PUBLICATION

IPPS Final Rule: CMS Addresses Allina Decision and Addresses New Medicare DSH Payment Calculations [Ober|Kaler]

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In the fiscal year 2014 Inpatient Prospective Payment System (IPPS) rule published in the *Federal Register* on August 19, 2013, CMS took two steps of note regarding the Medicare disproportionate share hospital (DSH) calculation. First, CMS addressed the decision by the United States District Court for the District of Columbia in *Allina Health Services v. Sebelius ("Allina")* which we discussed in our December 13, 2012 *Payment Matters* newsletter. Second, CMS explained the new DSH payment calculations and described the data on which the payment is to be calculated.

1. At issue in *Allina* is whether CMS's policy of excluding Medicare Part C days from the numerator of the Medicaid fraction and, instead, including those days in the Medicare fraction, was appropriate for periods after 2004. The District Court struck down the policy, stating that the policy first announced by CMS in 2004 but not added to the Code of Federal Regulations until 2007 was not a "logical outgrowth" of an earlier 2003 notice of proposed rulemaking (NPRM). The Court further stated that the 2003 NPRM was not written in a way that put interested parties on notice that a change in the regulations was being considered and that comments were required and that, in any event, the Secretary's explanation of her rationale for the policy was impermissibly abbreviated.

CMS has appealed the District Court's *Allina* decision, but also provided further explanation of its position in the most recent (August 19) rulemaking. CMS explained why the agency believes that Medicare Advantage (MA) enrollees should be included in the Medicare and not the Medicaid fraction of the DSH calculation and why that position was, in the agency's view, a logical outgrowth of the FY 2004 IPPS proposed rule (published in May 2003). Based on this analysis, CMS "re-adopt[ed] the policy of counting the days of patients enrolled in MA plans in the Medicare fraction of the DPP," which policy, CMS said, is "most consistent with the language of the statute, congressional intent, and the structure of the DSH calculation."

2. Additionally, CMS provided details on the new Medicare DSH calculation and how that calculation will be implemented effective October 1 of this year. As we have previously reported in the May 30, 2013 and April 4, 2013 *Payment Matters* newsletters, beginning October 1, CMS will be calculating and paying for DSH in a manner very different from that employed today. Under the new rules, 25% of the payment will be calculated using the current DSH methodology, which CMS refers to as the "empirically justified Medicare DSH payment." The remaining 75% will be based on a methodology calculated by: (1) taking 75% of the DSH payments, as estimated by the Secretary, that would have been paid to hospitals under the current system; (2) adjusting that number by a factor representing the percentage change since 2013 in the uninsured under-65 population; and then (3) determining each hospital's percentage share of that amount based on the hospital's relative share of total uncompensated care.

In addressing the new formula, CMS finalized its proposal to estimate the 75% of DSH payments that would otherwise have been paid under the current DSH formula (Factor 1) by using projections of the total Medicare DSH payments prepared in July of each year by the Office of the Actuary. CMS estimates that this amount will be approximately $9.579 billion for FY 2014 (an increase from the $9.2535 billion estimated in the proposed rule).

For purposes of determining the adjustment in Factor 2, CMS finalized its proposal to use the most recent Congressional Budget Office (CBO) estimates available and to include unauthorized immigrants in its estimate of the uninsured under-65 population. Notably, in calculating the Factor 2 Adjustment, CMS employed updated CBO data and estimates to determine the estimated uninsured population for 2014, with the result being that there will be an increase in the available pool for uncompensated care payments when compared to the amount estimated in the proposed rule.

Finally, in order to determine each DSH-eligible hospital's share of total uncompensated care (Factor 3), CMS finalized its proposal to employ, at least for 2014, insured low-income days as a proxy for uncompensated care cost. CMS confirmed that it will not, initially at least, use Worksheet S-10 as the source of the data to determine Factor 3. CMS, however, will continue to review the instructions for Worksheet S-10 and consider what revisions and clarifications might be necessary for it to become the source of the Factor 3 data in the future. Until then, Factor 3 is to be calculated on the basis of each eligible hospital's proportion of low-income insured days (Medicaid and Medicare SSI patient days) relative to the low-income insured days for all hospitals that receive DSH payments.

CMS projects that there will be 2,437 DSH-eligible hospitals in FY 2014. Nevertheless, CMS will calculate Factor 3 for all subsection (d) hospitals, including those that are projected to be ineligible to receive DSH payments. It is doing this so that these hospitals will be able to receive uncompensated care payments at the time of the cost report settlement should those hospitals be later determined eligible to receive DSH payments.

Additionally, in a reversal of what it had proposed, CMS has agreed to make interim uncompensated care payments on a per discharge basis rather than on a periodic basis. Hospitals had commented that the periodic payment approach would have resulted in MA plans not paying uncompensated care payments even though they had contracted to pay Medicare rates. By changing the payment of the uncompensated care amounts to a per discharge basis, MA plans will find it much simpler to determine what amounts they should pay.

Comments

With respect to CMS's *Allina* decision, it is plain that the agency will continue to fight hard to justify its 2004 rulemaking. Whether it will meet success with these efforts, however, will not be known for months to come. With regard to CMS's implementation of the new DSH system, it appears that CMS has done a faithful job of implementing the Affordable Care Act (ACA) provisions. Although the formula is far more complex than the earlier payment formula, this is simply a result of the ACA.