PUBLICATION

CMS Issues Revised 2006-2009 SSI Percentages [Ober|Kaler]

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On March 16, 2012, CMS issued revised ratios used in the calculation of the Medicare/SSI fraction of the Medicare DSH adjustment for federal fiscal years 2006-2009. CMS has yet to issue public guidance regarding the settlement of outstanding appeals, but based on conversations with Medicare administrative contractors, it appears that CMS will be instructing contractors to settle, through reopening if necessary, only cost reports for FY 2006 forward at this point. It also appears that the contractors will be instructed to issue notices of program reimbursement for the affected cost reports by the late fall or early winter.

The revised ratios were calculated in the manner that CMS described in CMS-1498-R, which was released in the spring of 2010. Consistent with that ruling, the ratios were recalculated to remove certain dual eligible days – such as exhausted benefit, Medicare secondary payer, and Medicare Advantage days – from the so-called Medicaid fraction. Those days were, instead, placed in the Medicare/SSI fraction. Anecdotal evidence suggests that, as a result, the majority of providers will see their DSH adjustments reduced under the revised data, because the denominator of the Medicare/SSI fraction (which is based on total Medicare days) expands based on the types of patient days that are included as "Medicare days." Stated otherwise, by removing patient days from the Medicaid fraction and including them in the Medicare/SSI fraction, CMS is able to decrease a provider's total DSH adjustment.

The revised percentages may be viewed here.

CMS has not yet issued revisions to the pre-2006 ratios, and does not appear to be in any hurry to do so. The ratios for those years continue to be mired in litigation, with many courts considering and rejecting CMS's inclusion of days in the Medicare fraction.

Ober|Kaler's Comments

The release of the revised ratios is important for at least two reasons. First, it will allow the Medicare contractors to begin the processing of final settlements for the many years of cost reports that have been held up pending this development. Those settlements, in turn, will allow hospitals to begin the formal appeals process to dispute the amounts that they have been paid for both DSH and non-DSH claims (GME, bad debt, etc.). Second, it signals what is likely to be a second round of litigation involving whether the revised methodology is, itself, correct. Many attorneys, including those at this firm, believe that the methodology is flawed.