THE UNIVERSITY OF KANSAS HOSPITAL
KUMED

Health System Finance
Budget, Reimbursement,
and Cost Accounting

October 6, 2005

Centers for Medicare and Medicaid Services
Department of Health & Human Services
Attention: CMS-2198-P
P.O. Box 8010
Baltimore, Maryland 21244-1850

Dear Sir or Madam:

The University of Kansas Hospital (UKH) appreciates the opportunity to comment on CMS's proposed rule regarding Medicaid DSH reporting and audit requirements. We are a 475-bed teaching hospital with approximately 400 residents.

The proposed rule requires the submission of the total unduplicated number of Medicaid eligible individuals receiving inpatient hospital and outpatient hospital services and the total annual unduplicated number of individuals with no source of third party coverage for the inpatient hospital and outpatient hospital services they receive. This is information that UKH does not currently collect. To comply with this requirement would take a significant amount of effort and time. We request that CMS removed this requirement, since it is burdensome and bears no relation to any DSH requirement.

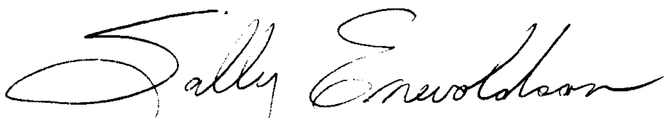
The proposed rule requires that for each audited state fiscal year, the DSH payments made in that fiscal year be measured against the actual uncompensated care cost in that same year. In addition, this must be completed no later than one year after the completion of each state's fiscal year. This requirement will place a substantial burden on UKH. If this provision is finalized, it will mean that UKH will have to provide the state with uncompensated care data for FY 2005 before it is required for the FY 2007 DSH computation. This is not practical, because uninsured patients are difficult to identify until all collection efforts with other payers have been pursued, which can take several years.

Identifying these patients is further complicated by the restrictions on which uninsured patient accounts qualify (e.g., you cannot claim accounts denied due to medical necessity issues). This requires a painstaking and time-intensive process of reviewing each account history to identify the reason that an insurance company did not pay. We request that CMS either remove this requirement entirely or extend the audit completion date to two years after the completion of each state's fiscal year.

CMS proposes to make the reporting and auditing requirements effective for state fiscal years beginning in state fiscal year 2005. This retroactive application is unfair in light of the number of new substantive interpretations of the Medicaid DSH requirements. We request that CMS make the reporting and auditing requirements effective only for future state fiscal years.

Thank you.

Sincerely,



Sally Enevoldson
Director of Reimbursement

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HAP

THE HOSPITAL & HEALTHSYSTEM ASSOCIATION OF PENNSYLVANIA

October 25, 2005

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, S.W.
Washington, DC 20201

Re: CMS-2198-P; Medicaid Program; Disproportionate Share Hospital Payment – Implementing the Medicare Modernization Act of 2003 Reporting and Auditing Requirements; Proposed Rule.

Dear Dr. McClellan:

On behalf of our more than 225 member hospitals and health care systems, The Hospital & Healthsystem Association of Pennsylvania (HAP) and the Delaware Valley Healthcare Council of HAP (DVHC) welcome this opportunity to comment on the proposed rule implementing the Medicaid disproportionate share hospital (DSH) payment reporting and auditing requirements found in the Medicare Modernization Act of 2003 (MMA). We have significant concerns with the proposed rule as presently drafted and believe it would negatively impact Medicaid DSH hospitals that serve as the safety net for providing hospital care to our state's most vulnerable citizens.

The proposed rule purports to only implement section 1001(d) of the MMA. However, section 1001 (d) of the MMA only established new reporting and auditing requirements for DSH payments, but did not amend section 1923(g) of the Social Security Act, which establishes hospital-specific DSH limits for the costs of uncompensated care. The proposed rule goes far beyond the requirements in the MMA and would result in substantial changes in current DSH policy as set forth in the Social Security Act.

The Medicaid DSH program was designed to recognize the financial burden borne by those hospitals that take care of a disproportionate number of low income and uninsured individuals, and provides financial assistance essential for these safety net providers to continue to take care of patients. These hospitals often shoulder critical community services such as trauma and burn care, high-risk neonatal care, and other health care services needed by the poor, the frail elderly, and persons with disabilities and chronic medical conditions. Because of the negative impact on safety net hospitals and on the patients they serve, HAP and DVHC strongly urge CMS to rethink its approach in this proposed rule.

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HAP and DVHC offer the following comments:

REPORTING REQUIREMENTS

Definition of Uncompensated Care
The definition of uncompensated care as found in the proposed rule substantively changes long-standing DSH policy without properly calling for public comment and reaches beyond the statutory requirements of the MMA. The proposed rule would alter the definition of uncompensated care to exclude both bad debt and physician services, despite the fact that the MMA left the underlying law governing DSH limits in place, and that Congress expressed no concern about the calculation of uncompensated care costs.

As a procedural matter, CMS should acknowledge that it is changing key portions of established policy and provide adequate notice to the public. Failure to do so constitutes a violation of the Administrative Procedure Act. The changed definition raises the following substantive concerns:

Exclusion of Bad Debt in Definition of Uncompensated Care

The proposed rule, in both the preamble and draft regulatory language, states that uncompensated care does not include bad debt for purposes of setting the hospital-specific DSH limit. This new definition of uncompensated care that excludes bad debt is inconsistent with the statute, legislative history and long-standing agency policy guidance and practice. The underlying statute (section 1923(g)(1)(A)) permits the inclusion of the costs of services provided to individuals with no health insurance or other source of third-party coverage. The legislative history of the Omnibus Budget Reconciliation Act of 1993 (OBRA) provision that originally established the hospital-specific DSH limit states that the costs of providing services to uninsured patients would be net of any out-of-pocket payments received from uninsured individuals.

In a 1994 letter to state Medicaid programs implementing the OBRA 1993 provision, CMS stated:

> One of the key provisions in the [DSH] limit is the determination of which of a hospital's patients "have no health insurance or source of third-party payment for services provided." A number of States have asked about the meaning of this provision, and whether it includes, for example, individuals with indemnity policies, or individuals whose policies contain day limits that are exhausted.
>
> [CMS] believes it would be permissible for States to include in this definition individuals who do not possess health insurance, which would apply to the service for which the individual sought treatment.

Thus, CMS determined that the cost of services provided to individuals with third-party coverage, but whose third-party coverage did not reimburse the hospital services the individual received, could be counted as uncompensated care costs.

In 2002 guidance to state Medicaid programs regarding the hospital-specific DSH limit and the upper payment limit, CMS reaffirmed its 1994 DSH policy when it stated that the calculation of uncompensated care is "net of third party payments."

A number of state Medicaid programs include the costs of care provided to uninsured individuals for which no payment is made and the costs associated with the non-payment of copayments and deductibles for individuals with third-party coverage in determining a hospital's qualifying costs for the hospital-specific DSH limit. (Current Medicare policy requires that hospitals seek payment from all individuals – Medicare and non-Medicare – with the means to pay copayments and deductibles.) The approaches adopted by these state Medicaid programs to establish qualifying costs for setting the hospital-specific DSH limit are consistent with the statute, legislative history and established CMS DSH policy.

The explicit exclusion of bad debt from the definition of uncompensated care will be harmful to DSH hospitals that are struggling to meet the health care needs of the growing numbers of uninsured and underinsured. The recent growth of health plans and health savings accounts that impose high deductibles or have exclusion limits is putting new burdens on hospitals in terms of unreimbursed costs for care provided to working, low income individuals and their families.

HAP and DVHC strongly recommend that CMS eliminate the definition of bad debt as included in the proposed rule and clarify that uncompensated care includes:

- **the costs of services furnished to individuals with no health care insurance, third-party coverage or third-party payment;**
- **the costs of services furnished to insured individuals whose policies, including health savings accounts or similar types of policies, do not cover the services provided to the individual due to his/her health plan's exclusions, limits, copayments or deductibles.**

Exclusion of Physician Services in Definition of Uncompensated Care

The proposed rule's preamble states that uncompensated care costs of physician services cannot be included in the calculation of the hospital-specific DSH limit. However, the statute does not specifically exclude physician services. In fact, the agency, in at least one communication to a state Medicaid program, allows for the inclusion of physician services in determining a hospital's unreimbursed costs. In this example, the costs associated with securing physicians to serve the hospital's Medicaid patient population are legitimate unreimbursed costs if the hospital does not separately bill for the services. The MMA does not require that CMS exclude physician services. Again, this policy goes beyond MMA statutory requirements to establish new CMS policy. **HAP and DVHC recommend that CMS allow physician costs associated with hospitals' services be included in determining a hospital's uncompensated care costs.**

Section 1011 Payments

Congressional intent, in enacting Section 1011, was to provide new resources rather than substitute existing resources for hospitals providing large volumes of uncompensated care to undocumented immigrants. While the preamble in the proposed rule directs state Medicaid programs to consider Section 1011 payments when determining a hospital's specific DSH limit, there is no statutory requirement to include Section 1011 payments when calculating the

hospital's uncompensated care burden. Section 1011 payments are not Medicaid payments, health plan payments, or payments from uninsured patients. The consideration of Section 1011 payments would likely result in reducing needed DSH dollars to hospitals serving high numbers of undocumented immigrants. **HAP and DVHC recommend that CMS delete the language in the preamble that requires states to offset Section 1011 payments when establishing a hospital's DSH limit.**

Reporting Unduplicated Patient Count of Medicaid Eligibiles and Uninsured Individuals
State Medicaid programs are required to report for each hospital an unduplicated count of Medicaid-eligible and uninsured patients. HAP AND DVHC OF HAP is concerned that states will look to hospitals to produce these patient counts. Many hospitals do not have the reporting systems in place that would allow them to generate unduplicated counts of patients served throughout the year that are Medicaid eligible or uninsured. Further, many questions arise as to how a hospital would classify certain patients, such as a patient that has Medicaid coverage for part of the year and is uninsured for part of the year. The proposed rule also fails to make the case as to why this information is necessary. **HAP and DVHC recommend that this unnecessary and burdensome reporting requirement be deleted.**

AUDIT REQUIREMENTS

The MMA requires that state Medicaid programs have their DSH programs independently audited and submit this independent certified audit to the Secretary on an annual basis. The proposed rule does not address how the audits will be paid for and there is a concern that the state Medicaid programs will pass on these additional costs to DSH hospitals. The cost for hospital audits often reaches as high as $50,000 per hospital. This estimate clearly suggests that the economic impact, if audit costs are passed on to hospitals as expected, will trigger the test of a major rule under Executive Order 12866 (September 1993 Regulatory Planning and Review) and should require a regulatory impact analysis. These safety net hospitals are not in the financial position to absorb these added audit costs. **HAP and DVHC recommend that CMS state affirmatively that the cost of the audits should not be passed on to hospitals.**

Definition of Independent Certified Audit
The proposed rule defines an independent certified audit as an audit conducted with generally accepted government auditing standards as defined by the Government Accountability Office. Most private sector audits use generally accepted accounting principles (GAAP) to audit hospital financial data. Applying a different set of auditing standards than GAAP to hospital financial data will result in an unnecessary burden on the hospitals trying to comply with information requests from the auditors. **HAP and DVHC recommend that state Medicaid programs be allowed to use GAAP standards in the independent certified audits.**

Retroactive Audit
The proposed rule retroactively applies the new reporting and auditing requirements to each state's fiscal year (FY) 2005. Most state fiscal years for 2005 have ended. Applying new audit rules retroactively is an undue burden on hospitals and makes little sense. While the MMA

required that CMS impose reporting and auditing requirements beginning in FY 2004, CMS has delayed implementation beyond the date specified in the MMA. The retroactive application of these new reporting and auditing requirements seems unfair and will impose a hardship for state Medicaid programs and DSH hospitals. **HAP and DVHC strongly recommend that retroactive application of the reporting and auditing requirements be deleted from the rule and that the reporting and auditing requirements be tied to the first state fiscal year beginning after the rule is finalized.**

Reducing Uncompensated Care Costs by DSH Payments
The audit verification #1 requires that a state's audit report verify that each hospital receiving DSH payments has reduced its uncompensated care costs for furnishing inpatient and outpatient hospital services to Medicaid eligible individuals and individuals with no source of third-party coverage to reflect the total amount of claimed DSH expenditures during the state fiscal year. The DSH statute defines uncompensated care costs as the cost of serving Medicaid and uninsured patients net of Medicaid payments and payments made by uninsured individuals, excluding DSH payments. The statutory language is clear that uncompensated care costs are not offset by DSH payments. This new requirement, which reduces a hospital's uncompensated care costs by claimed DSH expenditures, is contrary to the statute. **HAP and DVHC recommend that verification #1 be changed to require that the total amount of claimed DSH expenditures for each DSH hospital in the state is no more than the hospital's uncompensated care costs.**

Retroactive Verification of Same Year Actual Costs
The audit verification #2 requires that the DSH payments comply with the hospital-specific DSH limit by stating that the DSH payments made in the audited state fiscal year be measured against the actual uncompensated care cost for that fiscal year. This would require that states retroactively reconcile DSH payments with actual costs. The MMA does not require that payments be based on actual audited costs. Current CMS DSH policy allows states to use a prospective methodology to estimate current year uncompensated care costs for purposes of establishing the hospital's specific DSH limit (*the maximum amount that a hospital may receive in DSH payments*). The verification, through an audit, of DSH payments with the same year actual uncompensated care costs will place an enormous strain on hospitals through new burdensome and costly audits and increase the administrative costs for each state Medicaid program. This requirement in the proposed rule substantively changes current Medicaid DSH policy, again without statutory authority.

HAP and DVHC strongly recommend that CMS delete the requirement in the preamble and the regulatory language that audited DSH payments must be measured against actual uncompensated care cost for the same fiscal year. HAP and DVHC further recommend that CMS clarify that states be allowed to continue to use reasonable estimating methodologies to determine uncompensated care costs for purposes of establishing the hospital's specific DSH limit.

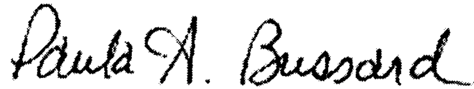
HAP

Conclusion

While The Hospital & Healthsystem Association of Pennsylvania and The Delaware Valley Healthcare Council of HAP strongly support clarity and consistency in DSH policy, the proposed rule fails to achieve these goals and makes substantive policy changes that clearly exceed congressional intent. The Medicaid DSH program is essential for safety net hospitals in Pennsylvania and across the country. The proposed rule, as presently drafted, will have significant ramifications for these hospitals, as well as for the patients they serve.

On behalf of our member hospitals and health systems, we appreciate the opportunity to comment on the proposed rule to implement the Medicaid DSH reporting and auditing requirements of the MMA. If you have any questions, or if we can be of further assistance, please contact Bob Greenwood, HAP's vice president, health care finance and insurance, at (717) 561-5358 or by email at bgreenwood@haponline.org., or Pamela Clarke, DVHC of HAP's vice president, managed care, at (215) 735-3265 or by email at pclarke@dvhc.org.

Sincerely,



PAULA A. BUSSARD
Senior Vice President, Policy and Regulatory Services

AN ASSOCIATION OF
MONTANA HEALTH
CARE PROVIDERS

October 16, 2005

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Re: CMS-2198-P; Medicaid Program; Disproportionate Share Hospital Payments -- Implementing the Medicare Modernization Act of 2003 Reporting and Auditing Requirements. Proposed Rule.

Dear Dr. McClellan:

MHA, An Association of Montana Health Care Providers, on behalf of our 57 member hospitals, appreciates the opportunity to comment on the proposed rule implementing the Medicaid Disproportionate Share Hospital (DSH) Payment reporting and auditing requirements found in the Medicare Modernization Act of 2003 (MMA). The Medicaid DSH program provides essential financial assistance to Montana's community hospitals. Montana hospitals, with few exceptions, are not-for-profit community institutions that provide access to care for all Montanans, including the poor, disabled and elderly. Montana, among states, has one of the highest percentages of uninsured residents and one of the lowest average incomes. Medicaid payments, especially payments from the DSH program, provide an extremely important resource to assure continued access to care.

MHA is very concerned about the proposed rule. Adoption of the rule would greatly reduce the DSH payments to many Montana hospitals, especially to hospitals located on are adjacent to Indian Reservations.

MHA endorses the comments provided by the American Hospital Association, which notes that he Medicaid DSH program has operated with little written regulatory guidance since the publication of the program's initial regulations in 1992. There have been two communications to the State Medicaid Directors in 1994 and 2002 that address questions specific to the hospital specific DSH caps. Much of the current DSH policy has been forged in negotiations between the Centers on Medicare and Medicaid (CMS) and individual state governments. The absence of consistent federal policy has been a source of frustration for hospitals.

It appears that CMS is choosing to use this proposed rule that implements the MMA reporting and auditing requirements to establish new DSH policy. Montana currently

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requires hospitals to report both charity and bad debt costs to the Medicaid program to assure that no hospital will receive an excess Medicaid DSH payment. This method is part of an approved State Plan, and has been in place for numerous years. The proposed regulation is a major departure from current practice.

CMS seeks to create a new definition of uncompensated care. The new definition of uncompensated care to both exclude bad debt and physician services are clear examples of the agency's attempt to substantively change long standing DSH policy without properly calling for direct public comment.

Uncompensated Care (UCC) (42 C.F.R. 447.299(c)(15))

Bad Debt The proposed rule, in both the preamble language and the draft regulatory language, states that uncompensated care does not include bad debt for purposes of setting the hospital specific DSH limit. This new definition of uncompensated care that excludes bad debt is not consistent with the statute, legislative history or long standing agency practice. The underlying statute (1923(g)(1)(A) permits the inclusion of the costs of services provided individuals with no health insurance or other source of third party coverage. The conference report language for the Omnibus Budget Reconciliation Act of 1993 (OBRA '93) provision, that originally established the hospital specific DSH limit, reveals Congress' intent in directing the agency on the various ways to determine the unreimbursed costs that hospitals bear. The report language states that the cost of providing services to uninsured patients would be net of any out of pocket payments received from uninsured individuals. The agency's 1994 letter to state Medicaid programs offered further guidance in the determination of unreimbursed costs by stating that the cost of services provided individuals with third party coverage, but whose third party coverage did not cover the hospital services the individual received, could be counted. The agency was clearly looking at the cost associated with the uninsured and the underinsured in implementing the hospital specific DSH limit. In 2002, the agency in its guidance to state Medicaid programs regarding the hospital specific DSH limit and the upper payment limit reaffirmed the 1994 DSH policy.

A number of state Medicaid programs include the costs of care provided uninsured individuals for which no payment is made and the costs associated with the non payment of copayments and deductibles for individuals with third party coverage in determining a hospital's qualifying costs for the hospital specific DSH limit. Montana is among states that have adopted this policy. MHA believes that Montana Medicaid policy is consistent with the statute, legislative history, and long established agency DSH policy.

Congress did not include statutory language to exclude bad debts from being considered part of uncompensated care. The statute does not raise the issue of indigence or willingness of the patient to pay for care. Rather it addresses the burden of providing care to uninsured, and underinsured patients for whom the hospital receives no payment. MHA believes that the proposed rule is inconsistent with Congressional intent, and actually works to weaken the statute's purpose. **MHA**

recommends that CMS change its definition of uncompensated care by striking references to bad debt in 42 C.F.R. 447.299(c)(15) and in its place clarify that uncompensated care includes the costs of services furnished to individuals with no health care insurance, third party coverage, or third party payment which includes individuals with health savings accounts and include the costs of services furnished insured individuals whose policies do not cover the services provided the individual due to their health plans exclusions, limits or deductibles.

Physician Services The preamble of the proposed rule states uncompensated care costs of physician services cannot be included in the calculation of the hospital specific DSH limit. The statute does not specifically exclude physician services. Montana hospitals, especially critical access hospitals, typically employ physicians and other practitioners in order to assure access to services. The hospital bears the risk for nonpayment for the providers' services while it incurs the cost of employment and other support. It is only reasonable to include unpaid provider costs as part of the hospital's uncompensated care costs reported to the Medicaid Program.

AHA has advised us that CMS, in at least one communication to a state Medicaid program, allows for the inclusion of physician services in determining a hospital's unreimbursed costs. The costs associated with securing physicians to serve the hospital's indigent patient population are legitimate unreimbursed costs and should be allowed. The MMA does not require that CMS exclude physician services. This is another example of CMS' reach beyond statutory requirements to establish new policy. **AHA has stated, and MHA concurs, that physician costs associated with hospital services should be included and references to excluding the physician costs in determining the hospital's uncompensated care costs in the preamble should be deleted.**

Reporting Unduplicated Patient Count of Medicaid Eligibiles and Uninsured Individuals (42 C.F.R. 447.299 (c)(16))

State Medicaid programs are required to report for each hospital an unduplicated count of Medicaid eligible and uninsured patients. It is likely that states will turn to hospitals to produce these patient counts. Many hospitals do not have the reporting systems in place that would allow them to generate unduplicated counts of patients served throughout the year that are Medicaid eligible or uninsured. Hospital data systems are not likely to capture this information. And many questions arise in how a hospital would classify certain patients such as a patient that has Medicaid coverage for part of the year and are uninsured for part of the year. The proposed rule fails to make the case why this information is necessary. **MHA believes that this reporting requirement would be unnecessarily burdensome for hospitals and recommends that it be deleted.**

Reporting of Indigent Care Revenue (42 C.F.R. 447.299(c)(12))

The proposed rule requires reporting of total payments received by hospitals from individuals with no source of third party coverage. Most hospitals' current accounting systems do not allow them to match payments received from individuals to payments received for individuals for which there was no third party coverage. **This would impose an excessive reporting burden on hospitals and AHA recommends that this reporting requirement be deleted.**

Reporting Total Costs (42 C.F.R. 447.299(c)(14))

The 1994 guidance to State Medicaid Directors allows a state to use the definition of allowable costs in its State Medicaid plan or any other definition as long as the costs determined under such a definition do not exceed the amounts that would be allowable under the Medicare principles of cost reimbursement. **MHA believes that the proposed rule should reaffirm this definition of allowable costs to assure greater consistency across all the state Medicaid DSH programs.**

Auditing Requirements (42 C.F.R 455.204)(b))

The proposed rule retroactively applies the new reporting and auditing requirements to each state's FY 2005. Montana's state fiscal year for 2005 has ended. The imposition of the new and substantive reporting and auditing requirements would be impossible for state Medicaid programs to retroactively identify the data requested. Further, the state would have to apply a new standard to hospitals that is inconsistent with its current state plan and administrative rules. Finally, the new rules impose an extremely heavy penalty on certain small hospitals. It is unlikely that these hospitals could repay any amounts to the Medicaid program from current operating income.

While the MMA required that CMS imposed reporting and auditing requirements beginning in fiscal year 2004, CMS has delayed implementation beyond the date specified in the MMA. The retroactive application of these new reporting and auditing requirements makes little sense now and will impose a hardship for state Medicaid programs as well as DSH hospitals. **MHA recommends that this retroactive application of the reporting and auditing requirements be deleted from the rule and that the reporting and auditing requirements be tied to the first state fiscal year beginning after the finalization of the rule. This will allow a state an opportunity to modify its Medicaid program design, administrative rules, state statutes and Medicaid state plan**

Same Year Actual Costs (42 C.F.R. 455.204(c))

The audit verification #2 requires that the DSH payments comply with the hospital specific DSH limit by requiring that the DSH payments made in the audited state fiscal year (SFY) have to be measured against the actual uncompensated care cost in the same audited SFY. This would require that states reconcile DSH payments to ensure such payments do not exceed actual costs, but the MMA, in fact, does not require that payments be based on actual audited costs. Current CMS DSH policy

allows states to use a prospective methodology to estimate current year uncompensated care costs. This approach allows for adjustments in future years to reconcile DSH payments with actual costs. The verification, through audit, of DSH payments with the same year actual uncompensated care costs will place an enormous burden on hospitals through new burdensome and costly audits as well as increase the administrative costs for each state Medicaid program.

Montana Medicaid annually surveys all hospitals near the beginning of its fiscal year. Hospitals report their data for a twelve month period, but this period does not match the state fiscal year. The state uses this data to provide the required assurances that its methods results in payments that are consistent with federal rules. Further, federal DSH payments are provided on a federal fiscal year, and at changing match percentages. It is not practical to attempt matching the state's payments to actual costs, unless such an effort were made after all related cost reporting periods were closed, audits performed and cost settlements performed. Even this effort would not provide a precise measure since hospitals' fiscal years won't always match state fiscal years.

The proposed rule also does not speak to how such additional audits will be paid for and there is a concern that the state will pass on the added costs for same year audits to the DSH hospitals. The cost for hospital audits can reach $50,000 or higher per hospital. This estimate clearly suggests that the economic impact of this one audit requirement will meet the test under the Regulatory Flexibility Act of a major rule and should require a regulatory flexibility analysis for small entities such as hospitals. **MHA strongly recommends that CSM delete the requirement in the preamble and the regulatory language that audited DSH payments must be measured against actual uncompensated care cost in the same audited SFY. MHA recommends that CMS clarify that states be allowed to continue to use reasonable estimating methodologies to determine uncompensated care costs.**

MHA appreciates this opportunity to comment on the proposed rule to implement the Medicaid DSH reporting and auditing requirements of the MMA. MHA does not object to the effort to better measure compliance with federal regulations, or to the plain meaning of the provisions of MMA. The proposed rule, as presently drafted, will have a significantly negative impact on Montana hospitals. Please contact me with any questions or to further discuss our comments. I can be reached at 406-442-1911 or e-mail at bob@mtha.org.

Sincerely,

Robert W. Olsen
Vice President

CC: MHA Member Institutions

FLORIDA HOSPITAL ASSOCIATION

An Association of Hospitals & Health Systems

October 19, 2005

Mark McClellan, M.D., Ph.D., Administrator
Centers for Medicare & Medicaid Services
P.O. Box 8010
Baltimore, MD 21244-1850

Re: CMS-2198-P; Medicaid Program; Disproportionate Share Hospital Payments – Implementing the Medicare Modernization Act of 2003 Reporting and Auditing Requirements (Proposed Rule)

Dear Dr. McClellan:

The Florida Hospital Association (FHA), on behalf of its member hospitals and health systems, appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' proposed rule implementing the Medicaid disproportionate share hospital (DSH) payment reporting and auditing requirements found in the Medicare Modernization Act of 2003 (MMA). The Medicaid DSH program provides essential financial assistance to the safety net hospitals in our state, as well as across the country. As proposed, these regulations would have a negative impact on Florida's Medicaid DSH hospitals and could impact their ability to continue to serve the poor and otherwise vulnerable patients in the state.

As noted in the comments prepared by the American Hospital Association on this issue, the Medicaid DSH program has operated with little written regulatory guidance since the publication of the program's initial regulations in 1992. There have been two communications to the State Medicaid Directors – one in 1994 and the other in 2002 – that addressed questions related to the hospital-specific DSH limits. Much of the current DSH policy has been established through negotiations between the Centers for Medicare & Medicaid (CMS) and individual state agencies. It appears that, through this proposed rule, CMS is acting to establish new DSH policy, as well as respond to the MMA provision related to reporting and auditing requirements. Our specific concerns are outlined below.

Bad Debt

The proposed rule, in both the preamble language and the draft regulatory language, states that uncompensated care does not include bad debt for purposes of setting the hospital-specific DSH limit. This new definition of uncompensated care is not consistent with the statute, legislative history, or long-standing agency practice. The underlying statute at 1923(g)(1)(A) permits the inclusion of the costs of services provided individuals with no health insurance or other source of third party coverage. The agency's 1994 letter to state Medicaid programs offered further guidance in the

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determination of unreimbursed costs by stating that the cost of services provided individuals with third party coverage, but whose third party coverage did not cover the hospital services the individual received, could be counted. In 2002, the agency in its guidance to state Medicaid programs regarding the hospital-specific DSH limit and the upper payment limit, reaffirmed the 1994 DSH policy.

Following what is perceived as current policy, a number of state Medicaid programs include the costs of care provided uninsured individuals for which no payment is made and the costs associated with the non-payment of copayments and deductibles for individuals with third party coverage in determining a hospital's qualifying costs for the hospital-specific DSH limit. The exclusion of bad debt from the definition of uncompensated care will be harmful to DSH hospitals that are struggling to meet the health care needs of the growing numbers of uninsured and underinsured, particularly with the increase in patient out-of-pocket liability and the expansion of high deductible health plans.

Section 1011

The preamble to the proposed rule directs state Medicaid programs to consider Section 1011 payments when determining the hospital-specific DSH limit. There is no statutory requirement to include Section 1011 payments when determining the hospital's uncompensated care burden. Section 1011 payments are neither Medicaid payments nor payments from uninsured patients. Congressional intent, in enacting Section 1011, was to provide new a funding source, rather than substitute existing resources, for hospitals providing large volumes of uncompensated care to undocumented immigrants. The consideration of Section 1011 payments would likely result in reducing needed DSH dollars to the hospitals in Florida that serve high numbers of uninsured undocumented immigrants.

Unduplicated Patient Count

The proposed rule requires state Medicaid programs to report for each hospital an unduplicated count of Medicaid eligible and uninsured patients. We are concerned that, while the state could develop an unduplicated count of Medicaid eligible patients, it would be very difficult for the state to develop a list of unduplicated uninsured individuals and an impossible task for the hospitals. Hospitals do not have access to information at other hospitals that would allow such a list to be developed and the cost for the state to develop such a list could be significant.

Retroactive Audit

The proposed rule retroactively applies the new reporting and auditing requirements to each state's 2005 fiscal year. For Florida, as with most states, FY2005 has already ended. The imposition of new and substantive reporting and auditing requirements would make it impossible for state Medicaid programs to comply because they would have to retroactively identify the requested data. Although the MMA required that the reporting and auditing requirements be in place for FY2004, the fact that this period has now passed should not justify the retroactive application of the new requirements to FY2005.

Same Year Actual Costs

The audit verification requires that the DSH payments comply with the hospital-specific DSH limit and indicates that the DSH payments made in the audited state fiscal year) are to be measured against the actual uncompensated care cost in the same audited period. This would require that states reconcile DSH payments to ensure such payments do not exceed actual costs. Current CMS DSH policy allows states to use a prospective methodology to estimate current year uncompensated care costs. This approach allows for adjustments in future years to reconcile DSH payments with actual costs. The verification, through audit, of DSH payments with the same year actual uncompensated care costs will place an enormous burden on hospitals through new complex and costly audits as well as increase the administrative costs for each state Medicaid program. There is also concern as to how these additional audit costs will be paid and whether they will be passed on to the hospitals. Some states have indicated that these audits could run $50,000 or higher per hospital.

Requirement to Reduce Uncompensated Care Costs by DSH Payments

The audit verification requires that a state's audit report confirm that each hospital receiving DSH payments has reduced its uncompensated care costs for furnishing inpatient hospital and outpatient hospital services during the state fiscal year to Medicaid eligible individuals and individuals with no source of third party coverage for the services in order to reflect the total amount of claimed DSH expenditures. The DSH statute defines uncompensated care costs as the cost of serving Medicaid and uninsured patients net of Medicaid payments and payments made by uninsured individuals, excluding DSH payments. The statutory language, however, is clear that uncompensated care costs are not offset by DSH payments. This verification requirement to reduce a hospital's uncompensated care costs by claimed DSH expenditures appears to be contrary to statute.

Again, the FHA appreciates the opportunity to comment on this proposed rule as it is important to protect access for vulnerable populations and to ensure the DSH funding to Florida's safety net providers. If there are any questions on these comments, please do not hesitate to contact me at (407) 841-6230 or via email at kathyr@fha.org

Sincerely,

Kathy Reep
Vice President/Financial Services

AHCCCS

Janet Napolitano, Governor
Anthony D. Rodgers, Director

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Our first care is your health care
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

October 17, 2005

Jim Frizzera
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS 2198-P
P.O. Box 8010
Baltimore, Maryland 21244-1850

Re: CMS-2198-P

Dear Mr. Frizzera:

Please accept the following comments from the Arizona Health Care Cost Containment System (AHCCCS) in response to the Federal Register Notice of August 26, 2005 regarding Disproportionate Share Hospital Payments in the Medicaid program.

AHCCCS has many concerns to outline with respect to the reporting and audit regulation as it is currently being proposed. In order to provide you with a thorough assessment, this letter identifies major questions and concerns that require further review.

1) How are states to report and audit DSH payments made in SFY 2005 when the proposed regulations were not provided until August 26, 2005, and regulations will not be finalized until after October 25, 2005? The audit requirements will not be effective until the end of the comment period and OMB approval. The SFY 2005 timeframe is unreasonable, and will potentially require recalculation of all FY 2005 DSH payments, with subsequent recoupments and repayments. The timeframe should be moved to 2006 after all requirements and regulations have been finalized.

2) Reporting Requirements (CFR Part 447.299) – CMS identifies specific calculations/value that states are to provide for each hospital.

    - (c)12 Indigent Care Revenue is defined **as total annual payments received by the hospital from individuals** with no source of third party coverage for inpatient and outpatient hospital services they receive. Comment: Clarification on the definition of Indigent Care Revenue is needed. Is this intended to provide clarification to SSA 1923 (g)(1)(A)? As stated, Indigent Care Revenue includes payments from all individuals with no source of TPL, many of which are not indigent. The majority of indigent individuals do not make payments to the hospital – rather state and other government programs make payments to hospitals on their behalf.

- (c)14 Total Cost of Care is defined to include "....total costs incurred for furnishing inpatient hospital and outpatient hospital services to individuals with no source of third party coverage for the hospital services they receive." Comment: How does Indigent Care Revenue, as defined in this section, impact total cost of care?
- (c)15 Uncompensated Care Costs– Comment: Nowhere in this regulation does CMS refer to the OBRA 93 limits, as defined in SSA 1923, however, the definition of UCC in this section is similar to the definition of the OBRA limit (costs incurred by the hospital for individuals who are either eligible for medical assistance under the State Plan or have no health insurance/TPL). Does uncompensated care recognize charity care or other government subsidies/payments for people with no insurance that are defined in SSA 1923 (g)?
- (c)16 Medicaid eligible and uninsured individuals are defined as the unduplicated number of Medicaid eligible individuals receiving hospital services, and the unduplicated number of individuals with no source of third party coverage for services received. Comment: Neither of these values is used to calculate or determine DSH payments, DSH OBRA 93 limits, or uncompensated care costs. Why are these items requested for DSH reporting?
- CMS' estimate that the reporting requirements will take approximately 30 minutes per hospital is not accurate. Several of the items requested are not required values for DSH calculations as per SSA 1923, and therefore the state will need to obtain them once the definitions are clarified.

