The Medicare DSH Adjustment

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Today’s Topics

- Overview of the DSH Adjustment
- Status of the SSI Fractions
- CMS Ruling No. 1498-R Implementation
- The Impact of Health Reform
- Medicare+Choice/Medicare Advantage Days
- Medicare/Medicaid Dual Eligible Days
- 1115 Waiver Days

Overview of the DSH Adjustment

WHY DID CONGRESS CREATE THE DSH ADJUSTMENT?

- Authorized by Congress in 1983 with the advent of IPPS
- In the COBRA of 1986, Congress prescribed the statutory DSH definition
  - 1886(d)(5)(F) of the Social Security Act
- In 1986, the Secretary promulgated the DSH rule
  - 42 C.F.R. § 412.106
Overview of the DSH Adjustment

WHAT IS THE DSH ADJUSTMENT?

- Percentage add-on to PPS payments per discharge
- Other factors
  - Bed count
  - Geographic classification
  - Status as a RRC or SCH
- The “Proxy” and “Pickle” DSH methods

HOW IS THE DSH ADJUSTMENT CALCULATED?

- Proxy Method
- Disproportionate Patient Percentage (DPP)
  - Determines qualification for DSH payment
  - Determines amount of DSH payment
- DPP = sum of two fractions (expressed as %)
  - Medicaid fraction
  - Medicare/SSI fraction
- Since April 2001, all acute inpatient PPS hospitals with DPP of at least 15% qualify
Overview of the DSH Adjustment

**HOW IS THE DSH ADJUSTMENT CALCULATED?**

DPP (in patient days) = Medicaid Fraction: Eligible for Medicaid & Not Entitled to Medicare Part A + Medicare/SSI Fraction: Entitled to SSI & Entitled to Medicare Part A

Entitled to Medicare Part A

<table>
<thead>
<tr>
<th>Fiscal Year (FY)</th>
<th>DSH Payment (in billions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 2000</td>
<td>$5.18</td>
</tr>
<tr>
<td>FY 2001</td>
<td>$5.68</td>
</tr>
<tr>
<td>FY 2002</td>
<td>$6.63</td>
</tr>
<tr>
<td>FY 2003</td>
<td>$7.10</td>
</tr>
<tr>
<td>FY 2004</td>
<td>$7.82</td>
</tr>
<tr>
<td>FY 2005</td>
<td>$9.00</td>
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<tr>
<td>FY 2006</td>
<td>$9.13</td>
</tr>
<tr>
<td>FY 2007</td>
<td>$9.33</td>
</tr>
<tr>
<td>FY 2008</td>
<td>$10.09</td>
</tr>
<tr>
<td>FY 2009</td>
<td>$10.42</td>
</tr>
<tr>
<td>FY 2010</td>
<td>$10.83</td>
</tr>
<tr>
<td>FY 2011</td>
<td>$11.59</td>
</tr>
</tbody>
</table>

Source: CMS, Office of the Actuary
Overview of the DSH Adjustment

<table>
<thead>
<tr>
<th>WHAT PERCENTAGE OF HOSPITALS QUALIFY FOR THE PAYMENT?</th>
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<tbody>
<tr>
<td>● FY 2003: 63%</td>
</tr>
<tr>
<td>● FY 2004: 67%</td>
</tr>
<tr>
<td>● FY 2005: 71%</td>
</tr>
<tr>
<td>● FY 2006: 73%</td>
</tr>
<tr>
<td>● FY 2007: 75%</td>
</tr>
<tr>
<td>● FY 2008: 75%</td>
</tr>
<tr>
<td>● FY 2009: 77%</td>
</tr>
<tr>
<td>● FY 2010: 76%</td>
</tr>
<tr>
<td>● FY 2011: 78%</td>
</tr>
</tbody>
</table>

