transparency and Clarity

A common thread underlying all of the comments related to the interpretation of the uninsured data sources to be used for the implementation of Section 3133 was a request for clarity and transparency. In particular, these commenters would like CMS to share, through the rulemaking process, citations of specific data sources, assumptions and calculations that were used in CMS's decision process, and justifications for using those data sources. For 2014 to 2017, commenters requested that CMS clarify why CBO estimates must be used and mention the specific CBO estimates (described by their publication/issue date) that would be used. For 2018 onwards, commenters requested that the chosen data source be made available on the CMS website.

¹⁹ Catholic Health East, Mercy Health System of SEPA, Carolinas Healthcare System

²⁰ Healthcare Association of New York State

²¹ Providence Health and Services

²² Southwest Consulting Associates, The Federation of American Hospitals

Comments on Uncompensated Care

Introduction

In this section, we review the comments that relate to how uncompensated care could be measured and collected in order to support the distribution of Medicare DSH payments. We indicate the number (or an indicator of volume) of commenters making the same comment in order to provide a rough gauge of support for a given topic area and often provide a reference to the organization source(s) of the comment(s). Our review is organized into four areas:

- Definition used in measuring uncompensated care
- Data sources available for capturing and measuring uncompensated care
- Impact of the uncompensated care definition on the distribution of Medicare DSH payments
- Considerations for Section 3133 implementation

Within each area, we provide a discussion arranged by sub-topic.

Definitions for Measuring Uncompensated Care

Several comments pertain to how uncompensated care could be defined under Section 3133. Specifically, we present four sub-categories below:

- Measuring bad debt
- Measuring charity care
- Including payment shortfalls
- Revisions to the ratio of cost to charges (RCC)

Comments on Uncompensated Care

MEASURING BAD DEBT

Most commenters agreed that bad debt should be an included element of defining uncompensated care. However, comments are inconsistent with respect to how bad debt should be defined. We received comments relating to three key aspects of how to incorporate bad debt into the definition of uncompensated care: 1) handling of self-pay discounts; 2) inclusion of Medicare non-reimbursable and non-Medicare bad debts; and 3) inclusion of self-pay after insurance (SPAI) costs. At the end of this section, we also present the remarks of one commenter that do not support the inclusion of bad debt in the definition of uncompensated care.

HANDLING OF SELF-PAY DISCOUNTS: Either under state mandates, or hospital-specific programs, hospitals often extend discounts to self-pay patients. For example, Tennessee requires a discount for self-pay patients of a percentage of the cost-to-charge ratio, and separately, Assembly Bill No 2609 caps fees that can be charged to uninsured patients with gross family income equal to or less than 500 percent of the FPL to no more than 115 percent of the applicable Medicare rate.²³ Several commenters *requested that self-pay discounts be added back into bad debts to appropriately reflect the amount of uncompensated care costs for the patients.*²⁴ For purpose of consistency, commenters requested guidance on where these payments should be reflected – either Column 1 or Column 2 of Lines 20-23 on the S-10 of the MCR.

When patients receive self-pay discounts, total charges are reduced by the discount that is reported on the cost report. However, if the ratio of cost-to-charges (RCC) is applied to these reduced charges to calculate the cost of the bad debt, commenters indicated that the cost is understated by the amount of the discounted charges factored by the ratio of cost-to-charges. For instance, if gross charges of \$100,000 are reduced to \$40,000 for a self-pay patient, bad debt costs would be calculated by the RCC times the \$40,000, not the \$100,000 if only the discounted portion is factored into the bad debt cost calculation. By adding the discounted charges back into the calculation of bad debt costs, hospitals are able to better reflect the true uncompensated care cost, as opposed to the discounted cost. Commenters noted that this methodology is consistent with how Medicare costs are calculated – in that Medicare charges are not reduced by contractual allowances (MS-DRG payments) prior to the application of the RCC.²⁵ Additionally, commenters noted that CMS should take all charges associated with bad debt and charity care into account as is done with the reporting requirements for self-pay discounts under IRS §501(r).²⁶

²³ BESLER Consulting

²⁴ BESLER Consulting, Community Health Systems, Carolina HealthCare System, Mercy Health System of SEPA, Catholic Health East. Federation of American Hospitals, Edward Coyle (NPC call)

²⁵ Community Health Systems

²⁶ Mercy Health System of SEPA

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While in a few instances adding back discounts could result in the appearance that payments exceed costs, commenters suggested that self-pay patient payments are generally immaterial in the aggregate so these payments would not skew the results. This recommended methodology is said to help hospitals receive their fair and accurate share of uncompensated care as it pertains to bad debt.

INCLUSION OF MEDICARE NON-REIMBURSABLE AND NON-MEDICARE BAD DEBTS: A significant number of comments were received related to the inclusion and exclusion of various bad debt categories in the definition of uncompensated care. All commenters agreed that non-Medicare bad debt should be included in the definition of uncompensated care. However, several comments *requested that Medicare non-reimbursable bad debt be included* in the definition of bad debt as well.²⁷ This request reflects the 30-35 percent of Medicare bad debt that is not currently reimbursed. At least one commenter opposed this idea and requested that Medicare bad debt be excluded.²⁸

During the NPC, CMS suggested that only Medicare cost report allowable bad debt should be reported in the S-10. However, some commenters reported that this restriction is inconsistent with the definition of bad debt in the current S-10, as provided in Provider Reimbursement Manual (PRM) Part 1 § 4010.²⁹ In PRM, for reporting purposes, bad debt is defined as non-Medicare bad debt and non-reimbursable Medicare bad debt. Therefore, commenters sought clarification on whether Medicare non-reimbursable bad debt should be included in the S-10 and whether it will be factored into the definition of uncompensated care.