3) Audit Reporting Requirements (CFR Part 455) – CMS provides specific verifications for States to provide for DSH including:

- Verification 2 requires that DSH payments made to each qualifying hospital comply with hospital-specific DSH payment limit. For each audited SFY, the DSH payments made in that audited SFY must be measured against the actual uncompensated care cost in that same audited SFY. Comment: As stated, this verification requirement implies that all States participating in DSH will make interim Medicaid DSH payments with retroactive settlement. Clarification is needed as to timing of audits related to the most recently available historical audited financial data to make prospective DSH payments. Example: Based on Arizona's DSH methodology approved by CMS, Arizona's prospective DSH payments made in SFY 05 were based on FYE 03 (most recently available) financial and utilization data (hospitals must continue to serve the AHCCCS population at levels consistent with history in order to be eligible, as confirmed by HCFA/CMS).

- The rules require the States to annually submit the independent audit report to CMS and define the submission requirements as "within 1 year of the independent audit". This rule does not, however, define any specific dates. Comment: The rule should define a specific period such as OMB Circular A-133, which defines the Single Audit report submission as "shall be submitted within the earlier of 30 days after receipt of the auditor's report(s), or nine months after the end of the audit period, unless a longer period is agreed to in advance by the cognizant or oversight agency for the audit".

Thank you for the opportunity to comment on the proposed regulations. Please contact me at (602) 417-4711 if I may be of assistance as you discuss these issues.

Sincerely,

Thomas J. Betlach
Deputy Director

6

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
KEVIN W. CONCANNON, DIRECTOR

October 25, 2005

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS – 2198-P
P.O. Box 8010
Baltimore, MD 21244-1850

REF: Comments on Medicaid Program; Disproportionate Share Hospital Payments – CMS-2198-P

RE: Reporting Requirements, Audit Requirements, Collection of Information Requirements, Regulatory Impact Statement

We appreciate the opportunity to submit comments on the Proposed Rule issued by the Centers for Medicare & Medicaid Services (CMS) in the August 26, 2005 in the Federal Register on the Medicaid Program; Disproportionate Share Hospital (DSH) Payments. While we support clarification that enables State DSH programs to better comply with federal requirements, we have concerns regarding the Proposed Rule. We are also concerned with the Proposed Rule's new substantive interpretations of longstanding Medicaid DSH requirements, which may go beyond Congressional intent in the MMA reporting language.

The following are a list of issues identified to date:

1. **General** - The Medicaid DSH program has operated through self-implementing statutes. The only two policy directives in the form of State Medicaid Director Letters in 1994 and 2002. CMS, through this NPRM on reporting and auditing requirements, is attempting to reach beyond the statutory provisions requirements of the MMA and set policy.
2. **General** - The approach CMS has taken to implement the MMA provision may be placing significant reporting burdens on hospitals and states.
3. **Bad Debt** – The NPRM is not clear about the inclusion of bad debt. It states that uncompensated care includes the care furnished to patients with no third party coverage. Previous CMS guidance allows state Medicaid programs to count bad debt from individuals that were provided care for which their third party insurance did not cover. Many state Medicaid programs interpreted this to allow the inclusion of non-payment of copays and deductibles as uncompensated care costs. The NPRM is very confusing on this point and clarification is necessary.
4. **Reporting Based on State Fiscal Year** – Establishment of a State Fiscal Year reporting timeline may prove problematic for many states. This is because some states currently include in their annual DSH data collections and CMS reporting, payments from two or more state fiscal years and distribute DSH on a federal fiscal year basis. State fiscal year reporting for DSH may also eliminate selection of a base year and trending forward. It is also unclear whether states will need to estimated DSH payments and then do a settlement, or whether DSH payments will need to be retrospective. Moreover, the lag in

hospital cost reporting provides states with a very small, possibly unmanageable, window of time to complete and submit the newly required independent certified audit.

5. **Direct Matching** – The draft regulations appear to require a direct matching between payments and the costs incurred. Due to the long time lags involved with the collection of cost, patient days, and payment information, it is unclear whether states will be able to meet this requirement.
6. **Exclusion of Physician Services** – NPRM states uncompensated care cost of physician services cannot be included in the calculation of the hospital specific DSH limit. This is problematic for all hospitals since physician services are part of the services that hospitals routinely provide to the uninsured. Some state Medicaid programs allow for the inclusion of physician service if hospital bills for the service such as hospital clinics. MMA does not call for the exclusion of physician services.
7. **Reporting of Non-duplicated Medicaid and Uninsured** – NPRM requires reporting of non-duplicated Medicaid eligibles and uninsured receiving care. This information has never been collected by most/all hospitals or by State Medicaid programs and we expect this will be difficult for many hospitals and could result in an excessive reporting burden.
8. **Reporting of Indigent Care Revenue** – NPRM requires reporting of total payments received by hospitals from individuals with no source of third party coverage. The issues to consider here are reporting burdens -- do hospitals keep self-pay collection logs? At what point is an individual coded as self pay?
9. **Section 1011: Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens** – NPRM states that states will have to consider Section 1011 funds for those hospitals close to their hospital specific DSH limit. This could result in the reduction of DSH from some hospitals and will require states to identify which hospitals received these payments and the amount of payments received prior to allocating DSH funds. MMA does not require this.
10. **Retroactive Audit** – NPRM applies new requirements to FY 2005 DSH programs. NPRM changes DSH policy in several areas and the retroactive audit could significantly affect already approved programs. Also as written, the new rules could also prevent states from making prospective estimates of Medicaid shortfalls and uninsured costs.
11. **Audit** – The MMA requires annual audits, but the NPRM is unclear on how DSH payments and the actual calculation of a hospital's uncompensated care are to be reconciled. Most state Medicaid programs set the hospital specific DSH limits based on estimates. The reconciliation of payments and actual UCC within the same year could be extremely difficult since most state Medicaid cost reports are open for longer than a year in some cases years.
12. **Certified Independent Audit** – What are the implications of a certified public audit? How constraining are the accepted practices of certified audits? Who pays for the audit, the state or the hospitals?
13. **Overpayment** – If audit reveals overpayment does state pay hospitals? What about underpayments if there are available dollars under the state cap?
14. **Definition of Cost** - NPRM grants states some leeway in the definition of costs. Is this an area where a more guidance or a prescriptive definition is necessary?
15. **Definition of Inpatient Hospital** – The proposed rule (P. 50265, under Verification 3 text) refers only to Medicaid regulations at 440.10 and 440.20(a) with respect to the definitions of inpatient and outpatient hospital services. The proposed rule does not,

however, reference Section 441.40, which provides definition of an Institution for Mental Disease (IMD). This is problematic since the Social Security Act clearly establishes that IMDs are entitled to participate in Medicaid DSH programs.

16. **Standard Documentation Requirements** - The NPRM applies these new changes to retroactively FY 2005 when most DSH plans are already in place. Medicaid State Plans, regulations, and/or statutes will need to be amended to reflect the new reporting and audit requirements, which are retroactive to 7/1/05.

Thank you for your time and consideration in responding to these comments and questions.

Sincerely,

Eugene Gessow
Iowa Medicaid Director

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NATIONAL ASSOCIATION of PUBLIC HOSPITALS and HEALTH SYSTEMS

1301 PENNSYLVANIA AVENUE, NW, SUITE 950, WASHINGTON DC 20004 | 202.585.0100 | FAX 202.585.0101

October 25, 2005

Via First Class Mail

Centers for Medicare and Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Regulations Development and Issuances Group
Attn: Jimmy Wickcliffe
CMS -2198-P
Room C5-11-04
7500 Security Boulevard
Baltimore, MD 21224-1850

Office of Information and Regulatory Affairs
Office of Management and Budget
Room 10235
New Executive Office Building
Washington, DC 20503
Attn: Katherine Astrich, CMS Desk Officer

Ref: CMS-2198-P – Medicaid Program; Disproportionate Share Hospital Payments; Proposed Rule

Dear Mr. Wickcliffe and Ms. Astrich:

Please find enclosed a copy of the comment letter that the National Association of Public Hospitals and Health Systems (NAPH) recently submitted to the Centers for Medicare and Medicaid Services (CMS) regarding the above-referenced Proposed Rule.[1] As explained in our cover letter and comments to CMS, NAPH members are likely to be especially impacted by the DSH reporting and audit requirements contained in the Proposed Rule. We are forwarding our comments to you pursuant to the Paperwork Reduction Act (PRA) of 1995 because, as explained in detail throughout the attached comments, NAPH believes that the information collection burden is significant, that in many cases the information requested is ambiguous or inaccurate and that there are better ways to implement the statutory requirements. We hope that CMS and the Office of Management and Budget will consider our recommendations to minimize the information collection burden.

NAPH appreciates the opportunity to submit these comments on the Proposed Rule regarding DSH reporting and auditing requirements. If you have any questions about these comments, please contact NAPH counsel Charles Luband, Barbara Eyman or Allison Orris at (202) 347-0066.

Sincerely,

Larry S. Gage
President

cc: Mark McClellan, Administrator, CMS
Dennis Smith, Director, Center for Medicaid and State Operations, CMS

Attachment

[1] 70 Fed. Reg. 50262 (Aug. 26, 2005).

NATIONAL ASSOCIATION of PUBLIC HOSPITALS and HEALTH SYSTEMS
1301 PENNSYLVANIA AVENUE, NW, SUITE 950, WASHINGTON DC 20004 | 202.585.0100 | FAX 202.585.0101

October 25, 2005

Via Courier

Dr. Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Ref: CMS-2198-P – Medicaid Program; Disproportionate Share Hospital Payments; Proposed Rule

Re: Reporting Requirements, Audit Requirements, Collection of Information Requirements, Regulatory Impact Statement

Dear Dr. McClellan:

The National Association of Public Hospitals and Health Systems (NAPH) appreciates the opportunity to submit comments on the above-referenced Proposed Rule.[1] NAPH represents more than 100 metropolitan area safety net hospitals and health systems. Our members provide certain essential specialized services to their entire communities, such as emergency and trauma care, burn care, and neonatal intensive care and are significant providers of care to low-income and uninsured patients. For example, approximately 38 percent of the inpatient services provided by NAPH members is to Medicaid recipients and another 23 percent is provided to uninsured patients. Medicaid disproportionate share (DSH) payments cover nearly a quarter of the unreimbursed care provided by NAPH members. NAPH members are likely to be especially impacted by the DSH reporting and audit requirements contained in the Proposed Rule.

NAPH generally supports reporting requirements that help ensure that state DSH payments comply with federal requirements and fulfill the statutory mandate to assist hospitals that serve a disproportionate share of low-income individuals. At the same time, NAPH has numerous concerns regarding the Proposed Rule.

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[1] 70 Fed. Reg. 50262 (Aug. 26, 2005), hereinafter "Proposed Rule."

First, NAPH is concerned that the preamble to the regulation inappropriately changes various aspects of Medicaid DSH policy and goes beyond Congressional intent in the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA). This is of particular concern given the proposed retroactive application of the regulation. To address these concerns, NAPH believes CMS should make the following changes in its final rule:

- Impose the reporting and audit requirements prospectively only, effective for the first state fiscal year that begins after the date of the final rule.
- Retract preamble language requiring uncompensated costs to be offset by payments for emergency services for undocumented immigrants received pursuant to Section 1011 of the MMA.
- Retract the statement in the preamble that indicates that the uncompensated care costs of providing physician services cannot be included in the calculation of the hospital-specific DSH limit. CMS should also reaffirm states' discretion to define costs for purposes of the hospital-specific limit, as described in CMS' 1994 letter to State Medicaid Directors.
- Eliminate the statement in the definition of "uncompensated care costs" in proposed 42 C.F.R. 447.299(c)(15) that bad debt cannot be included in such costs, and clarify that costs associated with underinsured individuals who are not covered for the services provided may be included.

NAPH also objects to some of the requirements in the proposed regulation as unnecessarily burdensome. To address these concerns, NAPH believes CMS should make the following changes to the final rule:

- Clarify the preamble and amend the language in proposed audit verification requirement #2 (42 C.F.R. 455.204(c)(2)) to eliminate the requirement that DSH payments made in any audited state fiscal year must be reconciled with actual same-year uncompensated care costs. Instead, states should be permitted to rely on reasonable prospective methodologies.
- Remove the requirement in proposed 42 C.F.R. 447.299(c)(16) that states indicate for each hospital an unduplicated patient count of Medicaid eligible and uninsured individuals served by each hospital.

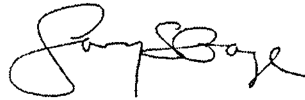
Finally, NAPH requests that CMS revise ambiguous language and correct technical errors in the preamble and Proposed Rule as detailed in the attached comments.

Overall, NAPH is concerned that the new Proposed Rule and accompanying preamble in many areas go far beyond the procedural aspects of reporting and auditing to interpret, often for the first time, underlying substantive requirements of the hospital-specific DSH limit. These policy interpretations go far beyond Congress' direction in the MMA, which focused solely on auditing and reporting requirements. The Proposed Rule is therefore very significant and will, in many cases, have a direct financial impact on hospitals' DSH payments. The DSH program, over the

years, has become the "lifeblood" for many safety net hospitals such as the members of NAPH who provide essential access to healthcare for the poor and uninsured. Policy changes in this program, particularly changes with significant economic impacts, directly affect their ability to provide this access.

NAPH appreciates the opportunity to submit these comments on the Proposed Rule regarding DSH reporting and auditing requirements. If you have any questions about these comments, please contact NAPH counsel Charles Luband, Barbara Eyman or Allison Orris at (202) 347-0066.

Sincerely,



Larry S. Gage
President

cc: Dennis Smith
Jimmy Wickcliffe, CMS Office of Strategic Operations and Regulatory Affairs
Katherine Astrich, Office of Information and Regulatory Affairs, OMB

Attachment

NATIONAL ASSOCIATION of PUBLIC HOSPITALS and HEALTH SYSTEMS
1301 PENNSYLVANIA AVENUE, NW, SUITE 950, WASHINGTON DC 20004 | 202.585.0100 | FAX 202.585.0101

COMMENTS ON PROPOSED RULE REGARDING DISPROPORTIONATE SHARE HOSPITAL REPORTING AND AUDIT REQUIREMENTS

Ref: CMS-2198-P – Medicaid Program; Disproportionate Share Hospital Payments; Proposed Rule (70 Fed. Reg. 50262 (Aug. 26, 2005))

I. THE PROPOSED RULE IMPOSES NEW SUBSTANTIVE REQUIREMENTS ON HOSPITALS

NAPH is concerned that the preamble to the Proposed Rule contains a number of new substantive interpretations of longstanding Medicaid DSH requirements, which go beyond Congressional intent in the MMA reporting language. For example the preamble indicates that physician service costs must be excluded from the hospital-specific DSH cap calculation and requires that DSH payments be reconciled against actual audited uncompensated care costs in that same state fiscal year. These are requirements that have never been announced in regulations or any other official guidance issued by CMS. The Proposed Rule therefore requires much more than mere reporting and auditing of programs as they currently exist. In many cases they will require restructuring of state DSH programs to conform to the newly announced standards.

A. *Reporting and Audit Requirements*: Prospective Application of Substantive Changes

In general, the retroactive application of regulations is disfavored, and this regulation should not be an exception. Moreover, states will not be able to implement new substantive requirements in years that have already passed. CMS has already delayed implementation beyond the date specified in Section 1001 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), which requires the Secretary of HHS to impose reporting and audit requirements beginning in fiscal year 2004. Given the delay in CMS' issuance of the regulation, it should not be effective until the first SFY that begins after the date the final rule is issued.

New substantive requirements contained in the preamble of the Proposed Rule and in the regulatory language are especially troublesome because the Proposed Rule would make the reporting and auditing requirements effective beginning with state fiscal year (SFY) 2005, which for many states has already ended.[1] It will be difficult, if not impossible, for states to retroactively identify data that CMS is now requesting. CMS has never issued regulations implementing the hospital-specific DSH limits adopted by Congress over a decade ago. To the extent that CMS retains substantive changes to DSH policy in this regulation, CMS should acknowledge that this regulation does more than merely implement reporting and auditing requirements against existing standards.

CMS should eliminate the substantive new policy interpretations imbedded in the Proposed Rule and preamble, and make the regulation effective in the first SFY beginning after the date of the final rule.

[1] 70 Fed. Reg. 50262 (Aug. 26, 2005) at 50267 (proposed 42 C.F.R. 447.299(c)) and 50268 (proposed 42 C.F.R. 455.204(b)).

B. *Reporting Requirements*: Calculation of the DSH-cap and Section 1011 Payments

The preamble to the Proposed Rule includes a comment regarding the interaction between DSH payments and MMA Section 1011 payments, which reimburse costs associated with emergency services provided to undocumented immigrants. Although the Proposed Rule notes that Section 1011 payments should not impact DSH payments for hospitals that have not reached their DSH caps, the preamble asserts that states "will need to consider a Section 1011 payment when determining the hospital's DSH limit, because the total DSH payments should not exceed the total amount of uncompensated care at the hospital."[2]

There is no legal basis for this interpretation. The statutory provision establishing the hospital-specific DSH limit specifies that the limit is equal to the costs of care provided to Medicaid or uninsured persons "net of payments under this title [Medicaid], other than under this section [Medicaid DSH], and by uninsured patients."[3] The statute specifies the revenues that are to be offset against costs and includes only non-DSH Medicaid revenues or payments ***by uninsured patients***. Section 1011 payments are neither Medicaid payments nor payments by uninsured patients and thus CMS does not have the authority to require states to reduce DSH limits by the amount of Section 1011 payments. Moreover, the offset undermines Congress' intent in enacting Section 1011 to provide new rather than substitute resources for hospitals providing large volumes of uncompensated care to undocumented immigrants.

CMS does not have the legal authority to require states to offset uncompensated Medicaid and uninsured costs by any Section 1011 payments received. NAPH requests that CMS clarify that Section 1011 payments do not factor into the calculation of the hospital-specific DSH limit regardless of whether a hospital is at or near its DSH cap. If CMS continues to assert that states should consider Section 1011 payments when determining the hospital's DSH limit, please provide the statutory basis for this requirement.

C. *Audit Requirements*: Inclusion of Physician Costs in Calculation of Uncompensated Care Costs (42 C.F.R. 455.204(c)(3))

NAPH objects to language in the preamble to the Proposed Rule that suggests that a hospital's physician costs cannot be included in the uncompensated care cost (UCC) calculation.[4] This language appears to be announcing a new standard that is not currently embodied in law, regulation or guidance and that is likely to produce substantial confusion.

The Proposed Rule requires states to verify that "only uncompensated care costs of providing inpatient and outpatient hospital services to Medicaid eligible individuals and uninsured individuals are included in the hospital-specific DSH payment limit."[5] In the preamble language describing this requirement, CMS takes the opportunity to state that "The uncompensated care

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[2] *Id.* at 50264.
[3] 42 U.S.C. §1396r-4(g)(1)(A).
[4] Although in this comment letter we adopt CMS' use of the term uncompensated care cost (UCC) in describing the hospital-specific DSH limit in 42 U.S.C. §1396r-4(g)(1)(A), see our discussion at Section III.E. regarding the appropriateness of this term.
[5] 70 Fed. Reg. at 50268 (proposed 42 C.F.R. 455.204(c)(3)).

costs of providing physician services cannot be included in the calculation of [the] hospital-specific DSH limit."[6] The regulatory language is silent on this issue.

This preamble is the first time CMS has stated that a hospital's physician costs cannot be included in the UCC calculation. In fact, in correspondence with at least one state Medicaid agency, CMS has purported to explain the conditions under which physician services ***could*** be included as a component of hospital services, and thus included in the hospital-specific limit.[7] States have previously relied on the description of "cost of services" contained in a 1994 letter to State Medicaid Directors, which stated that CMS "would permit the State to use the definition of allowable costs in its State plan, or any other definition, as long as the costs determined under such a definition do not exceed the amounts that would be allowable under the Medicare principles of cost reimbursement."[8]

In addition, CMS' regulatory definitions of inpatient services and outpatient services allow for inclusion of physician services. Inpatient hospital services are defined as services "furnished under the direction of a physician or dentist."[9] Outpatient hospital services are defined as services furnished "by or under the direction of a physician or dentist."[10] Although physician services are a separately defined service under the regulations, this separate definition does not mean that the two are mutually exclusive, just as the cost of prescription drugs administered to an inpatient or lab and x-ray services provided to an inpatient are allowable hospital costs.

Several states have permitted the inclusion of physician costs related to hospital services in the calculation of the hospital-specific limit. This position is logical, particularly with regard to uninsured patients, as many hospitals must compensate physicians for providing indigent care hospital services in order to ensure that the hospital services are available. Thus, without incurring costs for physicians providing care to the uninsured, hospitals would be unable to provide hospital services to this underserved population. Particularly for hospitals that serve a disproportionate share of low-income patients, hospital services would not be available without payments by the hospital to physicians.

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[6] *Id.* at 50265.

[7] *See, e.g.*, Letter to Ben Bearden, Director, Bureau of Health Services Financing, Louisiana Department of Health and Hospitals, from Andrew Frederickson, Dallas Regional Office Chief, Medicaid Operations and Financial Management Branch, CMS Division of Medicaid and State Operations, July 20, 2001. ("Therefore, to the extent that the State recognizes the provisions (sic) of direct patient services by physicians, CRNAs, and other mid-level practitioners as hospital services, the State may include the associated costs in the determination of the hospital specific limits."); Letter to Ben Bearden, Director, Bureau of Health Services Financing, Louisiana Department of Health and Hospitals, from Bill Brooks, Dallas Regional Office Chief, Financial and Programs Operation Branch, CMS Division of Medicaid and State Operations, May 21, 2003 ("Under [certain described] circumstances, these services would not be considered a physician service but rather would be part of the outpatient hospital service. Therefore, the uncompensated cost of these services could be included in the hospital-specific DSH limit."). Although NAPH does not acknowledge any validity in Medicaid law for the limitations CMS set forth in this correspondence, the correspondence nevertheless demonstrates CMS' acknowledgement of physician services as an element of hospitals' uncompensated care costs.

[8] Letter to State Medicaid Directors from Sally Richardson, Director, Center for Medicaid and State Operations, Health Care Financing Administration, Aug. 17, 1994.

[9] 42 C.F.R. §440.10(a)(2).

[10] 42 C.F.R. §440.20(a)(2).

CMS' position is not dictated by the statutory language. Further, CMS' interpretation conflicts with sound underlying policy justifications for allowing inclusion of these costs.

CMS should retract the statement in the preamble that the uncompensated care costs of providing physician services cannot be included in the calculation of the hospital-specific DSH limit. CMS should also reaffirm states' discretion to define costs for the purposes of the hospital-specific DSH limit, as described in CMS' 1994 letter to State Medicaid Directors.

D. *Reporting Requirements:* Definition of Uncompensated Care Costs (42 C.F.R. 447.299(c)(15))

The definition of "uncompensated care costs" provided in the preamble to the Proposed Rule and in the proposed regulatory text contains the statement that "[u]ncompensated care costs do not include bad debt or payer discounts."[11] This statement is inconsistent with the statutory language, which includes all costs related to Medicaid patients and individuals who "have no health insurance (or other source of third party coverage)."[12] If a patient does not have health insurance, the costs of services provided to that patient may be included, even if revenues related to that patient are uncollectible and eventually written off as bad debt. The touchstone for purposes of the DSH limit is whether the individual has third party coverage, not whether the hospital has or has not treated the patient's account as bad debt. The current language excluding bad debt is misleading and should be clarified or eliminated.

In addition, in a 1994 State Medicaid Director's Letter, CMS clarified that "it would be permissible for states to include in this definition [of uncompensated care costs] individuals who do not possess health insurance which would apply to the service for which the individual sought treatment."[13] This clarification should be reiterated in the Proposed Rule and applied to patients with insurance policies with high deductibles as well as those with exclusions, limits, etc. The uncompensated care costs of underinsured patients are equally as taxing on hospitals as costs associated with uninsured patients. In addition, any unreimbursed costs for services to patients with health savings accounts but no insurance coverage for the services provided should also be included, as these individuals also do not possess third party coverage.

CMS should eliminate the reference to bad debt in proposed 42 C.F.R. 447.299(c)(15) and clarify that uncompensated care costs include costs of services to insured patients whose policies do not cover the particular services provided by the hospital due to exclusions, limits, deductibles or otherwise and to patients with health savings accounts but no other source of third party coverage for the service.

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[11] 70 Fed. Reg. at 50268 (proposed 42 C.F.R. 447.299(c)(15)).
[12] 42 U.S.C. § 1396r-4(g)(1)(A).
[13] Letter to State Medicaid Directors from Sally Richardson, Director, Center for Medicaid and State Operations, Health Care Financing Administration, Aug. 17, 1994.

II. THE PROPOSED RULE WILL SUBJECT HOSPITALS TO BURDENSOME REQUIREMENTS

The Proposed Rule directly increases states' reporting requirements which will consequentially result in an increase in information state Medicaid programs will require from hospitals. In addition, the audit requirement will require auditors to conduct detailed reviews of hospital financial information, all of which is already reviewed by hospital auditors. The costs of compliance with these substantial new burdens (including those resulting from the new substantive requirements discussed above) could be significant for hospitals and NAPH urges CMS to avoid requiring states to report data that hospitals do not currently collect.

A. *Audit Requirements:* Same Year Actual Costs (42 C.F.R. 455.204(c)(2))

To verify that DSH payments comply with the hospital-specific DSH limit, audit verification requirement #2 requires that "for each audited SFY, the DSH payments made in that audited SFY must be measured against the actual uncompensated care cost in that same audited SFY."[14] It would be impossible for a state to know what the "actual uncompensated care costs in that same audited SFY" are before or during the year that the DSH payments are being made. In fact, in order to ensure that DSH payments do not exceed such actual audited costs, the state would have to undertake a reconciliation of DSH payments several months or years after the payments are made and audits have been completed.

CMS has never before required such a reconciliation and has instead allowed states flexibility to use estimates of current year uncompensated costs.[15] Moreover, CMS has approved several State Plan Amendments (SPAs) that provide for final DSH payments to be disbursed during or shortly after the current fiscal year. The Proposed Rule is introducing a substantive change in policy that will impose a massive new administrative burden on states and hospitals.

The imposition of such an administrative burden would divert scarce state and hospital resources from other productive activities to achieve at best only marginal gains in accuracy of the UCC calculation. To the extent that reliance on estimated costs based on prior year data may result in payments that are more or less than actual costs determined through subsequent audits, those variances will be accounted for in future year UCC computations. For example, using a prospective methodology, if an FY 2006 DSH payment to a hospital is based on FY 2004 costs, and the actual FY 2006 costs are subsequently determined, through an audit, to be significantly lower than the FY 2004 costs on which the FY 2006 DSH payments were based, the difference will be made up in the hospital's FY 2008 DSH payment (since the 2008 payment will be based on audited FY 2006 costs). Conversely, if the hospital's FY 2006 actual costs are subsequently determined to be significantly higher than the projected costs, the hospital will be permitted to receive higher DSH payments in FY 2008. Rather than requiring a reconciliation of the FY 2006 DSH payments in FY 2008, the same end could be achieved by basing FY 2008 payments on the FY 2006 data. Moreover, the financial exposure for the federal government through the use of estimated rather than reconciled data is not significant as total DSH expenditures are limited by

[14] 70 Fed. Reg. at 50265 and 50268 (proposed 42 C.F.R. 455.204(c)(2)).
[15] *See, e.g.*, Letter to Donna Checkett, Chair, State Medicaid Directors Association, from Sally Richardson, Director, Medicaid Bureau, Health Care Financing Administration, Jan. 10, 1995.

the statewide DSH allotment. The benefit obtained through the reconciliation mandate is therefore far outweighed by its costs.

Moreover, the statute does not require the interpretation CMS proposes to adopt. The statute provides that a DSH payment adjustment "during a fiscal year" is considered non-compliant with the limit if the adjustment exceeds the uncompensated costs for Medicaid and uninsured patients incurred "during the year."[16] CMS appears to be basing this burdensome reconciliation requirement solely on this language. While the provision does limit current year payments to current year costs, nothing in the language mandates the use of actual audited costs. Reliable estimates based on audited prior year data will, as noted above, produce sufficient controls on the DSH payments and fulfill Congress' intent of limiting DSH expenditures on a hospital-specific basis. Particularly at this time when Congress and the Administration are intently focused on reining in Medicaid expenditures, CMS should not impose unnecessary administrative burdens that will raise costs for states and hospitals (that ultimately will be shared by the federal government) that result neither in improved quality or access nor in any measurable gain in accuracy or efficiency. The requirement elevates bureaucratic form over substance and should be removed.

CMS should clarify the preamble description and amend the language in proposed 42 C.F.R. 455.204(c)(2) to eliminate the requirement that DSH payments made in any audited SFY must be measured against the actual uncompensated care cost in that same audited SFY. The regulation should continue to permit states to rely on reasonable prospective methodologies for determining UCC in a given year.

B. *Reporting Requirements*: Unduplicated Patient Count of Medicaid Eligible and Uninsured Individuals (42 C.F.R. 447.299(c)(16))

NAPH is concerned with the burden of requiring states to indicate for each DSH hospital an unduplicated count of Medicaid eligible and uninsured individuals.[17] Although most of the reporting items bear some relation to existing DSH requirements, either in terms of eligibility for DSH or in terms of the hospital-specific DSH cap, the requirement that states indicate for each hospital an unduplicated count of Medicaid eligible and uninsured patients does not appear to bear any relation to any DSH requirement. Not all hospitals collect this information and for some it may be burdensome to begin collecting it. Further, these data may be misleading or difficult to interpret—for example, how would a hospital classify individuals who had Medicaid coverage for some discharges and no insurance for others? Focusing resources on addressing these reporting issues is of questionable value when the data have no bearing on payment or other requirements. Because there is no clear relationship between the DSH program and these data, and because it may impose a substantial burden on hospitals, NAPH requests that this data element be removed from the reporting requirements.

CMS should remove the requirement in 42 C.F.R. 447.299(c)(16) that states indicate for each hospital an unduplicated count of Medicaid eligible and uninsured individuals.

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[16] 42 U.S.C. § 1396r-4(g)(1)(A).
[17] 70 Fed. Reg. at 50268 (proposed 42 C.F.R. 447.299(c)(16)).

C. *Regulatory Impact Statement and Collection of Information Requirements:* Burden on Small Entities

Given all of the additional burdens imposed on hospitals articulated in these comments, we strongly disagree with CMS' conclusions in its Regulatory Impact Statement. Executive Order 12866 requires agencies to prepare a regulatory impact analysis for major rules with economically significant effects. For rules that will have a significant economic impact, the Regulatory Flexibility Act (RFA) requires CMS to analyze options for regulatory relief of small businesses, such as hospitals. The newly announced DSH requirements contained in the Proposed Rule and discussed throughout this comment letter may result in decreased DSH funding for some hospitals, jeopardizing their ability to provide broad access to services for the uninsured and underinsured. In addition to the costs of compliance with new reporting requirements and the associated loss of DSH funding, the cost of auditing each DSH hospital's records to satisfy the new audit requirements will be substantial and could very well exceed $100 million annually, thus reaching the economic threshold that triggers a regulatory impact analysis (RIA) under Executive Order 12866. Similarly, NAPH objects to CMS' conclusion that because the Proposed Rule "would not have a significant economic impact on a substantial number of small entities" the agency did not need to conduct a regulatory flexibility analysis under the RFA.[18] NAPH urges CMS to revise the regulation to reduce the economic impact on hospitals as recommended elsewhere in these comments so that CMS' conclusion that there is no such impact will be accurate. Absent such revisions, however, CMS should reconsider its conclusion that the regulation would not have a significant economic impact and should undertake appropriate analyses under Executive Order 12866 and the RFA to consider how the burden on hospitals could be lessened.

Pursuant to the Paperwork Reduction Act (PRA) of 1995, CMS has solicited comments regarding the information collection burden, clarity of information collected and recommendations to minimize the information collection burden. As explained in detail throughout these comments, NAPH believes that the information collection burden is significant, that in many cases the information requested is ambiguous or inaccurate and that there are better ways to implement the statutory requirements. Therefore, NAPH is also providing copies of these comments to the CMS Office of Strategic Operations and Regulatory Affairs and to the Office of Management and Budget's Office of Information and Regulatory Affairs. We note further that while collection activities in response to audit requirements are exempt from the Paperwork Reduction Act, CMS should acknowledge that the new substantive requirements that it is announcing in the form of audit standards will impose independent new paperwork burdens on states separate and apart from the response to the audits. For example, CMS' proposal that the audits verify that DSH payments do not exceed actual year costs will impose a massive new DSH reconciliation requirement on states so that the audits do not conclude that they have exceeded the hospital-specific DSH limits. Therefore, we believe CMS should evaluate the paperwork burden associated with new standards announced as part of the audit requirements as well as the reporting requirements.

Absent significant revisions of the Proposed Rule, NAPH suggests that CMS reconsider the economic and paperwork impact that the Proposed Rule will have on hospitals.

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[18] 70 Fed. Reg. at 50267.

III. THE PROPOSED RULE INCLUDES AMBIGUOUS LANGUAGE AND TECHNICAL ERRORS

A number of the reporting requirements are ambiguously worded or contain technical errors. NAPH requests that the following items be clarified to facilitate implementation of the DSH reporting and audit requirements.

A. *Reporting and Audit Requirements*: Application to States with DSH Waivers

Some states have received waivers of DSH requirements under Section 1115 of the Social Security Act. For example, Massachusetts recently received such a waiver pursuant to which it is establishing a Safety Net Care Pool that combines DSH and other Medicaid payments. CMS should clarify that the reporting and audit requirements do not apply to states that no longer have traditional DSH programs subject to the limitations under Section 1923(g).

NAPH requests that CMS clarify that the proposed DSH reporting and audit requirements do not apply to states with DSH waivers.

B. *Audit Requirements*: Verification that States Have Reduced their Uncompensated Care Costs (42 C.F.R. 455.204(c)(1))

The language used to describe the first verification requirement is unnecessarily confusing and may therefore make compliance difficult. Verification #1 requires that a state's audit report verify that each hospital receiving DSH payments "has reduced its uncompensated care costs for furnishing inpatient hospital and outpatient hospital services during the SFY to Medicaid eligible individuals and individuals with no source of third party coverage for the services in order to reflect the total amount of claimed DSH expenditures."[19] Uncompensated care costs, as defined in the DSH statute, are the costs of serving Medicaid and uninsured patients "net of payments under this title [Medicaid], other than under this section [DSH], and by uninsured patients."[20] By definition, therefore, uncompensated care costs are not offset by DSH payments. The first verification requirement directs hospitals to reduce UCC by claimed DSH expenditures and therefore is contrary to the statutory language.