Source: CMS

Status of the SSI Fractions

<table>
<thead>
<tr>
<th>HOW DOES CMS MATCH THE SSI DATA?</th>
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<tbody>
<tr>
<td>■ <em>Baystate Medical Center v. Leavitt</em></td>
</tr>
<tr>
<td>● Court found that CMS failed to use “best available data” to calculate the Medicare/SSI fraction</td>
</tr>
<tr>
<td>■ FY 2011 IPPS Final Rule adopted a revised match process</td>
</tr>
<tr>
<td>● Shifted to a match process to include Social Security Numbers in addition to Title II numbers</td>
</tr>
<tr>
<td>● Expanded the number of identifiers used to conduct the match</td>
</tr>
<tr>
<td>● Added additional matching methods to capture anomalies</td>
</tr>
<tr>
<td>● Uses claims/eligibility data updated 15 months after FFY end</td>
</tr>
<tr>
<td>■ Addresses court’s concern that match process includes more recent SSI eligibility data</td>
</tr>
</tbody>
</table>
Status of the SSI Fractions

**WHEN ARE RATIOS PUBLISHED?**

- SSI Ratios are generally published annually and are based on the Federal Fiscal Year period (Oct. 1- Sept. 30)
- Section 951 of the MMA allows hospitals to request SSI eligibility information for patients during their cost reporting period. Under 42 C.F.R. § 412.106(b)(3), hospitals may request SSI ratio based on own cost reporting period
- Are used by CMS for cost report settlement and interim payments for Medicare DSH

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Status of the SSIFractions

**WHAT IS THE CURRENT STATUS OF SSI RATIOS?**

- CMS had announced a review of FY 2006 and FY 2007 SSI ratios thereby also delaying the release of SSI Ratios for subsequent years
  - Transmittal 1695 (Change Request 6329) March 6, 2009: Required hospitals to submit MA days for FY 2006 from 7/6/09 through 11/30/09
  - Transmittal 1311 (Change Request 5647) July 20, 2007: Requires hospitals to submit MA informational-only claims for FY 2007 forward
- March 16, 2012: CMS released revised SSI ratios for FY 2006 and FY 2007 as well as SSI ratios for FY 2008 and FY 2009
  - Calculated per the FY 2011 Rule
  - Includes MA patient day information
CMS Ruling No. 1498-R Implementation

What is a CMS Ruling?

- A decision of the Administrator that serves as a precedential final opinion or order or statement of policy or interpretation.

- A CMS Ruling binds all CMS components and all HHS components that adjudicate matters under the jurisdiction of CMS. 42 C.F.R. § 401.108.

- The Provider Reimbursement Review Board “must comply” with CMS Rulings. 42 C.F.R. § 405.1867.

What did the Ruling do?

- Declared that administrative appeals tribunals (e.g., PRRB and Administrator) no longer have jurisdiction over provider appeals addressing any one of three DSH issues;

- Required all administrative appeals tribunals to remand qualifying appeals to Medicare contractors;

- Described the process by which CMS and contractors would recalculate the provider’s DSH adjustment and make any payment; and

- Applied the provisions of the Ruling on all three DSH issues to open hospital cost reporting periods.
CMS Ruling No. 1498-R Implementation

What is a “qualifying appeal?”

• Any jurisdictionally proper pending appeal raising any one of three issues:
  ■ A challenge to the process used to match SSI eligibility and Medicare claims data to determine the SSI fraction (i.e., a Baystate appeal);
  ■ A claim to include non-covered days of dual eligible beneficiaries for cost reporting periods with discharges before October 1, 2004; and
  ■ A claim to include certain labor and delivery days for cost reporting periods beginning before October 1, 2009.

