

Improvements to Medicare Disproportionate Share Hospital (DSH) Payments: National Provider Call

January 8, 2013

PRESENTED BY:

Al Dobson, Ph.D., Dobson DaVanzo & Associates, LLC
Lane Koenig, Ph.D., KNG Health Consulting, LLC

PREPARED BY:

Al Dobson, Ph.D., Lane Koenig, Ph.D., Audrey El-Gamil, Anne Pick, M.P.H., Sheila Sankaran, M.A.

Dobson | DaVanzo



Dobson DaVanzo & Associates, LLC Vienna, VA 703.260.1760 www.dobsondavanzo.com

Presentation Overview

- **Goal of National Provider Call**
- **Dobson | DaVanzo Team Scope of Work**
- **Review of Section 3133**
- **Analytic Methods**
- **Uninsured Definitions and Data Sources**
- **Uncompensated Care Definitions and Data Sources**
- **Conclusions**
- **Next Steps**
- **Discussion: Public Comment**

Goal of National Provider Call

- **Solicit public comment to inform the implementation of Section 3133 of the Affordable Care Act (ACA) as it relates to definitions and measures of the uninsured and uncompensated care**
- **The National Provider Call will:**
 - Review Medicare DSH payment requirements under the ACA, which is effective in FY 2014
 - Present findings of our analyses identifying possible data sources and definitions for measuring the change in the uninsured and uncompensated care