NAPH recognizes that CMS likely based its formulation of the verification requirement on the statutory language, which contains similarly confusing terminology, requiring the audit to verify "the extent to which hospitals in the State have reduced their uncompensated care costs to reflect the total amount of claimed expenditures made under [the Medicaid DSH statute]."[21] It would be helpful if CMS would take the opportunity in this regulation to provide clarification of Congress' likely intent in adopting this provision. Specifically, we suggest that a more useful interpretation of this statutory language would be to require verification that DSH payments have not exceeded uncompensated care costs. This approach appears to conform to CMS' interpretation in the preamble.

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[19] *Id.* at 50268 (proposed 42 C.F.R. 455.204(c)(1)).
[20] 42 U.S.C. §1396r-4(g)(1)(A).
[21] 42 U.S.C. § 1396r-4(j)(2)(A).

NAPH suggests that CMS reword proposed 42 C.F.R. 455.204(c)(1) to require that the total amount of claimed DSH expenditures for each hospital that qualifies for a DSH payment in the State is no more than the hospital's uncompensated care costs.

C. *Reporting Requirements*: Supplemental/Enhanced Medicaid Payments (42 C.F.R. 447.299(c)(11))

The Proposed Rule requires states to report the "total annual amount of supplemental/enhanced Medicaid payments made to the hospital by the State for inpatient and outpatient hospital services furnished to Medicaid eligible individuals."[22] The Medicaid statute and regulations do not use the phrase "supplemental Medicaid payments" or "enhanced Medicaid payments." The Proposed Rule does not provide much guidance (in either the preamble or the regulation text) regarding the scope of these payments, other than to state that these payments do not include "DSH payments, regular Medicaid rate payments, and managed care organization payments."[23]

NAPH suggests that CMS explicitly state that it will defer to states with regard to what payments are categorized as supplemental/enhanced Medicaid payments or other Medicaid payments, so long as all Medicaid payments are captured in the listed categories.

D. *Reporting Requirements*: Total Cost of Care and Uncompensated Care Costs (42 C.F.R. 447.299(c)(14),(15))

The Proposed Rule indicates (in both the preamble and the regulatory language) that states should report "***separately***"[24] the "total annual cost" or the "total annual amount of uncompensated care costs," respectively, "for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals and to individuals with no source of third party coverage for the hospital services they receive." It is unclear what the word ***separately*** is referring to in this context. Theoretically, CMS could intend states to report four cost items for each hospital (i.e. cost for inpatient service for Medicaid patients, cost for outpatient services for Medicaid patients, cost for inpatient service for uninsured patients, cost for outpatient services for uninsured patients), or only one. The accompanying Excel spreadsheet indicates that only one combined item is intended. CMS should clarify this intent in the regulatory and preamble language.

NAPH recommends that the word "separately" be removed from 42 C.F.R. 447.299(c)(14) and 42 C.F.R. 447.299(c)(15) and that CMS clarify that only one data item must be reported for both "total cost of care" and "uncompensated care costs."

E. *Reporting and Audit Requirements*: Uncompensated Care Costs

CMS' use of the term "uncompensated care costs" throughout the regulation and preamble may be confusing because the hospital industry generally uses the same term to mean the combined costs related to charity care and bad debt for all patients (not limited to uninsured patients).[25] CMS intends a more limited use of the term in this regulation that would be restricted to UCC associated

[22] 70 Fed. Reg. at 50267 (proposed 42 C.F.R. 447.299(c)(11)).
[23] *Id.* at 50267.
[24] *Id.* at 50268 (proposed 42 C.F.R. 447.299(c)(14),(15)).
[25] *See, e.g.,* American Hospital Association, "Uncompensated Hospital Care Cost Fact Sheet," Feb. 2003.

with Medicaid and uninsured patients. To better facilitate hospital compliance, NAPH recommends that CMS use a different term, such as "uncompensated Medicaid and uninsured costs."

CMS should not use the term "uncompensated care costs" to refer to uncompensated costs associated only with Medicaid and uninsured patients.

F. *Audit Requirements:* Use of Local Funding (42 C.F.R. 455.204(c)(1))

In explaining audit verification requirement #1, the preamble to the Proposed Rule states that "Obligations of the qualifying DSH hospital to fund the non-Federal share of a DSH payment or any other Medicaid payment cannot be included as uncompensated care for purposes of the hospital-specific DSH limit."[26]

NAPH understands the intention of Verification #1 to clarify that amounts transferred or certified (through intergovernmental transfers (IGTs) or certified public expenditures (CPEs)) can not be claimed as an uncompensated care cost for purposes of determining the hospital-specific DSH limit. However, the language included in the preamble is so broad (i.e., "obligations of the qualifying DSH hospital") that it could wrongly be interpreted to bar the cost of provider taxes as well as IGTs and CPEs from the uncompensated care cost calculation. Medicare guidance clearly indicates that provider taxes are allowable costs.[27] If providers include these costs on the Medicare cost report, they will necessarily be included in the calculation of cost-to-charge ratios that are used to compute uncompensated care and Medicaid costs and will therefore impact the hospital-specific DSH cap. Including provider tax costs in uncompensated care costs is appropriate.

NAPH requests that CMS clarify that provider taxes are costs that may be included in a hospital's calculation of its uncompensated care costs.

G. *Reporting Requirements:* Disproportionate Share Hospital Payments (42 C.F.R. 447.299(c)(8))

In requesting information about DSH payments, CMS inappropriately requests information regarding payments made "under section 1923(g) of the Act."[28] Section 1923(g) describes limits on DSH payments. The payments are actually made pursuant to section 1923(a).

NAPH suggests that CMS rephrase the language in 42 C.F.R. 447.299(c)(8) to read "under section 1923(a) of the Act."

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[26] 70 Fed. Reg. at 50565.
[27] *See* Medicare Provider Manual, Section 2122.
[28] 70 Fed. Reg. at 50267.

8

State of New Hampshire

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JOHN A. STEPHEN
COMMISSIONER

October 25, 2005

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-2198-P
P. O. Box 8010
Baltimore, MD 21244-1850

Re: CMS-2198-P Medicaid Program; Disproportionate Share Hospital Payments; Proposed Rule

Dear Sir/Madam:

The State of New Hampshire Department of Health and Human Services appreciates the opportunity to submit comments on CMS-2198-P-Proposed Rule regarding Disproportionate Share Hospital (DSH) payments. New Hampshire has 29 inpatient facilities that participate in the Disproportionate Share Hospital Payment Program. We believe that the proposed rule places inordinate reporting and auditing requirements on the State and hospitals, as follows:

1. The proposed rules significantly increase reporting requirements. Currently, New Hampshire is limited by the timeframes for which some of the requested data is available and by the fact that the numbers within the calculations would come from varying sources. Further, whether the State uses its own resources to produce the data or opts to require the hospitals to report the required data carries certain disadvantages.

   a. Currently, there is no one source of data to meet the increased reporting requirements. The sources of data are from various data warehouses and under various State and hospital management systems. The likelihood that data will not be from consistent data sets is possible.

   b. Some of these data elements are not available within the specified timeframes. While Medicaid related data is readily available directly to the State, data regarding Medicare payments and discharges and non-Medicaid/non-Medicare data is not readily available to the State in efficient formats and timeframes required by the proposed rule.

   c. Data warehouses that include some of the data required by the proposed rule, such as discharges and total hospital compensation are currently under development in the State of New Hampshire. Reports need be designed for this reporting purpose, presumably at the state's expense.

   d. An option available to the state is to require the hospitals receiving a DSH payment to provide the data. However, hospitals will likely deem this to be an extraordinarily burdensome reporting requirement.

e. The proposed rule indicates a spreadsheet has been prepared for use to states for uniformity of reporting to CMS. To date, the spreadsheet is not available for review and comment.

f. Section 447.299 estimates 30 minutes per hospital to gather, accumulate, prepare, review, and submit this required information. New Hampshire considers this estimate to be grossly understated, and anticipates the report to be a significant administrative event, which doubles the management of the New Hampshire DSH program.

2. 455.204(a) and (b): There are significant issues posed by an effective date of audit beginning with state fiscal year 2005. As noted previously, many of the data elements are new and may be unavailable or require onerous obligation on those responsible for accumulating accurate and auditable information. We urge a prospective application of these requirements effective for the first state fiscal year that begins after the date of the final rule is issued, to allow sufficient time for respondents to identify data being required and processes to accumulate such data.

3. 455:201 Rules related to the independent certified audit also pose questions and issues.

   a. The rule states that the audit must be independent and certified. Does this presume that a certified public accountant or comparable professional must perform the audit or is the State allowed to engage the services of a contractor with different skill sets as long as the auditor is independent?

   b. 455:204(c)(1) The auditor is to verify, among other items, "the extent to which hospitals in the State have reduced their uncompensated care costs to reflect the total amount of claimed expenditures" and what costs are included in the uncompensated care. This presumes that the auditor has valid and audited base year figures upon which to compare the reduction. Some auditors may find that base year figures cannot be verified to the extent necessary to provide a valid base because data or audit trails not previously necessary, are now required.

   c. 455.204(c)(2) The rules requires the auditor to verify "for each audited SFY, the DSH payments made in that audited SFY must be measured against the actual uncompensated care cost in that same audited SFY." This would be impossible for the State as current year DSH payments are not made based on uncompensated care costs in the same year but based on the immediate prior year financial data available from the hospitals. As such, this requirement will pose unnecessary administrative burdens to both the hospitals and the state resulting in increased costs outweighing the benefit of the reconciliation mandate.

   d. The rule requires the auditor to verify payments and types of costs included. Most professional auditors will only render an opinion that they have applied standard auditing procedures and believe the figures are fairly presented. Does this level of assurance rise to the intention of the rule to "verify" the information? If so, then the auditing profession will have to develop "standard audit procedures" that are acknowledged by CMS and the States as being adequate.

e. The auditing requirements are also costly to both the hospitals and the State. The following specific comments supplement the comments submitted by the Audit Division of the New Hampshire Office of Legislative Budget Assistant.

   1) The increased audit requirements contained in Section .215 or A-133 require an independent auditor perform an audit, presumably at the State's expense.

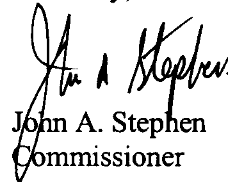
   2) The audit requirements are an additional burden to hospitals, creating another source of disincentive to hospital participation.

   3) The State of New Hampshire has invested an increasing amount of time and expense managing federal audits. One pertinent example is that Office of Inspector General has been in New Hampshire conducting a DSH audit since April 2005, spending up to 4 weeks at each hospital.

The DSH program has allowed New Hampshire hospitals to extend access to healthcare for many poor and uninsured individuals in New Hampshire. The new requirements include significant administrative expenses and responsibilities to both the State of New Hampshire and its hospitals. The New Hampshire Department of Health and Human Services is concerned that a likely outcome will be that hospitals decline to participate in the DSH program, resulting in a decline in the delivery of healthcare services to the uninsured citizens of New Hampshire.

The New Hampshire Department of Health and Human Services appreciates the opportunity to submit these comments on the Proposed Rule regarding DSH reporting and auditing requirements. If you have any questions about these comments, please contact James Fredyma, Controller, at 603-271-4333.

Sincerely,



John A. Stephen
Commissioner

(Submitted electronically to www.cms.hhs.gov/regulations/ecomments)

9

Jim Doyle
Governor

Helene Nelson
Secretary

State of Wisconsin

Department of Health and Family Services

DIVISION OF HEALTH CARE FINANCING

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October 25, 2005

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2198-P
P.O. Box 8010
Baltimore, MD 21244-1850

RE: CMS-2198-P

To Whom It Concerns:

The Wisconsin Medicaid agency submits the following comments on proposed regulations CMS-2198-P which were published August 26, 2005.

III. Provisions of the Proposed Regulations
B. Audit Requirements, Verification 3
Exclusion of Physician Services from Allowable Hospital Costs

Costs of provider based physician services for uninsured individuals should be allowed and offset with any payments the hospital receives from the uninsured individuals for the physician services.

Hospitals may incur physician costs for serving uninsured patients. This can especially occur through the treatment of uninsured persons in emergency rooms and under EMTALA requirements. We do not see that Medicaid regulations preclude a state Medicaid program from covering services of provider based physicians as part of its hospital reimbursement. Thus, physician services should be allowed as an inpatient and outpatient hospital cost for uninsured patients when the hospital incurs the physician fee or salary costs.

42 CFR 447.299(c)(16), ***Medicaid eligible and uninsured individuals***

The reporting of the unduplicated count of Medicaid and uninsured individuals should not be required.

Proposed 42 CFR 447.229(c)(16) requires the reporting of an unduplicated count of Medicaid recipients and uninsured persons receiving inpatient and outpatient hospital services.

First, the acquiring of an unduplicated count of uninsured individuals will place a new and additional information collection burden on hospitals. A state agency does not likely have detail claims or service histories of such patients and must rely on the hospital to accumulate this information.

Secondly, for a state Medicaid agency, this is also a new information collection requirement in that it asks for unduplicated counts of Medicaid recipients receiving hospital services for each specific DSH hospital. This added data is not readily available and for some Medicaid agencies may not be available without significant cost. This added cost should be taken into consideration in the regulatory impact estimates.

Finally, it is questionable how this data serves to "ensure the appropriateness of the [DSH] payment adjustments" as is called-for in the MMA.

Proposed 42 CFR 455.204(b) ***Timing***

Eighteen months should be allowed for submission of the proposed audit.

We do not consider one year after the completion of the state's fiscal year as sufficient to gather the necessary information from hospitals, calculate the required cost finding for Medicaid patients and uninsured patients, and get the required audit completed. Eighteen months would be more reasonable.

Proposed 42 CFR 455.204(c) ***Specific Requirements***
Use of State Fiscal Year

The computation, reporting and auditing of a state's compliance with the uncompensated care cost (UCC) test should be for the period of each DSH hospital's fiscal year, not the fiscal year of the state as is apparently proposed.

The proposed regulations at 42 CFR 455.204(c)(1) and (2) appear to require the period of a state's fiscal year as the annual time period for which a state is to calculate the uncompensated care (UCC) test. Paragraph (1) calls for "uncompensated care cost for furnishing inpatient hospital and outpatient services during the SFY to Medicaid eligible individuals and individuals with no source of third party coverage." Paragraph (2) similarly states, "For each audited SFY, the DSH payments made in that audited SFY must be measured against the actual uncompensated care cost in that same audited SFY."

The fiscal year of many DSH hospitals does not coincide with a state's fiscal year. This is a problem if determining "actual uncompensated care cost" will require direct matching between payments received and the costs incurred by the hospital during the period of the state's fiscal year and not the hospital's fiscal year. Hospitals will be burdened with preparing another annual cost report for an annual period that differs from its established fiscal year cost reporting period.

Many Medicaid agencies have adopted the Medicare (Title XVIII) practice of requiring a hospital cost report for the period of the hospital's established fiscal year, not the government's fiscal year. In addition, many states actually use the Medicare cost report, its cost finding calculations, and its available schedules for separately identifying and reporting the cost incurred by the hospital for Medicaid (Title XIX) recipient services.

Are hospitals now going to have to prepare another cost report for an annual fiscal period that differs from its fiscal year? From the Department of Health and Family Services' past experience with nursing facilities, such a deviation from an organization's established fiscal year for cost reporting is inviting significant accounting errors not to mention the increased time of the hospital to prepare such paperwork.

A more practical policy would be to have the UCC test be based on each hospital's fiscal year that ends in the state's fiscal year. Since the UCC test is a hospital-by-hospital test, not a state-wide aggregate test,

we do not think use of the hospital's fiscal year would allow states to manipulate its compliance to the UCC limit. Actually, use of a hospital's fiscal year would be more reliable and provide more visibility of compliance or non-compliance.

Proposed 42 CFR 455.204(c) ***Specific Requirements***
Paragraph (1)

Clarify that DSH revenues and uncompensated care costs are to be reported in the uniform cost reports that hospitals have to file with the state Medicaid agency.

A concern in paragraph (1), separate from the use of the SFY, is the call for verifying that a hospital "has reduced its uncompensated care costs for furnishing inpatient hospital and outpatient hospital services... in order to reflect the total amount of claimed DSH expenditures." This is specifically stated in the MMA as a required action. However, the proposed regulation does not clarify the object of its application. We believe it simply means that, in some manner, the hospital is to identify DSH revenue and offset such revenue against the uncompensated cost of services provided Medicaid patients and uninsured patients in the uniform cost reports that hospitals are to file with the state Medicaid agency under 42 CFR 447.253(f).

Proposed 42 CFR 455.204(c) ***Specific Requirements***
Paragraph (4), Inclusion of Managed Care Organizations

Managed care organizations should not be included in the UCC limit test because states do not set the MCOs' level of payments to hospitals.

Paragraph (4) in essence describes the UCC limit. The proposed regulations require the inclusion of the payments managed care organizations (MCO) made to DSH hospitals and the respective cost of those services. An MCO's payment to a hospital is not controlled by the state Medicaid agency. It is the MCO paying the hospital at a level of payment to which it and the hospital have agreed, not the state Medicaid program setting the level of payment and making the payment. However, the proposed regulations place the state in jeopardy of losing FFP on its DSH payments to the hospital if an MCO, at its sole discretion, is a generous payer to the hospital. Medicaid MCO services should be excluded from the UCC limit test.

Proposed 42 CFR 455.204(c) ***Specific Requirements***
Scope of Audit is Not Clear

The audit should clearly be limited to and directly associated with a state accurately preparing the required report based on data provided by hospitals and the state's Medicaid management information system.

It is not clear as the scope of the auditor's verification. States have to rely on hospitals to properly identify uninsured individuals, and to properly accumulate and record the services provided those individuals. It is the hospital reporting this data to the state and information the state has in its Medicaid information system on which the state will be able to submit the required reporting under 42 CFR 447.299. Do the specific requirements include for the audit to verify the accuracy of amounts hospitals

report to the state? This level of verification greatly expands the amount of time and cost of this regulation. The specific requirements need to clearly limit the scope of the audit to a state's compilation and calculation of the amounts that the state reports to CMS under the proposed reporting requirements.

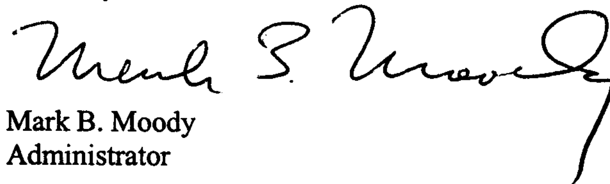
Proposed 42 CFR 447.299(7) ***Low-income utilization rate***
Proposed regulations do not conform to language of cited section 1923(b)(3)

The description of the low-income utilization rate that is proposed for reporting does not conform to the description of the low-income utilization rate as described in section 1923(b)(3) of the Social Security Act. The Act does not limit the ratio to services provided uninsured individuals. Secondly, subparagraph (B) of the Act only calls for the inclusion of "inpatient hospital services attributable to charity care."

Studies have shown that most DSH hospitals in the nation qualify for payment adjustment under the Medicaid inpatient utilization rate provisions of section 1923(b)(2) of the Act and that most hospitals do not pursue qualification under the low-income utilization provisions at 1923(b)(3). Thus, states will probably not have the data readily available for determining the ratio as described in the Act. *We would recommend only requiring states to report this low-income utilization rate if that is the sole provision of the Act under which a hospital qualifies for a DSH payment adjustment.* It should not be required if a hospital qualifies for a DSH payment under the Medicaid inpatient utilization rate provisions of the Act.

Thank you for the opportunity to comment on the proposed regulation CMS-2198-P.

Sincerely,



Mark B. Moody
Administrator

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October 21, 2005

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200 Independence Avenue, S.W.
Washington, DC 20201

Re: CMS-2198-P; Medicaid Program; Disproportionate Share Hospital Payments -- Implementing the Medicare Modernization Act of 2003 Reporting and Auditing Requirements; Proposed Rule.

Dear Dr. McClellan:

The Pickens County Medical Center appreciates the opportunity to comment on the proposed rule implementing the Medicaid Disproportionate Share Hospital (DSH) Payment reporting and auditing requirements found in the Medicare Modernization Act of 2003 (MMA). The Medicaid DSH program provides essential financial assistance to our nation's safety net hospitals. It is these hospitals that provide access to care for our nation's most vulnerable populations -- the poor, the disabled and the elderly. And they shoulder critical community services such as trauma and burn care, high-risk neonatal care, and disaster preparedness resources. The Pickens County Medical Center has numerous concerns with the proposed rule and believes the rule, as presently drafted, would have a tremendously negative impact on Medicaid DSH hospitals.

The Medicaid DSH program has operated with little written regulatory guidance since the publication of the program's initial regulations in 1992. There have been two communications to the State Medicaid Directors in 1994 and 2002 that address questions specific to the hospital specific DSH limits. Much of the current DSH policy has been forged in negotiations between the Centers on Medicare and Medicaid (CMS) and individual state governments. The absence of consistent federal policy has been a source of frustration for hospitals. Unfortunately, CMS has chosen to use this proposed rule implementing the MMA reporting and auditing requirements to establish new DSH policy. Pickens County Medical Center has four overriding concerns regarding the proposed rule:

1. the substantive changes to standard DSH policy not required by the MMA;
2. the definition of uncompensated care that excludes bad debt;
3. the retroactive application of the auditing requirements to Fiscal Year 2005; and
4. the reporting burden imposed on hospitals. AlaHA strongly urges CMS to rethink the approach adopted in this proposed rule.

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A. Reporting Requirements

Uncompensated Care (UCC) (42 C.F.R. 447.299(c)(15))

The new definition of uncompensated care to both exclude bad debt and physician services are clear examples of the agency's attempt to substantively change long standing DSH policy without properly calling for direct public comment.

Bad Debt The proposed rule, in both the preamble language and the draft regulatory language, states that uncompensated care does not include bad debt for purposes of setting the hospital specific DSH limit. This new definition of uncompensated care that excludes bad debt is not consistent with the statute, legislative history or long standing agency practice. The underlying statute (1923(g)(1)(A) permits the inclusion of the costs of services provided individuals with no health insurance or other source of third party coverage. The conference report language for the Omnibus Budget Reconciliation Act of 1993 (OBRA '93) provision, that originally established the hospital specific DSH limit, reveals Congress' intent in directing the agency on the various ways to determine the unreimbursed costs that hospitals bear. The report language states that the cost of providing services to uninsured patients would be net of any out of pocket payments received from uninsured individuals. The agency's 1994 letter to state Medicaid programs offered further guidance in the determination of unreimbursed costs by stating that the cost of services provided individuals with third party coverage, but whose third party coverage did not cover the hospital services the individual received, could be counted. The agency was clearly looking at the cost associated with the uninsured and the underinsured in implementing the hospital specific DSH limit. In 2002, the agency in its guidance to state Medicaid programs regarding the hospital specific DSH limit and the upper payment limit reaffirmed the 1994 DSH policy.

A number of state Medicaid programs include the costs of care provided uninsured individuals for which no payment is made and the costs associated with the non payment of copayments and deductibles for individuals with third party coverage in determining a hospital's qualifying costs for the hospital specific DSH limit. *(Current Medicare policy requires that hospitals seek payment from individuals with the means to pay their copayments and deductibles.)* The approaches adopted by these state Medicaid programs to establishing qualifying costs for setting the hospital specific DSH limit are consistent with the statute, legislative history, and long established agency DSH policy. A review of the legislative history of the MMA DSH reporting and auditing requirements **does not reveal** that Congress raised any concerns about how unreimbursed costs were determined for setting the hospital specific DSH limit by the agency or the individual state Medicaid programs. The explicit exclusion of bad debt from the definition of uncompensated care will be harmful to DSH hospitals that are struggling to meet the health care needs of the growing numbers of uninsured and underinsured. The recent growth of health plans that impose high deductibles or have exclusion limits as well as the growth of health savings account are putting new burdens on hospitals in terms of unreimbursed costs. Pickens County Medical Center argues that CMS' new definition of uncompensated care to exclude bad debt is inconsistent with the statute and long standing CMS DSH policy. **Pickens County Medical Center strongly recommends that CMS change its definition of uncompensated care by striking references to bad debt in 42 C.F.R. 447.299(c)(15) and in its place clarify that**

uncompensated care includes the costs of services furnished to individuals with no health care insurance, third party coverage, or third party payment and individuals with health savings accounts and includes the costs of services furnished insured individuals whose policies do not cover the services provided the individual due to their health plans exclusions, limits or deductibles.

Physician Services The preamble of the proposed rule states uncompensated care costs of physician services cannot be included in the calculation of the hospital specific DSH limit. The statute does not specifically exclude physician services. And the agency, in at least one communication to a state Medicaid program, allows for the inclusion of physician services in determining a hospital's unreimbursed costs. The costs associated with securing physicians to serve the hospital's indigent patient population are legitimate unreimbursed costs and should be allowed. The MMA does not require that CMS exclude physician services. This is another example of CMS' attempt to reach beyond MMA statutory requirements to establish new policy. **Pickens County Medical Center believes that physician costs associated with hospitals services should be included and references to excluding the physician costs in determining the hospital's uncompensated care costs in the preamble should be deleted.**

Section 1011 (Preamble)

The preamble in the proposed rule directs state Medicaid programs to consider Section 1011 payments when determining a hospital's hospital specific DSH limit. There is no statutory requirement to include Section 1011 payments when determining the hospital's uncompensated care burden. Section 1011 payments are neither Medicaid payments nor payments from uninsured patients. Congressional intent, in enacting Section 1011, was to provide new resources rather than substitute existing resources for hospitals providing large volumes of uncompensated care to undocumented immigrants. This is yet another example of CMS' attempt to reach beyond statutory authority to set new DSH policy. The consideration of Section 1011 payments would likely result in reducing needed DSH dollars to hospitals serving high numbers of uninsured undocumented immigrants. **Pickens County Medical Center recommends that CMS delete the language in the preamble that requires states to offset Section 1011 payments when establishing a hospital's DSH limit and to clarify that Section 1011 payments should not factor into the calculation of the hospital specific DSH limit regardless of the hospital is at or near its limit.**

Reporting Unduplicated Patient Count of Medicaid Eligibiles and Uninsured Individuals (42 C.F.R. 447.299 (c)(16))

State Medicaid programs are required to report for each hospital an unduplicated count of Medicaid eligible and uninsured patients. Pickens County Medical Center is concerned that states will turn to hospitals to produce these patient counts. Many hospitals do not have the reporting systems in place that would allow them to generate unduplicated counts of patients served through out the year that are Medicaid eligible or uninsured. And many questions arise in how a hospital would classify certain patients such as a patient that has Medicaid coverage for part of the year and are uninsured for part of the year. The proposed rule fails to make the case why this information is necessary. **Pickens County Medical Center believes that this**

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reporting requirement would be unnecessarily burdensome for our hospital and recommends that it be deleted.

Reporting of Indigent Care Revenue (42 C.F.R. 447.299(c)(12))

The proposed rule requires reporting of total payments received by hospitals from individuals with no source of third party coverage. Pickens County Medical Center is concerned that our hospital's current accounting systems will not allow us to match payments received from individuals to payments received for individuals for which there was no third party coverage. **This would impose an excessive reporting burden on our hospital and Pickens County Medical Center recommends that this reporting requirement be deleted.**

Reporting Total Costs (42 C.F.R. 447.299(c)(14))

The 1994 guidance to State Medicaid Directors allows a state to use the definition of allowable costs in its State Medicaid plan or any other definition as long as the costs determined under such a definition do not exceed the amounts that would be allowable under the Medicare principles of cost reimbursement. **Pickens County Medical Center believes that the proposed rule should reaffirm this definition of allowable costs to assure greater consistency across all the state Medicaid DSH programs.**

B. Auditing Requirements (42 C.F.R 455.204)

Retroactive Audit (42 C.F.R. 455.204(b))

The proposed rule retroactively applies the new reporting and auditing requirements to each state's FY 2005. Most state fiscal years for 2005 have ended. The imposition of the new and substantive reporting and auditing requirements would make it impossible for state Medicaid programs to comply because they would have to retroactively identify the requested data. While the MMA required that CMS impose reporting and auditing requirements beginning in fiscal year 2004, CMS has delayed implementation beyond the date specified in the MMA. The retroactive application of these new reporting and auditing requirements makes little sense now and will impose a hardship for state Medicaid programs as well as DSH hospitals. **Pickens County Medical Center strongly recommends that this retroactive application of the reporting and auditing requirements be deleted from the rule and that the reporting and auditing requirements be tied to the first state fiscal year beginning after the finalization of the rule.**

Same Year Actual Costs (42 C.F.R. 455.204(c))

The audit verification #2 requires that the DSH payments comply with the hospital specific DSH limit by requiring that the DSH payments made in the audited state fiscal year (SFY) have to be measured against the actual uncompensated care cost in the same audited SFY. This would require that states reconcile DSH payments to ensure such payments do not exceed actual costs. It is important to note that the MMA does not require that payments be based on actual audited costs. Current CMS DSH policy allows states to use a prospective methodology to estimate current year uncompensated care costs. This approach allows for adjustments in future years to

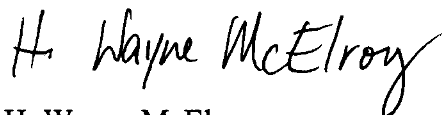
reconcile DSH payments with actual costs. The verification, through audit, of DSH payments with the same year actual uncompensated care costs will place an enormous burden on hospitals through new burdensome and costly audits as well as increase the administrative costs for each state Medicaid program. This is another example where the proposed rule substantively changes current Medicaid DHS policy. The proposed rule also does not speak to how such additional audits will be paid for and there is a concern that the state will pass on the added costs for same year audits to the DSH hospitals. The cost for hospital audits can reach $50,000 or higher per hospital. This estimate clearly suggests that the economic impact of this one audit requirement will meet the test of a major rule under the Regulatory Flexibility Act and should require a regulatory flexibility analysis for small entities such as hospitals. **Pickens County Medical Center strongly recommends that CSM delete the requirement in the preamble and the regulatory language that audited DSH payments must be measured against actual uncompensated care cost in the same audited SFY. Pickens County Medical Center recommends that CMS clarify that states be allowed to continue to use reasonable estimating methodologies to determine uncompensated care costs.**

Reduce Uncompensated Care Costs by DSH Payments (42 C.F.R. 455.204(c)(1))

The audit verification #1 requires that a state's audit report verify that each hospital receiving DSH payments has reduced its uncompensated care costs for furnishing inpatient hospital and outpatient hospital services during the SFY to Medicaid eligible individuals and individuals with no source of third party coverage for the services in order to reflect the total amount of claimed DSH expenditures. The DSH statute defines uncompensated care costs as the cost of serving Medicaid and uninsured patients net of Medicaid payments and payments made by uninsured individuals, excluding DSH payments. The statutory language is clear that uncompensated care costs are not offset by DSH payments. The first verification requirement that reduces a hospital's uncompensated care costs by claimed DSH expenditures is contrary to the statute. **Pickens County Medical Center recommends that verification #1 be changed to require that the total amount of claimed DSH expenditures for each hospital that qualifies for a DSH payment in the State is no more than the hospital's uncompensated care costs.**

Pickens County Medical Center appreciates this opportunity to comment on the proposed rule to implement the Medicaid DSH reporting and auditing requirements of the MMA. While Pickens County Medical Center has long advocated for greater transparency in the operation of the Medicaid DSH program and more consistent federal standards, the proposed rule has not achieved these goals and makes substantive policy changes that clearly exceeds Congressional intent. The Medicaid DSH program is a lifeline to many safety net hospitals across the country. The proposed rule, as presently drafted, will have a significantly negative impact on our facility.

Sincerely,



H. Wayne McElroy
Hospital Administrator

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COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
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HARRISBURG, PENNSYLVANIA 17105-2675

OCT 2 5 2005

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Mr. Jim Frizzera
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-2198-P
P.O. Box 8010
Baltimore, Maryland 21244-1850

Dear Mr. Frizzera:

RE: Comments on Proposed Rules [File Code: CMS-2198-P]

The Commonwealth of Pennsylvania, Department of Public Welfare appreciates the opportunity to comment on the proposed rules related to Disproportionate Share Hospital (DSH) Payments as set forth in the August 26, 2005, Federal Register. The Commonwealth would like to enter the following comments for CMS consideration related to the Proposed Rules in CMS-2198-P.

Comments Related to Section III. Provisions of the Proposed Regulations
A. Reporting Requirements

<u>General Comment</u>

The Proposed Rules include detailed instructions for reporting information to CMS related to DSH payments on an annual basis. The March 26, 2004, Federal Register Notice [CMS-2062-N], Section IV. Annual Reporting Requirements also contained specific reporting requirements related to DSH payments. Do the Proposed Rules [CMS-2198-P] supersede the reporting requirements detailed in the aforementioned Federal Register?

<u>General Comment</u>

The proposed rules do not indicate the submission dates for the Annual DSH Reports. The information requested by CMS relates to costs incurred by hospitals during a fiscal year. To the extent that CMS is requesting actual (and potentially audited) cost data for the fiscal year, that information must be gathered from hospitals and reviewed by the Commonwealth prior to completion of the Annual DSH Report. Therefore CMS must allow sufficient time for the Commonwealth to complete this process.

<u>General Comment</u>

Per 70 FR 50264: *"...we have prepared an Excel spreadsheet for States to use to transmit their DSH information to us."*

This Excel spreadsheet was not included with the Proposed Rules. The CMS website contains a Word file labeled as "Corrected Chart" that appears to contain the reporting elements required for the Annual DSH Reports. Is this Word document the same as the Excel spreadsheet mentioned in the Proposed Rule? If not, the Commonwealth would like to request a copy of the example Excel spreadsheet.

Medicaid Inpatient Utilization Rate

Per 70 FR 50264: *"The State would indicate the hospital's Medicaid inpatient utilization rate, as defined in section 1923(b)(2) of the Act."*

The Commonwealth calculates each hospital's Medicaid Inpatient Utilization Rate (MIUR) for purposes of determining DSH eligibility. The MIUR used for a current year's DSH eligibility is calculated based on data from prior years. Is CMS requesting the MIUR used to determine the current year's DSH eligibility, or is CMS requesting an MIUR calculated based on the hospitals' current year's operational data?

Low Income Utilization Rate

Per 70 FR 50264: *"The State would indicate the hospital's low income utilization rate, as defined in section 1923(b)(3) of the Act. The low income utilization rate determination should only include those individuals that have no source of third party coverage for the inpatient hospital service they receive."*

The Commonwealth calculates each hospital's Low Income Utilization Rate (LIUR) for purposes of determining DSH eligibility. The LIUR used for a current year's DSH eligibility is calculated based on data from prior years. Is CMS requesting the LIUR used to determine the current year's DSH eligibility, or is CMS requesting an LIUR calculated based on the hospitals' current year's operational data?

DSH Payments

Per 70 FR 50264: *"The State would indicate the total annual DSH payments made to the hospital. States need only report the single, aggregate annual amount of DSH payments made to the hospital, regardless of the number of separate DSH pools or the number of individual payments."*

There are certain circumstances in which the Commonwealth makes a portion of the fiscal year's DSH payments after the end of its fiscal year. Should the DSH payments reported be those made during the fiscal year, or those related to the fiscal year?