Implementation of the Ruling

• Under “alternative implementation procedure” providers can request remand for contractors to determine whether appeal qualifies for relief

• Unitary relief for qualifying appeals
  ■ CMS will apply the SSI data matching process adopted in FY 2011 IPPS Rule
  ■ Revised data matching process will include non-covered inpatient days
  ■ Revised data matching process will include labor and delivery room (LDR) inpatient days for patients who were entitled to Part A benefits

• Ruling restates CMS policy that non-covered days for dual eligible beneficiaries may not be included in Medicaid fraction
CMS Ruling No. 1498-R Implementation

Subsequent Events

- CMS Ruling 1498-R effective April 28, 2010
- Multiple motions for EJR challenging 1498-R granted by PRRB, reversed and remanded by Administrator on jurisdictional grounds
- Several cases pending in federal court challenging 1498-R – many stayed pending decision in Northeast Hosp. Corp. v. Sebelius (D.C. Cir.)

Health Reform: ACA Section 3133 (as amended by HCERA)

HOW WILL MEDICARE DSH CHANGE UNDER HEALTH REFORM?

- Health care reform legislation that was signed into law in March 2010 makes significant changes to the Medicare DSH adjustment beginning in FY 2014
  - Medicare DSH payments, as presently calculated, will be reduced to 25 percent
  - Hospitals receiving DSH will be entitled to additional payments based on the product of three new factors
- Limitations on judicial review
  - Estimates calculated by the Secretary
  - Periods selected by the Secretary
Health Reform: ACA Section 3133 (as amended by HCERA)

**WHAT ARE THE NEW FACTORS?**

- **Factor 1: Additional Payment Amount**
  - 75% of the estimated aggregate DSH payments

- **Factor 2: Adjusted Uninsurance Rate**
  - The percent change (for individuals under the age of 65) in the aggregate uninsurance rate when compared to the aggregate uninsurance rate in 2013, subject to an additional downward adjustment through FY 2019

- **Factor 3: Uncompensated Care**
  - For each hospital, the amount of uncompensated care relative to the aggregate amount of uncompensated care for all hospitals that receive a DSH adjustment

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Medicare+Choice/Medicare Advantage Days

- **BBA '97**
  - Enacted M+C program by establishing new Part C of the Social Security Act
  - Codified at 42 U.S.C. § 1395w-21 et seq.
  - Now called Medicare Advantage

- **Choice**
  - Individual may receive Medicare benefits under one of two means:
    - through original Medicare fee-for-service program under A and B; or
    - through enrollment in M+C/MA plan under Part C

- **Election**
  - An individual may elect to enroll in a Part C plan if she is entitled to benefits under Medicare Part A and enrolled in Part B
<table>
<thead>
<tr>
<th>Medicare+Choice/Medicare Advantage Days</th>
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</thead>
<tbody>
<tr>
<td><strong>The legal question –</strong></td>
</tr>
<tr>
<td>● Are Medicare Part C enrollees “entitled to benefits under part A” of Medicare for purposes of the DSH payment calculation?</td>
</tr>
<tr>
<td><strong>If yes –</strong></td>
</tr>
<tr>
<td>● include in the Medicare/SSI fraction (denominator and numerator); and</td>
</tr>
<tr>
<td>● exclude from the numerator of the Medicaid fraction</td>
</tr>
<tr>
<td>● this produces less DSH payment to hospitals</td>
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| CMS Position: |
|● M+C/MA enrollees are “entitled to benefits under part A” because that phrase refers to anyone who has met part A eligibility criteria |

| Hospital’s Position: |
|● M+C/MA enrollees are not “entitled to benefits under part A” because that phrase refers only to those patients who were entitled to have Medicare part A benefits paid on their behalf for the specific days spent in the hospital |

| First Case |
|● *Northeast Hospital Corporation v. Sebelius* |
|● DC Circuit decision issued in September 2011 |
Medicare+Choice/Medicare Advantage Days

- **District Court ruled in 2010**
  - Secretary's interpretation violates the plain language of the statute
  - Secretary's interpretation also is not reasonable because it is inconsistent with the agency’s prior interpretation of the same phrase in other related provisions

