HFMA Tennessee – October 2016

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Today's Topics

- Medicare DSH Topics
  - Traditional "empirically justified" DSH Payment Calculation
  - DSH Payment for Uncompensated Care
  - Final Rule for FFY 2017
  - Update on Current DSH Appeal Issues

POLLING QUESTION

Overview of the Medicare DSH Payment

- Congress mandated a DSH payment under IPPS in 1986
  - Added to section 1886(d)(5)(F) of the Social Security Act
  - Two reasons for additional payment
    - Low-income Medicare patients may be sicker and more costly to treat than average
    - Hospitals that treat a high proportion of low-income patients overall tend to incur higher than average costs per case due to specialized services and higher overhead
- ACA revised the DSH payment effective 10/1/13 (FFY 2014)
  - Added section 1886(r) to the Social Security Act
  - Redirects the majority of payment for uncompensated care

The Original DSH Adjustment

- Percentage add-on to IPPS payments per discharge
- Usually determined by the "disproportionate patient percentage" ("DPP")
  - Exception: A few hospitals qualify for DSH payment under the "Pickle" method based on state and local government subsidies for low-income patient care as a percentage of net inpatient revenue
- DPP = sum of two fractions (expressed as %)
  - Medicaid fraction
  - SSI fraction

Original DSH Adjustment - DPP

Disproportionate Patient Percentage, in patient days for a cost reporting period:

Medicaid Fraction:

Eligible for medical assistance under a State plan & not entitled to benefits under Medicare Part A

Total

+

SSI Fraction:

Entitled to benefits under federal SSI & entitled to benefits under Medicare Part A

Entitled to bens. under Medicare Pt A

New DSH Payment for Uncompensated Care

- ACA changed the DSH payment calculation beginning October 1, 2013 – FFY 2014
  - Added section 1886(r) to the Social Security Act
- Two payment components
  - 25% of the amount that the hospital would have been paid under the original DSH method based on its disproportionate patient percentage
  - Additional payment for uncompensated care
- Limitations on administrative and judicial review with respect to certain aspects of the calculation of the uncompensated care DSH payment
  - Estimates calculated by the Secretary
  - Periods selected by the Secretary

Origin of the ACA Changes to the DSH Payment

2007 MedPAC Report to Congress

- Concluded that 75% of the traditional DSH payments were not "empirically justified" by higher costs per case
- Observed that a portion of the traditional DSH payment could be redirected to offset a portion of hospitals' costs of uncompensated care
- Concluded that traditional DSH payments, based on Medicaid and low-income SSI/Medicare Part A patient days, are "poorly targeted to hospitals' shares of uncompensated care"

ACA Changes Related to Coverage Expansion

- Reduced the traditional DSH payment following MedPAC's finding on the "empirically justified" portion of the traditional DSH payment
- Established a new DSH payment for uncompensated care costs
- Provided for reductions to the new DSH payment for uncompensated care in proportion to expected expansion of public and private insurance coverage under other provisions of the ACA

Summary of 3 Factors Used To Calculate DSH Uncompensated Care Payments for FFYs 2014-2017

- Factor 1
  - 75% of the estimated aggregate traditional DSH payment that otherwise would be paid for the current FFY
- Factor 2
  - 1 minus the percentage change in the percent of individuals under age 65 who are uninsured for FFY 2013 compared with the percent who are uninsured for the current FFY, less
  - statutory reduction factor
    - 0.001 for FFY 2014
    - 0.002 for FFYs 2015- 2017
- Factor 3
  - Each eligible hospital's uncompensated care as a percentage of the total uncompensated care for all eligible hospitals

Final IPPS Rule for FFY 2017

- Factor 1: $10.797 billion
- Factor 2: 0.5536
  - Assumes a reduction in the uninsured rate from 18% in 2013 to 10% in 2017
- Aggregate Amount Available for Distribution: 5.977 Billion
  - Represents 7% reduction compared with FFY 2016 ($6.406 billion)
  - Represents 34% reduction compared with FFY 2014 ($9.046 billion)