Medicaid Managed Care Organization Payments

Per 70 FR 50264: *"The State would indicate the total annual amount paid to the hospital by Medicaid managed care organizations for inpatient hospital and outpatient hospital services furnished to Medicaid eligible individuals."*

Information on the amount of Medicaid payments made by Managed Care Organizations (MCOs) to hospitals is not readily-available to the Commonwealth. However, the Commonwealth collects self-reported information from hospitals related to Medicaid MCO payments. Would CMS accept the use of these self-reported amounts for purposes of the Annual DSH Reports?

Medicaid Eligible and Uninsured Individuals

Per 70 FR 50264: *"The State would indicate the total annual unduplicated number of Medicaid eligible individuals receiving inpatient hospital and outpatient hospital services and the total annual unduplicated number of individuals with no source of third party coverage for the inpatient hospital and outpatient hospital services they receive."*

The Commonwealth does not have access to the unduplicated number of Medicaid eligible and uninsured individuals and believes that gathering this data will be burdensome to both the Commonwealth and the hospitals. Please explain why the number of unduplicated individuals is relevant to CMS' review of DSH payments and DSH limits? The Commonwealth requests that this requirement be removed.

Section 1011 Payments

Per 70 FR 50264: *"For hospitals receiving DSH payments at or near their DSH limit, States will need to consider a section 1011 payment when determining the hospital's DSH limit, because the total DSH payments should not exceed the total amount of uncompensated care at the hospital."*

The Commonwealth does not have access to information on Section 1011 Payments made to hospitals by the Secretary. Furthermore, per the Social Security Act 1923(g)(1)(A), the only payments specifically included (i.e. "netted" from cost) in the DSH limit calculations are, "...payments under this title, other than under this section, and by uninsured patients..." It does not appear that the Section 1011 Payments are either Medicaid payments or payments made by uninsured patients and therefore are not required to be "netted" from cost for the purpose of the DSH limit calculations. Please explain the rationale for requiring states to consider Section 1011 Payments in DSH limit calculations.

Comments Related to Section III. Provisions of the Proposed Regulations
B. Audit Requirements

General Comment

Per 70 FR 50264: *"In addition, we are proposing to define that an 'independent audit' means an audit conducted according to the standards specified in the generally accepted government auditing standards issued by the Comptroller General of the United States."*

Would it be appropriate for the Commonwealth Auditor General's office to perform the Independent Audit of DSH Payments using the Generally Accepted Government Auditing Standards (GAGAS)?

There are three sets of standards within GAGAS: Financial Audits, Attestation Engagements, and Performance Audits. Which set of standards will apply to the Independent Audit of DSH payments?

<u>General Comment</u>

Per 70 FR 50264: *"Section 1923(j) of the Act requires that each State must submit annually the independent certified audit of its DSH program as a condition for receiving Federal payments under section 1903(a)(1) and 1923 of the Act."*

Will CMS withhold Federal Financial Participation from the Commonwealth until its Independent Audit of DSH Payments is completed and filed with CMS?

<u>General Comment</u>

Per 70 FR 50264: *"We are proposing a submission requirement within 1 year of the independent certified audit."*

Although the proposed rule specifies that the Independent Audit of DSH Payments must be submitted to CMS within one year of the audit, it does not specify when the audit must be completed. How soon after the close of the Commonwealth's fiscal year must the audit be completed?

<u>Verification 2:</u> DSH payments to hospitals comply with the hospital-specific DSH limit
Per 70 FR 50265: *"In order to evaluate compliance with this hospital-specific DSH limit, DSH payments made in the audited State fiscal year (SFY) must be measured against the actual uncompensated care costs in that same audited SFY..."*

The language in the Proposed Rules seems to indicate that the DSH limit calculations should be performed retrospectively, that is, the Commonwealth should compare DSH payments made in a fiscal year to the uncompensated costs incurred during that same fiscal year. This would require a "look back" analysis after all DSH payments are already made. If this is the intent of CMS, the Commonwealth would like to express its concern with this methodology, which creates a cost-based DSH reimbursement system.

Also, there are circumstances in which the Commonwealth makes a portion of the fiscal year's DSH payments after the end of its fiscal year. Should the amount of DSH payments reported be those <u>made</u> during the fiscal year, or those <u>related</u> to the fiscal year?

<u>Verification 3:</u> Only uncompensated care costs of providing inpatient and outpatient hospital services to Medicaid eligible individuals and uninsured individuals are included in the hospital-specific DSH payment limit.

Per 70 FR 50265: *"The uncompensated care costs of providing physician services cannot be included in the calculation of hospital-specific DSH limit[s]."*

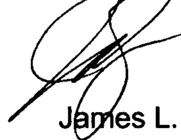
The Commonwealth's Medicaid outpatient payments to hospitals are "bundled," in that the payment includes both a hospital and physician component. Medicaid MCO outpatient payments are similar. Hospitals are unable to separate out the physician-related component of

the outpatient rates. In order to appropriately match costs to payments for the DSH limit calculations, the Commonwealth believes it is appropriate to include Medicaid outpatient costs related to hospital-based physicians in its DSH limit calculations. Would CMS consider this an appropriate inclusion of certain physician costs in the DSH limits?

The Commonwealth looks forward to viewing CMS' responses to these comments.

Please do not hesitate to contact me if you have any further questions.

Sincerely,



James L. Hardy

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Rec'd 10/31/05
J.M.W.

October 20, 2005

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Re: CMS-2198-P; Medicaid Program; Disproportionate Share Hospital Payments -- Implementing the Medicare Modernization Act of 2003 Reporting and Auditing Requirements; Proposed Rule.

Dear Dr. McClellan:

The Alabama Hospital Association (AlaHA), on behalf of our member hospitals, health care systems, and other health care organizations, appreciates the opportunity to comment on the proposed rule implementing the Medicaid Disproportionate Share Hospital (DSH) Payment reporting and auditing requirements found in the Medicare Modernization Act of 2003 (MMA). The Medicaid DSH program provides essential financial assistance to our nation's safety net hospitals. It is these hospitals that provide access to care for our nation's most vulnerable populations -- the poor, the disabled and the elderly. And they shoulder critical community services such trauma and burn care, high-risk neonatal care, and disaster preparedness resources. The Alabama Hospital Association has numerous concerns with the proposed rule and believes the rule, as presently drafted, would have a tremendously negative impact on Medicaid DSH hospitals.

The Medicaid DSH program has operated with little written regulatory guidance since the publication of the program's initial regulations in 1992. There have been two communications to the State Medicaid Directors in 1994 and 2002 that address questions specific to the hospital specific DSH limits. Much of the current DSH policy has been forged in negotiations between the Centers on Medicare and Medicaid (CMS) and individual state governments. The absence of consistent federal policy has been a source of frustration for hospitals. Unfortunately, CMS has chosen to use this proposed rule implementing the MMA reporting and auditing requirements to establish new DSH policy. AlaHA has four overriding concerns regarding the proposed rule:

1. the substantive changes to standard DSH policy not required by the MMA;
2. the definition of uncompensated care that excludes bad debt;
3. the retroactive application of the auditing requirements to Fiscal Year 2005; and
4. the reporting burden imposed on hospitals. AlaHA strongly urges CMS to rethink the approach adopted in this proposed rule.

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A. Reporting Requirements

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A number of state Medicaid programs include the costs of care provided uninsured individuals for which no payment is made and the costs associated with the non payment of copayments and deductibles for individuals with third party coverage in determining a hospital's qualifying costs for the hospital specific DSH limit. *(Current Medicare policy requires that hospitals seek payment from individuals with the means to pay their copayments and deductibles.)* The approaches adopted by these state Medicaid programs to establishing qualifying costs for setting the hospital specific DSH limit are consistent with the statute, legislative history, and long established agency DSH policy. A review of the legislative history of the MMA DSH reporting and auditing requirements **does not reveal** that Congress raised any concerns about how unreimbursed costs were determined for setting the hospital specific DSH limit by the agency or the individual state Medicaid programs. The explicit exclusion of bad debt from the definition of uncompensated care will be harmful to DSH hospitals that are struggling to meet the health care needs of the growing numbers of uninsured and underinsured. The recent growth of health plans that impose high deductibles or have exclusion limits as well as the growth of health savings account are putting new burdens on hospitals in terms of unreimbursed costs. AlaHA argues that CMS' new definition of uncompensated care to exclude bad debt is inconsistent with the statute and long standing CMS DSH policy. **AlaHA strongly recommends that CMS change its definition of uncompensated care by striking references to bad debt in 42 C.F.R. 447.299(c)(15) and in its place clarify that uncompensated care includes the costs of services**

furnished to individuals with no health care insurance, third party coverage, or third party payment and individuals with health savings accounts and includes the costs of services furnished insured individuals whose policies do not cover the services provided the individual due to their health plans exclusions, limits or deductibles.

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Section 1011 (Preamble)

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Retroactive Audit (42 C.F.R. 455.204(b))

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Same Year Actual Costs (42 C.F.R. 455.204(c))

The audit verification #2 requires that the DSH payments comply with the hospital specific DSH limit by requiring that the DSH payments made in the audited state fiscal year (SFY) have to be measured against the actual uncompensated care cost in the same audited SFY. This would require that states reconcile DSH payments to ensure such payments do not exceed actual costs. It is important to note that the MMA does not require that payments be based on actual audited costs. Current CMS DSH policy allows states to use a prospective methodology to estimate current year uncompensated care costs. This approach allows for adjustments in future years to reconcile DSH payments with actual costs. The verification, through audit, of DSH payments with the same year actual uncompensated care costs will place an enormous burden on hospitals through new burdensome and costly audits as well as increase the administrative costs for each

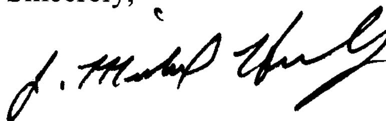
state Medicaid program. This is another example where the proposed rule substantively changes current Medicaid DHS policy. The proposed rule also does not speak to how such additional audits will be paid for and there is a concern that the state will pass on the added costs for same year audits to the DSH hospitals. The cost for hospital audits can reach $50,000 or higher per hospital. This estimate clearly suggests that the economic impact of this one audit requirement will meet the test of a major rule under the Regulatory Flexibility Act and should require a regulatory flexibility analysis for small entities such as hospitals. **AlaHA strongly recommends that CSM delete the requirement in the preamble and the regulatory language that audited DSH payments must be measured against actual uncompensated care cost in the same audited SFY. AlaHA recommends that CMS clarify that states be allowed to continue to use reasonable estimating methodologies to determine uncompensated care costs.**

Reduce Uncompensated Care Costs by DSH Payments (42 C.F.R. 455.204(c)(1))

The audit verification #1 requires that a state's audit report verify that each hospital receiving DSH payments has reduced its uncompensated care costs for furnishing inpatient hospital and outpatient hospital services during the SFY to Medicaid eligible individuals and individuals with no source of third party coverage for the services in order to reflect the total amount of claimed DSH expenditures. The DSH statute defines uncompensated care costs as the cost of serving Medicaid and uninsured patients net of Medicaid payments and payments made by uninsured individuals, excluding DSH payments. The statutory language is clear that uncompensated care costs are not offset by DSH payments. The first verification requirement that reduces a hospital's uncompensated care costs by claimed DSH expenditures is contrary to the statute. **AlaHA recommends that verification #1 be changed to require that the total amount of claimed DSH expenditures for each hospital that qualifies for a DSH payment in the State is no more than the hospital's uncompensated care costs.**

AlaHA appreciates this opportunity to comment on the proposed rule to implement the Medicaid DSH reporting and auditing requirements of the MMA. While AlaHA has long advocated for greater transparency in the operation of the Medicaid DSH program and more consistent federal standards, the proposed rule has not achieved these goals and makes substantive policy changes that clearly exceeds Congressional intent. The Medicaid DSH program is a lifeline to many safety net hospitals across the country. The proposed rule, as presently drafted, will have a significantly negative impact on these institutions. AlaHA stands ready to provide any assistance to remedy the concerns outlined. Please refer any questions to Tom Cooper at 334-272-8781 or e-mail at tcooper@alaha.org.

Sincerely,



J. Michael Horsley
President/CEO

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MCV Campus

V i r g i n i a C o m m o n w e a l t h U n i v e r s i t y

Medical Center

In the tradition of the Medical College of Virginia

Chief Executive Officer
VCU Health System
and
VCU Vice President
for Health Sciences

Sheldon M. Retchin, MD, MSPH

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OCT 25 2005

October 24, 2005

Via Courier

Dr. Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Ref: CMS-2198-P – Medicaid Program; Disproportionate Share Hospital Payments; Proposed Rule

Re: Reporting Requirements, Audit Requirements, Collection of Information Requirements, Regulatory Impact Statement

Dear Dr. McClellan:

The Virginia Commonwealth University Health System Authority (VCU Health System), appreciates this opportunity to submit comments as part of the notice and comment rulemaking process for the above-referenced Proposed Rule.[1]

VCU Health System is the primary safety net health system and largest provider of care to Medicaid and uninsured patients in the Commonwealth of Virginia. VCU Health System provides over a third of all of the uncompensated medical care statewide. In fiscal year 2004, VCU Health System provided $111.1M in uncompensated costs with another $116.1M estimated for FY05. As such, VCU Health System relies on significant disproportionate share hospital (DSH) funding and has a direct interest in the subject of this Proposed Rule.

[1] 70 Fed. Reg. 50262 (Aug. 26, 2005), hereinafter "Proposed Rule."

An Equal Opportunity/Affirmative Action University

VCU Health System is largely supportive of reporting standards designed to facilitate state compliance with federal DSH requirements. As a major provider of uncompensated care and recipient of DSH funding, VCU Health System actively supports effective management of the DSH program. In this context, VCU Health System has discrete yet significant reservations regarding the Proposed Rule.[2] In particular, VCU Health System urges CMS to retract the statement in the preamble to the Proposed Rule that suggests that hospitals' uncompensated costs for providing physician services may never be included in the calculation of the hospital-specific DSH limit. VCU Health System's specific comments are provided below.

* * * *

VCU HEALTH SYSTEM's COMMENTS ON PROPOSED RULE REGARDING DISPROPORTIONATE SHARE HOSPITAL REPORTING AND AUDIT REQUIREMENTS

CMS-2198-P

THE PREAMBLE TO THE PROPOSED RULE INAPPROPRIATELY PURPORTS TO PROHIBIT ANY INCLUSION OF HOSPITALS' INCURRED PHYSICIAN SERVICES COSTS IN THE CALCULATION OF THE UNCOMPENSATED COSTS OF CARE

VCU Health System is principally concerned that the preamble to the Proposed Rule improperly indicates that physician services costs must be excluded from the hospital-specific DSH cap calculation. Although this notion is not included in the regulatory language itself, this preamble language would appear to announce a new standard that is not contemplated in Medicaid laws or regulations and contradicts past CMS guidance to State Medicaid agencies.

The Proposed Rule would require states to verify that "only uncompensated care costs of providing inpatient and outpatient hospital services to Medicaid eligible individuals and uninsured individuals are included in the hospital-specific DSH payment limit."[3] The regulatory language does not address the role of hospitals' physician services. In the preamble language describing this requirement, however, CMS claims that:

> The uncompensated care costs of providing physician services cannot be included in the calculation of [the] hospital-specific DSH limit.[4]

This is the first time CMS has suggested that a hospital's legitimate physician costs may never be included in the DSH limit, and in fact would represent a policy reversal by the agency.

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[2] VCU generally supports and concurs with the comments submitted by the National Association of Public Hospitals and Health Systems (NAPH) in response to the Proposed Rule.

[3] 70 Fed. Reg. at 50268 (proposed 42 C.F.R. § 455.204(c)(3)).

[4] *Id.* at 50265.

We urge CMS to retract this language and to clarify that hospitals' uncompensated care costs properly include costs incurred for providing physician services for purposes of determining DSH limits. CMS should take these corrective actions because:

(1) Neither the Medicaid Act nor the statute providing authority for this Proposed Rule offer support for such a change in policy;

(2) The unilateral exclusion of physician services costs would contradict past CMS guidance to States; and

(3) This purported change in policy—unexplained and without benefit of notice and comment rulemaking—is ill-conceived and likely void, given the number of states that have relied on CMS' existing policy, some of which currently have ongoing disputes with CMS on this issue.

I. The Preamble Language is Not Supported By the Medicaid Statute or the MMA

Nothing in the Medicaid statute, including the changes in the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) that spawned the Proposed Rule, dictates this purported blanket exclusion of incurred physician costs in calculating a hospital's DSH limit. The Medicaid Act limits a hospital's DSH payments in a given year to the "costs incurred during the year of furnishing hospital services . . . by the hospital to individuals who either are eligible for medical assistance under the State plan or have no health insurance . . . for services provided during the year."[5] Although the statute certainly limits hospitals to costs actually incurred, this provision has never been found to single out hospitals' costs for physician services as ineligible for inclusion in the DSH cap calculation.

The history of the DSH provisions reflects expanded recognition of the full range of safety net hospitals' legitimate costs, rather than imposition of greater restrictions. For instance, in describing its 1993 statutory amendments to the DSH provisions, Congress clarified that incurred costs included both inpatient and outpatient services.[6] Moreover, at least one court has rejected the notion that "outpatient hospital services" necessarily exclude other services, holding that hospital-based rural health clinic costs could count towards a hospital's DSH limit.[7] Physician services are often a necessary component of hospital benefits. Thus, there is no justification in the federal DSH provisions for CMS suddenly to impose a wholesale exclusion on legitimately-incurred physician costs.

Nor does the MMA dictate such a change. The Proposed Rule purports to implement statutory reporting and audit requirements that did not alter any of the substantive standards regarding the calculation of costs under the hospital-specific DSH cap. It would be completely improper for CMS to employ preamble language—much less the Rule itself—to alter substantive standards under the auspices of new statutory *reporting* requirements.

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[5] 42 U.S.C. § 1396r-4(g)(1)(A).
[6] H.R. Conf. Rep. No. 103-213, at 835 (1993), *reprinted in* 1993 U.S.C.C.A.N. 1088, 1524.
[7] *Louisiana Dep't of Health and Hospitals v. CMS*, 346 F.3d 571 (5th Cir. 2003).

II. The Wholesale Exclusion of Physician Costs Contradicts Existing CMS Guidance and Practice

The preamble language flatly contradicts existing CMS guidance and would call into question state practices that have already received the agency's imprimatur. For at least a decade, states have relied on a CMS description of "cost of services" in the DSH context that is sufficiently broad to include the costs of physician services incurred by a hospital. In a 1994 letter to State Medicaid Directors, CMS announced that it "would permit the State to use the definition of allowable costs in its State plan, or any other definition, as long as the costs determined under such a definition do not exceed the amounts that would be allowable under the Medicare principles of cost reimbursement."[8]

Since then, CMS has endorsed the inclusion of physician costs even more explicitly. In correspondence with the Louisiana Department of Health and Hospitals, CMS purported to explain the conditions under which physician services *could* be included as a component of hospital services (and thus included in the hospital-specific DSH limit). In response to an inquiry from Louisiana, CMS acknowledged that its own regulations "provide the State some flexibility in defining what constitutes a hospital service." Thus, CMS concluded, "to the extent that the State recognizes the provisions [sic] of direct patient services by physicians, [certified registered nurse anesthetists], and other mid-level practitioners as hospital services, the State *may include the associated costs in the determination of the hospital specific limits*."[9]

In later correspondence with Louisiana and shared with the Commonwealth of Virginia, CMS offered more detailed parameters on the inclusion of physician services but continued to endorse the practice generally. In a series of letters between CMS and the Louisiana Medicaid agency in 2003, CMS interpreted its own regulations to permit physician services to be treated as outpatient hospital services included in a hospital's DSH limit when such services are not separately billed by the physician.[10] CMS wrote,

> Therefore, a state could cover the medical services of a physician under the Medicaid outpatient hospital service benefit if the hospital customarily bills all of its patients for these services as part of the outpatient visit. Under such circumstances, these services would not be considered a physician service but rather would be part of the outpatient hospital service. Therefore, *the*

[8] Letter to State Medicaid Directors from Sally Richardson, Director, Center for Medicaid and State Operations, Health Care Financing Administration (Aug. 17, 1994).
[9] Letter to Ben Bearden, Director, Bureau of Health Services Financing, Louisiana Department of Health and Hospitals, from Andrew Frederickson, Dallas Regional Office Chief, Medicaid Operations and Financial Management Branch, CMS Division of Medicaid and State Operations (July 20, 2001) (emphasis added).
[10] *See* 42 C.F.R. § 440.20 (defining hospital outpatient services).

uncompensated cost of these services could be included in the hospital-specific DSH limit.[11]

Louisiana had pointed to four other states that apparently included physician costs in its hospital-specific DSH calculations. CMS responded by reporting its initial conclusion that those four states "were not separately billing for physicians"—thereby further confirming the permissibility of counting at least those physician costs that are not separately billed.[12] Although VCU Health System certainly does not concede to the conditions CMS has expressed in its correspondence with Louisiana, and in fact believes that the 1994 State Medicaid Director letter regarding calculation of the hospital-specific DSH cap does not provide any authority for the limitations expressed, the correspondence nevertheless demonstrates CMS's acknowledgement of physician services as an element of hospitals' uncompensated care costs.

As a matter of public policy, VCU Health System believes that CMS's recognition of physician costs is the only reasonable position. Particularly with regard to uninsured patients, many hospitals must compensate physicians providing hospital services in order to ensure that the hospital services are available. Thus, without incurring costs for physicians providing care to the uninsured, hospitals would be unable to guarantee hospital services to this underserved population. That is, hospital services would often be unavailable without payments by the hospital to physicians—the precise result the DSH program undeniably seeks to avoid.

As the correspondence with Louisiana reveals, CMS has indicated its support over the past decade for certain restrictions on physician costs (although not via formal rulemaking). Leaving aside the dubious basis for such restrictions, suffice to say that CMS has repeatedly embraced the principle that physician costs *may* be included in hospital-specific DSH limits in certain circumstances. Moreover, the agency has implicitly or explicitly permitted numerous states to continue recognizing such a practice.

III. It is Inappropriate to Use Mere Preamble Language to Reverse a Policy Upon Which States Have Relied, and About Which Disputes are Currently Pending

Given CMS's repeated acknowledgement of the legitimacy of physician services costs in DSH cap calculations, it is not surprising that numerous states currently permit the inclusion of these costs in hospitals' DSH caps. Furthermore, it is our understanding that various states now have ongoing disputes in various stages—either formal or informal—as to the propriety of particular policies regarding the inclusion of physician services costs. Virginia is just such a state, having recently appealed a disallowance of $11 million relating to the inclusion of physician services costs incurred by VCU Health System's hospital and the University of Virginia Medical Center (UVA).

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[11] Letter to Ben Bearden, Director, Bureau of Health Services Financing, Louisiana Department of Health and Hospitals, from Bill Brooks, Dallas Regional Office Chief, Financial and Programs Operation Branch, CMS Division of Medicaid and State Operations (May 21, 2003) (emphasis added).
[12] *Id.*

In light of the states' ostensible reliance on previous CMS guidance and the pending appeals involving Virginia and perhaps other states, it is improper for the agency to attempt a change course unilaterally via one sentence in a preamble. Such an informal assertion, articulated at a time of growing scrutiny of states' policies in this area and without comprehensive explication, would not receive the deference otherwise accorded agency pronouncements.[13] Nor would it be a legitimate means of strengthening the agency's litigation position.

It is further problematic for CMS to affect what would be a policy reversal on a matter of such significance states on this thin a foundation. It is always preferable for an agency to explain the reasoning behind its policy interpretation, ideally through notice and opportunity for comment. Changes in policy—as opposed to initial interpretations—only heighten the expectation of an accompanying process. In fact, notice and comment rulemaking is often required for interpretive changes, even when the change is to what had been an informal pronouncement.[14] When not legally required, it is nevertheless preferred, and otherwise the new policy risks receiving little respect from reviewing courts.[15] CMS should therefore consider the utility and wisdom of employing unsupported preamble language to change longstanding, if informally developed, policy. VCU Health System believes mere mention in a preamble is insufficient and improper, especially given as the purported exclusion of all physician services costs would be arbitrary and unreasonable.

* * * *

For the foregoing reasons, VCU Health System requests that CMS retract the statement in the preamble regarding exclusion of physician services costs, and reaffirm that the uncompensated care costs incurred by hospitals in providing physician services may be included in the calculation of the hospital-specific DSH limit. We thank you for the opportunity to comment on the Proposed Rule.

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[13] *See Bowen v. Georgetown University Hospital*, 488 U.S. 204, 213 (1988) (no deference to an interpretation that "appears to be nothing more than an agency's convenient litigating position"); *Commonwealth of Massachusetts v. FDIC*, 102 F.3d 615, 621 (1st Cir. 1996) (*Chevron*-style deference not provided to less formal interpretations, including litigation positions); *see also Rabin v. Wilson-Coker*, 362 F.3d 190, 198 (2d Cir. 2004) (according less deference to CMS interpretation where "there is no indication in the record of the process through which CMS arrived at its interpretation").

[14] *See Paralyzed Veterans of America v. D.C. Arena L.P.*, 117 F.3d 579, 586 (D.C. Cir. 1997) (once agency gives its regulations an interpretation, it can only change that interpretation though notice and comment rulemaking); *Torch Operating Co. v. Babbitt*, 172 F.Supp.2d 113, 124-25 (D.D.C. 2001) (if agency gives a rule an interpretation and then later fundamentally modifies that interpretation, the agency must follow notice and comment rulemaking).

[15] *See Commonwealth of Massachusetts*, 102 F.3d at 621 (less deference to informal change in policy lacking formal statement of the agency's reasons for the change).

Sincerely,

Sheldon M. Retchin, M.D., M.S.P.H.
Chief Executive Officer, VCU Health System and
VCU Vice President for Health Sciences

::ODMA\PCDOCS\WSH\367620\3

Lifespan

OCT 25 2005

Mark Montella
Senior Vice President,
Government Relations

October 24, 2005

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Re: CMS-2198-P; Medicaid Program; Disproportionate Share Hospital Payments -- Implementing the Medicare Modernization Act of 2003 Reporting and Auditing Requirements; Proposed Rule.

Dear Dr. McClellan:

Lifespan Corporation and its member hospitals, E.P. Bradley Hospital, Newport Hospital, Rhode Island Hospital and The Miriam Hospital appreciate the opportunity to comment on the proposed rule implementing the Medicaid Disproportionate Share Hospital (DSH) Payment reporting and auditing requirements found in the Medicare Modernization Act of 2003 (MMA). Our comments are brief, as several national and state organizations will be providing detailed comments.

Definition of Uncompensated Care:

We request that CMS change its definition of uncompensated care by striking references to bad debt in 42 C.F.R. 447.299(c)(15). In its place, clarify that uncompensated care includes the costs of services furnished to individuals with no health care insurance, third party coverage, or other third party payment and includes the costs of services furnished to insured individuals, including those with health savings accounts, whose policies do not cover the services provided to the individual due to their health plans exclusions, limits, or deductibles.

Retroactive Audit:

We recommend the retroactive application of the reporting and auditing requirements be deleted from the rule and that the reporting and auditing requirements become effective during the first state fiscal year beginning after the finalization of the rule.

The CORO Building, 167 Point Street, Providence, RI 02903
Tel 401 444-3720 Fax 401 444-8700

Reporting Burden on States and Hospitals:

The requirement for "Unduplicated Patient Count of Medicaid Eligibiles and Uninsured Individuals" should be eliminated as it places a very significant burden on states and hospitals. Hospitals posses the ability to provide a count of patients they care for individually. There are no current systems in place or available to provide a state-wide unduplicated count. States would need to create this costly and difficult to administer system.

Reconciliation Process:

It is unclear from the proposed regulation what CMS' intent is for the actual data/audit information reported. Will states be required to reconcile actual hospital DSH payments in a fiscal year to audited uncompensated care costs? If so, will CMS require states to recover overpayments from hospitals whose audited uncompensated care costs are less than actual payments based on projected costs? Conversely, will CMS require states to provide additional payments to hospitals (up to the State aggregate DSH cap) whose audited uncompensated care costs are greater than the payments based on projected costs?

If it is CMS intent to require retroactive settlements, we would urge that the proposed rule be revised to expressly permit states, upon receipt of an audit showing additional actual costs not included in estimated costs, to compensate hospitals through post-audit adjustments.

Lifespan appreciates the opportunity to comment on the proposed rule and if you require any additional information please feel free to contact me.

Sincerely,

Mark Montella
Senior Vice President

cc: RI Congressional Delegation
Stacy Paterno

Rec'd 10/24/05 [illegible] 15

October 21, 2005

ECM Hospital
Shoals Hospital
ECM East Diagnostic
& Rehab Center

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Re: CMS-2198-P; Medicaid Program; Disproportionate Share Hospital Payments -- Implementing the Medicare Modernization Act of 2003 Reporting and Auditing Requirements; Proposed Rule.

Dear Dr. McClellan:

Shoals Hospital appreciates the opportunity to comment on the proposed rule implementing the Medicaid Disproportionate Share Hospital (DSH) Payment reporting and auditing requirements found in the Medicare Modernization Act of 2003 (MMA). The Medicaid DSH program provides essential financial assistance to our nation's safety net hospitals. It is these hospitals that provide access to care for our nation's most vulnerable populations -- the poor, the disabled and the elderly. And they shoulder critical community services such as trauma and burn care, high-risk neonatal care, and disaster preparedness resources. Shoals Hospital has numerous concerns with the proposed rule and believes the rule, as presently drafted, would have a tremendously negative impact on Medicaid DSH hospitals.

The Medicaid DSH program has operated with little written regulatory guidance since the publication of the program's initial regulations in 1992. There have been two communications to the State Medicaid Directors in 1994 and 2002 that address questions specific to the hospital specific DSH limits. Much of the current DSH policy has been forged in negotiations between the Centers on Medicare and Medicaid (CMS) and individual state governments. The absence of consistent federal policy has been a source of frustration for hospitals. Unfortunately, CMS has chosen to use this proposed rule implementing the MMA reporting and auditing requirements to establish new DSH policy.

Shoals Hospital has four overriding concerns regarding the proposed rule:

1. **the substantive changes to standard DSH policy not required by the MMA;**
2. **the definition of uncompensated care that excludes bad debt;**
3. **the retroactive application of the auditing requirements to Fiscal Year 2005; and**
4. **the reporting burden imposed on hospitals.**

SHOALS HOSPITAL STRONGLY URGES CMS TO RETHINK THE APPROACH ADOPTED IN THIS PROPOSED RULE.

Coffee Health Group
Post Office Box 818
Florence, AL 35631-0818

A. Reporting Requirements

Uncompensated Care (UCC) (42 C.F.R. 447.299(c)(15))

The new definition of uncompensated care to both exclude bad debt and physician services are clear examples of the agency's attempt to substantively change long standing DSH policy without properly calling for direct public comment.

Bad Debt

The proposed rule, in both the preamble language and the draft regulatory language, states that uncompensated care does not include bad debt for purposes of setting the hospital specific DSH limit. This new definition of uncompensated care that excludes bad debt is not consistent with the statute, legislative history or long standing agency practice. The underlying statute (1923(g)(1)(A) permits the inclusion of the costs of services provided individuals with no health insurance or other source of third party coverage. The conference report language for the Omnibus Budget Reconciliation Act of 1993 (OBRA '93) provision, that originally established the hospital specific DSH limit, reveals Congress' intent in directing the agency on the various ways to determine the unreimbursed costs that hospitals bear. The report language states that the cost of providing services to uninsured patients would be net of any out of pocket payments received from uninsured individuals. The agency's 1994 letter to state Medicaid programs offered further guidance in the determination of unreimbursed costs by stating that the cost of services provided individuals with third party coverage, but whose third party coverage did not cover the hospital services the individual received, could be counted. The agency was clearly looking at the cost associated with the uninsured and the underinsured in implementing the hospital specific DSH limit. In 2002, the agency in its guidance to state Medicaid programs regarding the hospital specific DSH limit and the upper payment limit reaffirmed the 1994 DSH policy.

A number of state Medicaid programs include the costs of care provided uninsured individuals for which no payment is made and the costs associated with the non payment of copayments and deductibles for individuals with third party coverage in determining a hospital's qualifying costs for the hospital specific DSH limit. *(Current Medicare policy requires that hospitals seek payment from individuals with the means to pay their copayments and deductibles.)* The approaches adopted by these state Medicaid programs to establish qualifying costs for setting the hospital specific DSH limit are consistent with the statute, legislative history, and long established agency DSH policy. A review of the legislative history of the MMA DSH reporting and auditing requirements **does not reveal** that Congress raised any concerns about how unreimbursed costs were determined for setting the hospital specific DSH limit by the agency or the individual state Medicaid programs. The explicit exclusion of bad debt from the definition of uncompensated care will be harmful to DSH hospitals that are struggling to meet the health care needs of the growing numbers of uninsured and underinsured. The recent growth of health plans that impose high deductibles or have exclusion limits as well as the growth of health savings account are putting new burdens on hospitals in terms of unreimbursed costs. Shoals Hospital argues that CMS' new definition of uncompensated care to exclude bad debt is inconsistent with the statute and long standing CMS DSH policy. **Shoals Hospital strongly recommends that CMS change its definition of uncompensated care by striking references**

to bad debt in 42 C.F.R. 447.299(c)(15) and in its place clarify that uncompensated care includes the costs of services furnished to individuals with no health care insurance, third party coverage, or third party payment and individuals with health savings accounts and includes the costs of services furnished insured individuals whose policies do not cover the services provided the individual due to their health plans exclusions, limits or deductibles.