INCLUSION OF SELF-PAY AFTER INSURANCE (SPAI): Self-pay after insurance refers to the deductible and coinsurances that are due to hospitals after the insurance plan has paid its negotiated rate. Select commenters *requested clarification from CMS as to whether these SPAI bad debts should be included in the definition of uncompensated care*.³⁰ In most cases, as expressed by the commenters, the insurance payments plus SPAI partial payments would exceed the cost of providing the care.

EXCLUSION OF BAD DEBT FROM THE DEFINITION OF UNCOMPENSATED CARE: One commenter suggested that bad debt should not be included in the definition of uncompensated care.³¹ The rationale for this decision is that bad debt does not reflect the financial need of patients – rather it reflects uncollectable deductibles and copayments across all payers. *Given that the intention of Medicare DSH payments is to cover the*

²⁷ Community Health System, Methodist Health System, The Federation of American Hospitals, St. John Providence Health System, Kentucky Hospital Association

²⁸ Baptist Memorial Health Care Corporation

²⁹ Federation of American Hospitals

³⁰ Community Health System

³¹ California Hospital Association

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cost of treating the uninsured, this commenter suggested that the inclusion of bad debt is inappropriate. This comment suggests that uncompensated care be defined as charity care (free care), discounted care, discounts provided as a result of medical hardship, and presumptive charity care. The inclusion of bad debt could redirect payments away from providers with low bad debt but high charity care.

MEASURING CHARITY CARE

All commenters agreed that charity care is a critical aspect of the uncompensated care methodology. However, there are different ways charity care can be defined and measured. While charity care policies differ for each hospital, there are some aspects that several commenters would like to have prescribed by CMS to ensure that they are recorded using a comparable methodology across hospitals. That is, while charity care policies differ, some commenters posited that the algorithm for determining the portion of charity care that is captured on the cost report should be consistent. While it would take enormous effort to gain consensus on how charity care should be uniformly defined, measured, and implemented, clear decision points on these select issues would improve uniformity in the measuring and reporting of charity care.

PRESUMPTIVE CHARITY CARE: Presumptive charity care is defined as care for a patient who is not or cannot be officially deemed eligible for charity care, but otherwise would have received it. According to one commenter's analysis, one-in-five patients struggle with applications and face challenges in functional literacy. Additionally, 26 million consumers do not possess the requisite documentation of assets or income required by hospitals to be granted charity care. As a result, many patients who would officially receive charity care do not even apply, so it is not granted.

Currently, worksheet S-10 Line 20 requires hospitals to exclude the cost for patients who fail to qualify for charity care. Only the cost of patient care for charity care patients deemed eligible is captured. As a result, to the extent that a hospital has a large presumptive care burden, the uncompensated care costs of the hospital are understated. It is the opinion of commenters that discussed this topic *that presumptive charity care should be included in the definition of uncompensated care under Line 20.*³² We note that this will be a difficult proposition to implement.

Commenters noted, nevertheless, that CMS should implement regulations on when patient care costs can be captured under presumptive charity care. Comments suggested that it should not be based merely on federal poverty limits (FPLs) and should only be considered after all efforts have been exhausted to secure alternative funding or eligibility (including eligibility for Medicaid) and some effort to obtain financial assistance program

³² BESLER Consulting, PARO Decision Support, Carolina HealthCare System, Catholic Health East, Mercy Health System of SEPA, Community Health Advisors, Montefiore Medical Center, Edward Coyle (NPC call)

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documentation.³³ It may be appropriate to determine eligibility for presumptive charity care in a manner consistent with other means tested programs, such as Supplemental Nutritional Assistance Program (SNAP), subsidized low-income housing and school lunches, Women, Infants and Children's (WIC) program, or benefits for homeless populations.³⁴ In addition, there are a variety of proprietary systems that estimate presumptive charity care.

The inclusion of presumptive charity care in Line 20 would also clarify an otherwise unclear situation of how hospitals should capture presumptive charity care as it relates to reporting to the Treasury on IRS Form 990 and how charity care can be captured as hospital's effort to improve community benefits. Furthermore, one commenter noted that these inclusions will minimize the need for significant documentation efforts by the hospital and necessary audit work by the MACs.³⁵

TIMING OF CHARITY CARE: The determination and write off of charity care often happens outside of the hospital fiscal year in which services are provided. Some commenters requested that the *charity care captured on Line 20 should include only the charity care that was written off in the reporting year, regardless of when the services were provided*.³⁶ Furthermore, the payments for charity care recorded (offsets for charity care) from non-contracted payers as well as patients should only reflect the amount actually received and not the payments that are expected to be received.³⁷ The current S-10 calls for charity care that was provided (not necessarily written off) during the period to be recorded in Line 20.³⁸ We note that these differences in reporting may even or average out for a given provider over time, consistency in reporting is requested.

INCLUSION OF PHYSICIAN CHARITY CARE: Three commenters noted that the charity care line should not only include services provided by the hospital, but it should also include services provided by physicians who are salaried at the hospitals.³⁹ Commenters noted that the physicians they employ serve all patients, regardless of their ability to pay. Safety-net hospitals, which operate in areas of wide-spread uninsured and low-income populations, rely on the salaried physicians to ensure uninsured patient access to physician services and preventative health care services. As a result, physician care provided by the hospital to uninsured populations reflects significantly more uncompensated care costs than those currently identified by the hospital. These

³³ BESLER Consulting, Catholic Health East, Mercy Health System of SEPA

³⁴ Community Health Advisors

³⁵ Montefiore Medical Center

³⁶ BESLER Consulting, NAVEOS Healthcare Data Analytics, The Federation of American Hospitals, Adventist Health Policy Association, Mercy Health System of SEPA, Greater New York Hospital Association, Florida Hospital Association, BKD CPAs and Advisors, University of Pittsburgh Medical Center, North Shore-Long Island Jewish Health System, National Association of Public Hospitals and Health Systems

³⁷ Montefiore Medical Center; currently Line 20 excludes payments from non-contracted payers which over represents charity care.