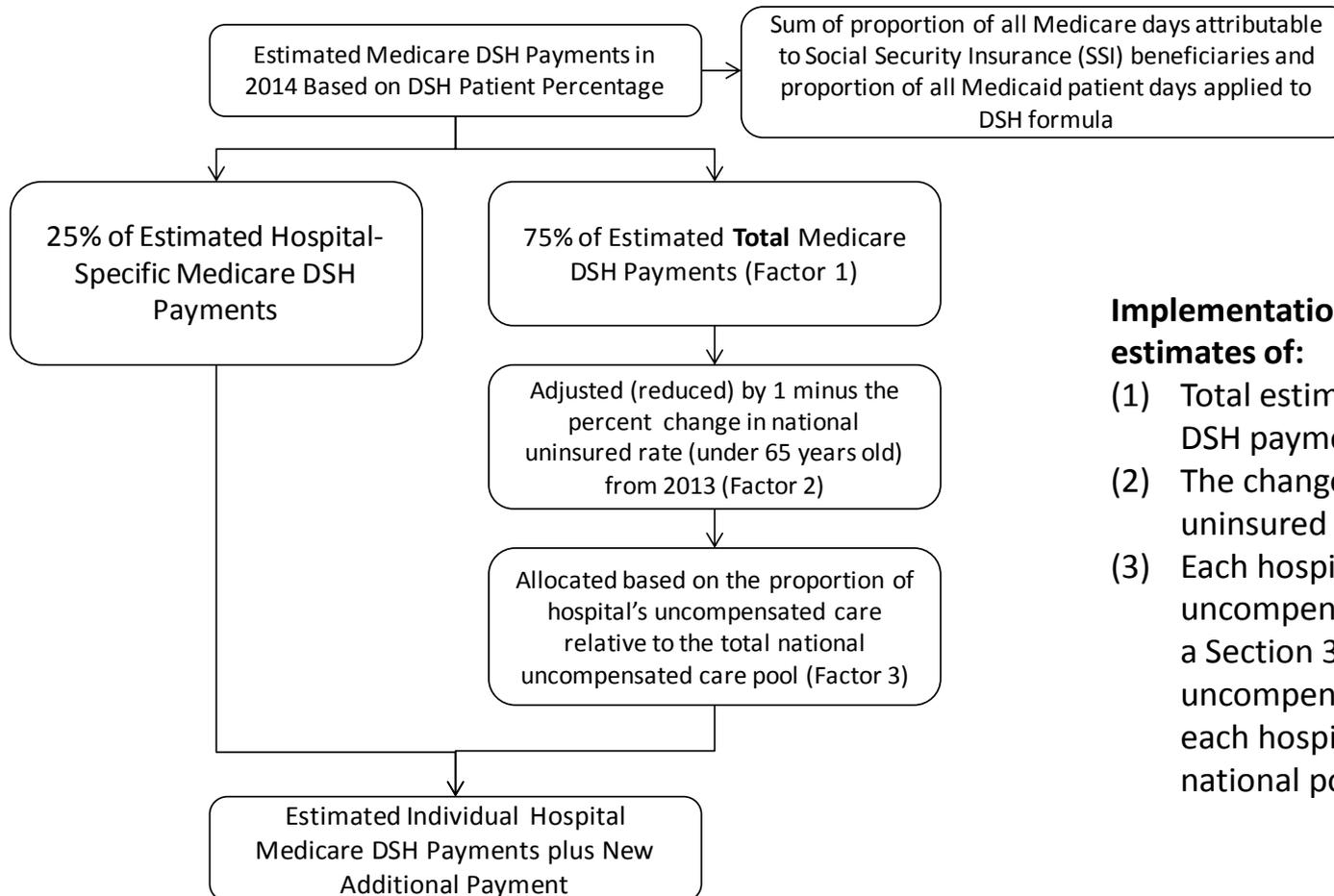
Scope of Work

- **Dobson DaVanzo & Associates, LLC, and its partner, KNG Health Consulting, LLC, have been commissioned to provide CMS with technical assistance as it implements a revised Inpatient Prospective Payment System (IPPS) Medicare DSH payment policy as called for by Section 3133 of the ACA of 2010**
- **The scope of work includes analyses of potential definitions and data sources for measuring the change in the uninsured and levels of uncompensated care**
- **The scope of work does not include interpretation of Section 3133 provisions**

Review of Section 3133

- **Beginning in FY 2014, 25% of estimated Medicare DSH payments will continue to be paid to each hospital**
 - The remaining 75% share of estimated Medicare DSH payments (Factor 1) will be adjusted by two additional factors and distributed as an additional payment
 - Factor 2: Reduce remaining 75% of estimated Medicare DSH payments as a result of the estimated decrease in the uninsured
 - Factor 3: Target remainder of 75% of estimated Medicare DSH payments to individual hospitals based on their proportion of the amount of uncompensated care provided by DSH hospitals

Review of Section 3133 (cont'd)



Implementation requires estimates of:

- (1) Total estimated Medicare DSH payments
- (2) The change in the uninsured rates
- (3) Each hospital's share of uncompensated care using a Section 3133 definition of uncompensated care for each hospital and a national pool

Analytic Methods

1. Focused literature review

- Identified possible definitions of uninsured and uncompensated care and data sources for measuring the uninsured and uncompensated care

2. Structured interviews

- Sought expertise from survey experts for uninsured data sources and other key stakeholders for direction on uncompensated care definitions

3. Analysis of data sources and definitions

- Assessed strengths and limitations of alternative data sources and consistency of possible definitions with existing measures

Uninsured Definitions and Data Sources

Legislative Context for Factor 2

- **FY 2014 – FY 2017: Section 3133 prescribes use of uninsured estimates from Congressional Budget Office (CBO)**
- **FY 2018 onwards: Section 3133 permits use of other sources:**
 - (ii) **2018 AND SUBSEQUENT YEARS.**—For fiscal year 2018 and each subsequent fiscal year, a factor equal to 1 minus the percent change in the percent of individuals who are uninsured, as determined by comparing the percent of individuals—
 - (I) who are uninsured in 2013 (as estimated by the Secretary, based on data from the Census Bureau or other sources the Secretary determines appropriate, and certified by the Chief Actuary of the Centers for Medicare & Medicaid Services); and
 - (II) who are uninsured in the most recent period for which data is available (as so estimated and certified), minus 0.2 percentage points for each of fiscal years 2018 and 2019

Researching Uninsured Data Sources

- **Review National Surveys.** Reviewed design and methodology for 5 surveys used to construct estimates of the uninsured
- **Interviews with Survey Experts and CBO Analyst.** Interviewed senior experts on each of the 5 surveys and CBO analyst to clarify our understanding of their methodologies
- **Comparative Analysis.** Compared data sources along several dimensions; identified strengths and limitations of each

Dimensions for Comparison

- **Conceptual definition and coverage.** How is “uninsured” defined and what population is being measured?
 - Any measure of uninsured should correlate with uncompensated care burden
- **Length of uninsured period.** Is the survey asking respondents about their insured status at the time of the survey or for some time period (partial-year or full-year) before the survey?