Physician Services

The preamble of the proposed rule states uncompensated care costs of physician services cannot be included in the calculation of the hospital specific DSH limit. The statute does not specifically exclude physician services. And the agency, in at least one communication to a state Medicaid program, allows for the inclusion of physician services in determining a hospital's unreimbursed costs. The costs associated with securing physicians to serve the hospital's indigent patient population are legitimate unreimbursed costs and should be allowed. The MMA does not require that CMS exclude physician services. This is another example of CMS' attempt to reach beyond MMA statutory requirements to establish new policy. **Shoals Hospital believes that physician costs associated with hospitals services should be included and references to excluding the physician costs in determining the hospital's uncompensated care costs in the preamble should be deleted.**

Section 1011 (Preamble)

The preamble in the proposed rule directs state Medicaid programs to consider Section 1011 payments when determining a hospital's hospital specific DSH limit. There is no statutory requirement to include Section 1011 payments when determining the hospital's uncompensated care burden. Section 1011 payments are neither Medicaid payments nor payments from uninsured patients. Congressional intent, in enacting Section 1011, was to provide new resources rather than substitute existing resources for hospitals providing large volumes of uncompensated care to undocumented immigrants. This is yet another example of CMS' attempt to reach beyond statutory authority to set new DSH policy. The consideration of Section 1011 payments would likely result in reducing needed DSH dollars to hospitals serving high numbers of uninsured undocumented immigrants. **Shoals Hospital recommends that CMS delete the language in the preamble that requires states to offset Section 1011 payments when establishing a hospital's DSH limit and to clarify that Section 1011 payments should not factor into the calculation of the hospital specific DSH limit regardless of the hospital is at or near its limit.**

Reporting Unduplicated Patient Count of Medicaid Eligibiles and Uninsured Individuals (42 C.F.R. 447.299 (c)(16))

State Medicaid programs are required to report for each hospital an unduplicated count of Medicaid eligible and uninsured patients. Shoals Hospital is concerned that states will turn to hospitals to produce these patient counts. Many hospitals do not have the reporting systems in place that would allow them to generate unduplicated counts of patients served throughout the year that are Medicaid eligible or uninsured. And many questions arise in how a hospital would classify certain patients such as a patient that has Medicaid coverage for part of the year and are uninsured for part of the year. The proposed rule fails to make the case why this information is

necessary. **Shoals Hospital believes that this reporting requirement would be unnecessarily burdensome for hospitals and recommends that it be deleted.**

Reporting of Indigent Care Revenue (42 C.F.R. 447.299(c)(12))

The proposed rule requires reporting of total payments received by hospitals from individuals with no source of third party coverage. Shoals Hospital is concerned that many hospitals' current accounting systems do not allow them to match payments received from individuals to payments received for individuals for which there was no third party coverage. **This would impose an excessive reporting burden on hospitals and Shoals Hospital recommends that this reporting requirement be deleted.**

Reporting Total Costs (42 C.F.R. 447.299(c)(14))

The 1994 guidance to State Medicaid Directors allows a state to use the definition of allowable costs in its State Medicaid plan or any other definition as long as the costs determined under such a definition do not exceed the amounts that would be allowable under the Medicare principles of cost reimbursement. **Shoals Hospital believes that the proposed rule should reaffirm this definition of allowable costs to assure greater consistency across all the state Medicaid DSH programs.**

B. Auditing Requirements (42 C.F.R 455.204)

Retroactive Audit (42 C.F.R. 455.204(b))

The proposed rule retroactively applies the new reporting and auditing requirements to each state's FY 2005. Most state fiscal years for 2005 have ended. The imposition of the new and substantive reporting and auditing requirements would make it impossible for state Medicaid programs to comply because they would have to retroactively identify the requested data. While the MMA required that CMS impose reporting and auditing requirements beginning in fiscal year 2004, CMS has delayed implementation beyond the date specified in the MMA. The retroactive application of these new reporting and auditing requirements makes little sense now and will impose a hardship for state Medicaid programs as well as DSH hospitals. **Shoals Hospital strongly recommends that this retroactive application of the reporting and auditing requirements be deleted from the rule and that the reporting and auditing requirements be tied to the first state fiscal year beginning after the finalization of the rule.**

Same Year Actual Costs (42 C.F.R. 455.204(c))

The audit verification #2 requires that the DSH payments comply with the hospital specific DSH limit by requiring that the DSH payments made in the audited state fiscal year (SFY) have to be measured against the actual uncompensated care cost in the same audited SFY. This would require that states reconcile DSH payments to ensure such payments do not exceed actual costs. It is important to note that the MMA does not require that payments be based on actual audited costs. Current CMS DSH policy allows states to use a prospective methodology to estimate current year uncompensated care costs. This approach allows for adjustments in future years to reconcile DSH payments with actual costs. The verification, through audit, of DSH payments

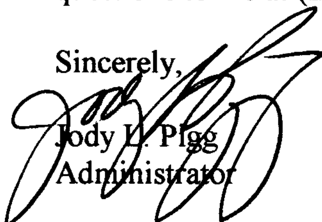
with the same year actual uncompensated care costs will place an enormous burden on hospitals through new burdensome and costly audits as well as increase the administrative costs for each state Medicaid program. This is another example where the proposed rule substantively changes current Medicaid DHS policy. The proposed rule also does not speak to how such additional audits will be paid for and there is a concern that the state will pass on the added costs for same year audits to the DSH hospitals. The cost for hospital audits can reach $50,000 or higher per hospital. This estimate clearly suggests that the economic impact of this one audit requirement will meet the test of a major rule under the Regulatory Flexibility Act and should require a regulatory flexibility analysis for small entities such as hospitals. **Shoals Hospital strongly recommends that CSM delete the requirement in the preamble and the regulatory language that audited DSH payments must be measured against actual uncompensated care cost in the same audited SFY. Shoals Hospital recommends that CMS clarify that states be allowed to continue to use reasonable estimating methodologies to determine uncompensated care costs.**

Reduce Uncompensated Care Costs by DSH Payments (42 C.F.R. 455.204(c)(1))

The audit verification #1 requires that a state's audit report verify that each hospital receiving DSH payments has reduced its uncompensated care costs for furnishing inpatient hospital and outpatient hospital services during the SFY to Medicaid eligible individuals and individuals with no source of third party coverage for the services in order to reflect the total amount of claimed DSH expenditures. The DSH statute defines uncompensated care costs as the cost of serving Medicaid and uninsured patients net of Medicaid payments and payments made by uninsured individuals, excluding DSH payments. The statutory language is clear that uncompensated care costs are not offset by DSH payments. The first verification requirement that reduces a hospital's uncompensated care costs by claimed DSH expenditures is contrary to the statute. **Shoals Hospital recommends that verification #1 be changed to require that the total amount of claimed DSH expenditures for each hospital that qualifies for a DSH payment in the State is no more than the hospital's uncompensated care costs.**

Shoals Hospital appreciates this opportunity to comment on the proposed rule to implement the Medicaid DSH reporting and auditing requirements of the MMA. While Shoals Hospital has long advocated for greater transparency in the operation of the Medicaid DSH program and more consistent federal standards, the proposed rule has not achieved these goals and makes substantive policy changes that clearly exceeds Congressional intent. The Medicaid DSH program is a lifeline to many safety net hospitals across the country. The proposed rule, as presently drafted, will have a significantly negative impact on these institutions. Shoals Hospital stands ready to provide any assistance to remedy the concerns outlined. Please refer any questions to me at (256) 386-1601.

Sincerely,



Jody L. Pigg
Administrator

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DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
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RICHARD J. CODEY
Acting Governor

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Commissioner

ANN CLEMENCY KOHLER
Director

October 17, 2005

Centers for Medicare & Medicaid
Services
Department of Health and Human Services
Attn: CMS-2198-P
P. O. Box 8010
Baltimore, MD 21244-1850

Ms. Katherine Astrich
CMS Desk Officer
Office of Information and Regulatory Affairs
Office of Management and Budget
Room 10235
New Executive Office Building
Washington, DC 20503

RE: CMS-2198-P

Dear Ms. Astrich:

This is in response to the solicitation of public comment on the proposed requirements for a Medicaid Disproportionate Share Annual Report for Hospitals and Institutions in the Federal Register dated August 26, 2005, page 50262. The Centers for Medicare and Medicaid Services (CMS) are proposing to implement information collection requirements in accordance with Public Law 105-33.

The referenced legislation amended the Social Security Act, requiring States to provide an annual report with the name of each qualifying disproportionate share hospital (DSH) and the disproportionate share payment amount for each hospital. The regulations implementing this statutory requirement were published on October 8, 1998 in the Federal Register (63 FR 54142). The Federal Register notice recommended hospital-specific data for the annual DSH report including the hospital name, type of hospital and the annual DSH payment amount. The August 26, 2005, Federal Register requires additional specific data to be included in the DSH report and provides a format for the report.

Based on a review of the data descriptions and format instructions in the August 26, 2005, Federal Register, there are several areas that seem to need further clarification and/or more specific instructions. The comments are as follows:

(1) The proposed reporting requirements refer to submission timing on two different pages which are inconsistent with each other. On Page 50264 of the Federal Register under the Audit Requirements section, it states "We are proposing a submission requirement within 1 year of the independent certified audit." On Page 50268 of the Federal Register under the List of Subjects section, where the proposed revisions to section 455.204(b) are indicated, it states "Timing. Beginning with State fiscal year (SFY) 2005, a State must submit to CMS an independent certified audit report no later than 1 year after the completion of each State's fiscal year."

(2) On Page 50263 of the Federal Register under the Provisions of the Proposed Regulations Reporting Requirements, it states "We are proposing that the following information reflects the data elements necessary to ensure that DSH payments are appropriate such that each qualifying hospital receives no more in DSH payments than the amount permitted under section 1923(g) of the Act." The States prepare hospital specific limit calculations on a prospective basis at the beginning of each SFY prior to its determination of DSH payments for the SFY. The payments are therefore made based on those prospective calculations. This prospective methodology gives the State assurances when making decisions regarding DSH payment allocations and the overall DSH cap. The proposed reporting requirements would be applying a retroactive methodology to hospital specific limit calculations and DSH payments. It appears the proposed reporting requirements would force States to recoup DSH payments that were made on hospital specific limit calculations using reasonable estimated costs and payments for Medicaid individuals and individuals with no source of third party coverage for the SFY.

(3) The proposed reporting requirements do not provide for any option to request an extension for the submission of the information or audit.

(4) The State is required to indicate the type of hospital and provides a list of types, but does not provide a definition for each type of hospital in order to ensure the proper and consistent classification.

(5) If a State utilizes different criteria for qualifying hospitals as a DSH than the Medicaid Inpatient Utilization Rate or the Low-Income Utilization Rate, these two calculations would be unnecessary. Requiring a State to calculate and submit the Medicaid Inpatient Utilization Rate and Low-Income Utilization Rate calculations would be an additional burden. Was this added effort considered in the estimate of States' time and effort to prepare and submit the required information?

(6) The State is required to indicate the total annual DSH payments made in the audited SFY. DSH payments may be made by the State at a minimum of up to one year

after the SFY being reported. Obtaining the audited SFY DSH payments by the end of the following SFY is not possible for the State.

(7) The State is required to indicate the Regular Medicaid Rate Payments paid to the hospital for the SFY being reported. This information is already submitted as part of the Medicaid claims information provided to CMS through the Medicaid Statistical Information System (MSIS). Claims may be submitted to the State for payment up to one year after the date of service. Therefore, payments made by the State for claims with dates of service in the SFY may be submitted up to a year after the service date by the hospital. The payment information would not be available before 12-months after the SFY at a minimum. Obtaining the amount paid by the state for the SFY being reported is not possible by the end of the SFY.

(8) The State is required to indicate the Medicaid Managed Care Organization Payments paid to the hospital for the SFY being reported. Claims may be submitted to the Medicaid Managed Care Organization (MCO) for payment up to one year after the date of service. Therefore, payments made by the MCO for claims with date of service in the SFY may be submitted up to a year after the service date by the hospital. The payments would not be available before 12-months after the SFY at a minimum. Obtaining the amount paid by the MCO for the SFY being reported is not possible by the end of the SFY.

(9) The State is required to indicate the Indigent Care Revenue paid to the hospital from individuals with no source of third party coverage for the SFY being reported. Payments may be made to the hospital by individuals with no source of third party coverage several years after the service date. Hospitals may not easily distinguish between the year a cash payment is made and the year the payment is applicable to. Obtaining the amount paid on a cash basis by individuals with no source of third party coverage would also take time and is not possible by the end of the SFY.

(10) The State is required to indicate the Transfers by the hospital to the State as a condition of the hospital receiving any Medicaid or DSH payment. This amount is not a requirement in the hospital specific limit calculation and not related to DSH. It would not seem necessary for the purpose of the proposed reporting requirements.

(11) The State is required to indicate the cost of services for Medicaid individuals and individuals with no source of third party coverage for the SFY being reported. Hospitals in the State accumulate and report costs based on the hospital's fiscal year utilizing the Medicare cost report (HCFA-2552-96). The audited cost reports are generally not available before 21-months after the hospital's year end. With most hospitals not having their fiscal year the same as the SFY, the cost information is not available on a SFY basis. Obtaining the cost on a SFY basis is not possible for the State. Obtaining the costs by the end of the SFY is not possible for the State.

(12) The State is required to indicate the cost of services for Uncompensated Care Costs which includes cost and payments for Medicaid individuals and individuals with no source of third party coverage for the SFY being reported. Hospitals in the State accumulate and report costs based on the hospital's fiscal year utilizing the Medicare cost report (HCFA-2552-96). The audited cost reports are generally not available before 21-months after the hospital's year end. With most hospitals not having their fiscal year the same as the SFY, the cost information is not available on a SFY basis. For Medicaid Payments paid to the hospital for the SFY being reported, claims may be submitted to the State for payment up to one year after the date of service. Therefore, payments made by the State for claims with date of service in the SFY may be submitted up to a year after the service date by the hospital. The payments would not be available before 12-months after the SFY at a minimum. Obtaining the cost and amount paid by the state for the SFY being reported is not possible by the end of the SFY.

(13) The State is required to indicate the total unduplicated number of Medicaid eligible individuals. This is a new reporting requirement. This information is already submitted as part of the Medicaid claims information provided to CMS through the Medicaid Statistical Information System (MSIS). Claims may be submitted to the State for payment up to one year after the date of service. Therefore, calculating the total unduplicated number of Medicaid eligible individuals for claims with date of service in the SFY may be submitted up to a year after the service date by the hospital. The payments would not be available before 12-months after the SFY at a minimum. Obtaining the amount paid by the state for the SFY being reported is not possible by the end of the SFY. Was this added effort considered in the estimate of States' time and effort to prepare and submit the required information?

(14) The State is required to indicate the total unduplicated number of individuals with no source of third party coverage. This is a new reporting requirement. The number of unduplicated individuals with no source of third party coverage is not maintained by the State. The information would have to be provided by the individual hospitals and may not be reasonably obtainable. How is it recommended that the State proceed and how would not providing this information effect the State? Was this added effort considered in the estimate of States' time and effort to prepare and submit the required information?

(15) The proposal indicates these reporting requirements will not impose any additional burden. However, this proposal requires a substantial increase in the volume of information reported. The comments above reflect the complexity of the requested additional information. It is unlikely the requirements of this proposal can be met without extensive additional effort.

We appreciate the opportunity to review and comment on the Disproportionate Share Annual Report instructions and format. If you have any questions, please contact me at (609) 588-2600 or David Lowenthal, Bureau of Financial Reporting, at (609) 588-2820.

Sincerely,

Ann Clemency Kohler
Director

ACK:C
c: John R. Guhl
David C. Lowenthal
Jimmy Wickcliffe, CMS

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COMMONWEALTH *of* VIRGINIA

Department of Medical Assistance Services

PATRICK W. FINNERTY
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October 21, 2005

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2198-P
P.O. Box 8010
Baltimore, MD 21244-1850

Dear CMS:

Thank you for the opportunity to comment on the proposed rule regarding the reporting of Medicaid Disproportionate Share Hospital (DSH) information. In addition to the Virginia-specific comments provided herein, Virginia is also providing general comments with other states through the law offices of Covington and Burling.

Virginia understands the need for the Department of Health and Human Services (HHS) to ensure compliance with the hospital specific DSH limit, and to implement the requirements of the Medicaid Modernization Act (MMA). However, as detailed below, we believe that some state specific flexibility should be allowed to avoid costly and unnecessary reporting and auditing. We also believe there should be a reconsideration of the timeframes in which reporting and auditing must be accomplished. In addition, further detail is needed in specifying the data period for which the required information is to be reported and audited. Finally, the statement in the Preamble of the proposed rule that the uncompensated care costs of physician services may not be included in the calculation of the hospital-specific DSH limit should be deleted because it does not relate to any provision of the proposed rule, is inconsistent with prior CMS policy, and is not supported by the underlying statute. The following comments further articulate these points:

- **§447.299 (c) : Data is to be reported by state fiscal year.**

  Comment: The language refers to the state fiscal year as the reporting period before listing the 16 data points to be reported annually for each DSH provider. It does not state whether cost, payment, and certain other statistical data points may be reported for provider fiscal years ending in the state fiscal year, which would be more feasible. Many of the data points are available only through cost reports, and therefore are only available by provider fiscal year. For example, if a

provider's fiscal year is the calendar year, the state has no way to determine the hospital's cost of serving Medicaid recipients (data point 14) in the state fiscal year.

Comment: The language does not say when the reporting is due from the state. Based on 1) the data reporting that is required, 2) the fact that some of these data will need to be audited under the proposed provisions of §455.204, and 3) the fact that the audit is proposed to be required by one year after the close of the state fiscal year to which the reporting and the audit apply, we assume the reporting is contemplated to be submitted less than a year after the close of the state fiscal year. More discussion of this will be found below, but it is important to point out again that much of the required data are found only on Medicaid cost reports which are submitted no sooner than five months after year-end and are desk reviewed no sooner than 11 months after year end. Given this, the reporting timeframes that appear to be contemplated are not realistic.

- **§447.299 (c)(6) : Report Medicaid inpatient utilization rate as defined in 1923(b)(2).**
- **§447.299 (c)(7) : Report low income utilization rate as defined in 1923(b)(3).**

Comment: Neither of these reporting requirements is specifically required in the MMA, and neither appears to make a contribution to determining Virginia's compliance with the applicable hospital-specific DSH limitation, which is the objective of the proposed regulation according to the MMA. We therefore believe they are an unnecessary reporting burden, at least for Virginia. Virginia's DSH methodology defines Medicaid inpatient utilization differently than does 1923(b)(2). For example, Virginia does not include dual eligible days in a hospital's Medicaid utilization rate for DSH purposes, while 1923(b)(2) appears to include these days. Using only the state-defined Medicaid utilization rate for the eligibility determination, Virginia's methodology includes more hospitals as DSH providers and pays a higher DSH adjustment than is specified in 1923(c). Therefore the state does not utilize the hospital data required under these provisions of the proposed rule, and it would be an additional and unnecessary data collection effort for Virginia to obtain this information. Since these data do not contribute to determining Virginia's compliance with the hospital-specific DSH limit or to Virginia's determination of its DSH payment, this seems to be an unnecessary burden for Virginia.

- **§447.299 (c)(12) : Report "Indigent care revenue".**

Comment: The term "indigent care revenue" may be confusing. We believe the language suggests that this term refers to revenue from individuals with no source of third party coverage, irrespective of the individuals' income, despite the fact that "indigent" usually implies low income. Is our interpretation correct?

- **§447.299 (c)(14) : Report the cost of inpatient and outpatient services provided to Medicaid and uninsured patients.**
- **§447.299 (c)(15) : Report separately the uncompensated care of Medicaid and of uninsured patients.**

Comment: For the vast majority of DSH hospitals in Virginia, we achieve compliance with the hospital-specific DSH limit because DSH payments are less than Medicaid uncompensated care alone, which is calculated for each hospital on the Medicaid cost reporting forms. For this reason, we do not require most DSH hospitals to report costs of uninsured patients on the cost reporting forms, and requiring them to do so would be an unnecessary and significant burden. We would like clarification as to whether the independent auditor can base certification on the fact that Medicaid losses alone justify the DSH payment, thereby allowing the auditor to ignore uninsured uncompensated care costs in the certification. We recommend for clarity sake that the proposed rule be amended to include a provision granting states the option to not report uninsured costs for some or all hospitals where Medicaid losses justify the DSH payment made.

- **§447.299 (c)(16) : Separately report the unduplicated number of Medicaid eligible individuals and uninsured individuals receiving inpatient and outpatient hospital services.**

Comment: This requirement is not enumerated in the MMA. It is feasible for states to report the unduplicated number of Medicaid eligible individuals. However, reporting unduplicated uninsured patients, as distinct from just the costs related to uninsured patients, is not feasible and appears to serve no purpose relative to the requirements this rule is intended to enforce. The Medicaid agency currently receives no data that would support an effort to count unduplicated uninsured persons receiving inpatient and outpatient hospital services. Medicaid agencies have no reason to collect claims of uninsured patients, and without the claims it is not possible to determine the unduplicated number of persons. Some individual hospitals may be able to conduct this count for their own patients, but it is unlikely that this is consistently the case. Particularly with respect to persons receiving outpatient services this would appear to be impractical. The effort necessary to develop an unduplicated count of uninsured patients is unreasonable and unnecessary, and was not accounted for in the impact estimate provided with the proposed regulation.

- **§455.204 (b) : Audit is required for SFY 2005 and subsequent fiscal years no later than 1 year after the completion of each state fiscal year.**

Comment: It is inappropriate to require an audit for SFY 2005, when the rule outlining the required data to be audited has only been proposed two months after

the close of SFY 2005 and will not be finalized until much later in SFY 2006. As explained above, much of the data requested under this proposed rule is irrelevant to a determination of Virginia's compliance with the provider specific DSH limit. Because of this, some required data have not been routinely collected, and therefore are simply not available for SFY 2005 within the time frame allowed by this rule promulgation process.

Comment: The requirement that the certified audit be completed one year after the close of the fiscal year is unattainable. The majority of the data required under this rule can only be derived from the Medicaid cost report, which is submitted at the same time as the Medicare cost report - no sooner than five months after the end of the fiscal year. In Virginia, settlement of the Medicaid cost report is no sooner than 11 months after the end of the fiscal year. If the first audits are to be completed by July 1, 2006, under ideal circumstances this allows one month to conduct and report on the independent audit for many of Virginia's DSH providers. Given the detail involved in the audit, it is clear that there will not be enough time to receive cost reports, review and settle the reports, and provide data to the auditor, who would need to certify this tentatively settled cost report data for each of Virginia's DSH providers.

- **§455.204 (c)(1) : The audit must verify that each hospital that qualifies for DSH payment has reduced its uncompensated care costs to reflect the total amount of claimed DSH expenditures.**

  Comment: The wording of this requirement is confusing and requires clarification. Based on the accompanying discussion found in the Federal Register, Virginia interprets this provision to mean that any amount of funds, certified or transferred by or from a hospital or other governmental entity, that is used to claim federal DSH funding, must be reported as a DSH payment to the hospital in the evaluation of the hospital-specific DSH limit. Is this a correct interpretation?

  Comment: This provision also states that the value to be audited is uncompensated care costs during the state fiscal year. As stated in previous comments above, CMS needs to clarify whether this means state fiscal year or provider fiscal years ending in the state fiscal year. Each cost report can only support an uncompensated care cost value for the provider's fiscal year. The regulation needs to indicate what states should do with respect to this issue.

- **§455.204 (c)(2) : The audit must verify that DSH payments made in each audited SFY must be measured against the actual uncompensated care cost in that same audited SFY.**

Comment: This provision again does not account for the discrepancy that exists between provider fiscal years and the state fiscal year. The regulation needs to address this reality.

Comment: The regulation also does not directly acknowledge that some DSH amounts are paid in a current year to satisfy a DSH amount that was due to the hospital in an earlier year. These DSH payments are appropriately charged or accrued against the uncompensated care cost of the earlier year, the year to which the DSH payment applied, not necessarily the one in which the funds changed hands. The regulation needs to acknowledge that each DSH payment needs to be compared to the uncompensated care cost of the year to which the DSH payment truly applies.

Comment: The fact that DSH funds can be paid in one year to satisfy a DSH obligation of an earlier year is another reason why it is not practical for these amounts to be audited within 12 months after the end of the year. The final DSH payments for the year will not always be known within the time period contemplated by the regulation.

- **§455.204 (c)(3) : The audit must verify that only uncompensated care costs of furnishing hospital services to Medicaid and uninsured individuals are included in the calculation of the hospital-specific DSH limit.**

Comment: We would request clarification of this requirement to verify that the existence of Medicaid uncompensated care costs greater than the DSH payment amount would permit the exclusion of uninsured costs from the calculation and certification of the hospital-specific limit by the independent auditor. If uninsured costs are always required for the auditor's certification, Virginia would need to obtain reporting of data that is not relevant in the determination of DSH payments or needed to prove compliance with the hospital specific DSH limit, and that is currently unavailable for the majority of Virginia's DSH hospitals. This requirement would also dictate significant additional work by the independent auditor (and added cost to the state and federal governments) for unnecessary data analysis. We again recommend for clarity sake that the proposed rule be amended to include a provision granting states the option to not report uninsured costs for some or all hospitals where Medicaid losses alone justify the DSH payment.

- **Exclusion of physician costs from calculation of the hospital-specific DSH limit.**

Comment: The language of the proposed rule does not prohibit the inclusion of hospital physician costs in the case of salaried physicians employed by the hospital delivering services. In fact, the proposed rule does not address this issue at all, nor could it since the rule addresses only DSH reporting requirements.

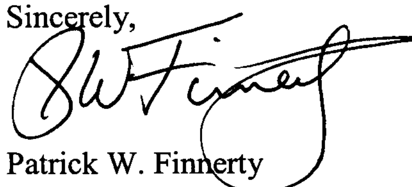
However, without a basis in the statute and contrary to longstanding policy, the Preamble of the proposed rule makes the unsupported statement to the effect that physician costs may not be included within a hospital's uncompensated care costs in determining the hospital-specific DSH limit. We consider these to be hospital costs. CMS itself heretofore has recognized physician services to be a legitimate part of a hospital's uncompensated care costs. If CMS is going to change this policy, it can do so only through duly promulgated notice and comment rulemaking, not by slipping an unsupported and irrelevant statement in a regulation establishing reporting requirements. In any event, we believe such a change in policy would be inconsistent with the underlying statute which contains no basis for excluding these costs from the calculation of a hospital's DSH limit.

Conclusion

While we understand CMS' desire and need to better understand state DSH programs, we believe that the proposed rule as written represents an overly burdensome approach beyond what is required under the MMA. The proposed rule needs to incorporate flexibility for states in which less extensive reporting and auditing would be sufficient to document compliance with the law. This would avoid the unnecessary expenditure of state and federal as well as hospital resources.

We look forward to CMS' consideration of the comments herein. If you have any questions regarding the issues outlined in this submittal, we remain fully willing to discuss the proposed rule at your convenience. Thank you for your time and consideration.

Sincerely,



Patrick W. Finnerty
Director

C: Manju Ganeriwala
Scott Crawford

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Michael F. Easley, Governor
Carmen Hooker Odom, Secretary

L. Allen Dobson, Jr., M.D., Assistant Secretary
for Health Policy and Medical Assistance

October 21, 2005

Centers for Medicare & Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Regulations Development and Issuances Group
Attn: Jimmy Wickliffe
CMS – 2198 – P Room C5 – 11 – 04
7500 Security Boulevard
Baltimore, MD 21224 – 1850

Re: Comments and Questions on CMS Proposed Regulations for DSH Payments - Reporting and Auditing Requirements

Dear Mr. Wickliffe:

The State of North Carolina, Department of Medical Assistance has reviewed the proposed CMS regulations for DSH Payments – Reporting and Auditing requirements as published in the Federal Register, Volume 70, No. 165, Friday, August 26, 2005. Please accept this letter as our formal submission of comments and questions to the proposed regulations.

1. As specified in our state plan, North Carolina's Medicaid Hospital and DSH Payment Programs operate on a federal fiscal year. This provides consistency with Medicare hospital payment systems, the timing of changes in our federal financial participation rate and with the timing of our DSH allotment. Also, the Medicaid upper payment limit tests and hospital-specific DSH limit tests are performed on a federal fiscal year basis. The requirement in the proposed regulation for states to report and audit their DSH and enhanced payment programs on a state fiscal year basis will cause significant administrative burden and will not accurately reflect the basis upon which the state is making payments. Therefore, it is the State's position that CMS should allow individual states to audit and report their DSH Payment Programs based on the federal fiscal year rather than a state's own fiscal year.

2. As proposed, the effective date for the regulations is for a period that is has already passed. We believe that CMS should be consistent with previous cost reporting requirements and make these new auditing and reporting requirements effective for the payment plan year that would begin on or after the date the final regulations are promulgated.

3. North Carolina's State Plan specifies that its DSH and enhanced payments are prospective and payment amounts are calculated using cost data from prior years brought forward for inflation to the payment period. North Carolina requests that the same data used in calculating the DSH and enhanced payments be used to fulfill CMS' auditing and reporting requirements. In this regard, the determination of hospitals' DSH eligibility involves data reporting lags. North Carolina currently collects information from hospitals' two fiscal years to the payment plan year for which DSH eligibility is being determined. Since this is the data being used to

determine DSH payments, North Carolina believes that this should be the data which will be audited and reported to CMS.

4. The Excel spreadsheet attached to the September 23, 2005, Federal Register has a column for "Uncompensated Care Costs". Currently, North Carolina calculates this cost by using the ratio of cost to charges from the hospital's most recent "as filed" cost report and applies this ratio to a twelve-month period of uncompensated charges as reported by the hospital. Does CMS agree with this method or does CMS intend to provide an alternate method?

5. What is the purpose of the requirement to report unduplicated numbers of Medicaid recipients and individuals with no third party coverage receiving inpatient and outpatient services? The state would have to obtain the unduplicated number of uninsured individuals from individual hospitals. This will be very difficult for many hospitals to report. In addition, if CMS' intent is to obtain a total statewide unduplicated number, neither the state nor CMS would be able to use each hospital's reported count to eliminate uninsured individuals who receive hospital services from more than one hospital during a year.

6. The proposed regulations require the State to submit an annual independent certified audit of the DSH program. The State would like for CMS to elaborate as to define what is meant by an "independent audit". As part of its Medicaid hospital payment program, North Carolina currently contracts with a private CPA firm to conduct audits of hospitals' Medicaid cost reports. Can the state employ its current outside auditors to conduct audit and reporting requirements required by the proposed regulations, recognizing that audit programs will be modified to meet the additional auditing and reporting requirements demanded? It is the state's position our current audit process will be more efficient and less burdensome, particularly for individual hospitals if all auditing were to be conducted by a single firm.

7. Auditing Requirement Verification 2 appears to eliminate the prospective nature of DSH payments. This is problematic when a State Plan specifies that its DSH and enhanced payments are prospective and calculated using data from prior years brought forward for inflation to the payment period. As noted above, North Carolina argues that these auditing and reporting requirements involve the same data used in calculating the DSH and enhanced payments per its State Plan.

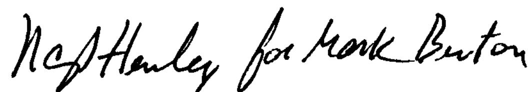
8. Auditing Requirement Verification 3 requires that the uncompensated care costs related to the provision of physician services not be included in determining the DSH limit. North Carolina argues instead that since physician services are a covered Medicaid service, the associated cost of uncompensated care incurred by the hospital providing such physician services be an included cost.

9. The proposed regulations require that the State consider Section 1011 payments when calculating the hospital specific DSH limit. Since these payments are made directly to the hospital by CMS, is it the intent of CMS to provide each state a hospital specific report that quantifies the Section 1011 payments and the time period during which the payments were made? If not, how does CMS propose the State collect and validate these payments?

10. As specified in its State Plan, North Carolina makes DSH payments to DSH eligible out-of-state hospitals that service North Carolina Medicaid recipients. What is North Carolina's responsibility in terms of hospital-specific DSH limit calculations and auditing and reporting requirements insofar as these out-of-state hospitals are concerned?

The Division of Medical Assistance appreciates the opportunity to express its comments and concerns regarding the proposed regulations. It is hoped that these comments and questions will assist CMS in developing the regulations and DMA looks forward to CMS' response. If CMS has any questions or needs clarification, DMA personnel will be pleased to assist.

Sincerely,



Mark T. Benton
Senior Deputy Director and Chief Operating Officer
Division of Medical Assistance

Cc: Office of Information and Regulatory Affairs
Carmen Hooker Odom
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OCT 25 2005

October 25, 2005

VIA HAND DELIVERY

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue S.W.
Washington, D.C. 20201

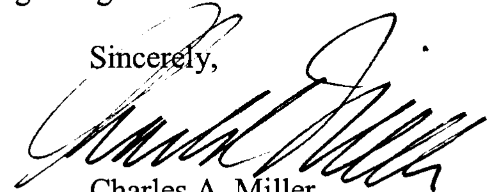
Re: CMS-2198-P

Dear Dr. McClellan:

Enclosed please find comments on the proposed regulations implementing the disproportionate share hospital ("DSH") auditing and reporting regulations, submitted by the States of Alaska, Connecticut, Idaho, Illinois, Kansas, Louisiana, Missouri, New Jersey, North Carolina, Oklahoma, Rhode Island, Tennessee, Utah, Vermont, Virginia and Washington. We have also submitted a copy of these comments electronically.

Please contact me if you have any questions regarding these comments.

Sincerely,



Charles A. Miller

Enclosure

Before the
UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
Baltimore, MD 21244

OCT 25 2005

In The Matter Of	)	
	)	
Medicaid Program;	)	
Disproportionate Share	)	CMS-2198-P
Hospital Payments	)	
Proposed Rule	)	

The States of Alaska, Connecticut, Idaho, Illinois, Kansas, Louisiana, Missouri, New Jersey, North Carolina, Oklahoma, Rhode Island, Tennessee, Utah, Vermont, Virginia and Washington (the "Commenting States") submit the following comments on the proposed regulations implementing the disproportionate share hospital ("DSH") auditing and reporting regulations contained in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ("MPDIMA"). 70 FR 50262 (Aug. 26, 2005).

As a general matter, the Commenting States request that CMS clarify that the proposed regulations are not intended to alter existing policy that permits states to apply the individual hospital DSH limit on a prospective basis. There is ambiguity in the preamble and the proposed regulations on this issue. Proposed 42 C.F.R. § 455.204(C)(2) states that "for each audited SFY, the DSH payments made in that audited SFY must be measured against the *actual* uncompensated care cost in that same audited SFY" (emphasis added), yet the preamble provides that the audit "must verify whether the State has included only costs incurred for inpatient hospital and outpatient hospital services in the *estimate* of uncompensated care costs for each DSH hospital." 70 FR at 50265 (emphasis added). The proposed regulations also require that the audit report must describe the State's methodology used to calculate the uncompensated

costs, leaving room for the use of either retrospective or prospective methodologies to calculate costs. 42 C.F.R. § 455.204(c)(6) (proposed).

CMS has always acknowledged that the law permits States to base their DSH payments on a prospective estimate of a hospital's uncompensated care costs for a given year, derived from the hospital's costs in prior years, and many if not most States utilize this approach. In fact, before DSH allotments were established for each State by statute, HCFA (the predecessor to CMS) established the state allotments through *estimates* of state Medicaid expenditures in a given year. *See* 58 FR 43171 (Aug. 13, 1993).

Most States have found that the prospective methodology for distributing DSH payments is preferable, because it assures hospitals that they may rely upon payments received without risk of later recoupment based on an after-the-fact reconciliation audit. Thus, some States expend their entire DSH allotment based on prospective estimates of each DSH hospital's uncompensated care expenses. Requiring a retrospective audit to confirm that the DSH payments received did not exceed actual costs would mean that these States may have to reallocate their DSH allotment long after payments had been made, by taking payments away from some hospitals and giving additional payments to other hospitals. This would introduce much uncertainty into the DSH payment process and discourage hospitals from actually using the DSH payments until actual costs had been finalized for all hospitals in the State.

