REVINT SOLUTIONS INSIGHTS

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Regain DSH Reimbursement by Medicare DSH Uncompensated Care Pool

To Our Healthcare Clients and Friends:

In today's world of healthcare, hospital financial executives cannot afford to leave hundreds of thousands or even millions on the table. That is exactly what will happen if you are not positioned correctly for the new methodology surrounding Medicare DSH reimbursement. Therefore, your reimbursement experts must be aware of the changing rules, instructions, and implications surrounding Medicare DSH Uncompensated Care Pool reporting on Worksheet S-10.

BACKGROUND

The Medicare Disproportionate Share (DSH) Payment adjustment was implemented in May 1986. The purpose was to provide additional reimbursement for hospitals treating a large share of low-income patients who tend to be sicker and costlier to treat than other patients with the same diagnosis. Additionally, it was felt that DSH funding would preserve access to care for Medicare and low-income populations by providing hospitals with additional financial assistance.

To qualify, a hospital must meet the empirically justified DSH threshold calculation based on two fractions – the Medicare Proxy and the Medicaid Proxy qualifying a hospital for a DSH Payment adjustment at a 15% threshold:

Medicare Proxy:		Medicaid Proxy:	
$\frac{\text{Medicare SSI Days}}{\text{Total Medicare Pts A \& C Days}}$	+	$\frac{\text{Medicaid, Non-Medicare Days}}{\text{Total Patient Days}}$	= 15% or greater

The Affordable Care Act (ACA) implementation changed how Medicare Disproportionate Share (DSH) payments were paid to qualifying hospitals. Beginning with Federal Fiscal Year (FFY) 2014 there are now two methods to the DSH calculation. Hospitals still must qualify for the empirically justified threshold, as stated above which will be 25% of what was previously paid for DSH. The second part is the Uncompensated Care Pool which will distribute the remaining 75% of the Medicare DSH budget. However, before calculating the UCP, the pool amount is then reduced by the percentage of uninsured patients becoming insured under the ACA Medicaid Expansion.

The Centers of Medicare and Medicaid (CMS') intention has always been to distribute the UCP dollars for DSH qualifying hospitals based on their Uncompensated Care Costs (UCC) per the Medicare cost report Worksheet S-10, Line 30. CMS defined Uncompensated Care as Charity Care and non-Medicare Bad Debt costs.

BACKGROUND CONT'D...

Due to inconsistent reporting of uncompensated care costs on Worksheet S-10, CMS has used a "Days Proxy" to distribute the UCP dollars for cost reports that began with Federal Fiscal Year 2014. The "Days Proxy" was based on Medicaid-eligible and SSI days.

Now, beginning with Federal Fiscal year 2018 CMS has implemented a transition from the Days Proxy to the Worksheet S-10 uncompensated care costs which uses a 3-year average. For FFY 2018 the Days Proxy will represent 2/3 and Worksheet S-10 will be 1/3 of the average to calculate Factor 3. For FFY 2019 the factors are reversed where S-10 will represent 2/3 and the Days Proxy 1/3. Then for FFY 2020, CMS intends to fully use Worksheet S-10 Uncompensated Costs (Line 30) to distribute the UCP as shown in the chart below:

Proposed Transition Timetable			
	Year 1	Year 2	Year 3
FFY 2018	Days Proxy 2012	Days Proxy 2013	S-10: 2014
FFY 2019	Days Proxy 2013	S-10: 2014	S-10: 2015
FFY 2020	S-10: 2014	S-10: 2015	S-10: 2016

CHALLENGES

CMS' mixed messages over the last five years has created challenges for the hospital financial team. The definitions and instructions have changed several times. The method for reporting Charity Care depends on the FFY. From FFY 2014 – 2016 hospitals are to report Charity Care dollars based on the patients "service dates" within your hospital cost report year. However, beginning with FFY 2017 hospitals are to report their Charity Care dollars based on the hospital "write-off" date within their cost report year regardless of the patients dates of service. The Charity Care "write-off" methodology will be aligned with the instructions for Bad Debts.

The hospital reimbursement team will need to be cognizant of cost instruction changes in Transmittals 10 and 11. This includes that these cost report instruction changes are effective with the start of FFY 2014 (October 1, 2013).

CMS opened a window to revise the 2014 and 2015 Worksheet S-10 that has now closed. If you did not take advantage, it would not hurt to ask your MAC (Medicare Administrative Contractor) audit team if they will allow you to do so now. The 2016 cost report revision window will open this summer with a probable due date of September 30, 2018. It is important to report the correct uncompensated care costs as they will be used to distribute your DSH UCP for three years (per chart above).

Additionally, CMS has stated that they will begin auditing Worksheet S-10 for the Charity Care and Bad Debt amounts. This means that the hospital will need to have patient-level documentation to verify that the amounts reported are correct. CMS does not reveal their audit program, but speculation is that the audit of these amounts will be similar to how the MAC audits the empirical DSH logs and Medicare Bad Debts.

The adoption of Worksheet S-10 will have major implications not only on the DSH hospitals receiving uncompensated care payments but also on the low-income population they serve as modifications to these payments may ultimately impact care, which was one of several reasons for the DSH Payment Adjustment in the first place.

INSIGHTS

Hospitals must adequately prepare for the upcoming transition which could have a potentially devastating consequence on the hospital and the patients served. The time to prepare for these changes are now. Several suggestions on how to prepare for the transition include:

- Hospitals should review their Charity Care, Bad Debt, and other related policies to ensure that S-10 Charity Care and Bad Debt write-off amounts are in alignment with the hospital policies and the S-10 cost report instructions as revised by Transmittals 10 and 11. As stated above, starting with cost reports beginning on or after October 1, 2016 (FFY 2017) Charity Care will now be based on the "date of the hospital write-off" instead of the previous instruction which was based on the patients "date of service".
- Hospitals should be prepared to amend the Worksheet S-10 amounts for their 2016 cost reports, when CMS announces an opening window to amend. Additionally, ask your MAC if you can reopen to revise your 2014 and/or 2015 cost report for S-10 before being audited.
- It should be noted that the FFY 2018 Proposed Rule states that Worksheet S-10 will be eligible for desk review and audit beginning with the 2017 cost reports. For 2014-2016 cost reports CMS has in structed the MAC's to review S-10 "with more scrutiny". CMS did not define want "more scrutiny" means.
- MAC's will require Charity Care and Total Bad Debt patient detail logs be available for auditing your S-10 uncompensated care amounts.

SUMMARY

The bottom line for each hospital financial executive is that each hospital is now competing for Federal DSH UCP dollars with all other DSH eligible hospitals. Without thorough review of the cost report changing cost report instructions and CMS guidance, hospitals could be leaving hundreds of thousands, and in some instances millions of dollars on the table in Medicare DSH reimbursement. The playing field may not be level, (expansion states have seen their Charity Care amounts decrease, while non-expansion states have remained steady or increased) so you will need to accurately optimize your Charity Care and Bad Debts based on CMS guidance and cost report instructions.

We are pleased to have this opportunity to present this information to you. If you have any questions or require assistance, please feel free to contact me at 571.455.3617.

Truly Yours,
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Meet the Author | Mike Sabo

Mike Sabo is the Senior Vice President of Regulatory Affairs, Product Strategy, and Medicare Reimbursement for Revint Solutions. Mike has been in the healthcare industry over 40 years serving in positions at the Medicare Fiscal Intermediary (MAC), two major teaching New Jersey healthcare systems, and as a consultant.

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