Dimensions for Comparison (cont'd)

- **Recall period.** How far back in time does a respondent have to remember in order to answer the survey question correctly?
 - Shorter recall periods are likely to elicit more accurate responses regarding changes in insurance status
- **Timeliness.** What is the time period between the reference period, the time period for which data are being collected, and the release of uninsured estimates?

Dimensions for Comparison (cont'd)

- **Continuity of data series.** Have the survey definitions changed over time or are they expected to change?
 - Implementation of the ACA may result in modifications to surveys to collect additional information or existing information differently
- **Medicaid coverage.** How accurately is the survey capturing those respondents who are covered by Medicaid?
- **Undocumented immigrants.** Does the survey design inhibit participation by undocumented immigrants?

Five National Surveys

Survey	Sponsor	Description
Current Population Survey, Annual Social and Economic Supplement (CPS-ASEC)	U.S. Census Bureau and Bureau of Labor Statistics	<ul style="list-style-type: none"> • CPS is a computerized monthly survey—Respondents participate for 4 consecutive months, leave sample for 8 months, return for another 4 months • CPS contains questions on labor force participation and earnings • ASEC data are collected from mid-February to mid-April each year • ASEC contains health insurance coverage questions and other questions related to socioeconomic status and well-being • Sample size: 60,000 households
American Community Survey (ACS)	U.S. Census Bureau	<ul style="list-style-type: none"> • Ongoing paper survey—Mailed to respondents, who complete it and return it by mail • Contains questions on economic, social, demographic, and housing characteristics and provides local-level estimates. Health insurance question was added in 2008 • Sample size: 2 million households

Five National Surveys (cont'd)

Survey	Sponsor	Description
Survey of Income Program and Participation (SIPP)	U.S. Census Bureau	<ul style="list-style-type: none"> • Computerized longitudinal panel survey—Respondents interviewed 3 times/year for 3-4 years • Contains questions on labor force participation, health insurance coverage, and federal program participation • Sample size: Ranges from 14,000 to 36,700 households per panel
Medical Expenditure Panel Survey (MEPS)	Agency for Healthcare Research and Quality	<ul style="list-style-type: none"> • Computerized panel survey—Respondents interviewed several times over 2 years • Contains questions on health conditions, health services utilization and costs, labor force participation, health insurance coverage • Sample size: 14,000 households and 35,000 individuals
National Health Interview Survey (NHIS)	National Center for Health Statistics	<ul style="list-style-type: none"> • Computerized ongoing survey • Contains questions on health characteristics, health services utilization, and demographic and socioeconomic characteristics • Sample size: 35,000 households and 87,500 individuals

Commonalities Across Surveys

- **Conceptual definition of uninsured**
- **Sampling frame**
- **Data collection method**
- **Medicaid coverage estimation**
- **Undocumented immigrants**

Differences Across Surveys

Survey	Length of Uninsured Period	Recall Period	Timeliness	Continuity
CPS-ASEC	<ul style="list-style-type: none"> Current: Previous calendar year Starting in 2014: <ul style="list-style-type: none"> Point-in-time Previous calendar year 	<ul style="list-style-type: none"> Variable, up to 14-16 months 	<ul style="list-style-type: none"> Estimates released 9 months after reference period 	<ul style="list-style-type: none"> Updated questions on previous-year insurance coverage and new point-in-time question scheduled to be introduced in 2014 Break in full-year data series expected between 2012 and 2013
ACS	<ul style="list-style-type: none"> Point-in-time—At time of survey 	<ul style="list-style-type: none"> Current 	<ul style="list-style-type: none"> Estimates released 10 months after reference period 	<ul style="list-style-type: none"> Health insurance question will be revised Break in series expected sometime after 2013
SIPP	<ul style="list-style-type: none"> Multiple periods can be measured with microdata 	<ul style="list-style-type: none"> Variable, up to 4 months 	<ul style="list-style-type: none"> No regular release schedule 	<ul style="list-style-type: none"> Health insurance questions will be revised Break in series expected sometime after 2014

