

# NY HFMA Cost Report Seminar

- Medicare DSH under Healthcare Reform
- Recent developments in DSH
- Comments from users of Datamart system
- Recommendations using the Datamart system

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# Healthcare Reform 2010

**Patient Protection and Affordable Care Act (PPACA)** signed into law in the United States by President Barack Obama - March 23, 2010

As amended by...

The Senate Manager's Amendment to the PPACA, adopted and amended to the PPACA legislation as Title X

**The HCERA Health Care & Education Reconciliation Act of 2010** - signed into law on March 30, 2010

The Reconciliation bill makes numerous modifications to the Patient Protection and Affordable Care Act.

# Healthcare Reform Overview

Implementation over a period from enactment through 2020  
with a concentration on the period 2010 - 2014

## Key Provisions:

- Prohibits denial of coverage/claims based on pre-existing conditions
- Adds across-the board coverage mandates
- **Expands Medicaid eligibility**
- Subsidizes insurance premiums
- Establishes health insurance exchanges
- Incentivizes businesses to provide health care benefits
- **Reductions in Medicare reimbursement**
- New demonstration projects and quality-based reimbursement programs

# ...and the money comes from where?

- Cuts in Medicare reimbursement (including Medicare DSH)
- New Medicare taxes for high-income brackets
- New excise taxes
- Improved fairness in the Medicare Advantage program relative to traditional Medicare slowing the growth of Medicare provider payments
- Fees and taxes on medical devices, pharmaceutical companies and health insurers
- Tax penalty for citizens who do not obtain health insurance (unless they are exempt due to low income or other reasons)
- Limitations on FSA contributions
- Modifications to the tax code

# Reimbursement & Revenue Cycle Implications Medicare DSH Fiscal Year 2014

- Reduces **Medicare** Disproportionate Share Hospital (DSH) payments to 25 percent of the amount that otherwise would be made beginning in FFY 2014
- Nationwide effect of 10 year reduction of > \$20B
- Provides an additional payment to reflect uncompensated care costs, based on a formula that takes into account:
  - the aggregate reduction in payments to all hospitals attributable to the reduction in DSH payments (the 75 % not being paid for DSH)
  - the reduction in uninsured individuals in a year (relative to 2013)
  - each hospital's share of uncompensated care provided by all hospitals

# Reimbursement & Revenue Cycle Implications Medicare DSH Fiscal Year 2014

**Additional payment:** In addition to the revised 25% payment made to eligible hospitals for fiscal year 2014 and each subsequent fiscal year, the Secretary shall pay to such hospitals an additional amount equal to the product of the following factors:

- **Factor one** - A factor equal to the difference between:
  - (i) the aggregate amount of payments that *would have been* made to DSH hospitals if this new section did not apply for such fiscal year (the 100% dollar value of what would have been paid); and
  - (ii) the aggregate amount of DSH payments that *will be* made to hospitals for such fiscal year (the 25% dollar value)

Interpretation: total national \$ difference between old and new DSH payment calculations

# Reimbursement & Revenue Cycle Implications Medicare DSH Fiscal Year 2014

- **Factor two:** For each of fiscal years 2014 – 2019, a factor equal to 1 minus the percent change in the percent of individuals under the age of 65 who are uninsured minus .1 (2014) or .2 (2015-2019), as determined by comparing the percent of such individuals:
  - Under 65 who are uninsured in 2013 (as calculated); minus
  - Individuals under 65 who are uninsured in the most recent period for which data is available.

For 2018 and subsequent years, the factor shall be:

- Individuals\* who are uninsured in 2013; minus
- Individuals who are uninsured in the most recent period for which data is available.

**Interpretation:** Downward adjustment to the additional payment amount based on drop in uninsured population plus an additional artificial adjustment.

\*PPACA does not specifically define “individuals for the purpose of this calculation as being those under the age of 65

# Reimbursement & Revenue Cycle Implications Medicare DSH Fiscal Year 2014

**Factor three** - A factor equal to the percent, for each hospital, that represents the quotient of:

- (i) the amount of uncompensated care for the hospital (for a period selected and estimated by the Secretary) and
- ii) the aggregate amount of uncompensated care for all hospitals that receive a payment for such period (as estimated)

Interpretation: hospital-specific % of total national uncompensated care

Has CMS defined what they mean by “uncompensated care”?  
Obviously the more uncompensated care the more money for hospital. Will Worksheet S-10 be the source for this calculation?