Final IPPS Rule for FFY 2017

- CMS changed calculation of Factor 3 for FFY 2017
- For FFYs 2014-2016, CMS used Medicaid + Medicare/SSI days as a proxy for uncompensated care
  - For example, for FFY 2016, CMS used Medicaid days from 2012 cost reports and Medicaid/SSI days for FFY 2013
  - Factor 3 is then calculated as percentage-to-total each eligible hospital – i.e.:

    $$\frac{\text{the sum of an eligible hospital's Medicaid + Medicare/SSI days}}{\text{the total number of Medicaid + Medicare/SSI days for all eligible hospitals}}$$
- For FFY 2017, CMS continued using Medicaid and Medicare/SSI days as a proxy, but computed an average Factor 3 percentage for each eligible hospital using data for 3 prior years:
  - 2011 Medicaid days & FFY 2012 Medicare/SSI days – percent-to-total
  - 2012 Medicaid days & FFY 2013 Medicare/SSI days – percent-to-total
  - 2013 Medicaid days & FFY 2014 Medicare/SSI days – percent-to-total
  - Add and divide by 3

Final IPPS Rule for FFY 2017

- CMS proposed other changes to Factor 3, but decided not to implement them in the final rule for FFY 2017
- CMS proposed to begin a transition to the use of uncompensated care data from cost report worksheet S-10 for the calculation of Factor 3
- CMS proposed to determine Factor 3 for FFY 2018 using an average calculated on the basis of
  - 2012 Medicaid days & FFY 2013 Medicare/SSI days – percent-total
  - 2013 Medicaid days & FFY 2014 Medicare/SSI days – percent-to-total
  - 2014 S-10 data (charity and non-Medicare bad debt) – percent-to-total
- Proposed plan would have used S-10 data exclusively for FFY 2020

POLLING QUESTION

Final IPPS Rule for FFY 2017

- CMS decided not to implement transition to S-10 after comments expressing concern about the reliability of data reported on S-10
- Final rule indicates that CMS's plan is to create process for review and quality control of S-10 data, and use in Factor 3 when ready, but "not later than" FFY 2021
- Final rule indicates that CMS expects to revise cost report instructions to S-10 and will hold town hall meetings and FAQs
- Although none of this has happened yet, and despite what the agency said in the proposed and final rule for FFY 2017, there has been some talk that CMS might use S-10 data for FFY 2018

Final IPPS Rule for FFY 2017

- Final rule indicates that CMS intends to use charity care reported on worksheet S-10, line 23 plus non-Medicare bad debt reported on line 29
  - Will not include the Medicaid short-fall reported on S-10
- Final rule indicates that CMS will revise the instructions for S-10 to include charity care based on the date of write-off instead of date of service – prospectively from October 1, 2016 forward
- Final rule confirms hospitals have discretion to design policies so that discounts offered to uninsured patients are considered “charity care” reportable on line 20 of S-10
- Final rule indicates that CMS will reconsider the instructions for S-10, line 20 to clarify when discounts would be charity care vs. bad debt
- Final rule indicates that CMS will continue to explore appropriate trimming to CCRs, akin to process for outlier payments

Interim and Final Payments for Uncompensated Care

- Interim DSH uncompensated care payments paid per discharge (total uncompensated care payment amount divided by the average number of discharges in 3 prior years)
- Final DSH uncompensated care payments made on the cost report, prorated to reflect the proportion of the cost reporting period in each FFY

  Example: Hospital CRP ending December 31st

  - Interim DSH uncompensated care payments made for discharges from 10/1/13 - 12/31/13 using FFY 2014 DSH uncompensated care amount (per discharge)
  - Reconciled at final settlement of the 12/31/13 cost report using ¼ of the Hospital's FFY 2014 uncompensated care DSH payment amount if the Hospital qualifies for the traditional DSH payment for the 12/31/13 cost reporting period
  - Interim payments made to the Hospital for discharges on or after 1/1/14 will be reconciled at final settlement of the 12/31/14 cost report with ¾ of the uncompensated care DSH payment amount for FFY 2014 and ¼ of the amount for FFY 2015 if the Hospital qualifies the traditional DSH payment for the 12/31/14 cost reporting period.

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Hospital Eligibility for Uncompensated Care DSH Payment

- Eligible hospitals:
  - Subsection (d) and Puerto Rico subsection (d) IPPS hospitals that qualify for the traditional DSH payment for a cost reporting period ending after 9/30/13
- Ineligible hospitals:
  - IPPS hospitals that do not qualify for traditional DSH payment for a cost reporting period
  - IPPS-exempt hospitals
  - Maryland hospitals
  - Hospitals participating in Rural Community Hospital Demonstration
  - Critical access hospitals (paid reasonable cost)
  - Sole community hospitals paid hospital-specific rates
    - Comparison of Federal rate to HSR will include uncompensated care DSH payment in Federal Rate