- **DC Circuit ruled in Sept. 2011**
  - 2 of the 3 judges
    - Concluded that the plain language of the statute does not foreclose the Secretary’s current interpretation of “entitled”
    - But they did not decide whether that interpretation is permissible
  - 1 of the 3 judges
    - Concluded that the Secretary’s interpretation violates the plain language of the statute and is otherwise unreasonable
  - All 3 judges ruled
    - The Secretary’s current policy cannot be applied retroactively to the periods at issue in the case, which preceded the agency’s 2004 announcement of its current policy

Medicare+Choice/Medicare Advantage Days

- **Ramifications**
  - Medicare/SSI fractions for FFY 2005 and later
    - The Northeast decision does not answer the question for these periods
    - Other pending cases on the issue for later years
  - Other related issues
    - Medicare/Medicaid dual eligible days
Medicare/Medicaid Dual Eligible Days

**WHAT ARE DUAL ELIGIBLE DAYS?**

- Days where a patient is participating in Medicaid and Medicare Part A but no payments are made under Medicare Part A for various reasons
- Are beneficiaries “entitled to benefits under part A” for days that are not covered and paid under part A?
- Common Examples
  - Exhausted benefits (90 days per spell of illness + 60 lifetime reserve days)
  - Medicare Secondary Payor
  - Medical or technical denials

Medicare/Medicaid Dual Eligible Days

**WHAT ARE THE PARTIES’ POSITIONS?**

- **CMS Position**
  - All of these days belong in the SSI fraction and must be excluded from the numerator of the Medicaid fraction
- **Hospital Position**
  - All of these days must be excluded from SSI fraction and the Medicaid-eligible portion must be included in the numerator of the Medicaid fraction
Medicare/Medicaid Dual Eligible Days

WHAT HAVE THE COURTS SAID?

■ First Case
  • Metropolitan Hospital, Inc. v. Sebelius, 702 F. Supp. 2d 808 (W.D. Mich. 2010)
  • District Court declared Secretary's position invalid - violates the plain language of the DSH statute
  • "Metro Hospital 2" (Nov. 2010) and "Metro Hospital 3" (Sept. 2011)
  • On Appeal to Sixth Circuit (Nos. 11-2465, 11-2466)

Medicare/Medicaid Dual Eligible Days

WHAT HAVE THE COURTS SAID?

■ Second Case
  • DC District Court ruled that the application of its policy to prohibit the inclusion of dual eligible days in the Medicaid fraction was unlawful retroactive rulemaking in the 1997 cost reporting period at issue
  • What are the implications to hospitals for periods prior to 10/1/04?
### 1115 Waiver Days

**Section 1115 of the Social Security Act**
- Authorizes demonstration programs under several federal/state programs created by the Social Security Act, including Medicaid
- Authorizes the Secretary to waive some requirements for those programs, including Medicaid eligibility criteria
- Authorizes the Secretary to consider expenditures made under an approved demonstration program as an expenditure made under the applicable state plan

**CMS 2000 Rulemaking**
- Established that expansion waiver days may be counted in the DSH calculation as Medicaid patient days effective January 20, 2000
- Stated that these days could not be counted as Medicaid patient days for prior periods

**Deficit Reduction Act of 2005**
- Amended the DSH statute to provide the Secretary discretion, prospectively, to include or exclude expansion waiver days
- “Ratified” CMS’s prior rules, including the 2000 rulemaking

**DC Circuit Decision in Cookeville**
- Upheld the disallowance of TennCare expansion waiver days for periods before Jan. 20, 2000
- Concluded that Congress merely clarified the agency’s pre-existing discretion under section 1115
- Accepted the agency’s statement that its prior policy, before the 2000 rulemaking, was to exclude expansion waiver days

**What’s left?**
- For periods before the 2000 rulemaking
  - At least one case challenging the disallowance before the 6th Circuit
- For current periods
  - How is the agency applying the current rule (42 C.F.R. § 412.106(b)(4)(i) & (ii))?  
    - “[A] patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan or under a waiver authorized under section 1115(a)(2) of the Act on that day”
    - “[F]or purposes of counting days . . . hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115”

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