³⁸ PMR page 80

³⁹ BESLER Consulting, Montefiore Medical Center, Lutheran Medical Center

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commenters *requested that the S-10 be updated to include uncompensated care related to hospital employed physician services provided to the uninsured or under-insured.*

INCLUDING PAYMENT SHORTFALLS

The issue of whether or not to include payment shortfalls from government or other local programs yielded the highest number of comments of all topic areas. While there does not appear to be unanimous consensus on whether stakeholders think shortfalls should be included in the definition of uncompensated care, most arguments lean toward inclusion of all payment shortfalls, primarily on the grounds of equity and reducing the redistributive effects of Section 3133 implementation. That said, there were arguments presented in both directions.

RATIONALE FOR INCLUDING PAYMENT SHORTFALLS FROM GOVERNMENT AND

STATE/LOCAL PROGRAMS: A considerable number of providers recommended the inclusion of payment shortfalls from all sources into the measure of uncompensated care.⁴⁰ This would include Medicaid shortfalls, as well as other government and state/local program, and commercial shortfalls. Commenters presented three reasons to support their recommendation for a broad, all encompassing, definition of uncompensated care:

- ***Be Consistent with Existing DSH Payments:*** While the intent of the DSH program is to cover the uncompensated care costs for treating the uninsured, the current DSH program determines Medicare DSH payments using an algorithm that factors in the number of Medicaid days provided by the hospital. Therefore, to the extent that the intention of the DSH program remains unchanged, any change in the methodology under Section 3133 should include Medicaid shortfalls. If these payment shortfalls were not to be included, there could be considerable dislocation and redistribution of remaining Medicare DSH payments. Providers with a high proportion of Medicaid payments, but a low proportion of charity care and bad debt, would continue to receive payments that are more comparable to existing payment levels. Furthermore, at the extreme, one commenter added that CMS should consider weighting hospitals with high Medicaid shortfalls higher to ensure that these costs are covered by DSH payments.
- ***Jeopardize Financial Stability of Safety-Net Providers:*** Excluding payment shortfalls could redistribute Medicare DSH payments away from hospitals with high Medicaid days but low charity care. This could jeopardize the financial

⁴⁰ BESLER Consulting, Association of American Medical Colleges, California Hospital Association, Baystate Medical Center, Methodist Medical Center, Mercy Health System of SEPA, Dignity Health, NAVEOS Healthcare Data Analytics, Lutheran Medical Center, Adventist Health Policy Association, Montefiore Medical Center, Catholic Health East, Kentucky Hospital Association, North Shore-Long Island Jewish Health System, National Association of Public Hospitals and Health Systems, Massachusetts Hospital Association, Southcoast Health System, American Hospital Association, Healthcare Association of New York State, Florida Hospital Association, Legion Crittenton Health, Safety Net Hospital Alliance of Florida, Daniel McHale (NPC Call)

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stability of low-margin safety-net providers. Providers who serve a high proportion of Medicaid patients are often the only available provider to these beneficiaries.

- **Protect Payments for States that Opt into Medicaid Expansion and Decrease Charity Care:** States that opt into Medicaid expansion under the ACA will likely experience an increase in the proportion of services that are provided for Medicaid enrollees. As this proportion increases, the amount of charity care provided would likely decrease if Medicaid shortfalls were not allowed. If the uncompensated care definition does not include the Medicaid shortfalls, hospitals in states with Medicaid expansion would experience additional Medicaid shortfalls, which would not be considered under Section 3133.

In order to capture uncompensated care using this broader definition, commenters suggested that uncompensated care be calculated using the following lines.

Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (line 19)
+ Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29) (line 30)
<hr/>
Total unreimbursed and uncompensated care cost (line 19 plus line 23, and 30) (line 31)

Whereas:

- Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs = Sum of difference between net revenues and cost for Medicaid program (Line 8), Difference between net revenue and costs for stand-alone SCHIP (line 12), and Difference between net revenue and costs for state and local indigent programs (line 16)
- Cost of non-Medicare uncompensated care = Sum of Cost of charity care (line 23) and cost of non-Medicare bad debt expense (line 29)

There were several dissenting reasons presented by commenters on why the inclusion of Medicaid and all other shortfalls would be inappropriate:⁴¹

- **Medicaid Payment Rates Vary Significantly by State and Would Disproportionately Allocate Medicare DSH Funds to Certain States:** Unlike Medicare, Medicaid payments differ significantly by state. Given that Section 3133 would not change the amount of Medicare DSH payments available nationally (besides the reduction due to the change in the uninsured), inclusion of the Medicaid shortfalls could significantly redistribute Medicare DSH payments away from hospitals with high charity care into states with high Medicaid shortfalls.
- **DSH Payments for States without Medicaid Expansion Could be Diverted to other States with Medicaid Expansion, “Penalizing” Certain Hospitals:** Contrary

⁴¹ The Federation of American Hospitals, The MetroHealth System

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to the last reason presented for including Medicaid shortfalls, one commenter noted that by including Medicaid shortfalls, hospitals in states without Medicaid expansion would be penalized for the state's decision. That is, as Medicaid expansion would increase the proportion of Medicaid enrollees in each state (or hospital) – and ultimately increase the amount of Medicaid shortfalls – including shortfalls in the definition of uncompensated care would divert payments away from hospitals without Medicaid expansion into states that did opt-in.