Hospital Eligibility for Uncompensated Care DSH Payment

- Eligibility is estimated in advance, using prior-period data, for purposes of calculating interim payments
- Eligibility is finally determined at cost report settlement for a cost reporting period ending after 9/30/13 based on DSH data for that cost reporting period, *i.e.*, whether the hospital qualifies for the traditional DSH payment for that cost reporting period

Operational / Implementation Issues

- DSH Cap (12%) applies to "empirically justified" (traditional) DSH payment
  - Empirically justified DSH payment effectively limited to 3% DSH adjustment for
    - an urban hospital < 100 beds; and
    - a rural hospital < 500 beds and not rural referral center or Medicare-dependent hospital
- Hospitals that: i) have < 500 beds; and ii) are redesignated from urban to rural as a result of new OMB labor market area delineations; and iii) do not become an RRC, would be subject to the DSH cap on the empirically justified DSH payment
  - Transition: these hospitals would receive 2/3 of the difference between the uncapped DSH amount and capped DSH amount in the first year after it loses its urban status and 1/3 of the difference in the second year after it loses its urban status
- DSH cap does not apply to DSH uncompensated care payment
- Medicare Advantage plans paying what "original Medicare" would pay must include an uncompensated care DSH payment amount per discharge

Operational / Implementation Issues – cont'd

- For FFY 2015 and after, for hospitals that merged before the current FFY and after the period used to calculate Medicaid and SSI days, CMS calculates Factor 3 for the surviving hospital using the Medicaid and Medicare/SSI days for both of the hospitals
  - This is a change from the policy that was applied for FFY 2014
  - The new policy applies for FFY 2015 and after only if surviving hospital / new owner voluntarily terminated the provider agreement for the merged hospital
- For hospitals that merge after development of the final rule for FFY, interim payments will be based on the Medicaid and Medicare/SSI days for the surviving hospital (for a prior period), but the final payment will be based on the surviving hospital's actual number of Medicaid and Medicare/SSI days for the current cost reporting period

DSH Uncompensated Care Payment – Preclusion of Review

Florida Health Sciences Center v. Secretary, U.S. Department of Health & Human Services, 15-5163 (D.C. Cir. July 26, 2016)

- Addressed the statutory preclusion of review provisions concerning the calculation of the uncompensated care DSH payment
- Hospital contended that HHS knowingly used inaccurate Medicaid days data for the period it selected to calculate the DSH uncompensated care payment amount for FFY 2014
- DC Circuit ruled that the preclusion of review provision in the statute bars hospital's challenge to its DSH uncompensated care payment amount

Original DSH – Current, Ongoing Appeal Issues

- Part C / Medicare Advantage Patient Days
- SSI Fraction – Amended Ruling 1498
- General Assistance / Charity Care Patient Days

Original DSH – Part C Patient Days

- Background:
  - BBA ’97 enacted Medicare + Choice program by establishing new Part C of the Social Security Act
  - Now called Medicare Advantage
- Individual may elect to receive Medicare benefits through enrollment in a Medicare Advantage plan under Part C if she is entitled to benefits under Medicare Part A and enrolled in Part B
- Issue in Dispute:
  - Whether these patients should be considered to be “entitled to benefits under Part A” in calculating the Medicaid and SSI fractions

Original DSH – Part C Patient Days

- 2004 - HHS promulgated rule on Part C days
  - 69 Fed. Reg. at 49,099
    - Include Part C days in the SSI fraction beginning October 1, 2004 (FFY 2005)
    - Exclude Medicaid-eligible, Part C days from numerator of the Medicaid fraction
- 2011 - DC Circuit reversed application of the 2004 rule to prior periods
  - *Northeast Hospital Corp. v. Sebelius*, 657 F.3d 1 (D.C. Cir. 2011)
  - CMS issued TDL in 2012 directing MACs to settle pending appeals to include Part C days in the Medicaid fraction numerator for discharges prior to the October 1, 2004 effective date of the 2004 rule

Original DSH – Part C Patient Days

- *Allina I* - DC Circuit vacated 2004 rule change
  - Challenge to the application of the 2004 rule in the calculation of the SSI fractions, including Part C days, for FFY 2007
  - D.C. Circuit affirmed the district court's vacatur of the 2004 rule change, concluding that the final rule was not a logical outgrowth of the proposed rule. *Allina Health Servs. v. Sebelius*, 746 F.3d 1102 (D.C. Cir. 2014)
  - Court sent the case back HHS to decide how proceed now that the 2004 rule change has been vacated
  - The ongoing dispute centers on 2005-2013 and whether Part C days should be excluded from the SSI ratios and counted in the numerator of the Medicaid fraction for those years
  - CMS did a notice-and-comment rule on the treatment of Part C days in 2013, but that rule is effective only after October 1, 2013