# Reimbursement & Revenue Cycle Implications Medicare DSH Fiscal Year 2014

## 2014 Example

- Assumption: National uninsurance rate falls 2% between 2012 and 2013

- Hospital receives:

(Medicare DSH formula amount) \*25%

plus

(75% of estimated aggregate national DSH payments) x (1-2% -0.1%) x (hospital-specific % of total uncompensated care)

**Assume \$7.0B is 100% DSH value \* 75% = 5.25b**

(~\$5.25b) x (.979) = \$5.14b x (hospital-specific % of total uncompensated care)

# Reimbursement & Revenue Cycle Implications Medicare DSH Fiscal Year 2014

- Limitations on review - There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the following:
  - Any estimate of the Secretary for purposes of determining the factors
  - Any period selected by the Secretary for such purposes
- To what extent will expanded coverage offset reduction in DSH reimbursement?
- Uncompensated care reporting could be critical

# Reimbursement & Revenue Cycle Implications 340 B Program

## Retroactive to 1/1/10

Expands eligibility for the 340(B) drug discount program to other entities. DSH payment adjustments were available only to hospitals paid under the Medicare Prospective Payment System (PPS) and hospitals excluded from the PPS have been historically unable to participate in the 340B program. (Website at : <http://www.hrsa.gov/opa/>)

- PPS-excluded children's hospitals and cancer hospitals will be able to participate if they would meet the DSH payment adjustment percentage of greater than 11.75 percent if they were otherwise a PPS hospital.
- CAHs are eligible to participate by virtue of having CAH status and meeting other program requirements. DSH percentage criterion not applicable.
- Sole Community Hospitals (SCHs) and Medicare designated Rural Referral Centers (RRCs) can now qualify if their Medicare DSH Payment Adjustment is 8%. Historically, the DSH payment adjustment had to be 11.75%.
- PPACA also introduces new methods for monitoring and enforcing compliance with 340B program rules.

# Reimbursement & Revenue Cycle Implications Medicaid Expansion January 1, 2014

- Expand **Medicaid** to all individuals under age 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 133% FPL based on modified adjusted gross income (as under current law, undocumented immigrants are not eligible for Medicaid).
- All newly eligible adults will be guaranteed a benchmark benefit package that at least provides the essential health benefits.
- States have the option to expand Medicaid eligibility to childless adults beginning on April 1, 2010, but will receive their regular FMAP until 2014.

# Reimbursement & Revenue Cycle Implications Medicaid Expansion January 1, 2014

- To finance the coverage for the newly eligible individuals, states will receive:
  - ✓ 100% federal funding (FMAP) for 2014 through 2016
  - ✓ 95% federal financing in 2017
  - ✓ 94% federal financing in 2018
  - ✓ 93% federal financing in 2019
  - ✓ 90% federal financing for 2020 and subsequent years.

What will Feb., 2011 option allowing States waiver from federal mandate do to Medicaid patient numbers? Can States meet the federal requirements for waiver?

# Reimbursement & Revenue Cycle Implications Then again...

- Will reform survive or be repealed?
  - As of March, 2011 three Federal judges have voted for constitutionality of the law and two have voted against
  - Expected to go to Supreme Court where there are 9 Justices, 5 Republican selected and 4 Democratic
  - Do we really expect the whole law to go away...I don't think so. Watch the elections
- Is the timetable reasonable or will it move?
  - Already seeing some delays
- What will the implementing regulations look like?
  - Watch them closely

# Recent DSH Developments

- Checking of Medicare Part A eligibility:
  - CMS has made available, a limited view of the HIPAA Transaction System (HETS) which allows hospitals to check Medicare Part A eligibility.
  - Info about the HETS system, including connectivity and file formatting are available at :  
<http://www.cms.hhs.gov/hetshelp>.
- CMS issuance of Revised SSI%'s:
  - On June 24, 2009 CMS issued revised 2007 SSI%'s. Subsequent years were expected in late 2010 and are still not out.