- ***Exclusion of Medicaid payment shortfalls would not necessarily lead to a redistribution of Medicare DSH payments as long as both Medicaid payments and costs include or exclude direct graduate medical education (DGME):***

Comments received from GNYHA⁴² included a written response from a representative in the CMS Cost Reporting Division that indicated that the cost report instructions inappropriately instruct hospitals to include all Medicaid payments, including DGME in Medicaid revenues but exclude DGME in the RCC used to produce Medicaid costs. This underestimates Medicaid shortfalls. This results from an imbalance in the Medicaid cost and Medicaid payments as reflected in the S-10. According to the written exchange between CMS and GNYHA, hospitals would be permitted to exclude DGME from Medicaid revenue until S-10 instructions are clarified. This would increase Medicaid shortfall estimates relative to current reporting. However, if this inconsistency is not rectified, the hospital Medicaid losses would be understated. When GNYHA included DGME costs (thinking it was otherwise reported in Medicaid revenue) into the RCC for an impact analysis, this resulted in an “overestimate” of Medicaid shortfalls for several academic medical centers. To the extent that academic medical centers in New York actually adjusted their DGME revenue to align with costs, excluding Medicaid shortfalls from the definition of uncompensated care in the simulation would result in less net redistribution in DSH payments among hospitals in New York. Therefore, GYNHA now supports this recommendation.

- ***Hospitals with large Medicaid volume would likely receive more DSH payment regardless of the Level of Payment Shortfall:*** Commenters noted that the inclusion of Medicaid Shortfalls may not differentiate between hospitals with low shortfall and high frequencies, and high shortfall and low frequencies.⁴³ Total shortfall for a hospital is a function of the payment to cost ratio and frequency (weight) of the payer. Therefore a hospital with a low shortfall (e.g., payment-to-cost ratio of 0.90) but a high frequency (e.g., 50 percent of all patients) may have more payment shortfalls in total than a hospital with a low payment to cost ratio

⁴² Email comments to Ing-Jye Cheng and Marc Hartstein from GNYHA on January 29, 2013; forwarded to the Dobson | DaVanzo Team by Karen Heller.

⁴³ Rick Leinfelder (NPC call)

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(e.g., payment-to-cost-ratio of 0.40) and a low frequency (e.g., 10 percent of all patients). Therefore, DSH payments could be diverted to states with relatively high Medicaid DSH payment and high volume and away from states with a poor Medicaid reimbursement but lower volume. This could significantly impact small hospitals and safety net hospitals in states with low Medicaid reimbursement. However, hospitals with a high frequency have less of an opportunity to cost-shift these underpayments to commercial or other payers.

- **Intention of Medicare DSH to Cover the Cost of the Uninsured:** Despite the current use of Medicare DSH payments to support overall hospital margins, one commenter noted that the intention of the Medicare DSH program is to cover the cost of the uninsured and other patients who are unable to pay for hospital services. Therefore, it was not the intention of Congress at the implementation of the Medicare DSH program to subsidize the shortfalls of states' Medicaid programs through the Medicare Trust Fund.⁴⁴

REVISIONS TO THE RATIO OF COST TO CHARGES (RCC)

Beyond the way uncompensated care is defined, the majority of commenters requested revisions of the way charges are converted to costs using the ratio of cost to charges (RCC). Currently, Line 1 of the S-10 is used to convert bad debt and charity care charges into costs. The RCC referenced in the S-10 is derived from Worksheet C⁴⁵ and includes only Medicare allowable costs.

INCLUSION OF GME COSTS: The majority of commenters *requested that the RCC used to convert charges to cost factor in the cost of training residents (graduate medical education costs)*.⁴⁶ Line 1 of the S-10 currently does not include these costs. While the Medicare program provides funding for a portion of the costs to train residents through the DGME, these payments only cover approximately 21 percent of teaching hospitals' direct costs.⁴⁷ Commenters requested that CMS consider using the GME costs reported in Worksheet B Part 1 (column 24, Line 118) to capture these additional costs. Without these GME costs included, commenters reported that teaching hospitals are disadvantaged and that the methodology would not capture true uncompensated care costs.

⁴⁴ The Federation of American Hospitals

⁴⁵ Part 1 Line 200, column 3 divided by Line 200 column 8

⁴⁶ BESLER Consulting, Association of American Medical Colleges, California Hospital Association, The MetroHealth System, Florida Hospital Association, Methodist Medical Center, Greater New York Hospital Association, Massachusetts Hospital Association, National Association of Public Hospitals and Health Systems, North Shore-Long Island Jewish Health System, Adventist Health Policy Association, Safety Net Hospital Alliance of Florida, Montefiore Medical Center, Lutheran Medical Center, Kentucky Hospital Association, Healthcare Management Solutions, LLC, Dignity Health, Florida Hospital Association, American Hospital Association, Hospital Association of New York State, University of Utah Hospital and Clinics

⁴⁷ Association of American Medical Colleges

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Furthermore, as discussed in the payment shortfall section above, the instructions for completing the cost report are inconsistent, in that Medicaid payments include DGME yet DGME costs are excluded from the RCC. To ensure an accurate report of actual payments and costs, DGME should be included in the hospital's RCC.⁴⁸

ADJUSTED FOR EFFICIENCY: One commenter also *requested that the RCC used to convert charges to cost be adjusted so as not to benefit inefficient providers.*⁴⁹ The rationale is that if the costs of a hospital are used to determine the amount of uncompensated care that is reported and used to determine the Medicare DSH payments, inefficient providers are possibly rewarded through higher RCCs and higher DSH payment than efficient providers with the same amount of uncompensated care charges. In this instance, hospitals are not incentivized to control costs and increase efficiency. The commenter noted that this was one of the reasons why CMS moved away from “cost-based reimbursement” in 1983 and developed MS-DRGs for hospital payments. Adjustment factors for patient acuity and geographic variation would also be requested to “normalize” costs.