Original DSH – Part C Patient Days

- *Allina II* (D.D.C. August 17, 2016)
  - Addressed CMS's calculation of the SSI fractions for 2012, which included Part C days in the SSI fraction, shortly after the DC Circuit had vacated the 2004 rule change in the first case
  - In August, the district court upheld that calculation
  - That decision has been appealed to the DC Circuit
  - DC Circuit will likely issue its decision in the next 18 months or so

POLLING QUESTION

Original DSH Payment - Ruling 1498-R2

- CMS issued Ruling 1498-R in April 2010
- Ruling 1498-R changed the process CMS uses to calculate the SSI ratios following a 2008 federal district court decision in *Baystate*
- Ruling 1498-R also required the PRRB to remand certain appeals:
  - Appeals challenging prior calculations of the SSI ratios for any cost year; and
  - Appeals on the treatment of Part A non-covered days (e.g. exhausted benefit days) in the DSH payment calculation for discharges prior to the October 1, 2004
  - October 1, 2004 is the effective date of a 2004 rule including Part A exhausted benefit days in the SSI ratio and excluding the Medicaid-eligible portion of such days from the numerator of the Medicaid fraction
- Ruling 1498-R provided that for both types of appeals, a revised SSI ratio including Part A non-covered days would be applied on remand

Original DSH Payment - Ruling 1498-R2

- CMS issued Ruling 1498-R2 in April 2015
- Ruling 1498-R2 amends the prior Ruling with respect to the revised SSI ratios that would be applied on remand of an appeal from the PRRB or in an initial NPR for a cost reporting period involving discharges before October 1, 2004
- Election:
  - Hospitals may elect on remand to apply a revised SSI fraction with or without Part A non-covered days included in the numerator and denominator, *i.e.,* based either on "total days" or "covered days" for a cost reporting period beginning before October 1, 2004
  - This election also may be made by a hospital that has not yet received an initial NPR for a cost reporting period beginning before October 1, 2004
- The Rulings do not apply to Part C days that were excluded from the SSI ratios for discharges before October 1, 2004

Original DSH Payment - Ruling 1498-R2

- Ruling 1498-R2 says that CMS will issue further implementation instructions and guidance
- Instructions will address
  - The process for making elections
  - The mechanism for receiving patient-level data underlying the revised SSI ratios
  - This “routine use” data will be provided without cost with a respect to cost year that is remanded under Ruling 1498-R2 and for years ending after December 8, 2004
- CMS has not yet issued these instructions

Original DSH Payment - Ruling 1498-R2

- In June, the Government settled a number of cases in which hospitals had challenged in court the validity of the remand provisions of Ruling 1498-R
- More recently, the federal district court ruled hospitals cannot a challenge a remand determination made by the PRRB under the Ruling until after further appeal from a revised NPR
  - *Empire Health Foundation v. Burwell*, No. 15-2251 (D.D.C. Sept. 19, 2016)
  - Board remanded appeals on the SSI fraction under Ruling 1498
  - After the Board remanded, the hospitals challenged that order in Court
  - The Court ruled that the Board remand order under 1498-R is not a final agency decision, so hospitals cannot challenge a Board decision remanding a case until after a further appeal from a revised determination on remand

Original DSH Payment – GA or Charity Care Days

BACKGROUND

- In many cases, the Medicaid State plan addresses patient days or costs of services furnished to individuals who are not otherwise eligible for traditional Medicaid under statutory eligibility criteria:
  - Individuals who receive “general assistance” including medical benefits under a State program but who are not otherwise eligible for Medicaid
  - Individuals who qualify for charity care
- GA or charity care patient days or costs may be addressed in Medicaid State plan provisions governing:
  - the calculation of a Medicaid DSH payment, or
  - Medicaid supplemental payment for inpatient hospital services

Original DSH Payment – GA or Charity Care Days

- HHS' position is that GA and charity care days may not be counted as Medicaid-eligible patient days in the Medicare DSH payment calculation even if these patient days or costs are considered in the calculation of a Medicaid DSH or supplemental payment made under the State plan
- Several court decisions have upheld that policy following the DC Circuit's 2008 decision in *Adena Reg'l Med. Ctr. v. Leavitt*, 527 F.3d 176 (D.C. Cir. 2008)
- Every other court that has considered the issue has followed the decision in *Adena*.