The DSH reporting and auditing requirements contained in MPDIMA were intended only to ensure compliance with the DSH requirements, not to change the DSH requirements themselves. Nothing in the statute either requires or encourages a change in CMS's long-standing policy that DSH payments can be based on a prospective estimate of a hospital's uncompensated care costs.

Moreover, the proposed regulations require that the audit must be submitted within one year of the completion of the State fiscal year. 42 C.F.R. § 455.204(b) (proposed). This requirement could not be met if the regulations required a retrospective audit, because final settlement of hospitals' cost reports is typically contingent upon completion by a Medicare intermediary of audits that can take several years. Moreover, because many hospitals' fiscal years do not coincide with the State fiscal year, cost reports for two different fiscal years would be needed in order to complete one audit that complies with the proposed requirements. Not only would it take much longer than a year in order to finalize these cost reports, trying to combine two different cost reports into one audit would add more time to the process.

However, if the audit requirement is simply to verify the manner in which the DSH limit was applied prospectively, the one-year timeline may be realistic for years subsequent to the adoption of a final regulation for states using prospective methods, and hospitals with fiscal years different than the State's should not present as much of a concern, because the prospectively-determined limit would have been calculated based on cost reports for earlier time periods.

Accordingly, the Commenting States request that CMS clarify that the proposed regulations are not intended to disturb the use of prospective calculations to apply the individual hospital DSH limit.

The Commenting States also submit the following comments on specific aspects of the preamble and the proposed regulations.

1. Varying Methodologies to Ascertain Costs

In the preamble to the proposed regulations, CMS states that "each State must develop a methodology to compute the hospital-specific DSH limit for each DSH hospital in the State." 70 FR at 50265.

Comment: The Commenting States seek clarification that the same methodology for determining uncompensated care costs need not be used for every DSH hospital in the State. As CMS recognized in a 1994 State Medicaid Director letter, any definition of "allowable cost" is acceptable, "as long as the costs determined under such a definition do not exceed the amounts that would be allowable under the Medicare principles of cost reimbursement." *See* Letter from Sally K. Richardson to State Medicaid Directors at 3 (Aug. 17, 1994). In some States, a variety of methodologies may be used to determine the uncompensated care costs for different categories of hospitals, such as public and private hospitals, or for particular hospitals. Using different methodologies for different hospitals is entirely justified, because not every hospital has the same accounting practices or incurs the same types of costs.

2. Physician Services Costs

The preamble to the proposed regulations states that the "uncompensated care costs of providing physician services cannot be included in the calculation of hospital-specific DSH limit." 70 FR at 50265.

Comment: Prohibiting the costs attributable to physician services from counting towards a hospital's uncompensated care costs is not consistent with the wording or purpose of the DSH statute. The definition of the hospital-specific DSH limit contained in Section 1923(g) states that DSH payments in a given year must not exceed "the costs incurred during the year of furnishing hospital services." If the hospital bears the costs of the physicians, the costs are

necessarily part of the "costs incurred...of furnishing hospital services." Uncompensated care costs should include *all* unreimbursed costs incurred by the hospital in serving the uninsured. Otherwise, the purposes of the DSH statute -- to assist safety net hospitals and other hospitals to meet *their* costs of serving the uninsured -- would be thwarted.

CMS has articulated no policy reason why physician services costs borne by hospitals for uninsured patients should be treated any differently than other costs of serving those patients. In fact, the absolute bar on including hospital-incurred physician services costs in the calculation of uncompensated care costs is a departure from other statements from CMS on this issue. CMS has previously recognized that States *may* include the uncompensated costs of physician services in the calculation of the hospital-specific DSH limit if hospitals do not separately bill for these services when provided to Medicaid patients. *See* Letter from Bill Brooks, Chief, Financial and Programs Operation Branch, CMS Region VI, to Ben Bearden, Director, Bureau of Health Services Financing, Louisiana Dept. of Health and Hospitals at 2 (May 21, 2003). Even that position is still too limited, because it fails to recognize that physician services costs should be included in the calculation of the hospital-specific limit whenever hospitals bear the costs of physicians who serve indigents, not just when the hospital also assumes responsibility for the cost of physicians that serve Medicaid patients. Incurring the costs of physicians who serve uninsured individuals may be the only way the hospitals can assure the availability of physicians to serve these individuals, particularly in the case of hospitals that serve large numbers of the uninsured. If hospitals cannot be reimbursed at all for this significant cost of serving uninsured individuals, they may actually be discouraged from providing medical care to this population.

3. Bad Debt Is A Cost

The description of uncompensated care costs in proposed 42 C.F.R. § 447.299(c)(15) provides, "Uncompensated care costs do not include bad debt or payer discounts."

Comment: Bad debt should be included in the calculation of uncompensated care costs. Bad debt represents the portion of revenue treated as received for accounting purposes, but not actually received, due to the fact that some payers do not pay even though they are obligated to do so. Bad debt is thus an allowable cost, as recognized by generally accepted accounting principles. Not including bad debt would understate uncompensated care costs (or overstate revenue, which is deducted to determine uncompensated care costs).

4. Single Audit Requirement

Proposed Section 455.204(a) provides that "a State must submit an independent certified audit to CMS" (emphasis added).

Comment: This language could be read to mean that the State itself must obtain one independent audit verifying data for its entire DSH program. Instead of requiring only one statewide audit, however, it would be more efficient and less burdensome -- and still consistent with MPDIMA -- for the individual hospitals to make the required verifications for their own financial data. Most hospitals already have their financial information reviewed and certified by an independent auditor, so the auditor could complete these verifications as part of the standard audit process. Subjecting each hospital's DSH data to another audit at the State level would require States to engage an independent firm by soliciting Requests for Proposal; that process alone would take many months to complete. The independent firm would then have to base the audit on hospital data which itself would not be immediately available. The audit would require

an extensive review, by auditors unlikely to be familiar with the history and practices of each hospital, of each hospital's books to determine the costs expended and the payments received. Such a process would be extremely time-consuming and very expensive for the State, and it would not add any value to the auditing process. Moreover, should CMS require an independent audit, it would be virtually impossible for States to meet the one-year filing deadline discussed below.

5. Audit Standards

The proposed "Definitions" at Section 455.201 requires that the "independent certified audit" must be conducted "in accordance with generally accepted government auditing standards, as defined by the Comptroller General of the United States."

Comment: The proposed requirement that the audit must be conducted pursuant to the government auditing standards is unduly burdensome. Most auditors in the private sector use generally accepted accounting principles ("GAAP") to audit hospitals' financial data. Thus, the independent auditors involved in performing hospital audits and who use the GAAP standards to do these audits may not even be familiar with the generally accepted government auditing standards. In any case, it is inefficient to require these auditors to perform another audit of the same data using different auditing standards. At a minimum, States or hospitals should be allowed to use either the GAAP standards or the government auditing standards in meeting the audit requirements.

6. Timing of Audits

Proposed Section 455.204(b) requires that an independent certified audit report must be submitted to CMS no later than one year after completion of each state's fiscal year, beginning with SFY 2005.

Comment: For states that determine the individual hospital DSH limit prospectively, the one-year filing requirement may be attainable (at least after these rules take effect) if the requirement is only to validate the accuracy of the prospective calculation. But for those States that do base the determination on current year costs, a report based on a final audit of hospital cost reports could not be submitted within one year. Final settlement of hospitals' cost reports is typically contingent upon completion by a Medicare intermediary of audits -- a process that can take several years. CMS should allow these States additional time to submit the audit certifications, so these certifications can be based on the finally settled cost report. Alternatively, CMS could clarify the rule to permit the required report to be based on a hospital's as-filed cost report. If necessary, there could be later reconciling adjustment after the cost report is finally settled and an audit certification can be made.

7. **Fiscal Year Requirements**

The proposed regulations require States to report data and obtain independent certified audits based on the state fiscal year. *See* 42 C.F.R. §§ 447.299(c), 455.204(b) (proposed).

Comment: A number of States with July-June fiscal years operate their DSH program based on the federal fiscal year. Requiring these States to report data and to conduct audits based on their state fiscal year would be very burdensome, because it would necessitate reviewing and combining hospital cost data for two separate DSH payment years. CMS should revise the proposed regulations to allow States to make the required reports and to submit the required audits relative to the fiscal year on which the DSH payments are based -- regardless of whether that year coincides with the state or federal fiscal year.

Similarly, for states that determine the limit retrospectively, insistence on a state fiscal year basis of audit could necessitate auditing hospital cost reports for two years whenever the hospital's fiscal year differs from that of the state. The Commenting States urge CMS to modify the proposed regulations to call for audits based on the fiscal year of each DSH hospital.

8. Prospective Payments

Proposed Section 455.204(c)(4) requires States to verify that "any Medicaid payments (including regular Medicaid rate payments, supplemental/enhanced Medicaid payments, and Medicaid managed care organization payments) made to a disproportionate share hospital for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals, which are in excess of the Medicaid incurred costs of such services, are applied against the uncompensated care costs of furnishing inpatient hospital and outpatient hospital services to individuals with no source of third party coverage for such services."

Comment: The Commenting States understand the general purpose of this requirement and do not question it. But there is one circumstance in which it would be inappropriate to require States to reduce the DSH-reimbursable deficit -- that is where the basic Medicaid payments are determined on a prospective basis and individual hospitals are able to control costs sufficiently to earn a profit on their Medicaid business. To require that profit to be offset against uncompensated care costs would mean that a hospital that undertakes aggressive cost containment in the end would receive less in total Medicaid revenues than another hospital that forgoes cost containment (and therefore realizes no profit on its basic Medicaid payments) but incurs the same level of unreimbursed uninsured costs.

To illustrate, assume that Hospital A and Hospital B deliver identical services to Medicaid inpatients and the same dollar volume of services to uninsured patients. Both hospitals

receive $100 in DRG prospective payments. But while Hospital B incurs $100 in costs in serving Medicaid inpatients, Hospital A, through cost containment efforts, held its costs to $80. In addition, each hospital incurs $50 in costs to serve uninsured patients. The State reimburses 100% of unreimbursed uninsured costs through DSH payments. If federal policy requires the hospital's uninsured deficit to be reduced by Medicaid DRG payments in excess of cost, the result is that Hospital A receives total payments of $130 ($100 in DRG payments and only $30 in DSH) while Hospital B receives total payments of $150 ($100 in DRG payments and $50 in DSH), solely because it is less efficient.

The Commenting States urge CMS to modify its proposed regulations to provide that for purposes of applying the individual hospital DSH limit, a hospital's costs of serving Medicaid patients will be deemed to be no less than the base payment made to that hospital under a prospective payment system.

9. Unduplicated Patient Count

Proposed Section 447.299(c)(16) requires States to report, for each DSH hospital, the unduplicated number of Medicaid eligible individuals and uninsured individuals receiving inpatient and outpatient services.

Comment: CMS should eliminate this reporting requirement. Hospitals are currently not required to report the number of uninsured individuals receiving services, and we do not believe they routinely compile data in this manner. Moreover, the regulations and preamble provide no guidance on how States are supposed to identify whether individuals have been double-counted as both a Medicaid recipient and an uninsured individual. Trying to establish an unduplicated number may be burdensome and confusing: how are States supposed to count individuals who have Medicaid coverage for part of a year, but are uninsured for the

remainder of the year? Moreover, the purpose of this reporting requirement is not clear, as the total number of unduplicated Medicaid and uninsured individuals seems to have only a minimal relationship to a hospital's uncompensated care costs or the payments they receive for these costs.

10. Section 1011 Payments

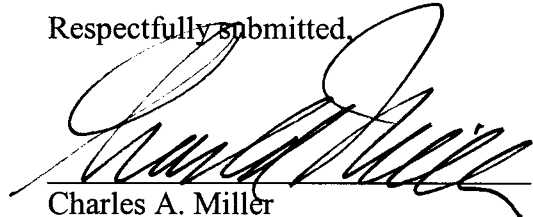
In the preamble to the proposed regulations, CMS states that payments under Section 1011 of the MPDIMA, which provides for federal payments directly to hospitals for otherwise unreimbursed costs of providing services to aliens, "will not impact the calculation of a hospital's Medicaid DSH payment amount if the hospital has not reached its DSH cap," but that these payments should be considered if a DSH hospital is at or near its DSH limit.

Comment: There is no basis in the Social Security Act for requiring that a hospital's uncompensated care costs must be offset by Section 1011 payments. Under Section 1923(g) of the Act, the DSH limit for an individual hospital is equal to the costs of care provided to Medicaid or uninsured individuals "net of payment under [Title XIX], other than under [Section 1923], and by uninsured patients." A Section 1011 payment is neither a payment under Title XIX or a payment by an uninsured patient. As a result, these payments should not be included in any calculation of a hospital's uncompensated care costs.

CONCLUSION

For the foregoing reasons, the Commenting States respectfully request that the proposed regulations, and CMS' explanation of them, be modified in accordance with the foregoing comments.

Respectfully submitted,



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Attorneys for the States of Alaska, Connecticut, Idaho, Illinois, Kansas, Louisiana, Missouri, New Jersey, North Carolina, Oklahoma, Rhode Island, Tennessee, Utah, Vermont, Virginia, and Washington

October 25, 2005

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October 27, 2005

VIA FIRST CLASS MAIL

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue S.W.
Washington, D.C. 20201

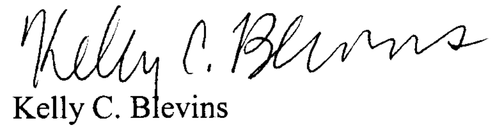
Re: CMS-2198-P

Dear Dr. McClellan:

Please add the State of Maine to the list of States joining in the comments previously submitted on the proposed regulations implementing the disproportionate share hospital ("DSH") auditing and reporting requirements, on behalf of the States of Alaska, Connecticut, Idaho, Illinois, Kansas, Louisiana, Missouri, New Jersey, North Carolina, Oklahoma, Rhode Island, Tennessee, Utah, Vermont, Virginia and Washington.

Please contact me if you have any questions regarding these comments.

Sincerely,



Kelly C. Blevins

21

THOMAS L. GARTHWAITE, M.D.
Director and Chief Medical Officer

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Chief Operating Officer

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October 24, 2005

Mark B. McClellan, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Bldg.
200 Independence Ave., SW
Washington, DC 20201

Dear Dr. McClellan:

CMS-2198-P; PROPOSED RULE REGARDING MEDICAID DISPROPORTIONATE SHARE HOSPITAL PAYMENTS, 70 FED. REG. 50262 (AUG. 26, 2005)

On behalf of Los Angeles County Department of Health Services (LAC/DHS), I am writing in response to the CMS proposed rule implementing section 1001(d) of the Medicare Prescription Drug Improvement and Modernization Act of 2003 which impacts Medicaid program disproportionate share hospital ("DSH") payments. LAC/DHS is concerned that substantive changes to the federal DSH program proposed in the rule would jeopardize critical funding for our hospitals and all public hospitals in California

The LAC/DHS provides a full range of hospital and ambulatory care services to the highly diverse and multi-ethnic population of Los Angeles County; including:

- 600,000 inpatient days of service
- 2,500,000 ambulatory care visits
- 300,000 ER visits
- 400,000 public health visits

Over 50% of the Department's patients are Medi-Cal and over 30% are medically uninsured.

Medicaid DSH funds are critical to the future viability of our hospital. Any new policy interpretation that results in substantially lower DSH payments or affects prior year DSH payments will have a significant financial impact on our hospital, and will threaten our ability to continue to serve our community.

LAC/DHS endorses the comments submitted by both the California Association of Public Hospitals and Health Systems and the National Association of Public Hospitals and Health Systems in response to this proposed rule. We would like to highlight some of those comments.

- **The Proposed Rule Implements DSH Program Changes That Are Beyond the Scope of the Statute's Reporting and Audit Requirements.**

  The proposed rule would impose new substantive requirements that go beyond the statute. LAC/DHS objects to many of the proposed substantive changes. If CMS intends to implement substantive DSH policy changes, it must do so through a straightforward rulemaking process that identifies and acknowledges the changes so that all interested parties will have a meaningful opportunity to comment.

- **The Financial Stability of Disproportionate Share Hospitals Requires Finality with Respect to Prior Year DSH Payment Determinations.**

  LAC/DHS must have finality with respect to prior year DSH determinations. Because the proposed rule and certain statements in the preamble are inconsistent in some respects with California's approved DSH program, the finality of prior period DSH payments will be uncertain if the rule is adopted. If our hospital loses DSH funding from prior years it would cause financial instability and place at risk key services we provide to our community. It is our recommendation that any changes made should only be applied going forward.

- **The Exclusion of Physician Costs from the Determination of Uncompensated Care Costs is a New Policy, and Would Be Particularly Devastating for Public Disproportionate Share Hospitals.**

  CMS states in the preamble that the uncompensated care costs of providing physician services cannot be included in determining whether the OBRA 1993 limits are properly calculated. Physician services are critical to a hospital's ability to provide care to patients. Excluding the costs of these services from the determination of uncompensated care costs would have a significant negative

impact on public hospitals. We recommend that the language at issue be stricken, and replaced with clarifying language that expressly recognizes physician service costs incurred for the hospital patients as an appropriate component of the OBRA 1993 limit calculation.

➢ **Bad Debt and Payer Discounts Are Not Deductions From Uncompensated Care Costs.**

The proposed rule attempts to impose additional substantive rules relating to the treatment of bad debts and payer discounts. The proposed rule states that uncompensated care costs "do not include bad debt or payer discounts." This broad statement could result in additional reductions in determining uncompensated care costs that are not supported by statute. The rule should be clarified to expressly provide that all uncompensated care costs associated with hospital services to Medicaid beneficiaries and the uninsured are included in the OBRA 1993 limit without regard to whether the hospital records a bad debt or payer discount for that patient. In no event should uncompensated care costs be reduced by bad debt or payer discount amounts.

➢ **Supplanting DSH Payments with Section 1011 Funding for the Undocumented is Not Authorized by the DSH Statute and is Inconsistent with Congressional Intent.**

The preamble to the proposed rule states that payments received by a hospital under section 1011 of the MMA for services rendered to undocumented patients must be considered in determining the hospital's OBRA 1993 limit. This proposal is inconsistent with Congressional intent of section 1011.

For those hospitals at or near their limit, CMS' suggested treatment of section 1011 payments would supplant DSH payments with section 1011 funds, thereby eliminating the financial relief such payments are intended to provide our hospital. This result is inconsistent with the purpose of section 1011, which was to provide financial relief to hospitals that provide emergency services to the undocumented population. LAC/DHS recommends that CMS issue a clear statement that section 1011 funds are not to be treated as an offset against uncompensated care costs in determining a hospitals OBRA 1993 limit.

➢ **Retrospective Reconciliation of the OBRA 1993 Limits Using Year of Service Data is a Policy Change that Cannot be Applied Retroactively.**

The proposed rule would require that DSH payments made to a hospital for a particular SFY be compared against the hospital's actual uncompensated care costs in that same SFY. Because the data necessary to determine uncompensated care costs for the year is not available until after the year has ended, states would in effect be required to retrospectively reconcile DSH payments made during the SFY months or even years after the year has ended. This new policy is inconsistent with California's long-standing program reflected in its approved state plan, which calls for a prospective DSH payment determination. Public hospitals require finality with respect to their DSH payments. The proposed change will create unwarranted financial instability and should be deleted.

➢ **The Proposed New Definition of the Low-Income Utilization Rate that Limits the Calculation to Uninsured Patients is Inconsistent with the Federal Statute.**

Under the proposed rule, states would be required to report each hospital's low-income utilization rate in a new way that goes beyond current statute. States have calculated the low-income utilization rates for many years pursuant to state plan methodologies that are tailored to their available hospital data. There is no policy rationale for imposing a new limitation on this calculation, given that Congress has provided states considerable flexibility in designating disproportionate share hospitals. The language at issue should be retracted.

➢ **The Unduplicated Uninsured Patient Count Reporting Requirement is Unduly Burdensome for Many Hospitals**

The proposed requirement to provide an unduplicated count of Medicaid and uninsured individuals is burdensome and appears to exceed current statutory authority by requesting information that is irrelevant to DSH payment adjustment determination.

Many of the patients served by the safety net hospitals fail to provide accurate identifying information. In addition, the same person could be uninsured, insured or Medicaid-eligible at different time during the same year. It will be costly and burdensome to address these complexities in an attempt to produce an

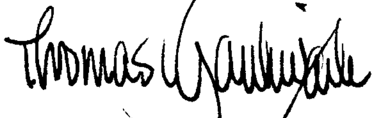
unduplicated count of patients. Therefore, LAC/DHS recommends that CMS remove this requirement from the proposed rule.

- **Verification 1 Regarding the Reduction of Uncompensated Care Costs is Ambiguous.**

  We support the CAPH comment on the need to clarify this issue.

LAC/DHS appreciates the opportunity to submit these comments on the proposed rule. If you have any questions about these comments, please contact Gary W. Wells at (213) 240-7882.

Very truly yours,



Thomas L. Garthwaite, M.D.
Director and Chief Medical Officer

TLG:amg

c: Each Supervisor
   Chief Administrative Officer
   Los Angeles County Congressional Delegation
   National Association of Public Hospitals
   California Association of Public Hospitals
   LAC/DHS Federal Lobbyist

(PROPOSED RULE REGARDING MEDICAID DSH)

101 Sivley Road • Huntsville, Alabama 35801 • 256/265-1000

October 25, 2005

Mark McClellan, M.D., Ph.D., Administrator
Centers for Medicare & Medicaid Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Re: CMS-2198-P; Medicaid Program; Disproportionate Share Hospital Payments -- Implementing the Medicare Modernization Act of 2003 Reporting and Auditing Requirements; Proposed Rule.

Dear Dr. McClellan:

Huntsville Hospital appreciates the opportunity to comment on the proposed rule implementing the Medicaid Disproportionate Share Hospital (DSH) Payment reporting and auditing requirements found in the Medicare Modernization Act of 2003 (MMA). The Medicaid DSH program provides essential financial assistance to our nation's safety net hospitals. It is these hospitals that provide access to care for our nation's most vulnerable populations -- the poor, the disabled and the elderly. And they shoulder critical community services such trauma and burn care, high-risk neonatal care, and disaster preparedness resources. Huntsville Hospital has numerous concerns with the proposed rule and believes the rule, as presently drafted, would have a tremendously negative impact on Medicaid DSH hospitals.

The Medicaid DSH program has operated with little written regulatory guidance since the publication of the program's initial regulations in 1992. There have been two communications to the State Medicaid Directors in 1994 and 2002 that address questions specific to the hospital specific DSH limits. Much of the current DSH policy has been forged in negotiations between the Centers on Medicare and Medicaid (CMS) and individual state governments. The absence of consistent federal policy has been a source of frustration for hospitals. Unfortunately, CMS has chosen to use this proposed rule implementing the MMA reporting and auditing requirements to establish new DSH policy. Huntsville Hospital has four overriding concerns regarding the proposed rule:

1. the substantive changes to standard DSH policy not required by the MMA;
2. the definition of uncompensated care that excludes bad debt;
3. the retroactive application of the auditing requirements to Fiscal Year 2005; and
4. the reporting burden imposed on hospitals. Huntsville Hospital strongly urges CMS to rethink the approach adopted in this proposed rule.

A. Reporting Requirements

Uncompensated Care (UCC) (42 C.F.R. 447.299(c)(15))

The new definition of uncompensated care to both exclude bad debt and physician services are clear examples of the agency's attempt to substantively change long standing DSH policy without properly calling for direct public comment.

Bad Debt The proposed rule, in both the preamble language and the draft regulatory language, states that uncompensated care does not include bad debt for purposes of setting the hospital specific DSH limit. This new definition of uncompensated care that excludes bad debt is not consistent with the statute, legislative history or long-standing agency practice. The underlying statute (1923(g)(1)(A) permits the inclusion of the costs of services provided individuals with no health insurance or other source of third party coverage. The conference report language for the Omnibus Budget Reconciliation Act of 1993 (OBRA '93) provision, that originally established the hospital specific DSH limit, reveals Congress' intent in directing the agency on the various ways to determine the unreimbursed costs that hospitals bear. The report language states that the cost of providing services to uninsured patients would be net of any out of pocket payments received from uninsured individuals. The agency's 1994 letter to state Medicaid programs offered further guidance in the determination of unreimbursed costs by stating that the cost of services provided individuals with third party coverage, but whose third party coverage did not cover the hospital services the individual received, could be counted. The agency was clearly looking at the cost associated with the uninsured and the underinsured in implementing the hospital specific DSH limit. In 2002, the agency in its guidance to state Medicaid programs regarding the hospital specific DSH limit and the upper payment limit reaffirmed the 1994 DSH policy.

A number of state Medicaid programs include the costs of care provided uninsured individuals for which no payment is made and the costs associated with the non payment of copayments and deductibles for individuals with third party coverage in determining a hospital's qualifying costs for the hospital specific DSH limit. *(Current Medicare policy requires that hospitals seek payment from individuals with the means to pay their copayments and deductibles.)* The approaches adopted by these state Medicaid programs to establishing qualifying costs for setting the hospital specific DSH limit are consistent with the statute, legislative history, and long established agency DSH policy. A review of the legislative history of the MMA DSH reporting and auditing requirements **does not reveal** that Congress raised any concerns about how unreimbursed costs were determined for setting the hospital specific DSH limit by the agency or the individual state Medicaid programs. The explicit exclusion of bad debt from the definition of uncompensated care will be harmful to DSH hospitals that are struggling to meet the health care

needs of the growing numbers of uninsured and underinsured. The recent growth of health plans that impose high deductibles or have exclusion limits as well as the growth of health savings account are putting new burdens on hospitals in terms of unreimbursed costs. Huntsville Hospital argues that CMS' new definition of uncompensated care to exclude bad debt is inconsistent with the statute and long standing CMS DSH policy.

Huntsville Hospital strongly recommends that CMS change its definition of uncompensated care by striking references to bad debt in 42 C.F.R. 447.299(c)(15) and in its place clarify that uncompensated care includes the costs of services furnished to individuals with no health care insurance, third party coverage, or third party payment and individuals with health savings accounts and includes the costs of services furnished insured individuals whose policies do not cover the services provided the individual due to their health plans exclusions, limits or deductibles.

Physician Services The preamble of the proposed rule states uncompensated care costs of physician services cannot be included in the calculation of the hospital specific DSH limit. The statute does not specifically exclude physician services. And the agency, in at least one communication to a state Medicaid program, allows for the inclusion of physician services in determining a hospital's unreimbursed costs. The costs associated with securing physicians to serve the hospital's indigent patient population are legitimate unreimbursed costs and should be allowed. The MMA does not require that CMS exclude physician services. This is another example of CMS' attempt to reach beyond MMA statutory requirements to establish new policy.

Huntsville Hospital believes that physician costs associated with hospital services should be included and references to excluding the physician costs in determining the hospital's uncompensated care costs in the preamble should be deleted.

Section 1011 (Preamble)

The preamble in the proposed rule directs state Medicaid programs to consider Section 1011 payments when determining a hospital's hospital specific DSH limit. There is no statutory requirement to include Section 1011 payments when determining the hospital's uncompensated care burden. Section 1011 payments are neither Medicaid payments nor payments from uninsured patients. Congressional intent, in enacting Section 1011, was to provide new resources rather than substitute existing resources for hospitals providing large volumes of uncompensated care to undocumented immigrants. This is yet another example of CMS' attempt to reach beyond statutory authority to set new DSH policy. The consideration of Section 1011 payments would likely result in reducing needed DSH dollars to hospitals serving high numbers of uninsured undocumented immigrants.

Huntsville Hospital recommends that CMS delete the language in the preamble that requires states to offset Section 1011 payments when establishing a hospital's DSH limit and to clarify that Section 1011 payments should not factor into the calculation of the hospital specific DSH limit regardless of the hospital is at or near its limit.

Reporting Unduplicated Patient Count of Medicaid Eligibiles and Uninsured Individuals (42 C.F.R. 447.299 (c)(16))

State Medicaid programs are required to report for each hospital an unduplicated count of Medicaid eligible and uninsured patients. Huntsville Hospital is concerned that states will turn to hospitals to produce these patient counts. Many hospitals do not have the reporting systems in place that would allow them to generate unduplicated counts of patients served through out the year that are Medicaid eligible or uninsured. And many questions arise in how a hospital would classify certain patients such as a patient that has Medicaid coverage for part of the year and are uninsured for part of the year. The proposed rule fails to make the case why this information is necessary.

Huntsville Hospital believes that this reporting requirement would be unnecessarily burdensome for hospitals and recommends that it be deleted.

Reporting of Indigent Care Revenue (42 C.F.R. 447.299(c)(12))

The proposed rule requires reporting of total payments received by hospitals from individuals with no source of third party coverage. Huntsville Hospital is concerned that many hospitals' current accounting systems do not allow them to match payments received from individuals to payments received for individuals for which there was no third party coverage.

This would impose an excessive reporting burden on hospitals and Huntsville Hospital recommends that this reporting requirement be deleted.

Reporting Total Costs (42 C.F.R. 447.299(c)(14))

The 1994 guidance to State Medicaid Directors allows a state to use the definition of allowable costs in its State Medicaid plan or any other definition as long as the costs determined under such a definition do not exceed the amounts that would be allowable under the Medicare principles of cost reimbursement.

Huntsville Hospital believes that the proposed rule should reaffirm this definition of allowable costs to assure greater consistency across all the state Medicaid DSH programs.

B. Auditing Requirements (42 C.F.R 455.204)

Retroactive Audit (42 C.F.R. 455.204(b))

The proposed rule retroactively applies the new reporting and auditing requirements to each state's FY 2005. Most state fiscal years for 2005 have ended. The imposition of the new and substantive reporting and auditing requirements would make it impossible for state Medicaid programs to comply because they would have to retroactively identify the requested data. While the MMA required that CMS impose reporting and auditing requirements beginning in fiscal year 2004, CMS has delayed implementation beyond the date specified in the MMA. The

retroactive application of these new reporting and auditing requirements makes little sense now and will impose a hardship for state Medicaid programs as well as DSH hospitals.

Huntsville Hospital strongly recommends that this retroactive application of the reporting and auditing requirements be deleted from the rule and that the reporting and auditing requirements be tied to the first state fiscal year beginning after the finalization of the rule.

Same Year Actual Costs (42 C.F.R. 455.204(c))

The audit verification #2 requires that the DSH payments comply with the hospital specific DSH limit by requiring that the DSH payments made in the audited state fiscal year (SFY) have to be measured against the actual uncompensated care cost in the same audited SFY. This would require that states reconcile DSH payments to ensure such payments do not exceed actual costs. It is important to note that the MMA does not require that payments be based on actual audited costs. Current CMS DSH policy allows states to use a prospective methodology to estimate current year uncompensated care costs. This approach allows for adjustments in future years to reconcile DSH payments with actual costs. The verification, through audit, of DSH payments with the same year actual uncompensated care costs will place an enormous burden on hospitals through new burdensome and costly audits as well as increase the administrative costs for each state Medicaid program. This is another example where the proposed rule substantively changes current Medicaid DHS policy. The proposed rule also does not speak to how such additional audits will be paid for and there is a concern that the state will pass on the added costs for same year audits to the DSH hospitals. The cost for hospital audits can reach $50,000 or higher per hospital. This estimate clearly suggests that the economic impact of this one audit requirement will meet the test of a major rule under the Regulatory Flexibility Act and should require a regulatory flexibility analysis for small entities such as hospitals.

Huntsville Hospital strongly recommends that CSM delete the requirement in the preamble and the regulatory language that audited DSH payments must be measured against actual uncompensated care cost in the same audited SFY. Huntsville Hospital recommends that CMS clarify that states be allowed to continue to use reasonable estimating methodologies to determine uncompensated care costs.

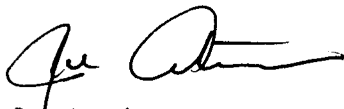
Reduce Uncompensated Care Costs by DSH Payments (42 C.F.R. 455.204(c)(1))

The audit verification #1 requires that a state's audit report verify that each hospital receiving DSH payments has reduced its uncompensated care costs for furnishing inpatient hospital and outpatient hospital services during the SFY to Medicaid eligible individuals and individuals with no source of third party coverage for the services in order to reflect the total amount of claimed DSH expenditures. The DSH statute defines uncompensated care costs as the cost of serving Medicaid and uninsured patients net of Medicaid payments and payments made by uninsured individuals, excluding DSH payments. The statutory language is clear that uncompensated care costs are not offset by DSH payments. The first verification requirement that reduces a hospital's uncompensated care costs by claimed DSH expenditures is contrary to the statute.

Huntsville Hospital recommends that verification #1 be changed to require that the total amount of claimed DSH expenditures for each hospital that qualifies for a DSH payment in the State is no more than the hospital's uncompensated care costs.

Huntsville Hospital appreciates this opportunity to comment on the proposed rule to implement the Medicaid DSH reporting and auditing requirements of the MMA. While Huntsville Hospital has long advocated for greater transparency in the operation of the Medicaid DSH program and more consistent federal standards, the proposed rule has not achieved these goals and makes substantive policy changes that clearly exceeds Congressional intent. The Medicaid DSH program is a lifeline to many safety net hospitals across the country. The proposed rule, as presently drafted, will have a significantly negative impact on these institutions. Huntsville Hospital stands ready to provide any assistance to remedy the concerns outlined. Please refer any questions to David Frederick, Chief Financial Officer, at 256-265-8123 or e-mail at davidf@hhsys.org.

Sincerely,



L. Joe Austin
Chief Executive Officer

LJA/crb

October 25, 2005

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Re: CMS-2198-P; Medicaid Program; Disproportionate Share Hospital Payments -- Implementing the Medicare Modernization Act of 2003 Reporting and Auditing Requirements; Proposed Rule.

Dear Dr. McClellan:

East Alabama Medical Center (EAMC) appreciates the opportunity to comment on the proposed rule implementing the Medicaid Disproportionate Share Hospital (DSH) Payment reporting and auditing requirements found in the Medicare Modernization Act of 2003 (MMA). The Medicaid DSH program provides essential financial assistance to our nation's safety net hospitals. It is these hospitals that provide access to care for our nation's most vulnerable populations -- the poor, the disabled and the elderly. And they shoulder critical community services such as trauma and burn care, high-risk neonatal care, and disaster preparedness resources. EAMC has numerous concerns with the proposed rule and believes the rule, as presently drafted, would have a tremendously negative impact on Medicaid DSH hospitals.