We note that this would be very difficult to do, as CMS would need to define and identify efficient providers.

Data Sources Available for Capturing and Measuring Uncompensated Care

Beyond the concern about identifying a definition of uncompensated care that does not disadvantage providers by hospital type or geographic location, a significant number of comments were received related to the validity and reliability of the data sources available to measure uncompensated care under Section 3133. Specifically, we present three sub-categories below:

- Standardization and data quality
- Need for hospitals to resubmit S-10 data prior to implementation
- Use of judicial review and MAC audits

STANDARDIZATION AND DATA QUALITY

A large number of commenters noted that there is considerable variation and numerous inconsistencies in how uncompensated care is calculated and reported on the S-10. These inconsistencies can produce divergent results that could greatly impact the amount of Medicare DSH payment hospitals receive. Some went as far as noting that the S-10 data is highly “flawed” in this respect⁵⁰.

⁴⁸ Email comments to Ing-Jye Cheng and Marc Hartstein from GNYHA on January 29, 2013; forwarded to the Dobson | DaVanzo Team by Karen Heller.

⁴⁹ Community Health Systems

⁵⁰ National Association of Urban Hospitals, Baystate Medical Center

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CLARIFY INSTRUCTIONS: Many suggest that the reason for the lack of data quality and standardization is the imprecision in the cost report instructions, which leads hospitals to complete the forms differently. Now that payments will be linked to the submitted cost reports, a large number of *commenters urged CMS to clarify the instructions*.⁵¹

Specifically, commenters asked for two areas of consistency. First, commenters would like CMS to align the S-10 cost reporting period with the federal fiscal year to reduce the hospital burden and CMS burden in data analysis and allocation within the reporting period.⁵² Hospitals could be required to provide costs effective “for cost reporting periods beginning in FFY 2014.” Therefore, a hospital with a fiscal year starting on July 1, 2014 would only have to provide S-10 data starting in July, 2014, and would not need to provide a separate cost report to cover discharges from October 2013 through June 2014. Second, two commenters requested that the Medicaid DSH survey be incorporated into the S-10 so that the two reports would reconcile and each hospital would be reporting uncompensated care in a consistent manner.⁵³ Regardless of CMS’ decision, commenters would like this addressed in the proposed rule.⁵⁴

STANDARDIZE INCLUSION OF ALL PAYMENT SOURCES: A few commenters noted that there is considerable variation in how hospitals report Medicaid shortfalls and revenue they receive from their local and state government indigent care programs.⁵⁵ One commenter’s experience led them to recognize that hospitals clearly diverge in their reporting of indigent, charity care, and unreimbursed costs and revenues. Some hospitals may simply exclude some revenue sources, while others may report revenue or Medicaid shortfalls in different lines on the S-10. The commenter appropriately noted that the lines in which hospitals report their various forms of uncompensated care and revenue on the S-10 matter, as the redistribution of Medicare DSH payments are competitive and one hospital’s methodology will affect every other hospital eligible for Medicare DSH payment. As a result, commenters noted that *careful instructions and auditing are critical to prevent uneven, unjust and unintended consequences*.

CONSIDER INCLUSION OF REGIONAL PROGRAMS: This issue is even more pronounced among public and private hospitals in how they capture their revenue sources. Specifically, one commenter notes that the S-10 does not include the Delivery System Reform Incentive Payments (DSRIP) that were created in California’s section 1115 waivers, realignment tax dollars and certified public expenditures.⁵⁶ Therefore, the

⁵¹ Massachusetts Hospital Association, Lutheran Medical Center, NAVEOS Healthcare Data Analytics, Lehigh Valley Health Network, The Federation of American Hospitals, University of Utah Hospital and Clinics, Private Essential Access Community Hospitals (PEACH), Dignity Health

⁵² BESLER Consulting

⁵³ Mercy Health System of SEPA, St. John Providence Health System

⁵⁴ North Philadelphia Health System

⁵⁵ National Association of Urban Hospitals

⁵⁶ Dignity Health

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revenue received by these hospitals is not captured, possibly overstating the hospital's uncompensated care costs. Unless this is corrected or standardized, private hospitals could be disadvantaged since a disproportionate amount of Medicare DSH payment may be allocated to public hospitals. As a result, a few commenters *requested that CMS carefully consider regional variation in the reporting of additional revenue sources for public hospitals that currently may not be captured in the S-10.*⁵⁷ One comment specifically requested that a remedy to this issue would be to have separate Medicare DSH pools – one for private hospitals and one for public hospitals.⁵⁸ Another commenter added that careful consideration should be used when including regional programs, as some sources of revenue do not relate to the provision of care. For example, DSRIP payments under California's section 1115 waiver are provided to support improving the way care is delivered with the goal of achieving higher quality and efficiencies, not to provide reimbursement for uninsured or other services.⁵⁹

NEED FOR HOSPITALS TO RESUBMIT S-10 DATA PRIOR TO IMPLEMENTATION

The inconsistencies noted above caused several commenters to state that the existing S-10 data from FY 2010 and FY 2011 cannot be used for the implementation of Section 3133. At the very least, many commenters *requested an opportunity to resubmit FY 2010 and FY 2011 cost reports after CMS has finalized the definitions of uncompensated care and provided more specific instructions on how the cost reports should be completed.*⁶⁰ This might also allow hospitals that have not yet submitted S-10 data to do so.