Original DSH Payment – GA or Charity Care Days

- The most recent decision is from the Sixth Circuit, addressing Kentucky charity care days
  - *Owensboro Health/Jackson Purchase v. Burwell*, Nos. 15-6109/6110 (6th Cir.)
  - KHCP is a State program. KHCP patient days are considered in the calculation of the Medicaid DSH payment under the State plan.
  - The charity care patients are not otherwise eligible for Medicaid – they are not in mandatory or optional Medicaid eligibility groups under the Federal Medicaid statute
  - The Court concluded "eligible for medical assistance under a State plan" is synonymous with "eligible for Medicaid" and that since KHCP patients are by definition not eligible for Medicaid, those patient days cannot be included in DSH calculation

Original DSH Payment – GA or Charity Care Days

- 2016 decision on New Jersey charity care days
  - *Cooper Hospital v. Burwell*, Case No. 14-1991 (DDC)
  - The New Jersey charity care days are counted in the Medicaid DSH payment under the State plan and State receives Federal matching funds for the Medicaid DSH payment
  - The district court ruled that the charity care patients are not eligible for medical assistance under a State plan, and therefore may not be counted in the Medicaid fraction numerator, because these individuals are not in mandatory or optional Medicaid eligibility groups
  - Court also rejected argument that arbitrary and capricious or unconstitutional to treat these NJ patients different than patients in states with expansion waivers (which may be included
  - Hospital appealed decision to DC Circuit
- 2015 decision on GA days in Washington State
  - *Verdant Health Commission v. Burwell*, 127 F. Supp. 3d 1116 (W.D. Wash. 2015)
  - The GA days are counted in the calculation of the Medicaid DSH payment
  - The Ninth Circuit previously ruled that the same types of Washington GA days may not be included in the Medicare DSH payment calculation, in another case involving many of the same hospitals. *University of Washington Medical Center v. Sebelius*, 634 F.3d 1029 (2011).
  - District Court agreed that these days may not be included in the Medicare DSH payment calculation. An appeal is pending in the Ninth Circuit.

Original DSH Payment – GA or Charity Care Days

- In 2014, the Third Circuit rejected the argument that the Secretary's different treatment of GA days and the patient days for similar individuals who are covered under an approved demonstration project violates Equal Protection or is otherwise arbitrary and capricious. *Nazareth Hospital v. Secretary, HHS*, 747 F.3d 172 (3d Cir. 2014)
- In the past two years, courts reached the same conclusion for three different State plans in *Cooper*, *Owensboro Health, Verdant Health*
  - *Cooper* and *Verdant Health* have been appealed and are pending before the DC Circuit and Ninth Circuit, respectively

Original DSH Payment – Waiver Days

- The patient days for individuals covered under an approved Medicaid expansion demonstration project waiver (section 1115 waiver) are treated differently than GA or charity care days that are not covered under a demonstration project but are considered in the calculation of a Medicaid DSH payment
- The Medicare DSH payment calculation may include patient days for individuals who are covered for inpatient hospital services under an approved demonstration project under Section 1115 of the Social Security Act with title XIX matching funds. 42 CFR § 412.106(b)

Original DSH Payment – Additional Medicaid Eligible Days

- Hospitals are required to verify Medicaid eligibility with the State for each Medicaid patient day claimed in the DSH calculation – 42 CFR 412.106(b)(4)
- Hospitals routinely identify additional Medicaid eligible days after the cost report is filed
  - This often occurs due to retroactive Medicaid eligibility determinations, for example
- Appeals to include additional Medicaid eligible days, not counted in the as-filed cost report, can generate disputes about jurisdiction in some cases
  - Hospital may be required to show there was some “practical impediment” to identifying and claiming the additional days at issue in the appeal when the cost report was filed

Original DSH Payment – Additional Medicaid Eligible Days

- Final OPPS Rule for CY 2016 – Allows One Cost Report Amendment for Additional Medicaid Eligible Days
  - The preamble to the final OPPS rule says that CMS will instruct the MACs that they "must accept one amended cost report" for additional Medicaid-eligible patient days
  - The amended report must be submitted within 12 months after the due date for the original cost report due date
  - The amended report must be "solely for the specific purpose of revising a claim for DSH by using updated Medicaid-eligible patient days, after a hospital receives updated Medicaid eligibility information from the state."
- This should help alleviate the need to appeal and potentially fight over jurisdiction in appeals to include additional Medicaid eligible days in the calculation of the original DSH payment

THANK YOU

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