The Medicaid DSH program has operated with little written regulatory guidance since the publication of the program's initial regulations in 1992. There have been two communications to the State Medicaid Directors in 1994 and 2002 that address questions specific to the hospital specific DSH limits. Much of the current DSH policy has been forged in negotiations between the Centers on Medicare and Medicaid (CMS) and individual state governments. The absence of consistent federal policy has been a source of frustration for hospitals. Unfortunately, CMS has chosen to use this proposed rule implementing the MMA reporting and auditing requirements to establish new DSH policy. EAMC has four overriding concerns regarding the proposed rule:

1. The substantive changes to standard DSH policy not required by the MMA;
2. The definition of uncompensated care that excludes bad debt;
3. The retroactive application of the auditing requirements to Fiscal Year 2005; and
4. The reporting burden imposed on hospitals. EAMC strongly urges CMS to rethink the approach adopted in this proposed rule.

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A. Reporting Requirements

Uncompensated Care (UCC) (42 C.F.R. 447.299(c)(15))

The new definition of uncompensated care to both exclude bad debt and physician services are clear examples of the agency's attempt to substantively change long standing DSH policy without properly calling for direct public comment.

Bad Debt The proposed rule, in both the preamble language and the draft regulatory language, states that uncompensated care does not include bad debt for purposes of setting the hospital specific DSH limit. This new definition of uncompensated care that excludes bad debt is not consistent with the statute, legislative history or long standing agency practice. The underlying statute (1923(g)(1)(A) permits the inclusion of the costs of services provided individuals with no health insurance or other source of third party coverage. The conference report language for the Omnibus Budget Reconciliation Act of 1993 (OBRA '93) provision, that originally established the hospital specific DSH limit, reveals Congress' intent in directing the agency on the various ways to determine the unreimbursed costs that hospitals bear. The report language states that the cost of providing services to uninsured patients would be net of any out of pocket payments received from uninsured individuals. The agency's 1994 letter to state Medicaid programs offered further guidance in the determination of unreimbursed costs by stating that the cost of services provided individuals with third party coverage, but whose third party coverage did not cover the hospital services the individual received, could be counted. The agency was clearly looking at the cost associated with the uninsured and the underinsured in implementing the hospital specific DSH limit. In 2002, the agency in its guidance to state Medicaid programs regarding the hospital specific DSH limit and the upper payment limit reaffirmed the 1994 DSH policy.

A number of state Medicaid programs include the costs of care provided uninsured individuals for which no payment is made and the costs associated with the non payment of copayments and deductibles for individuals with third party coverage in determining a hospital's qualifying costs for the hospital specific DSH limit. *(Current Medicare policy requires that hospitals seek payment from individuals with the means to pay their copayments and deductibles.)* The approaches adopted by these state Medicaid programs to establishing qualifying costs for setting the hospital specific DSH limit are consistent with the statute, legislative history, and long established agency DSH policy. A review of the legislative history of the MMA DSH reporting and auditing requirements **does not reveal** that Congress raised any concerns about how unreimbursed costs were determined for setting the hospital specific DSH limit by the agency or the individual state Medicaid programs. The explicit exclusion of bad debt from the definition of uncompensated care will be harmful to DSH hospitals that are struggling to meet the health care needs of the growing numbers of uninsured and underinsured. The recent growth of health plans that impose high deductibles or have exclusion limits as well as the growth of health savings account are putting new burdens on hospitals in terms of unreimbursed costs. EAMC argues that CMS' new definition of uncompensated care to exclude bad debt is inconsistent with the statute and long standing CMS DSH policy. **EAMC strongly recommends that CMS change its definition of uncompensated care by striking references to bad debt in 42 C.F.R. 447.299(c)(15) and in its place clarify that uncompensated care includes the costs of services furnished to individuals with no health care insurance, third party coverage, or third party**

payment and individuals with health savings accounts and includes the costs of services furnished insured individuals whose policies do not cover the services provided the individual due to their health plans exclusions, limits or deductibles.

Physician Services The preamble of the proposed rule states uncompensated care costs of physician services cannot be included in the calculation of the hospital specific DSH limit. The statute does not specifically exclude physician services. And the agency, in at least one communication to a state Medicaid program, allows for the inclusion of physician services in determining a hospital's unreimbursed costs. The costs associated with securing physicians to serve the hospital's indigent patient population are legitimate unreimbursed costs and should be allowed. The MMA does not require that CMS exclude physician services. This is another example of CMS' attempt to reach beyond MMA statutory requirements to establish new policy. **EAMC believes that physician costs associated with hospitals services should be included and references to excluding the physician costs in determining the hospital's uncompensated care costs in the preamble should be deleted.**

Section 1011 (Preamble)

The preamble in the proposed rule directs state Medicaid programs to consider Section 1011 payments when determining a hospital's hospital specific DSH limit. There is no statutory requirement to include Section 1011 payments when determining the hospital's uncompensated care burden. Section 1011 payments are neither Medicaid payments nor payments from uninsured patients. Congressional intent, in enacting Section 1011, was to provide new resources rather than substitute existing resources for hospitals providing large volumes of uncompensated care to undocumented immigrants. This is yet another example of CMS' attempt to reach beyond statutory authority to set new DSH policy. The consideration of Section 1011 payments would likely result in reducing needed DSH dollars to hospitals serving high numbers of uninsured undocumented immigrants. **East Alabama Medical Center recommends that CMS delete the language in the preamble that requires states to offset Section 1011 payments when establishing a hospital's DSH limit and to clarify that Section 1011 payments should not factor into the calculation of the hospital specific DSH limit regardless of the hospital is at or near its limit.**

Reporting Unduplicated Patient Count of Medicaid Eligibiles and Uninsured Individuals (42 C.F.R. 447.299 (c)(16))

State Medicaid programs are required to report for each hospital an unduplicated count of Medicaid eligible and uninsured patients. EAMC is concerned that states will turn to hospitals to produce these patient counts. Many hospitals do not have the reporting systems in place that would allow them to generate unduplicated counts of patients served through out the year that are Medicaid eligible or uninsured. And many questions arise in how a hospital would classify certain patients such as a patient that has Medicaid coverage for part of the year and are uninsured for part of the year. The proposed rule fails to make the case why this information is necessary. **EAMC believes that this reporting requirement would be unnecessarily burdensome for hospitals and recommends that it be deleted.**

Reporting of Indigent Care Revenue (42 C.F.R. 447.299(c)(12))

The proposed rule requires reporting of total payments received by hospitals from individuals with no source of third party coverage. EAMC is concerned that many hospitals' current accounting systems do not allow them to match payments received from individuals to payments received for individuals for which there was no third party coverage. **This would impose an excessive reporting burden on hospitals and EAMC recommends that this reporting requirement be deleted.**

Reporting Total Costs (42 C.F.R. 447.299(c)(14))

The 1994 guidance to State Medicaid Directors allows a state to use the definition of allowable costs in its State Medicaid plan or any other definition as long as the costs determined under such a definition do not exceed the amounts that would be allowable under the Medicare principles of cost reimbursement. **EAMC believes that the proposed rule should reaffirm this definition of allowable costs to assure greater consistency across all the state Medicaid DSH programs.**

B. Auditing Requirements (42 C.F.R 455.204)

Retroactive Audit (42 C.F.R. 455.204(b))

The proposed rule retroactively applies the new reporting and auditing requirements to each state's FY 2005. Most state fiscal years for 2005 have ended. The imposition of the new and substantive reporting and auditing requirements would make it impossible for state Medicaid programs to comply because they would have to retroactively identify the requested data. While the MMA required that CMS impose reporting and auditing requirements beginning in fiscal year 2004, CMS has delayed implementation beyond the date specified in the MMA. The retroactive application of these new reporting and auditing requirements makes little sense now and will impose a hardship for state Medicaid programs as well as DSH hospitals. **EAMC strongly recommends that this retroactive application of the reporting and auditing requirements be deleted from the rule and that the reporting and auditing requirements be tied to the first state fiscal year beginning after the finalization of the rule.**

Same Year Actual Costs (42 C.F.R. 455.204(c))

The audit verification #2 requires that the DSH payments comply with the hospital specific DSH limit by requiring that the DSH payments made in the audited state fiscal year (SFY) have to be measured against the actual uncompensated care cost in the same audited SFY. This would require that states reconcile DSH payments to ensure such payments do not exceed actual costs. It is important to note that the MMA does not require that payments be based on actual audited costs. Current CMS DSH policy allows states to use a prospective methodology to estimate current year uncompensated care costs. This approach allows for adjustments in future years to reconcile DSH payments with actual costs. The verification, through audit, of DSH payments with the same year actual uncompensated care costs will place an enormous burden on hospitals through new burdensome and costly audits as well as increase the administrative costs for each state Medicaid program. This is another example where the proposed rule substantively changes

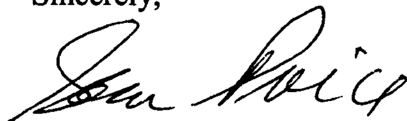
current Medicaid DHS policy. The proposed rule also does not speak to how such additional audits will be paid for and there is a concern that the state will pass on the added costs for same year audits to the DSH hospitals. The cost for hospital audits can reach $50,000 or higher per hospital. This estimate clearly suggests that the economic impact of this one audit requirement will meet the test of a major rule under the Regulatory Flexibility Act and should require a regulatory flexibility analysis for small entities such as hospitals. **EAMC strongly recommends that CSM delete the requirement in the preamble and the regulatory language that audited DSH payments must be measured against actual uncompensated care cost in the same audited SFY. EAMC recommends that CMS clarify that states be allowed to continue to use reasonable estimating methodologies to determine uncompensated care costs.**

Reduce Uncompensated Care Costs by DSH Payments (42 C.F.R. 455.204(c)(1))

The audit verification #1 requires that a state's audit report verify that each hospital receiving DSH payments has reduced its uncompensated care costs for furnishing inpatient hospital and outpatient hospital services during the SFY to Medicaid eligible individuals and individuals with no source of third party coverage for the services in order to reflect the total amount of claimed DSH expenditures. The DSH statute defines uncompensated care costs as the cost of serving Medicaid and uninsured patients net of Medicaid payments and payments made by uninsured individuals, excluding DSH payments. The statutory language is clear that uncompensated care costs are not offset by DSH payments. The first verification requirement that reduces a hospital's uncompensated care costs by claimed DSH expenditures is contrary to the statute. **EAMC recommends that verification #1 be changed to require that the total amount of claimed DSH expenditures for each hospital that qualifies for a DSH payment in the State is no more than the hospital's uncompensated care costs.**

EAMC appreciates this opportunity to comment on the proposed rule to implement the Medicaid DSH reporting and auditing requirements of the MMA. While EAMC has long advocated for greater transparency in the operation of the Medicaid DSH program and more consistent federal standards, the proposed rule has not achieved these goals and makes substantive policy changes that clearly exceeds Congressional intent. The Medicaid DSH program is a lifeline to many safety net hospitals across the country. The proposed rule, as presently drafted, will have a significantly negative impact on these institutions. EAMC stands ready to provide any assistance to remedy the concerns outlined.

Sincerely,



Samuel A. Price, Jr.
Vice President Finance

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FRANCES MAHON DEACONESS HOSPITAL

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October 20, 2005

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Re: CMS-2198-P; Medicaid Program; Disproportionate Share Hospital Payments -- Implementing the Medicare Modernization Act of 2003 Reporting and Auditing Requirements. Proposed Rule.

Dear Dr. McClellan:

Frances Mahon Deaconess Hospital appreciates the opportunity to comment on the proposed rule implementing the Medicaid Disproportionate Share Hospital (DSH) Payment reporting and auditing requirements found in the Medicare Modernization Act of 2003 (MMA). The Medicaid DSH program provides essential financial assistance to Montana's community hospitals. Montana hospitals, with few exceptions, are not-for-profit community institutions that provide access to care for all Montanans, including the poor, disabled and elderly. Montana, among states, has one of the highest percentages of uninsured residents and one of the lowest average incomes. Further, the county we serve has one of the lowest average incomes within Montana. Medicaid payments, especially payments from the DSH program, provide an extremely important resource to assure our ability to provide continued access to care for the people we serve.

We are very concerned about the proposed rule. Adoption of the rule would greatly reduce the DSH payments to our hospital. These payments have been critical to our operations over the past two years.

We endorse the comments provided by the American Hospital Association and MHA which notes that he Medicaid DSH program has operated with little written regulatory guidance since the publication of the program's initial regulations in 1992. There have been two communications to the State Medicaid Directors in 1994 and 2002 that address questions specific to the hospital specific DSH caps.

Much of the current DSH policy has been forged in negotiations between the Centers on Medicare and Medicaid (CMS) and individual state governments. The absence of consistent federal policy has been a source of frustration for hospitals.

It appears that CMS is choosing to use this proposed rule that implements the MMA reporting and auditing requirements to establish new DSH policy. Montana currently requires hospitals to report both charity and bad debt costs to the Medicaid program to assure that no hospital will receive an excess Medicaid DSH payment. This method is part of an approved State Plan, and has been in place for numerous years. The proposed regulation is a major departure from current practice.

CMS seeks to create a new definition of uncompensated care. The new definition of uncompensated care to both exclude bad debt and physician services are clear examples of the agency's attempt to substantively change long standing DSH policy without properly calling for direct public comment.

Uncompensated Care (UCC) (42 C.F.R. 447.299(c)(15))

Bad Debt The proposed rule, in both the preamble language and the draft regulatory language, states that uncompensated care does not include bad debt for purposes of setting the hospital specific DSH limit. This new definition of uncompensated care that excludes bad debt is not consistent with the statute, legislative history or long standing agency practice. The underlying statute (1923(g)(1)(A) permits the inclusion of the costs of services provided individuals with no health insurance or other source of third party coverage. The conference report language for the Omnibus Budget Reconciliation Act of 1993 (OBRA '93) provision, that originally established the hospital specific DSH limit, reveals Congress' intent in directing the agency on the various ways to determine the unreimbursed costs that hospitals bear. The report language states that the cost of providing services to uninsured patients would be net of any out of pocket payments received from uninsured individuals. The agency's 1994 letter to state Medicaid programs offered further guidance in the determination of unreimbursed costs by stating that the cost of services provided individuals with third party coverage, but whose third party coverage did not cover the hospital services the individual received, could be counted. The agency was clearly looking at the cost associated with the uninsured and the underinsured in implementing the hospital specific DSH limit. In 2002, the agency in its guidance to state Medicaid programs regarding the hospital specific DSH limit and the upper payment limit reaffirmed the 1994 DSH policy.

A number of state Medicaid programs include the costs of care provided uninsured individuals for which no payment is made and the costs associated

with the non payment of copayments and deductibles for individuals with third party coverage in determining a hospital's qualifying costs for the hospital specific DSH limit. Montana is among states that have adopted this policy. We echo MHA belief that Montana Medicaid policy is consistent with the statute, legislative history, and long established agency DSH policy.

Congress did not include statutory language to exclude bad debts from being considered part of uncompensated care. The statute does not raise the issue of indigence or willingness of the patient to pay for care. Rather it addresses the burden of providing care to uninsured, and underinsured patients for whom the hospital receives no payment. MHA believes that the proposed rule is inconsistent with Congressional intent, and actually works to weaken the statute's purpose. **FMDH recommends that CMS change its definition of uncompensated care by striking references to bad debt in 42 C.F.R. 447.299(c)(15) and in its place clarify that uncompensated care includes the costs of services furnished to individuals with no health care insurance, third party coverage, or third party payment which includes individuals with health savings accounts and include the costs of services furnished insured individuals whose policies do not cover the services provided the individual due to their health plans exclusions, limits or deductibles.**

Physician Services The preamble of the proposed rule states uncompensated care costs of physician services cannot be included in the calculation of the hospital specific DSH limit. The statute does not specifically exclude physician services. Many Montana hospitals, such as ours, typically employ physicians and other practitioners in order to assure access to services. The hospital bears the risk for nonpayment for the providers' services while it incurs the cost of employment and other support. It is only reasonable to include unpaid provider costs as part of the hospital's uncompensated care costs reported to the Medicaid Program.

AHA has advised MHA, who in turn has advised us, that CMS, in at least one communication to a state Medicaid program, allows for the inclusion of physician services in determining a hospital's unreimbursed costs. The costs associated with securing physicians to serve the hospital's indigent patient population are legitimate unreimbursed costs and should be allowed. The MMA does not require that CMS exclude physician services. This is another example of CMS' reach beyond statutory requirements to establish new policy. **AHA and MHA have stated, and we concur, that physician costs associated with hospital services should be included and references to excluding the physician costs in determining the hospital's uncompensated care costs in the preamble should be deleted.**

Reporting Unduplicated Patient Count of Medicaid Eligibiles and Uninsured Individuals (42 C.F.R. 447.299 (c)(16))

State Medicaid programs are required to report for each hospital an unduplicated count of Medicaid eligible and uninsured patients. It is likely that states will turn to hospitals to produce these patient counts. Our hospital does not have the reporting systems in place that would allow us to generate unduplicated counts of patients served throughout the year that are Medicaid eligible or uninsured. Further, many questions arise in how we would classify certain patients such as a patient that has Medicaid coverage for part of the year and are uninsured for part of the year. The proposed rule fails to make the case why this information is necessary. **FMDH believes that this reporting requirement would be unnecessarily burdensome for our hospital and recommend that it be deleted.**

Reporting of Indigent Care Revenue (42 C.F.R. 447.299(c)(12))

The proposed rule requires reporting of total payments received by hospitals from individuals with no source of third party coverage. Our hospital's current accounting systems do not allow us to aggregate this data. **This would impose an excessive reporting burden on hospitals and FMDH recommends that this reporting requirement be deleted.**

Reporting Total Costs (42 C.F.R. 447.299(c)(14))

The 1994 guidance to State Medicaid Directors allows a state to use the definition of allowable costs in its State Medicaid plan or any other definition as long as the costs determined under such a definition do not exceed the amounts that would be allowable under the Medicare principles of cost reimbursement. **We again echo MHA belief that the proposed rule should reaffirm this definition of allowable costs to assure greater consistency across all the state Medicaid DSH programs.**

Same Year Actual Costs (42 C.F.R. 455.204(c))

The audit verification #2 requires that the DSH payments comply with the hospital specific DSH limit by requiring that the DSH payments made in the audited state fiscal year (SFY) have to be measured against the actual uncompensated care cost in the same audited SFY. This would require that states reconcile DSH payments to ensure such payments do not exceed actual costs, but the MMA, in fact, does not require that payments be based on actual audited costs. Current CMS DSH policy allows states to use a prospective methodology to estimate current year uncompensated care costs. This approach allows for adjustments in future years to reconcile DSH payments with actual

costs. The verification, through audit, of DSH payments with the same year actual uncompensated care costs will place an enormous burden on hospitals through new burdensome and costly audits as well as increase the administrative costs for each state Medicaid program.

Montana Medicaid annually surveys all hospitals near the beginning of its fiscal year. Hospitals report their data for a twelve month period, but this period does not match the state fiscal year. The state uses this data to provide the required assurances that its methods results in payments that are consistent with federal rules. Further, federal DSH payments are provided on a federal fiscal year, and at changing match percentages. It is not practical to attempt matching the state's payments to actual costs, unless such an effort were made after all related cost reporting periods were closed, audits performed and cost settlements performed. Even this effort would not provide a precise measure since hospitals' fiscal years won't always match state fiscal years.

The proposed rule also does not speak to how such additional audits will be paid for and there is a concern that the state will pass on the added costs for same year audits to the DSH hospitals. The cost for hospital audits can reach $50,000 or higher per hospital. This estimate clearly suggests that the economic impact of this one audit requirement will meet the test under the Regulatory Flexibility Act of a major rule and should require a regulatory flexibility analysis for small entities such as hospitals. We support **MHA's strong recommendation that CMS delete the requirement in the preamble and the regulatory language that audited DSH payments must be measured against actual uncompensated care cost in the same audited SFY. We also support MHA's additional recommendation that CMS clarify that states be allowed to continue to use reasonable estimating methodologies to determine uncompensated care costs.**

FMDH appreciates this opportunity to comment on the proposed rule to implement the Medicaid DSH reporting and auditing requirements of the MMA. Like MHA, we do not object to the effort to better measure compliance with federal regulations, or to the plain meaning of the provisions of MMA. The proposed rule, as presently drafted, will have a significantly negative impact on Montana hospitals. We strongly urge you to consider the comments noted in this letter.

Sincerely,

Randall G. Holom
Chief Executive Officer

NATIONAL ASSOCIATION of PUBLIC HOSPITALS and HEALTH SYSTEMS
1301 PENNSYLVANIA AVENUE, NW, SUITE 950, WASHINGTON DC 20004 | 202.585.0100 | FAX 202.585.0101

OCT 25 2005

October 25, 2005

Via Courier

Dr. Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Ref: CMS-2198-P – Medicaid Program; Disproportionate Share Hospital Payments; Proposed Rule

Re: Reporting Requirements, Audit Requirements, Collection of Information Requirements, Regulatory Impact Statement

Dear Dr. McClellan:

The National Association of Public Hospitals and Health Systems (NAPH) appreciates the opportunity to submit comments on the above-referenced Proposed Rule.[1] NAPH represents more than 100 metropolitan area safety net hospitals and health systems. Our members provide certain essential specialized services to their entire communities, such as emergency and trauma care, burn care, and neonatal intensive care and are significant providers of care to low-income and uninsured patients. For example, approximately 38 percent of the inpatient services provided by NAPH members is to Medicaid recipients and another 23 percent is provided to uninsured patients. Medicaid disproportionate share (DSH) payments cover nearly a quarter of the unreimbursed care provided by NAPH members. NAPH members are likely to be especially impacted by the DSH reporting and audit requirements contained in the Proposed Rule.

NAPH generally supports reporting requirements that help ensure that state DSH payments comply with federal requirements and fulfill the statutory mandate to assist hospitals that serve a disproportionate share of low-income individuals. At the same time, NAPH has numerous concerns regarding the Proposed Rule.

[1] 70 Fed. Reg. 50262 (Aug. 26, 2005), hereinafter "Proposed Rule."

First, NAPH is concerned that the preamble to the regulation inappropriately changes various aspects of Medicaid DSH policy and goes beyond Congressional intent in the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA). This is of particular concern given the proposed retroactive application of the regulation. To address these concerns, NAPH believes CMS should make the following changes in its final rule:

- Impose the reporting and audit requirements prospectively only, effective for the first state fiscal year that begins after the date of the final rule.
- Retract preamble language requiring uncompensated costs to be offset by payments for emergency services for undocumented immigrants received pursuant to Section 1011 of the MMA.
- Retract the statement in the preamble that indicates that the uncompensated care costs of providing physician services cannot be included in the calculation of the hospital-specific DSH limit. CMS should also reaffirm states' discretion to define costs for purposes of the hospital-specific limit, as described in CMS' 1994 letter to State Medicaid Directors.
- Eliminate the statement in the definition of "uncompensated care costs" in proposed 42 C.F.R. 447.299(c)(15) that bad debt cannot be included in such costs, and clarify that costs associated with underinsured individuals who are not covered for the services provided may be included.

NAPH also objects to some of the requirements in the proposed regulation as unnecessarily burdensome. To address these concerns, NAPH believes CMS should make the following changes to the final rule:

- Clarify the preamble and amend the language in proposed audit verification requirement #2 (42 C.F.R. 455.204(c)(2)) to eliminate the requirement that DSH payments made in any audited state fiscal year must be reconciled with actual same-year uncompensated care costs. Instead, states should be permitted to rely on reasonable prospective methodologies.
- Remove the requirement in proposed 42 C.F.R. 447.299(c)(16) that states indicate for each hospital an unduplicated patient count of Medicaid eligible and uninsured individuals served by each hospital.

Finally, NAPH requests that CMS revise ambiguous language and correct technical errors in the preamble and Proposed Rule as detailed in the attached comments.

Overall, NAPH is concerned that the new Proposed Rule and accompanying preamble in many areas go far beyond the procedural aspects of reporting and auditing to interpret, often for the first time, underlying substantive requirements of the hospital-specific DSH limit. These policy interpretations go far beyond Congress' direction in the MMA, which focused solely on auditing and reporting requirements. The Proposed Rule is therefore very significant and will, in many cases, have a direct financial impact on hospitals' DSH payments. The DSH program, over the

years, has become the "lifeblood" for many safety net hospitals such as the members of NAPH who provide essential access to healthcare for the poor and uninsured. Policy changes in this program, particularly changes with significant economic impacts, directly affect their ability to provide this access.

NAPH appreciates the opportunity to submit these comments on the Proposed Rule regarding DSH reporting and auditing requirements. If you have any questions about these comments, please contact NAPH counsel Charles Luband, Barbara Eyman or Allison Orris at (202) 347-0066.

Sincerely,

Larry S. Gage
President

cc: Dennis Smith
Jimmy Wickcliffe, CMS Office of Strategic Operations and Regulatory Affairs
Katherine Astrich, Office of Information and Regulatory Affairs, OMB

Attachment

NATIONAL ASSOCIATION of PUBLIC HOSPITALS and HEALTH SYSTEMS
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COMMENTS ON PROPOSED RULE REGARDING DISPROPORTIONATE SHARE HOSPITAL REPORTING AND AUDIT REQUIREMENTS

Ref: CMS-2198-P – Medicaid Program; Disproportionate Share Hospital Payments; Proposed Rule (70 Fed. Reg. 50262 (Aug. 26, 2005))

I. THE PROPOSED RULE IMPOSES NEW SUBSTANTIVE REQUIREMENTS ON HOSPITALS

NAPH is concerned that the preamble to the Proposed Rule contains a number of new substantive interpretations of longstanding Medicaid DSH requirements, which go beyond Congressional intent in the MMA reporting language. For example the preamble indicates that physician service costs must be excluded from the hospital-specific DSH cap calculation and requires that DSH payments be reconciled against actual audited uncompensated care costs in that same state fiscal year. These are requirements that have never been announced in regulations or any other official guidance issued by CMS. The Proposed Rule therefore requires much more than mere reporting and auditing of programs as they currently exist. In many cases they will require restructuring of state DSH programs to conform to the newly announced standards.

A. *Reporting and Audit Requirements*: Prospective Application of Substantive Changes

In general, the retroactive application of regulations is disfavored, and this regulation should not be an exception. Moreover, states will not be able to implement new substantive requirements in years that have already passed. CMS has already delayed implementation beyond the date specified in Section 1001 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), which requires the Secretary of HHS to impose reporting and audit requirements beginning in fiscal year 2004. Given the delay in CMS' issuance of the regulation, it should not be effective until the first SFY that begins after the date the final rule is issued.

New substantive requirements contained in the preamble of the Proposed Rule and in the regulatory language are especially troublesome because the Proposed Rule would make the reporting and auditing requirements effective beginning with state fiscal year (SFY) 2005, which for many states has already ended.[1] It will be difficult, if not impossible, for states to retroactively identify data that CMS is now requesting. CMS has never issued regulations implementing the hospital-specific DSH limits adopted by Congress over a decade ago. To the extent that CMS retains substantive changes to DSH policy in this regulation, CMS should acknowledge that this regulation does more than merely implement reporting and auditing requirements against existing standards.

CMS should eliminate the substantive new policy interpretations imbedded in the Proposed Rule and preamble, and make the regulation effective in the first SFY beginning after the date of the final rule.

[1] 70 Fed. Reg. 50262 (Aug. 26, 2005) at 50267 (proposed 42 C.F.R. 447.299(c)) and 50268 (proposed 42 C.F.R. 455.204(b)).

B. *Reporting Requirements*: Calculation of the DSH-cap and Section 1011 Payments

The preamble to the Proposed Rule includes a comment regarding the interaction between DSH payments and MMA Section 1011 payments, which reimburse costs associated with emergency services provided to undocumented immigrants. Although the Proposed Rule notes that Section 1011 payments should not impact DSH payments for hospitals that have not reached their DSH caps, the preamble asserts that states "will need to consider a Section 1011 payment when determining the hospital's DSH limit, because the total DSH payments should not exceed the total amount of uncompensated care at the hospital."[2]

There is no legal basis for this interpretation. The statutory provision establishing the hospital-specific DSH limit specifies that the limit is equal to the costs of care provided to Medicaid or uninsured persons "net of payments under this title [Medicaid], other than under this section [Medicaid DSH], and by uninsured patients."[3] The statute specifies the revenues that are to be offset against costs and includes only non-DSH Medicaid revenues or payments ***by uninsured patients***. Section 1011 payments are neither Medicaid payments nor payments by uninsured patients and thus CMS does not have the authority to require states to reduce DSH limits by the amount of Section 1011 payments. Moreover, the offset undermines Congress' intent in enacting Section 1011 to provide new rather than substitute resources for hospitals providing large volumes of uncompensated care to undocumented immigrants.

CMS does not have the legal authority to require states to offset uncompensated Medicaid and uninsured costs by any Section 1011 payments received. NAPH requests that CMS clarify that Section 1011 payments do not factor into the calculation of the hospital-specific DSH limit regardless of whether a hospital is at or near its DSH cap. If CMS continues to assert that states should consider Section 1011 payments when determining the hospital's DSH limit, please provide the statutory basis for this requirement.

C. *Audit Requirements*: Inclusion of Physician Costs in Calculation of Uncompensated Care Costs (42 C.F.R. 455.204(c)(3))

NAPH objects to language in the preamble to the Proposed Rule that suggests that a hospital's physician costs cannot be included in the uncompensated care cost (UCC) calculation.[4] This language appears to be announcing a new standard that is not currently embodied in law, regulation or guidance and that is likely to produce substantial confusion.

The Proposed Rule requires states to verify that "only uncompensated care costs of providing inpatient and outpatient hospital services to Medicaid eligible individuals and uninsured individuals are included in the hospital-specific DSH payment limit."[5] In the preamble language describing this requirement, CMS takes the opportunity to state that "The uncompensated care

[2] *Id.* at 50264.
[3] 42 U.S.C. §1396r-4(g)(1)(A).
[4] Although in this comment letter we adopt CMS' use of the term uncompensated care cost (UCC) in describing the hospital-specific DSH limit in 42 U.S.C. §1396r-4(g)(1)(A), see our discussion at Section III.E. regarding the appropriateness of this term.
[5] 70 Fed. Reg. at 50268 (proposed 42 C.F.R. 455.204(c)(3)).

costs of providing physician services cannot be included in the calculation of [the] hospital-specific DSH limit."[6] The regulatory language is silent on this issue.

This preamble is the first time CMS has stated that a hospital's physician costs cannot be included in the UCC calculation. In fact, in correspondence with at least one state Medicaid agency, CMS has purported to explain the conditions under which physician services ***could*** be included as a component of hospital services, and thus included in the hospital-specific limit.[7] States have previously relied on the description of "cost of services" contained in a 1994 letter to State Medicaid Directors, which stated that CMS "would permit the State to use the definition of allowable costs in its State plan, or any other definition, as long as the costs determined under such a definition do not exceed the amounts that would be allowable under the Medicare principles of cost reimbursement."[8]

In addition, CMS' regulatory definitions of inpatient services and outpatient services allow for inclusion of physician services. Inpatient hospital services are defined as services "furnished under the direction of a physician or dentist."[9] Outpatient hospital services are defined as services furnished "by or under the direction of a physician or dentist."[10] Although physician services are a separately defined service under the regulations, this separate definition does not mean that the two are mutually exclusive, just as the cost of prescription drugs administered to an inpatient or lab and x-ray services provided to an inpatient are allowable hospital costs.

Several states have permitted the inclusion of physician costs related to hospital services in the calculation of the hospital-specific limit. This position is logical, particularly with regard to uninsured patients, as many hospitals must compensate physicians for providing indigent care hospital services in order to ensure that the hospital services are available. Thus, without incurring costs for physicians providing care to the uninsured, hospitals would be unable to provide hospital services to this underserved population. Particularly for hospitals that serve a disproportionate share of low-income patients, hospital services would not be available without payments by the hospital to physicians.

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[6] *Id.* at 50265.
[7] *See, e.g.*, Letter to Ben Bearden, Director, Bureau of Health Services Financing, Louisiana Department of Health and Hospitals, from Andrew Frederickson, Dallas Regional Office Chief, Medicaid Operations and Financial Management Branch, CMS Division of Medicaid and State Operations, July 20, 2001. ("Therefore, to the extent that the State recognizes the provisions (sic) of direct patient services by physicians, CRNAs, and other mid-level practitioners as hospital services, the State may include the associated costs in the determination of the hospital specific limits."); Letter to Ben Bearden, Director, Bureau of Health Services Financing, Louisiana Department of Health and Hospitals, from Bill Brooks, Dallas Regional Office Chief, Financial and Programs Operation Branch, CMS Division of Medicaid and State Operations, May 21, 2003 ("Under [certain described] circumstances, these services would not be considered a physician service but rather would be part of the outpatient hospital service. Therefore, the uncompensated cost of these services could be included in the hospital-specific DSH limit."). Although NAPH does not acknowledge any validity in Medicaid law for the limitations CMS set forth in this correspondence, the correspondence nevertheless demonstrates CMS' acknowledgement of physician services as an element of hospitals' uncompensated care costs.
[8] Letter to State Medicaid Directors from Sally Richardson, Director, Center for Medicaid and State Operations, Health Care Financing Administration, Aug. 17, 1994.
[9] 42 C.F.R. §440.10(a)(2).
[10] 42 C.F.R. §440.20(a)(2).

CMS' position is not dictated by the statutory language. Further, CMS' interpretation conflicts with sound underlying policy justifications for allowing inclusion of these costs.

CMS should retract the statement in the preamble that the uncompensated care costs of providing physician services cannot be included in the calculation of the hospital-specific DSH limit. CMS should also reaffirm states' discretion to define costs for the purposes of the hospital-specific DSH limit, as described in CMS' 1994 letter to State Medicaid Directors.

D. ***Reporting Requirements:*** **Definition of Uncompensated Care Costs (42 C.F.R. 447.299(c)(15))**

The definition of "uncompensated care costs" provided in the preamble to the Proposed Rule and in the proposed regulatory text contains the statement that "[u]ncompensated care costs do not include bad debt or payer discounts."[11] This statement is inconsistent with the statutory language, which includes all costs related to Medicaid patients and individuals who "have no health insurance (or other source of third party coverage)."[12] If a patient does not have health insurance, the costs of services provided to that patient may be included, even if revenues related to that patient are uncollectible and eventually written off as bad debt. The touchstone for purposes of the DSH limit is whether the individual has third party coverage, not whether the hospital has or has not treated the patient's account as bad debt. The current language excluding bad debt is misleading and should be clarified or eliminated.

In addition, in a 1994 State Medicaid Director's Letter, CMS clarified that "it would be permissible for states to include in this definition [of uncompensated care costs] individuals who do not possess health insurance which would apply to the service for which the individual sought treatment."[13] This clarification should be reiterated in the Proposed Rule and applied to patients with insurance policies with high deductibles as well as those with exclusions, limits, etc. The uncompensated care costs of underinsured patients are equally as taxing on hospitals as costs associated with uninsured patients. In addition, any unreimbursed costs for services to patients with health savings accounts but no insurance coverage for the services provided should also be included, as these individuals also do not possess third party coverage.