# Recent DSH Developments

- CMS- 1498-R issued May 3, 2010 (Signed 4/28/2010): Settled 3 main issues for jurisdictionally pending PRRB appeals and open cost reports.
  - 1) The data matching process for SSI fractions used more current and accurate data. CMS agrees to revise SSI%'s based on Baystate findings or as indicated in the FY2011 IPPS rulemaking. Revised SSI%'s on hold from 2008 forward.
  - 2) Issue of Medicare non-covered days like exhausted benefit days, Medicare secondary payer days. Only a Medicare Fraction (SSI) issue as these patients are deemed "Part A eligible". (CMS maintains that Medicare HMO days with SSI and Part A have been included since 1990)

# Recent DSH Developments

- CMS- 1498-R issued May 3, 2010 (Signed 4/28/2010):
  - 3) Labor & Delivery days- Basically it is no longer an issue. CMS agrees that days where Mom is admitted directly into L&D room without occupying a routine inpatient bed, are allowable in DSH.

# Recent DSH Developments

- CMS- 1498-R issued May 3, 2010 (Signed 4/28/2010):
  - CMS states that for these 3 issues, they will resolve the issue for all jurisdictionally proper appeals.
  - The caveats of how they are resolved are numerous and I refer you to the actual Change request for the various scenarios.
  - **NGS is waiting for instructions from CMS on how to implement various components of the Change Request.**
  - Going forward, SSI% will be calculated giving effect to the Baystate remand.
  - All revised NPRs are still subject to Appeal but CMS' hope is that they will be greatly reduced.

# Recent DSH Developments

- 42 CFR 412.106(b)(4)(iv):
  - For cost reports beginning on or after 10/1/2009 a provider may report its days on Worksheet S-3 based on date of discharge (current practice), date of admission or dates of service.
  - If you wish to change, you need to notify CMS thru NGS in writing at least 30 days before the beginning of cost report year.
  - Must specify the method you are changing to
  - NGS will check to make sure you are not including days that were already included in the prior year before you made the change.
  - NGS has said that they have not received any requests for the change for 2011 which is understandable.

# MISCNY DSH Process

- MISCNY- Medicaid Information Service Center of New York has replaced the name Datamart, at least from the State standpoint.
- While the reimbursement calculation is changing, we will still be required to accumulate DSH listings to support the hospital request for reimbursement on the cost report (get that 25%)
- Around 2007, the Datamart DSH Process became available in NY. Its been in use for about 5 years but it is not a required method of accumulation.

# Comments From Providers/Consultants:

- “I still find the process very confusing and therefore I use a consultant to accumulate days”
- “We were involved in the discussions of the process back in 2007 and feel we have a good handle on the process and are confident in the results.”
- “Garbage in Garbage out”- The information we get from State is only as good as the accuracy of the State information.
- An inaccurate discharge list is not going to lead to an accurate DSH eligible list
- “I use the process for PPS DSH but not for the LIP adjustment.”

# Comments From Providers/Consultants:

- “The main benefit of the new process is the reliance NGS puts on the reports. This significantly reduces the amount of work on audit and limits their review to items we deem as Includable that were on the Excludable list.”
- What I got out of this is you need to get into the reports heavily to understand the data and follow the process closely the first year or so. It does get easier and more understandable.

# Comments From National Government Services

- In general we are finding that there are not as many issues as there were before Datamart
- The accumulation based on the Excluded codes allows them to focus in on where potential errors (in the State reports) usually exist
- Spend most of their time auditing those category of days that were on the Excludable list that the provider maintains are Includable: (Provider needs to identify these)
  - Incorrect Medicare Part A designation by State
  - Mom/Baby matches
  - Psych or Rehab patients who occupied PPS bed

# Comments From National Government Services

Suggestion from NGS:

- Provider should send its Discharge list to State at same time they request Includable and Excludable paid day reports. This way the paid and eligible but unpaid data is run at the same time and contradicting info is minimized.
- Reconcile your Discharge lists to Worksheet S-3 of cost report to make sure you have identified, as closely as possible, the entire population that may be eligible.
- The “Output” report that is State’s eligibility response to your Discharge list has a name and run date. NGS will request that report from State when it audits your list.

# Comments from GNYHA

- While the Datamart process has been up and operating for about 5 years, in general the process has been working well. There were some minor adjustments needed at the beginning, as is required with any new process, but basically it has been a positive experience.