The need for this resubmission process was articulated by several commenters who reviewed the submitted cost reports from FY 2010 and FY 2011. Based on one commenter's analysis of California's filings, the commenters concluded that the submitted S-10's (and the existing instructions for the S-10) cannot be used for implementing Section 3133 payments.⁶¹ For example, there are two California hospitals that have reported uncompensated care costs that are 635 percent and 106 percent of their net patient revenue, respectively. These estimates reflect an enormous increase from the uncompensated care reported in previous years (\$1 million to \$477 million for one hospital and \$4.4 million to \$261 million for another). Without an opportunity to revise these reports, these two hospitals would receive about 10 percent of all Medicare DSH payment for California hospitals.

⁵⁷ Private Essential Access Community Hospitals (PEACH), Dignity Health

⁵⁸ Private Essential Access Community Hospitals (PEACH)

⁵⁹ California Hospital Association

⁶⁰ BESLER Consulting, Southwest Consulting Associates, North Shore-Long Island Jewish Health System, NAVEOS Healthcare Data Analytics, Montefiore Medical Center, Greater New York Hospital Association, North Philadelphia Health System, National Association of Urban Hospitals

⁶¹ Private Essential Access Community Hospitals (PEACH)

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Another commenter reviewed a national sample of cost reports and found similar examples in Virginia, Texas, Kentucky, and Wyoming where reported uncompensated care was twice or three times larger than the reported net patient revenue.⁶² These large data anomalies could result in a small number of hospitals receiving a disproportionate amount of redistributed Medicare DSH payment. In one example, ten hospitals across the country that currently receive 0.7 percent of all Medicare DSH payment could receive 16 percent of the redistributed payment. Other states, such as District of Columbia and Pennsylvania, however, are reporting significantly low levels of uncompensated care relative to the proportion of uninsured patients and average income. Other analyses from additional commenters were provided that further indicated that CMS should very carefully assess the redistribution effects of using S-10 data as reported to support the implementation of Section 3133.

Furthermore, as indicated by GNYHA's additional comments regarding the inclusion of DGME costs in the RCC, several hospitals may have excluded Medicaid DGME payments from the cost report to align with the instructions on how to capture costs. Correcting this imbalance would require hospitals to resubmit their S-10 if CMS changes the instructions.⁶³

USE OF JUDICIAL REVIEW AND MAC AUDITS

As indicated by the requests for consistency across hospitals in completing the S-10, CMS received comments asking that it implement an audit process to ensure adherence to the instructions of the S-10. We understand that Section 3133 does not allow for administrative or judicial review of either 1) estimates of the Secretary for purposes of determining the factors that are used to calculate the DSH pool, or 2) any period selected by the Secretary for such purposes.⁶⁴ However, this section might allow for audits to occur prior to the Secretary's allocation of DSH payments. Therefore, commenters ***requested that all S-10s be audited either by CMS or the MACs prior to implementation.***⁶⁵ Commenters noted that the precedent for this audit would be the way Medicare wage indices are reviewed.⁶⁶ The audits could require hospitals to produce documentation of their charity care and bad debt write-offs or other documents that support the completion of the S-10. In the event that the audits cannot be completed prior to the implementation, one commenter suggested that CMS should be open to adjusting

⁶² National Association of Urban Hospitals

⁶³ Email comments to Ing-Jye Cheng and Marc Hartstein from GNYHA on January 29, 2013; forwarded to the Dobson | DaVanzo Team by Karen Heller.

⁶⁴ <http://www.gpo.gov/fdsys/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf>, page 315

⁶⁵ Baystate Medical Center, Southwest Consulting Associates, NAVEOS Healthcare Data Analytics, Greater New York Hospital Association, Private Essential Access Community Hospitals (PEACH)

⁶⁶ Greater New York Hospital Association

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the amounts originally distributed to hospitals if corrected data or audits indicate that errors were contained in the S-10s from which DSH payments were based.⁶⁷

Similarly, one commenter asked if CMS was going to question the reasonableness of a hospital's charity care policy, or possibly compare the charity care minimum salary level to that of Federal standards.⁶⁸ This has been done in the review of provider's indigent care policy as it applies to bad debts.

Impact of the Uncompensated Care Definition on the Distribution of Medicare DSH Payments

Implementation of Section 3133 could significantly impact the Medicare DSH payments received by hospitals across the country. Due to the number of "moving pieces" within the Section's three factors, commenters explicitly expressed a need for impact analyses and transparency in the FY 2014 IPPS Proposed Rule. Their requests are grouped into two sub-categories presented:

- Need for impact analyses
- Need for transparency

NEED FOR IMPACT ANALYSES

Commenters *requested that the FY 2014 IPPS Proposed Rule contain an impact analysis that would help each hospital determine the impact of Section 3133 on their Medicare DSH payment.*⁶⁹ In addition to the overall impact, some commenters requested that the text contain an example for a real hospital that walks through the methodology and how the total Medicare DSH payments were calculated. This will allow each hospital to replicate the methodology using their own internal data to help them plan for the transition in the amount of Medicare DSH payment they receive. We note that this in itself could be very difficult (if not impossible) if the universe of hospitals has not reported their costs using the new S-10. The allocation of the 75 percent pool will be difficult to determine unless CMS uses current DSH payments as a proxy for uncompensated care for hospitals that have not yet reported S-10 data.