Differences Across Surveys (cont'd)

Survey	Length of Uninsured Period	Recall Period	Timeliness	Continuity
MEPS	<ul style="list-style-type: none"> • Uninsured for first-half of year • Uninsured for entire year • Uninsured at any time during survey year 	<ul style="list-style-type: none"> • Variable, up to 6 months 	<ul style="list-style-type: none"> • Estimates released 11-20 months after reference period 	<ul style="list-style-type: none"> • No break in series expected
NHIS	<ul style="list-style-type: none"> • Point-in-time—At time of interview • Uninsured at least part of year prior to interview • Uninsured more than 12 months at time of interview 	<ul style="list-style-type: none"> • Variable, up to 12 months 	<ul style="list-style-type: none"> • Estimates released 6 months after reference period 	<ul style="list-style-type: none"> • No break in series expected

Point-in-Time vs. Other Estimates

- **Point-in-time estimates have several advantages over other types of estimates**
 - Full-year and partial-year estimates do not capture movement in and out of the uninsured pool as well as point-in-time estimates
 - Shorter recall period for point-in-time estimates is likely to yield more accurate estimates than estimates based on longer recall periods
 - Point-in-time estimates are more likely to be correlated with any measure of uncompensated care, as compared with full- and partial-year estimates

Assessment of Data Sources

- **Timeliness.** The time between the reference period and the release of estimates
- **Continuity.** Does the data source provide a continuous time series from 2013 onwards?
- **Data Collection.** What topics are covered in the survey (i.e., health topics)? How often are data collected (i.e., once a year or throughout the year)? How are data collected?
- **Accuracy.** What is the sample size? What are the standard errors associated with the survey estimates?

Assessment of Data Sources (cont'd)

Survey/Source	Point-in-Time Estimates?	Timeliness	Continuity	Data Collection	Accuracy
		Time between reference period and release date		Type of data collected and collection timing/mode	
CPS-ASEC	Yes (2014)	Good	Fair	Good	Excellent
ACS	Yes	Good	Fair	Good	Excellent
SIPP	Yes	Fair	Fair	Good	Good
MEPS	Yes	Good	Excellent	Excellent	Good
NHIS	Yes	Excellent	Excellent	Excellent	Excellent
CBO*	Yes	Not applicable	Excellent	Not applicable	Not applicable

*CBO's estimates and projections are based on a model that uses SIPP microdata

Uncompensated Care Definitions and Data Sources

Identifying Existing Definitions of Uncompensated Care

- **Through a literature review and stakeholder interviews, we found variation in how existing programs and entities define uncompensated care including:**
 - Federal programs (Medicare, Indian Health Service, Health Information Technology for Economic and Clinical Health)
 - States (waiver and non-waiver Medicaid)
 - Ratings and research organizations
 - Provider organizations
- **Across programs and entities, charity care and bad debt were always included in definitions of uncompensated care**
- **Some entities also include payment shortfalls from government-funded plans, or third party payers**

High-Level Summary: Literature Review

Program/Entity	Bad Debt	Charity Care	Includes Governmental Payment Shortfalls	Includes Commercial and/or Discounts
Federal Entities				
Medicare (Worksheet S-10)	X	X		
Health Information Technology for Economic and Clinical Health	X	X		
MedPAC	X	X		
Medicaid				
Arizona (waiver state)	X	X	X	
Florida (waiver state)	X	X	X	
Maryland (non-waiver state)	X	X		
New York (non-waiver state)	X	X		
Ratings Organizations				
Standard & Poor	X	X		X
Healthcare Financial Management Association	X	X		
PricewaterhouseCoopers	X	X		X
Provider Organizations				
American Hospital Association (Trend Watch)	X	X		
Catholic Health Association	X	X	X	

Cross-Cutting Themes of Existing Uncompensated Care Definitions

- **Uncompensated care is most often defined as charity care plus bad debt but may include governmental and/or commercial payer payment shortfalls**
 - Charity care – care provided to uninsured who meet financial eligibility requirements and for whom the hospital does not expect to receive payment
 - Bad debt – unreimbursed care provided to persons for whom the hospital expected but did not receive payment
 - Payer shortfalls – difference between payments and costs by payer