# DSH data accumulation

The DSH reports provide 3 pieces of information:

1. Detailed paid days claims data
2. If the days are includable or excludable for Medicare DSH purposes
3. Medicaid eligibility of a patient during an inpatient stay (this includes the eligibility period and the program code)

# DSH data accumulation

A written request for the Medicaid Paid reports, Medicaid eligibility reports and Recipient Profiles can be sent to:

Randall B. Mix  
MISCNY – DSH Reports  
800 North Pearl Street, Room 322  
Albany, New York 12204

# DSH data accumulation

The request must include

- A cover letter on hospital letterhead signed by the requestor
- MMIS Provider ID (eight digits including leading zeros)
- Reports requested (Paid/Unpaid reports, eligibility reports or recipient profiles)
- Date range of the request. If you wish to request more than one year state the date range.
- Include contact name, phone number, e-mail address and address where the reports should be sent. Reports can only be sent directly to the hospital. **If you are working with a consultant and they are preparing the request an authorization letter must accompany the request. The data will be sent to the hospital contact and then the hospital can forward the reports to the consultant.**

# DSH data accumulation

- Authorization Letter
  - The authorization letter should be on hospital letterhead signed by the requesting hospital employee
  - The letter must include the reports requested, provider name, MMIS Provider ID and years requested
  - Authorization letters are valid for one year from the date of signing.

# DSH data accumulation

- The request for Medicaid Paid claims data and Medicaid eligibility data must be made simultaneously.
- Data is updated monthly. Each month's data is available to process on the third Monday of the following month.
- Turnaround time is entirely dependent on the workload of the MISCNY employees. If there is a deadline you are trying to meet the staff at MISCNY will try to accommodate the request.

# DSH data accumulation

- The format for the patient listing is as follows:
  - 8 digit Medicaid Recipient ID formatted as text
  - 9 digit SSN formatted as text with leading zeros, no dashes
  - Admission Date formatted MMDDYYYY
  - Discharge Date formatted MMDDYYYY
  - Column headers must be in all CAPS; RECIP\_ID, SSN, ADMIT, DISCH
  - Only 1 tab with default “sheet1” as name
- Submit a password protected, encrypted CD with the request
- Use a writable CD so the results can be recorded and sent back
- Email the encryption password to [rbm02@health.state.ny.us](mailto:rbm02@health.state.ny.us)
- MISCNY will not accept any data via a secure e-mail server.
- Name the file using the provider’s name and the fiscal year(s) covered.

# DSH data accumulation

- MISCNY will encrypt the completed reports and save them onto the CD that the hospital provided.
- The encryption password will be e-mailed to the contact listed on the request letter. If no e-mail was provided the hospital will have to contact MISCNY for the password.
- The completed reports will consist of 4 files
  - Paid days detail file – two tabs: includable/excludable
  - Summary paid days file
  - Copy of the input file for Medicaid eligibility inquiry
  - Output detail file for Medicaid eligibility
- A file layout for converting the text files is provided.

# DSH data accumulation

File layout for converting text files

<b>Datamart Inpatient DSH - Phase 1 Results File Definition</b>				
<b>Field Name</b>	<b>Type</b>	<b>Length</b>	<b>Start Pos</b>	<b>End Pos</b>
PROV_ID	CHAR	8	1	8
RECIP_ID	CHAR	8	9	16
ADMISSION_DATE	DATE	8	17	24
DISCHARGE_DATE	DATE	8	25	32
LINK_CRN	CHAR	16	33	48
DRG_CODE	CHAR	4	49	52
PAID_AMOUNT	NUMBER	12	53	64
SERVICE_DATE	DATE	8	65	72
END_OF_SERVICE_DATE	DATE	8	73	80
MEDICAID_ONLY_DAYS	NUMBER	4	81	84
TOTAL_LENGTH_OF_STAY	NUMBER	4	85	88
PAYMENT_DATE	DATE	8	89	96
DISCH_RECIP_MEDICAID_COVERAGE_CODE	CHAR	2	97	98
DISCH_RECIP_Medicare_CODE	CHAR	1	99	99
MEDICARE CODE BEGIN DATE	DATE	8	100	107
MEDICARE CODE END DATE	DATE	8	108	115
MEDICAL_RECORD_NUMBER	CHAR	20	116	135
INVOICE_NUMBER	CHAR	8	136	143
BLUE_CROSS_FULL_DAYS	NUMBER	3	144	146
RECIP_LAST_NAME	CHAR	30	147	176
RECIP_FIRST_NAME	CHAR	30	177	206
RECIP_SSN	CHAR	9	207	215
RECIP_DOB	DATE	8	216	223
RECIP_SEX_CODE	CHAR	1	224	224
RECIP_MIDDLE_INITIAL	CHAR	1	225	225
DISCH_RECIP_AID_CATEGORY_CODE_1240	CHAR	2	226	227
AC_BEGIN_DATE	DATE	8	228	235
AC_END_DATE	DATE	8	236	243
DISCH_RATE_CODE	CHAR	4	244	247
DX_CODE_1	CHAR	10	248	257