Additionally, any adverse effects by type of hospital (e.g., public vs. private, ownership type, geographic location) should be noted in the IPPS Proposed Rule. To the extent that the impact analyses indicate a significant re-distribution of Medicare DSH payments, two commenters requested a hold-harmless of DSH payments of a certain level.⁷⁰ Another commenter suggested that to cushion large redistribution impacts, CMS should identify

⁶⁷ Montefiore Medical Center

⁶⁸ BESLER Consulting

⁶⁹ BESLER Consulting, Massachusetts Hospital Association, National Association of Public Hospitals and Health Systems, Lehigh Valley Health Network

⁷⁰ Safety Net Hospital Alliance of Florida, Dixon Hughes Goodman, LLP

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“super-DSH facilities” that have such high uncompensated care costs that they need to be protected at some level. Commenters offered the following criteria for these facilities: 1) disproportionate indigent patient population of 40 percent or greater; Medicaid discharges of 40 percent or greater; uncompensated care costs of 4 percent or greater; charity care costs of 2.5 percent or greater; and commercially insured cases/discharges of 25 percent or less.⁷¹

NEED FOR TRANSPARENCY

Commenters *requested that all assumptions and calculations be transparent and clearly presented in the IPPS Proposed Rule*.⁷² Due to the potential high re-distributional impact of Section 3133, all hospitals should have a clear understanding of how Medicare DSH payments are calculated, and how they will change over time. This transparency is critical as hospitals attempt to change their cost structures to operate under potentially-reduced Medicare DSH payment.

Included in the need for transparency is the need for retroactive adjustments in the event of litigation settlement. One commenter noted⁷³ that CMS should implement a mechanism to allow for retroactive adjustment if any of the numerous pending cases are not resolved before the implementation of Section 3133. Another commenter asked CMS to recognize the importance of DSH payments to low-DSH states, and to minimize their reduction in payments.⁷⁴

Considerations for Section 3133 implementation

The last category of comments received from commenters relate to how Section 3133 could be implemented. We received comments on three-types of implementation considerations for CMS’ review. Specifically, we received comments on:

- Eligibility of Non-DSH hospitals to receive Section 3133 payments
- Impact of Section 3133 payments on 340B Hospitals
- Delays in implementation and need for transitions

ELIGIBILITY OF NON-DSH HOSPITALS TO RECEIVE SECTION 3133 PAYMENTS

Several commenters indicated concern about how Section 3133 would affect hospitals that are currently not eligible for DSH. These commenters indicated that the legislation is not clear concerning whether non-DSH hospitals would be eligible to receive a portion of the 75 percent pool. These commenters *requested that non-DSH hospitals be excluded*

⁷¹ Lutheran Medical Center

⁷² Mercy Health System of SEPA

⁷³ Southwest Consulting Associates

⁷⁴ Safety Net Hospital Alliance of Florida

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*from Section 3133 and not be eligible to receive payments due to their share of uncompensated care.*⁷⁵

One commenter further asked for clarification of whether hospitals currently eligible for Medicare DSH payments will be required to support, at time of submission and audit of cost report, the Medicaid eligible days which are part of the DSH calculation. Since Medicaid days will no longer determine Medicare DSH payments, will another proxy be used to determine eligibility for Medicare DSH? Another commenter asked if there is a length of time non-DSH eligible hospitals would have to wait before being eligible for the 75 percent, if at all.⁷⁶

IMPACT OF SECTION 3133 PAYMENTS ON 340B HOSPITALS

340B status allows eligible hospitals to purchase prescription drugs from manufacturers at discounted rates.⁷⁷ Currently 340B qualification is a function of the DSH calculation, requiring a DSH percentage greater than 11.75 percent. While 340B qualification is not included in the DSH funding or payment addressed in Section 3133, a few commenters *requested clarification that 340B status would not be affected by the implementation of Section 3133 payments.*⁷⁸

DELAYS IN IMPLEMENTATION AND NEED FOR TRANSITIONS

As indicated by the comments presented in this report, stakeholders have many concerns about how Medicare DSH payments under Section 3133 will be defined, measured, and implemented. The potential for a large redistribution in Medicare DSH payments has led many commenters to *request at least a one-year delay in the implementation of Section 3133.*⁷⁹ This would allow CMS to provide better instructions for S-10 to ensure consistency across hospitals, fully audit the existing S-10 data to identify areas of inconsistency, and allow CMS to conduct a more thorough impact analysis by type of hospital. One commenter suggested that this delay should be permissible, as CBO did not score savings for Section 3133 until 2015.⁸⁰ A variant of this would be for hospitals to resubmit their S-10 after the instructions are clarified by CMS.

Regardless of the implementation date, commenters also asked CMS to consider a transition period that blends current Medicare DSH payments with the methodology to be chosen under Section 3133. Since many hospitals are expecting to receive significant decreases in their Medicare DSH payments, a transition period could reduce the financial

⁷⁵ BESLER Consulting, Mercy Health System of SEPA, The Federation of American Hospitals, North Shore-Long Island Jewish Health System, Lehigh Valley Health Network, Dignity Health, University of Pittsburgh Medical Center, Catholic Health east, Westmoreland Consulting

⁷⁶ BKD CPAs and Advisors, Alaska

⁷⁷ <http://www.hrsa.gov/opa/>

⁷⁸ Mercy Health System of SEPA, Catholic Health East, Indiana University Health Bloomington

⁷⁹ Baystate Medical Center, Greater New York Hospital Association, National Association of Urban Hospitals, Private Essential Alliance of Community Hospitals, Dixon Hughes Goodman, LLP, Lutheran Medical Center, Montefiore Medical Center

⁸⁰ Greater New York Hospital Association

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impact on the hospital and allow for cost structures and processes to adjust in order to not adversely impact the hospital or the patients they serve. While most commenters did not identify the length of the requested transition, one commenter asked for an “extended” transition of 10 years.⁸¹

Despite commenters’ remarks, it is the Dobson | DaVanzo Team’s understanding that under legislation, Section 3133 must be implemented for FY 2014. In doing so, we propose that CMS possibly consider using current DSH payments in whole or in part for the first year of implementation as a proxy for uncompensated care.