Cross-Cutting Themes of Existing Uncompensated Care Definitions (cont'd)

- **Uncompensated care is reported as costs rather than charges. Cost-to-charge ratios (CCRs) for hospitals are typically often used to calculate uncompensated care costs (charges x CCR = costs)**
- **Charity patients must meet guidelines to qualify for uncompensated care, such as uninsured, disqualified for a federal program, under a certain Federal Poverty Level (FPL) etc. Each hospital defines its charity care patients and different costs according to these definitions**
- **Definitions of charity care varied significantly by states, counties, and hospitals in order to accommodate the population served, and the financial mission/“giving ability” of the institution**

Data Sources Analyzed to Calculate Uncompensated Care

- Based on findings from our literature review and stakeholder interviews, the most common definition of uncompensated care is:

Bad Debt + Charity Care = Uncompensated Care

- **We examined a variety of data sources to determine how this definition of uncompensated care (and others) could be measured during implementation**
 - AHA Annual Survey/AHA TrendWatch
 - Publicly-available hospital financial data (from state agencies)
 - Medicaid DSH audit data
 - IRS Form 990 (Nonprofit hospitals)
 - “Old” Medicare Cost Report (CMS-2552-96)
 - “New” Medicare Cost Report (CMS-2552-10)
- **We compared data sources across several dimensions and determined strengths and limitations of each data source**

Medicare Cost Report: Worksheet S-10 (CMS-2552-10)

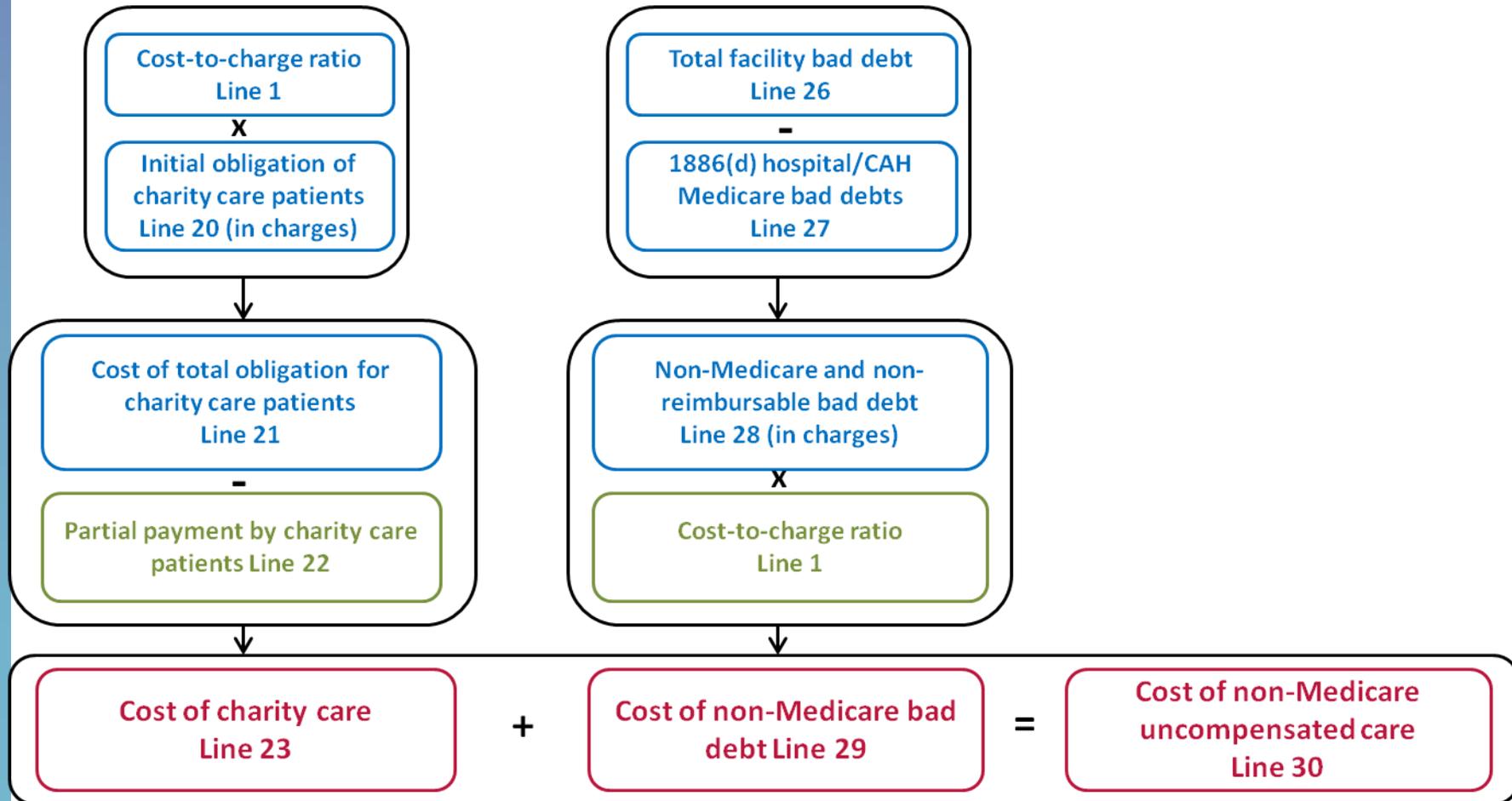
- **S-10 was the only publicly available data source that contains the required variables to capture uncompensated care as described previously**

