Medical DSH and the Uncompensated Care Pool Distribution Transition to Worksheet S-10

**NAVEOS, the premier healthcare data analytics firm specializing in government revenue enhancement services for healthcare providers offers DSH hospitals advice and recommendations to be sure your hospital is positioned to receive its proper DSH amounts.**

Sterling, VA (PRWEB) August 15, 2017 -- The Medicare Disproportionate Share (DSH) Payment adjustment was implemented in May 1986 following Congressional passage of the Deficit Reduction Act of 1984. The original 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.

The empirically justified DSH calculation, under the Primary Method, is 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:**

Medicare SSI Days/ Total Medicare Pts A& C Days

**Medicaid Proxy:**

Medicaid, Non-Medicare Days = 15% or greater/ Total Patient Days

**Affordable Care Act:**

Nearly four years ago, the Affordable Care Act (ACA) implementation changed how Medicare Disproportionate Share (DSH) payments were paid to qualifying hospitals. Hospitals still had to qualify for a DSH Payment Adjustment by meeting the empirically justified 15% DSH threshold. However, beginning October 1, 2013, the DSH payment amount calculated, using the formula above, was reduced from 100% to 25%. The ACA then created an Uncompensated Care Pool (UCP) that would distribute the remaining 75% of the Medicare DSH budget. Before calculating the UCP, the pool amount was reduced by the percentage of uninsured patients becoming insured under the ACA Medicaid Expansion.

CMS’ intention was 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 stated that the UCC will be determined by Charity Care and non-Medicare Bad Debt costs, excluding Medicaid and other shortfalls.

Following industry resistance due to inconsistent reporting on Worksheet S-10, CMS delayed the use of this worksheet, implementing instead a “Low-income Days Proxy” based on Medicaid-eligible and SSI days. Essentially, the UCP calculation used the low-income days as in the empirically justified calculation. The days...
used for the UCP were based on 3 or 4-year look-backs for FFY 2014 - 2016. For FFY 2017 CMS used a 3-year average of Days Proxy based on Medicaid Days (2011-2013) and SSI Days (2012-2014). The 3-year average will calculate a hospital’s Factor 3 which is used to distribute the UCP.

Industry feedback has prompted CMS to revised Worksheet S-10 instructions. First, in the Total Bad Debt instruction in 2014 and now as part of Transmittal 10 (November 2016), CMS has revised the reporting period for Charity Care, aligning with the reporting period with Total Bad Debts. Previously, Charity Care was to reported on Worksheet S-10 based on patient “service dates” within the hospital’s cost report year. Transmittal 10 changed that to be the amounts the hospital “wrote off” during the hospital’s cost report year. This allows a more reasonable time frame for the charity care write-offs. You now may have write-offs of patients from service dates that are outside of the hospital cost report year. This makes sense since charity care determinations can take time to ascertain.

Further complicating matters, the Supreme Court ruled that States had the ability to opt out of Medicaid Expansion. This has created UCP pool distribution inequity for expansion vs. non-expansion States whether the Days Proxy or the Worksheet S-10 methodology is used. Expansion States would do better if the Days Proxy remained as they saw additional Medicaid days and reimbursement increase while their charity care decreased.

However, the non-expansion States did not see Medicaid days and reimbursement increases. Their UCC stayed stable or increase. Under the Worksheet S-10 methodology they will fare better unless additional healthcare reform makes changes to the UCP calculation.

CMS Mixed Message

In the FFY 2017 Inpatient Prospective Payment System (IP-PPS) Final Rule, CMS indicated that they will implement using Worksheet S-10 to calculate the UCP no later than FFY 2021. They also stated that this would start with the 2017 Medicare cost reports. However, in April 2017, CMS has changed their guidance with the release of the FFY 2018 IP-PPS Proposed Rule.

Uncompensated Care Pool transition to Worksheet S-10: In the FFY 2018 Proposed Rule CMS has stated they are proposing to initiate a 3-year transition from the Days Proxy to Worksheet S-10 beginning with the start of FFY 2018 (October 1, 2017) and fully-implementing S-10 in FFY 2020.

The transition will include the 3-year average introduced in 2017. 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: (reference table on right)

Hospital's Next Steps:

The accelerated 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

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these payments may ultimately impact care, which was one of several reasons for the DSH Payment Adjustment in the first place.

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 Transmittal 10. As stated above, 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 2015 and 2016 cost reports, should CMS open a window to amend (in the FFY 2018 Final Rule). CMS opened a 2014 cost report window for Worksheet S-10. In the Final Rule (August 2, 2016) they gave hospitals till September 30, 2017 to amend. Should CMS open a window they may ask for both years at the same time or hopefully open the 2015 window this year and 2016 next year;
• The Charity Care definition change is effective with cost report periods beginning October 1, 2016, based on the date the hospital wrote off the Charity Care amount. As mentioned above, previously the write-off was based on the patients’ specific “date of service”. This will create two interpretations for reporting of Charity Care dollars. Hospitals should review and base their revisions on their best-case scenario;
• 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. They seem to indicate that prior years will not be reviewed;
• Charity Care and Total Bad Debt patient detail log will become a necessity in order to have your S-10 amounts available for audit.

Each hospital is now competing for Federal DSH UCP dollars with all other DSH eligible hospitals. The playing field may not be level, so you will need to accurately optimize your Charity Care and Bad Debts based on CMS guidance and cost report instructions. The Disproportionate Share Adjustment (empirically justified) and Uncompensated Care Pool combined amounts have been declining from $12.5 in FFY 2014 to $10.96 in the Proposed FFY 2018 rule. Make sure your hospital is positioned to receive its proper DSH amounts.

About NAVEOS

NAVEOS the proven leader in maximizing the value of governmental program reimbursements for healthcare providers. By leveraging our bespoke software, COMPASS, NAVEOS has been able to find close to $1 billion in additional reimbursement revenue for providers since 2005.

Our fully-automated solution and sophisticated eligibility heuristics typically deliver anywhere between 2-4% additional Medicare Disproportionate Share (DSH) value, while maintaining a best-in-class audit accuracy rate.

Our unique methodology for value creation has established NAVEOS as an industry thought leader in healthcare reimbursement data analytics. Our services continue to evolve as the Affordable Care Act (ACA) presents new and diverse challenges that can only be met through the innovative analysis of “Big Data”.

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