CONSIDER PROXIES OR ALTERNATIVE METHODOLOGIES TO ENSURE CONSISTENCY AND LIMIT REDISTRIBUTION

Two commenters (Community Health Systems and Mercy Health System of SEPA) recommended alternative ways to measure uncompensated care that would result in consistent and standardized reporting across hospitals. The first recommendation, provided by Community Health Systems, is driven by the inconsistent way bad debt is reported. According to Community Health Systems, hospitals can either report bad debt as a percent of revenue, or a collection percentage – both acceptable under GAAP. However, the particular methodology that is used could produce significantly different results. Therefore, they proposed that CMS implement a new proxy for uncompensated care that relies on: 1) total charges for uninsured patients; and 2) payments for uninsured patients. Charges could be converted to costs using the RCC, and reduced by payments to produce the total uncompensated care for the hospital. Community Health Systems indicated that South Carolina, Texas and Louisiana currently use this methodology for determining uncompensated care. Note that this methodology would not include bad debt or payment shortfalls from other payers.

Another commenter suggested that to limit the redistribution of payments to larger, higher volume hospitals based on the absolute dollar value of bad debt and charity care, CMS should consider an alternative methodology. Specifically, one commenter suggested that adjustments or weighting of hospital specific bad debt or charity care can be calculated as either: 1) a percent of total business, 2) percent of Medicaid, SCHIP, state/local indigent programs, or 3) aggregate DSH percentage.⁸² This would align all hospitals’ uncompensated care costs with their base revenue or patient protection to ensure distribution of Medicare DSH payments to small hospitals with a large uninsured population.

⁸¹ Montefiore Medical Center

⁸² Mercy Health System of SEPA, Catholic Health East

Implementation Questions and Other Issues

Other than providing comments and suggestions on how uninsured rates and uncompensated care could or should be defined, several commenters provided clarifying questions of CMS in how Section 3133 would be implemented, and how payments would be distributed. In this conclusion section, we summarize the questions received and requests for CMS to provide clarification or direction in the FY 2014 NPRM. We then conclude with our assessment of the four most important comments and present CMS with alternative recommendations for how to implement Section 3133.

Impact of Section 3133 Payments on Medicare Advantage (Part C) Payments

Medicare Advantage (Part C) payments are currently calculated using a negotiated percent of traditional Medicare payments through the Medicare Hospital Pricer. It is estimated that about 28 percent of all Medicare beneficiaries are enrolled in a Medicare Advantage Plan. Unless otherwise corrected for, hospitals could face significant decreases in their Medicare Advantage payments due to the change in traditional Medicare DSH payments. Specifically, to the extent to which only the 25 percent portion is included in the Pricer for 2014 until the 75 percent can be assessed, hospitals could have their Part C payments reduced. Several commenters are *requesting more information on how Part C payments will be protected and offer suggestions*.⁸³

One commenter noted that the Pricer should continue to use current DSH payments – pre-Section 3133 – until such time as capitation rates are calculated based on data that incorporated the entire impact of Section 3133 on Part A payments (25 percent and 75 percent).⁸⁴ That is, until Section 3133 is fully implemented and its impact is assessed, the Pricer should maintain the existing DSH payments to calculate Part C payments. Another commenter suggested that once the DSH payments are calculated for each hospital, they

⁸³ The Federation of American Hospitals, Massachusetts Hospital Association, North Shore-Long Island Jewish Health Systems, Montefiore Medical Center, Greater New York Hospital Association, ACA Healthcare

⁸⁴ The Federation of American Hospitals

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should be converted to an add-on payment for IPPS rates so that the changes flow through the Medicare Advantage rates.⁸⁵

A possible solution presented by a commenter is that Medicare Advantage plans should be required to pay out any remaining payments that result after the 75 percent is distributed to hospitals. This can be throughout the year as data become available (similar to how the 75 percent will be distributed to hospitals). Commenters are concerned that if this is not specifically addressed and implemented as Congress has intended the additional 75 percent that is not applied to Part C would be treated as an unintended savings to the government or health insurer.

Distribution of Medicare DSH Payments under Section 3133

Commenters have expressed concern on how payments will be distributed to the hospitals and the potential lag in payments. Five clarifying questions were received for CMS' comments:⁸⁶

- How will the 25 percent DSH payment be paid, through claims processing DRG payments as it is currently or as part of a bi-weekly pass through payment?
- How will the 75 percent uncompensated care payment be paid, through claims processing DRG payments or as part of a bi-weekly pass through payment?
- Will there be an audit and a settlement amount due to/from hospital/Medicare for the 25 percent DSH payment?
- Will there be an audit and a settlement amount due to/from hospital/Medicare for the 75 percent uncompensated care payments?
- Will capital DSH payment remain the same, be eliminated, or be weighted at 25 percent?⁸⁷

⁸⁵ Greater New York Hospital Association

⁸⁶ BESLER Consulting, UY Hospital

⁸⁷ Lehigh Valley Health Network