Cost of charity care (line 23)

+ Cost of non-Medicare bad debt expense (line 29)

Cost of non-Medicare uncompensated care (line 30)

Worksheet S-10: Line Components



Worksheet S-10: Stakeholder Considerations

- **Through our stakeholder interviews, we identified areas for further consideration/clarification:**
 - Inclusion of all uncompensated costs and unreimbursed costs (contained in line 19)
 - Line 19: Total unreimbursed costs for Medicaid, SCHIP and state/local indigent care programs
 - Under this definition, total unreimbursed costs would equal **Line 19 + Line 30 = Line 31**
 - Inclusion of charity care write-offs for services provided outside of the reporting period (due to the difficulty of receiving documentation from patients in a timely manner)
 - Inclusion of GME costs in the calculation of cost-to-charge ratios (CCRs) by using costs from Worksheet B (Column 24, Line 118)
 - Currently Line 1 of S-10 (CCR) does not account for GME
 - Including GME costs on S-10 could more accurately match costs to gross revenues (charges)
 - Would affect cost-to-charge ratio reported in Line 1

Worksheet S-10: Timing of Data Release

- **The new Worksheet S-10 data (CMS-2552-10) will be available in time for CMS to develop its FY 2014 IPPS NPRM**
 - New form CMS-2552-10 is reported in cost reports for hospital fiscal years on or after May 1, 2010
 - Given the lag in cost report submission and approval, S-10 data are available for hospitals approximately 8 months from the end of the hospital Fiscal Year
 - Many hospitals did not report CMS-2552-10 data in hospital FY 2010. More complete data are available in hospital FY 2011. As of November 2012, the uptake of S-10 for FY 2010 was approximately 50% of hospitals, and 75% of hospitals for FY 2011
 - As of 2012 year end, most hospitals will have reported S-10 data to be used in the 2014 IPPS NPRM

Conclusions

- **For measurement of the change in the uninsured from FY 2018 onwards (Factor 2), point-in-time estimates of insurance status have several advantages over other estimates**
- **Other considerations for selecting an uninsured data source are timeliness, continuity, the survey focus, and accuracy**
- **The common definition of bad debt plus charity care aligns with existing measures and uses of uncompensated care but stakeholder concerns suggest that other types of uncompensated care be considered for inclusion in the Section 3133 definition of uncompensated care**

Next Steps

- **No Section 3133 DSH policies will be released by CMS until the FY 2014 NPRM is available**
 - CMS will address data sources, definitions, procedures, and timing in the NPRM

Discussion: Public Comment

- **Public comments**
- **Additionally, stakeholders can submit formal comments on the implementation of Section 3133 by emailing Section3133DSH@cms.hhs.gov, by January 15th**