**Codes Excluded from the NYS Datamart "Paid Day Report"  
For Medicare DSH Purposes\***

Category	(Old Codes) = Current Codes				# of Codes in Category
	(Old Codes)	(Current Codes)	(Old Codes)	(Current Codes)	
Recipient Medicaid Coverage Code	( 0 ) = 00	( C ) = 02	( J ) = 14	** ( R ) = 33	18 (A)
	( 3 ) = 21	( D ) = 09	( N ) = 04	( V ) = 06	
	( 4 ) = 22	( F ) = 18	( O ) = 17	( Y ) = 11	
	( 8 ) = 08	( H ) = 08	** ( P ) = 30		
	( 9 ) = 09	( I ) = 13	** ( Q ) = 32		
Recipient Medicare Code	1	C(1)	H	R	10
	2	E	I		
	A(2)	G	Q		
Recipient Aid Category Code	2	37	47	76	14 (B)
	20	40	56	77	
	28	41	59		
	35	42	64		
Discharge Rate Code	2852	2962	2992	3135	4804
	2853	2963	3130	3136	4805
	2858	2970	3131	3137	4806
	2948	2971	3132	4212	4807
	2954	2990	3133	4213	4808
	2955	2991	3134	ZZZZ	26

Notes: \* These codes are reviewable for inclusion in the "Medicaid Eligible Day Report" if they meet the applicable criteria.

\*\* Approximately 10% of P, Q and R cases are Medicaid fee-for-service payments for a beneficiary, not a GME (313x) payment. The Datamart system will include days in P, Q and R that are not related to one of the 313x codes and that do not have any other excludable code applicable to that stay.

(A) The Recipient Medicaid Coverage Codes alpha values were converted to numeric values in June 2008. Data produced prior to June 2008 will contain the values listed in parentheses ( old codes).

(B) For the period 1/1/02 forward, Aid Cat 38 is 100% includable. However for the period before 1/1/02 all patient days associated with this code should be excluded from the Paid Day Report, please note that only individuals aged 21-64 are identified as Federally non-participating (FNP). Patient days associated with other individuals with this Aid Cat code may be includable in the Medicaid Eligibility Day Report if they meet the applicable criteria.

# Preparation of DSH Listings

- If a DSH listing has never been generated using the Datamart System BESLER suggests inputting the higher of the hospitals prior year DSH days or the internal DSH days for the year in question.
- We suggest that you put together your Medicaid DSH listing **no earlier** than 6 months after the end of the cost reporting period. This will allow time for all claims to be processed and for claims pending Medicaid eligibility to be updated in the Datamart system.

# Preparation of DSH listing

- CMS expects any request for DSH reimbursement reported on its submitted cost report to be supported by a listing of eligible patients.
- It is not required for Provider to submit a DSH listing with the cost report although it is preferred that you do send one.
- NGS currently has been advising providers when they are going to start their Desk Review and asking them if they have any updated data (like DSH list) they want considered for Desk Review. This call is not a CMS or an NGS requirement but a courtesy.

# Appealable Issues

- BESLER suggests calculating the estimated impact of a few issues and inputting that impact on the protested line of your submitted cost report. We suggest doing this to preserve your appeal rights should you decide to appeal the issues.
- Some issues we feel are worthy of protesting are
  - SSI % - we recommend calculating the impact of a 1% increase to the published SSI.
  - Medicare Managed Care/Medicaid Eligible days – Currently these days are considered Medicare Part A days and not allowable in the Medicaid fraction of the Medicare DSH calculation. We recommend calculating the impact of including these days in the Medicaid fraction of the Medicare DSH calculation.



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