CMS should eliminate the reference to bad debt in proposed 42 C.F.R. 447.299(c)(15) and clarify that uncompensated care costs include costs of services to insured patients whose policies do not cover the particular services provided by the hospital due to exclusions, limits, deductibles or otherwise and to patients with health savings accounts but no other source of third party coverage for the service.

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[11] 70 Fed. Reg. at 50268 (proposed 42 C.F.R. 447.299(c)(15)).
[12] 42 U.S.C. § 1396r-4(g)(1)(A).
[13] Letter to State Medicaid Directors from Sally Richardson, Director, Center for Medicaid and State Operations, Health Care Financing Administration, Aug. 17, 1994.

II. THE PROPOSED RULE WILL SUBJECT HOSPITALS TO BURDENSOME REQUIREMENTS

The Proposed Rule directly increases states' reporting requirements which will consequentially result in an increase in information state Medicaid programs will require from hospitals. In addition, the audit requirement will require auditors to conduct detailed reviews of hospital financial information, all of which is already reviewed by hospital auditors. The costs of compliance with these substantial new burdens (including those resulting from the new substantive requirements discussed above) could be significant for hospitals and NAPH urges CMS to avoid requiring states to report data that hospitals do not currently collect.

A. Audit Requirements: Same Year Actual Costs (42 C.F.R. 455.204(c)(2))

To verify that DSH payments comply with the hospital-specific DSH limit, audit verification requirement #2 requires that "for each audited SFY, the DSH payments made in that audited SFY must be measured against the actual uncompensated care cost in that same audited SFY."[14] It would be impossible for a state to know what the "actual uncompensated care costs in that same audited SFY" are before or during the year that the DSH payments are being made. In fact, in order to ensure that DSH payments do not exceed such actual audited costs, the state would have to undertake a reconciliation of DSH payments several months or years after the payments are made and audits have been completed.

CMS has never before required such a reconciliation and has instead allowed states flexibility to use estimates of current year uncompensated costs.[15] Moreover, CMS has approved several State Plan Amendments (SPAs) that provide for final DSH payments to be disbursed during or shortly after the current fiscal year. The Proposed Rule is introducing a substantive change in policy that will impose a massive new administrative burden on states and hospitals.

The imposition of such an administrative burden would divert scarce state and hospital resources from other productive activities to achieve at best only marginal gains in accuracy of the UCC calculation. To the extent that reliance on estimated costs based on prior year data may result in payments that are more or less than actual costs determined through subsequent audits, those variances will be accounted for in future year UCC computations. For example, using a prospective methodology, if an FY 2006 DSH payment to a hospital is based on FY 2004 costs, and the actual FY 2006 costs are subsequently determined, through an audit, to be significantly lower than the FY 2004 costs on which the FY 2006 DSH payments were based, the difference will be made up in the hospital's FY 2008 DSH payment (since the 2008 payment will be based on audited FY 2006 costs). Conversely, if the hospital's FY 2006 actual costs are subsequently determined to be significantly higher than the projected costs, the hospital will be permitted to receive higher DSH payments in FY 2008. Rather than requiring a reconciliation of the FY 2006 DSH payments in FY 2008, the same end could be achieved by basing FY 2008 payments on the FY 2006 data. Moreover, the financial exposure for the federal government through the use of estimated rather than reconciled data is not significant as total DSH expenditures are limited by

[14] 70 Fed. Reg. at 50265 and 50268 (proposed 42 C.F.R. 455.204(c)(2)).

[15] *See, e.g.*, Letter to Donna Checkett, Chair, State Medicaid Directors Association, from Sally Richardson, Director, Medicaid Bureau, Health Care Financing Administration, Jan. 10, 1995.

the statewide DSH allotment. The benefit obtained through the reconciliation mandate is therefore far outweighed by its costs.

Moreover, the statute does not require the interpretation CMS proposes to adopt. The statute provides that a DSH payment adjustment "during a fiscal year" is considered non-compliant with the limit if the adjustment exceeds the uncompensated costs for Medicaid and uninsured patients incurred "during the year."[16] CMS appears to be basing this burdensome reconciliation requirement solely on this language. While the provision does limit current year payments to current year costs, nothing in the language mandates the use of actual audited costs. Reliable estimates based on audited prior year data will, as noted above, produce sufficient controls on the DSH payments and fulfill Congress' intent of limiting DSH expenditures on a hospital-specific basis. Particularly at this time when Congress and the Administration are intently focused on reining in Medicaid expenditures, CMS should not impose unnecessary administrative burdens that will raise costs for states and hospitals (that ultimately will be shared by the federal government) that result neither in improved quality or access nor in any measurable gain in accuracy or efficiency. The requirement elevates bureaucratic form over substance and should be removed.

CMS should clarify the preamble description and amend the language in proposed 42 C.F.R. 455.204(c)(2) to eliminate the requirement that DSH payments made in any audited SFY must be measured against the actual uncompensated care cost in that same audited SFY. The regulation should continue to permit states to rely on reasonable prospective methodologies for determining UCC in a given year.

B. *Reporting Requirements*: Unduplicated Patient Count of Medicaid Eligible and Uninsured Individuals (42 C.F.R. 447.299(c)(16))

NAPH is concerned with the burden of requiring states to indicate for each DSH hospital an unduplicated count of Medicaid eligible and uninsured individuals.[17] Although most of the reporting items bear some relation to existing DSH requirements, either in terms of eligibility for DSH or in terms of the hospital-specific DSH cap, the requirement that states indicate for each hospital an unduplicated count of Medicaid eligible and uninsured patients does not appear to bear any relation to any DSH requirement. Not all hospitals collect this information and for some it may be burdensome to begin collecting it. Further, these data may be misleading or difficult to interpret—for example, how would a hospital classify individuals who had Medicaid coverage for some discharges and no insurance for others? Focusing resources on addressing these reporting issues is of questionable value when the data have no bearing on payment or other requirements. Because there is no clear relationship between the DSH program and these data, and because it may impose a substantial burden on hospitals, NAPH requests that this data element be removed from the reporting requirements.

CMS should remove the requirement in 42 C.F.R. 447.299(c)(16) that states indicate for each hospital an unduplicated count of Medicaid eligible and uninsured individuals.

[16] 42 U.S.C. § 1396r-4(g)(1)(A).
[17] 70 Fed. Reg. at 50268 (proposed 42 C.F.R. 447.299(c)(16)).

C. *Regulatory Impact Statement and Collection of Information Requirements:* Burden on Small Entities

Given all of the additional burdens imposed on hospitals articulated in these comments, we strongly disagree with CMS' conclusions in its Regulatory Impact Statement. Executive Order 12866 requires agencies to prepare a regulatory impact analysis for major rules with economically significant effects. For rules that will have a significant economic impact, the Regulatory Flexibility Act (RFA) requires CMS to analyze options for regulatory relief of small businesses, such as hospitals. The newly announced DSH requirements contained in the Proposed Rule and discussed throughout this comment letter may result in decreased DSH funding for some hospitals, jeopardizing their ability to provide broad access to services for the uninsured and underinsured. In addition to the costs of compliance with new reporting requirements and the associated loss of DSH funding, the cost of auditing each DSH hospital's records to satisfy the new audit requirements will be substantial and could very well exceed $100 million annually, thus reaching the economic threshold that triggers a regulatory impact analysis (RIA) under Executive Order 12866. Similarly, NAPH objects to CMS' conclusion that because the Proposed Rule "would not have a significant economic impact on a substantial number of small entities" the agency did not need to conduct a regulatory flexibility analysis under the RFA.[18] NAPH urges CMS to revise the regulation to reduce the economic impact on hospitals as recommended elsewhere in these comments so that CMS' conclusion that there is no such impact will be accurate. Absent such revisions, however, CMS should reconsider its conclusion that the regulation would not have a significant economic impact and should undertake appropriate analyses under Executive Order 12866 and the RFA to consider how the burden on hospitals could be lessened.

Pursuant to the Paperwork Reduction Act (PRA) of 1995, CMS has solicited comments regarding the information collection burden, clarity of information collected and recommendations to minimize the information collection burden. As explained in detail throughout these comments, NAPH believes that the information collection burden is significant, that in many cases the information requested is ambiguous or inaccurate and that there are better ways to implement the statutory requirements. Therefore, NAPH is also providing copies of these comments to the CMS Office of Strategic Operations and Regulatory Affairs and to the Office of Management and Budget's Office of Information and Regulatory Affairs. We note further that while collection activities in response to audit requirements are exempt from the Paperwork Reduction Act, CMS should acknowledge that the new substantive requirements that it is announcing in the form of audit standards will impose independent new paperwork burdens on states separate and apart from the response to the audits. For example, CMS' proposal that the audits verify that DSH payments do not exceed actual year costs will impose a massive new DSH reconciliation requirement on states so that the audits do not conclude that they have exceeded the hospital-specific DSH limits. Therefore, we believe CMS should evaluate the paperwork burden associated with new standards announced as part of the audit requirements as well as the reporting requirements.

Absent significant revisions of the Proposed Rule, NAPH suggests that CMS reconsider the economic and paperwork impact that the Proposed Rule will have on hospitals.

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[18] 70 Fed. Reg. at 50267.

III. THE PROPOSED RULE INCLUDES AMBIGUOUS LANGUAGE AND TECHNICAL ERRORS

A number of the reporting requirements are ambiguously worded or contain technical errors. NAPH requests that the following items be clarified to facilitate implementation of the DSH reporting and audit requirements.

A. *Reporting and Audit Requirements*: Application to States with DSH Waivers

Some states have received waivers of DSH requirements under Section 1115 of the Social Security Act. For example, Massachusetts recently received such a waiver pursuant to which it is establishing a Safety Net Care Pool that combines DSH and other Medicaid payments. CMS should clarify that the reporting and audit requirements do not apply to states that no longer have traditional DSH programs subject to the limitations under Section 1923(g).

NAPH requests that CMS clarify that the proposed DSH reporting and audit requirements do not apply to states with DSH waivers.

B. *Audit Requirements*: Verification that States Have Reduced their Uncompensated Care Costs (42 C.F.R. 455.204(c)(1))

The language used to describe the first verification requirement is unnecessarily confusing and may therefore make compliance difficult. Verification #1 requires that a state's audit report verify that each hospital receiving DSH payments "has reduced its uncompensated care costs for furnishing inpatient hospital and outpatient hospital services during the SFY to Medicaid eligible individuals and individuals with no source of third party coverage for the services in order to reflect the total amount of claimed DSH expenditures."[19] Uncompensated care costs, as defined in the DSH statute, are the costs of serving Medicaid and uninsured patients "net of payments under this title [Medicaid], other than under this section [DSH], and by uninsured patients."[20] By definition, therefore, uncompensated care costs are not offset by DSH payments. The first verification requirement directs hospitals to reduce UCC by claimed DSH expenditures and therefore is contrary to the statutory language.

NAPH recognizes that CMS likely based its formulation of the verification requirement on the statutory language, which contains similarly confusing terminology, requiring the audit to verify "the extent to which hospitals in the State have reduced their uncompensated care costs to reflect the total amount of claimed expenditures made under [the Medicaid DSH statute]."[21] It would be helpful if CMS would take the opportunity in this regulation to provide clarification of Congress' likely intent in adopting this provision. Specifically, we suggest that a more useful interpretation of this statutory language would be to require verification that DSH payments have not exceeded uncompensated care costs. This approach appears to conform to CMS' interpretation in the preamble.

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[19] *Id.* at 50268 (proposed 42 C.F.R. 455.204(c)(1)).
[20] 42 U.S.C. §1396r-4(g)(1)(A).
[21] 42 U.S.C. § 1396r-4(j)(2)(A).

NAPH suggests that CMS reword proposed 42 C.F.R. 455.204(c)(1) to require that the total amount of claimed DSH expenditures for each hospital that qualifies for a DSH payment in the State is no more than the hospital's uncompensated care costs.

C. *Reporting Requirements*: Supplemental/Enhanced Medicaid Payments (42 C.F.R. 447.299(c)(11))

The Proposed Rule requires states to report the "total annual amount of supplemental/enhanced Medicaid payments made to the hospital by the State for inpatient and outpatient hospital services furnished to Medicaid eligible individuals."[22] The Medicaid statute and regulations do not use the phrase "supplemental Medicaid payments" or "enhanced Medicaid payments." The Proposed Rule does not provide much guidance (in either the preamble or the regulation text) regarding the scope of these payments, other than to state that these payments do not include "DSH payments, regular Medicaid rate payments, and managed care organization payments."[23]

NAPH suggests that CMS explicitly state that it will defer to states with regard to what payments are categorized as supplemental/enhanced Medicaid payments or other Medicaid payments, so long as all Medicaid payments are captured in the listed categories.

D. *Reporting Requirements*: Total Cost of Care and Uncompensated Care Costs (42 C.F.R. 447.299(c)(14),(15))

The Proposed Rule indicates (in both the preamble and the regulatory language) that states should report "***separately***"[24] the "total annual cost" or the "total annual amount of uncompensated care costs," respectively, "for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals and to individuals with no source of third party coverage for the hospital services they receive." It is unclear what the word ***separately*** is referring to in this context. Theoretically, CMS could intend states to report four cost items for each hospital (i.e. cost for inpatient service for Medicaid patients, cost for outpatient services for Medicaid patients, cost for inpatient service for uninsured patients, cost for outpatient services for uninsured patients), or only one. The accompanying Excel spreadsheet indicates that only one combined item is intended. CMS should clarify this intent in the regulatory and preamble language.

NAPH recommends that the word "separately" be removed from 42 C.F.R. 447.299(c)(14) and 42 C.F.R. 447.299(c)(15) and that CMS clarify that only one data item must be reported for both "total cost of care" and "uncompensated care costs."

E. *Reporting and Audit Requirements*: Uncompensated Care Costs

CMS' use of the term "uncompensated care costs" throughout the regulation and preamble may be confusing because the hospital industry generally uses the same term to mean the combined costs related to charity care and bad debt for all patients (not limited to uninsured patients).[25] CMS intends a more limited use of the term in this regulation that would be restricted to UCC associated

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[22] 70 Fed. Reg. at 50267 (proposed 42 C.F.R. 447.299(c)(11)).
[23] *Id.* at 50267.
[24] *Id.* at 50268 (proposed 42 C.F.R. 447.299(c)(14),(15)).
[25] *See, e.g.*, American Hospital Association, "Uncompensated Hospital Care Cost Fact Sheet," Feb. 2003.

with Medicaid and uninsured patients. To better facilitate hospital compliance, NAPH recommends that CMS use a different term, such as "uncompensated Medicaid and uninsured costs."

CMS should not use the term "uncompensated care costs" to refer to uncompensated costs associated only with Medicaid and uninsured patients.

F. *Audit Requirements:* Use of Local Funding (42 C.F.R. 455.204(c)(1))

In explaining audit verification requirement #1, the preamble to the Proposed Rule states that "Obligations of the qualifying DSH hospital to fund the non-Federal share of a DSH payment or any other Medicaid payment cannot be included as uncompensated care for purposes of the hospital-specific DSH limit."[26]

NAPH understands the intention of Verification #1 to clarify that amounts transferred or certified (through intergovernmental transfers (IGTs) or certified public expenditures (CPEs)) can not be claimed as an uncompensated care cost for purposes of determining the hospital-specific DSH limit. However, the language included in the preamble is so broad (i.e., "obligations of the qualifying DSH hospital") that it could wrongly be interpreted to bar the cost of provider taxes as well as IGTs and CPEs from the uncompensated care cost calculation. Medicare guidance clearly indicates that provider taxes are allowable costs.[27] If providers include these costs on the Medicare cost report, they will necessarily be included in the calculation of cost-to-charge ratios that are used to compute uncompensated care and Medicaid costs and will therefore impact the hospital-specific DSH cap. Including provider tax costs in uncompensated care costs is appropriate.

NAPH requests that CMS clarify that provider taxes are costs that may be included in a hospital's calculation of its uncompensated care costs.

G. *Reporting Requirements:* Disproportionate Share Hospital Payments (42 C.F.R. 447.299(c)(8))

In requesting information about DSH payments, CMS inappropriately requests information regarding payments made "under section 1923(g) of the Act."[28] Section 1923(g) describes limits on DSH payments. The payments are actually made pursuant to section 1923(a).

NAPH suggests that CMS rephrase the language in 42 C.F.R. 447.299(c)(8) to read "under section 1923(a) of the Act."

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[26] 70 Fed. Reg. at 50565.
[27] *See* Medicare Provider Manual, Section 2122.
[28] 70 Fed. Reg. at 50267.

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October 25, 2005

Via First Class Mail

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Attn: Katherine Astrich, CMS Desk Officer

Ref: CMS-2198-P – Medicaid Program; Disproportionate Share Hospital Payments; Proposed Rule

Dear Mr. Wickcliffe and Ms. Astrich:

Please find enclosed a copy of the comment letter that the National Association of Public Hospitals and Health Systems (NAPH) recently submitted to the Centers for Medicare and Medicaid Services (CMS) regarding the above-referenced Proposed Rule.[1] As explained in our cover letter and comments to CMS, NAPH members are likely to be especially impacted by the DSH reporting and audit requirements contained in the Proposed Rule. We are forwarding our comments to you pursuant to the Paperwork Reduction Act (PRA) of 1995 because, as explained in detail throughout the attached comments, NAPH believes that the information collection burden is significant, that in many cases the information requested is ambiguous or inaccurate and that there are better ways to implement the statutory requirements. We hope that CMS and the Office of Management and Budget will consider our recommendations to minimize the information collection burden.

NAPH appreciates the opportunity to submit these comments on the Proposed Rule regarding DSH reporting and auditing requirements. If you have any questions about these comments, please contact NAPH counsel Charles Luband, Barbara Eyman or Allison Orris at (202) 347-0066.

Sincerely,

Larry S. Gage
President

cc: Mark McClellan, Administrator, CMS
Dennis Smith, Director, Center for Medicaid and State Operations, CMS

Attachment

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[1] 70 Fed. Reg. 50262 (Aug. 26, 2005).

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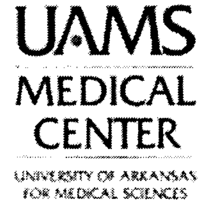

October 24, 2005

Via Courier

Dr. Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Ave., S.W.
Washington, D.C. 20201

Re: UAMS Comments on CMS-2198-P – Medicaid Program; Disproportionate Share Hospital Payments; Proposed Rule

Dear Dr. McClellan:

The University of Arkansas for Medical Sciences (UAMS) values the opportunity to comment on the above-referenced Proposed Rule, *Medicaid Program; Disproportionate Share Hospital Payments*.[1]

UAMS is the largest provider of care to Medicaid and uninsured patients in Arkansas and is the only medical school in the state. UAMS is located almost exactly in the center of the state and consequently, UAMS's hospital (University Hospital) serves as a healthcare provider of first, and last, resort for many of the state's uninsured, indigent population. Although Arkansas is a "low" disproportionate share hospital (DSH) state, Medicaid DSH is nevertheless an extremely important funding stream for University Hospital (we remain hopeful, however, that Congress will correct the inequities in DSH funding in the future). In the meantime, we are concerned about the impact that the regulations proposed by CMS will have on UAMS, both now and in the future.

UAMS endorses the detailed comments submitted by the National Association of Public Hospitals and Health Systems on the Proposed Rule. In addition, UAMS has specific concerns regarding particular aspects of the Proposed Rule and its impact on UAMS and makes the following recommendations:

- CMS should reconsider certain aspects of the proposed reporting and auditing requirements that will be unnecessarily burdensome on states and hospitals.

[1] 70 Fed. Reg. 50262 (Aug. 26, 2005), hereinafter "Proposed Rule."

- CMS should retract certain substantive changes to DSH standards, which may not be imposed under the auspices of new reporting and auditing requirements.

- CMS should not implement these new regulations retroactively.

UAMS separately describes each of its concerns in the comments below.

I. The Proposed Rule Would Impose Significant New Burdens on Safety Net Hospitals such as UAMS University Hospital

UAMS Comments Regarding:

- **Proposed Rule Section III. A., Reporting Requirements**
- **Proposed Rule Section IV, Collection of Information Requirements**
- **Proposed Rule Section VI, Regulatory Impact Statement**

The Proposed Rule would implement the requirement in the MMA that states provide certain information about hospitals receiving DSH payments. State Medicaid agencies would be obligated to report 16 categories of information for each hospital receiving DSH funding, including DSH Payments, Supplemental/Enhanced Medicaid Payments, Indigent Care Revenue, Transfers, and Uncompensated Care Costs.[2] CMS has provided a spreadsheet template that could be used to satisfy these reporting requirements.

These new requirements will lead to significant additional burdens on safety net hospitals, including UAMS. Arkansas' Medicaid agency does not have direct access to all of the information requested, and will necessarily depend on safety net hospitals that receive DSH funding to provide much of the data, in the format described. We do not currently collect all of the data requested according to the specifications outlined in the Proposed Rule and preamble. Although we submit the newly required S-10 Worksheet (S-10) for our Medicare Cost Reports, the information required by that Worksheet does not directly parallel the data requested in the new reporting requirements. In addition, although both seek determinations of hospitals' total uncompensated care costs, they apply different methodologies for calculating such costs. Thus, UAMS and other DSH recipients will be confronted with making one set of calculations for their annual cost reports and another for their state's annual DSH report.

In any event, the 16 proposed categories far exceed the MMA's requirements. The MMA only provides that annual reports must identify "each disproportionate share hospital that received a payment adjustment . . . and the amount of the payment adjustment made to such hospital . . . ."[3] The statute further provides CMS authority to collect "[s]uch other information . . . necessary to ensure the appropriateness of the payment adjustments."[4] CMS should consider whether each of the information categories, as defined, is "necessary" to fulfill its statutory obligations and whether the scope of each category is also "necessary." For instance, CMS proposes to require an unduplicated patient count of

[2] 70 Fed. Reg. at 50267-68 (proposed 42 C.F.R. § 447.299(c)).
[3] 108 Pub. L. No. 173, § 1001(d).

Medicaid-eligible and uninsured patients for each hospital.[5] We currently do not collect this information, and this data would appear to have no direct relevance to the propriety of DSH payments.

With these considerations in mind, UAMS disputes CMS's assertion that the Proposed Rule "would not have a significant economic impact on a substantial number of small entities" such as hospitals.[6] CMS is responsible for assessing the impact that regulations have on hospitals including UAMS, which are generally categorized as small businesses under the standards of the Regulatory Flexibility Act. CMS should revise the regulations to reduce the economic impact on hospitals; alternatively, the agency should acknowledge the significant economic impact that the Proposed Rule will have on UAMS and other DSH hospitals.

CMS has solicited comments regarding the information collection burden, clarity of information collected and recommendations to minimize the information collection burden, in accordance with the Paperwork Reduction Act (PRA) of 1995. For the reasons described herein, UAMS believes that the information collection burden on hospitals and states will be significant. Moreover, there are likely more efficacious means of implementing the statutory requirements—for instance, by more closely tracking the existing S-10 categories.

UAMS is opposed to the excessive administrative burden imposed on hospitals, which will need to provide data to the state to respond to all of the proposed reporting elements. The reporting requirements proposed by CMS far exceed the statutory requirements. UAMS requests that CMS consider less burdensome means of collecting necessary information and address the economic and paperwork impact that the Proposed Rule will have on hospitals.

II. The Proposed Auditing Requirements Improperly Impose New Substantive Standards on DSH Payments

UAMS Comments Regarding:

- **Proposed Rule Section III.B, Audit Requirements**

A. Limitation to Same-Year Actual Costs

To ensure that DSH payments comply with the hospital-specific DSH limit, the Proposed Rule requires the independent audit to verify that "for each audited [state fiscal year (SFY)], the DSH payments made in that audited SFY [are] measured against the actual uncompensated care cost in that same audited SFY."[7] In order to measure DSH payments against the "actual" uncompensated care costs from the same audited fiscal

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[4] *Id.*
[5] 70 Fed. Reg. at 50268 (proposed 42 C.F.R. § 447.299(c)(16)).
[6] *Id.* at 50267 (proposed 42 C.F.R. § 447.299(c)(8)).
[7] *Id.* at 50268 (proposed 42 C.F.R. § 455.204(c)(2)).

year, states will have to undertake retrospective reviews of annual DSH payments well after the close of the fiscal year. This conflicts with CMS guidance and practice, and is not mandated under preexisting Medicaid law or the MMA.[8]

In the past, CMS has provided states with flexibility to use reasonable estimates of current-year uncompensated costs.[9] Many states base current year DSH payments on estimates derived from data from previous cost report years. The Proposed Rule would introduce a significant change in policy that would inflict serious administrative and practical difficulties on states and DSH hospitals. CMS does not explain how this audit may be conducted by states that already have CMS approval to use prospective methodologies.

Even if this new position were consistent with the statute, there would be little benefit from this proposed change in policy. To the extent that reliance on estimated costs based on prior year data may result in payments that are more or less than actual costs determined through subsequent audits, those variances will be accounted for in future year computations of DSH limits. The financial exposure for the federal government through the use of estimated rather than reconciled data is not significant and is statutorily limited by statewide DSH allotments. CMS has not pointed to any systematic findings that call into question the reasonableness of approved methodologies.

CMS should clarify the preamble and amend the language in the Proposed Rule to retract the requirement that DSH payments must be retroactively reconciled against the actual uncompensated care costs for the fiscal year. The regulations should continue to allow states to adopt reasonable prospective methodologies for determining annual uncompensated care costs.

B. Exclusion of Physician Costs

The Proposed Rule requires states to verify that "only uncompensated care costs of providing inpatient and outpatient hospital services to Medicaid eligible individuals and uninsured individuals are included in the hospital-specific DSH payment limit."[12] In the preamble language elaborating upon this requirement, CMS asserts that, "The uncompensated care costs of providing physician services cannot be included in the calculation of [the] hospital-specific DSH limit."[13]

UAMS does not currently include physician costs in the determination of its hospital-specific DSH limit. Thus, the question of whether physician costs may or may not be included in the calculation of uncompensated costs does not have a direct financial

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[8] The DSH statute only requires that payment adjustments be limited to uncompensated costs "during the year." 42 U.S.C. § 1396r-4(g)(1)(A). It does not curtail the use of estimates or prospective methodologies in calculating such amounts.

[9] *See, e.g.*, Letter to Donna Checkett, Chair, State Medicaid Directors Association, from Sally Richardson, Director, Medicaid Bureau, Health Care Financing Administration (Jan. 10 1995).

[12] 70 Fed. Reg. at 50268 (proposed 42 C.F.R. § 455.204(c)(3)).

[13] *Id.* at 50265.

impact on UAMS at this time. Nevertheless, we disagree with CMS' proposed new policy on this point, and are concerned that this unnecessarily constrained view of allowable DSH costs may impact us in the future, should we be fortunate enough to see Arkansas' DSH allotment grow to an adequate level comparable to that of other states.

Hospitals would not be able to provide inpatient or outpatient "hospital services" without adequate physician coverage. Particularly with respect to uninsured and/or indigent patients, ensuring access to hospital care depends on the availability of physicians who are willing and able to serve them. To the extent that hospitals and their related institutions incur actual costs for ensuring such physician coverage – through salaries, contractual arrangements or otherwise – those costs should be fully includable in uncompensated costs for purposes of calculating the limit on DSH payments.

CMS should retract the suggestion in the preamble that a hospital's uncompensated costs of providing physician services must be excluded from the calculation of its hospital-specific DSH limit.

C. Payments for Emergency Services to Undocumented Immigrants

The preamble to the Proposed Rule includes a comment regarding the interaction between DSH payments and another MMA provision that reimburses costs associated with emergency services provided to undocumented immigrants. Although CMS notes that these so-called "Section 1011 payments" should not impact DSH payments for hospitals that have not reached their DSH caps, the preamble asserts that states "will need to consider a Section 1011 payment when determining the hospital's DSH limit, because the total DSH payments should not exceed the total amount of uncompensated care at the hospital."[14]

Again, because of Arkansas' low DSH allotment, UAMS will not be impacted by CMS' interpretation at this time. Nevertheless, we disagree with CMS' position on this issue. The DSH provisions provide that the hospital-specific DSH cap will be equal to the costs of care provided to Medicaid or uninsured people "net of payments under this title [Medicaid], other than under this section [Medicaid DSH], and by uninsured patients."[15] Revenues are offset against costs, and include only non-DSH Medicaid revenues or payments *by uninsured patients*. Section 1011 payments are neither Medicaid payments nor payments by uninsured patients. As a result, the statute prohibits requiring states to reduce DSH limits by the amount of Section 1011 payments to hospitals.

CMS should retract the statement that Section 1011 funds should be offset against uncompensated costs of care, and should clarify that Section 1011 payments do not factor into the calculation of the hospital-specific DSH limit.

III. The Proposed Rule Should Not Be Imposed Retroactively.

UAMS Comments Regarding:

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[14] *Id.* at 50264.
[15] 42 U.S.C. § 1396r-4(g)(1)(A).

- **Proposed Rule Section III, Provisions of the Proposed Regulations**

CMS proposes to make both the reporting and auditing requirements effective for state fiscal years beginning with 2005, which for Arkansas and many other states has already ended. In general, the retroactive application of regulations is disfavored, and it would be difficult for states such as Arkansas to implement these new substantive requirements for years that have already passed.

CMS has already delayed implementation beyond the date specified in Section 1001 of the MMA. That provision requires CMS to impose reporting and audit requirements beginning in fiscal year 2004. Given the delay in CMS's issuance of the Proposed Rule, the resulting regulations should not be effective until the state fiscal year that begins after the date the final rule is published.

It is particularly important to avoid retroactive application here, as CMS purports to impose new substantive standards on state DSH programs, such as the exclusion of hospitals' uncompensated physician services costs and the offsetting of Section 1011 payments. Moreover, the Proposed Rule seeks collection of certain information that many states and hospitals do not currently track, such as unduplicated patient counts. To the extent that CMS retains these provisions in this regulation, CMS should acknowledge that this regulation does more than merely implement reporting and auditing requirements against existing standards—making retroactive compliance untenable.

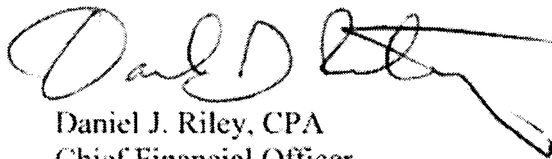
The regulations should be effective only prospectively, beginning with the first state fiscal year after the regulations are finalized.

* * * *

UAMS sincerely appreciates the opportunity to submit comments on the Proposed Rule. Please contact Dan Riley at (501) 686-8496 if you should have any questions regarding the comments herein.

Sincerely,

UAMS Medical Center



Daniel J. Riley, CPA
Chief Financial Officer

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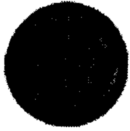

CALIFORNIA HOSPITAL ASSOCIATION

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P.E.A.C.H., INC.
Private Essential Access Community Hospitals

CALIFORNIA ASSOCIATION OF
PUBLIC HOSPITALS AND HEALTH SYSTEMS

October 25, 2005

OCT 25 2005

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2198-P, P.O. Box 8010
Baltimore, MD 21244-1850

Re: CMS-2198-P; Medicaid Program; Disproportionate Share Hospital Payments -- Proposed Rule.

Dear Dr. McClellan:

The Coalition for Fair Payments to Healthcare Providers Treating Undocumented Immigrants respectfully submits the following comments regarding the proposed rule implementing the Medicaid Disproportionate Share Hospital (DSH) Payment reporting and auditing requirements found in Section 1001(d) of the Medicare Modernization Act of 2003 (MMA). Section 1011 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) funds emergency services provided to undocumented immigrants. The Coalition represents the American Hospital Association (AHA) and the state hospital associations of Arizona, California, Florida, Illinois, New Jersey, New Mexico, New York, North Carolina, South Carolina and Texas, as well as the Healthcare Association of San Diego and Imperial Counties and the Greater New York Hospital Association.

We appreciate the extensive effort that the Centers for Medicare & Medicaid Services (CMS) has invested in this proposal. However, we would like to express our concerns in response to CMS' proposed clarification regarding the receipt of Section 1011 payments and its audit requirement proposal.

Section 1011

During the course of numerous discussions with CMS the Coalition has made it clear that we opposed any offset for DSH payments and requested clarification as to whether Section 1011 payments would offset DSH funds dispersed through state Medicaid programs.

In response to our request for clarification, CMS directs state Medicaid programs to consider Section 1011 payments when determining a hospital's specific DSH limit, the maximum amount of Federal dollars a hospital can receive in DSH payments. There is, however, no statutory requirement to include Section 1011 payments when calculating the hospital's uncompensated care burden. Section 1011 payments are not Medicaid payments, health plan payments or payments from uninsured patients. Congressional intent, in enacting Section 1011, was to provide new resources rather than substitute existing resources for hospitals providing large volumes of uncompensated care to undocumented immigrants. It appears that CMS is attempting to reach beyond statutory authority to set new DSH policy.

Section 1011 payments are not Medicaid payments, health plan payments or payments from uninsured patients. Congressional intent, in enacting Section 1011, was to provide new resources rather than substitute existing resources for hospitals providing large volumes of uncompensated care to undocumented immigrants. The Coalition believes that this provision, if implemented, will have an adverse impact on the already vulnerable DSH-eligible hospitals. These hospitals are forced to rely on supplemental Medicaid payments in order to maintain the access to care for all, but especially for their low-income patients. Including Section 1011 payments as part of the DSH limitation could reduce the amount of supplemental payments these hospitals can receive without adequately covering the cost of health care provided to undocumented immigrants

The Coalition recommends that CMS delete the language in the preamble that requires states to offset Section 1011 payments when establishing a hospital's DSH limit. In addition, CMS should clarify that Section 1011 payments should not factor into the calculation of the hospital-specific DSH limit regardless of the hospital is at or near its limit.

Audit Requirements

The MMA requires that state Medicaid programs have their DSH programs independently audited and submit this independent certified audit to the Secretary on an annual basis. The proposed rule does not address how the audits will be paid for and there is a concern that the state Medicaid programs will pass on these additional costs to DSH hospitals. The cost for hospital audits can reach as high as $50,000 or higher per hospital. This estimate clearly suggests that the economic impact, if audit costs are passed on to hospitals as expected, will trigger the test of a major rule under Executive Order 12866 (September, 1993 Regulatory Planning and Review) and should require a regulatory impact analysis. These safety net hospitals are not in the financial position to absorb these added audit costs. The Coalition recommends that CMS state affirmatively that the cost of the audits should not be passed on to hospitals.

The Coalition appreciates the opportunity to share our thoughts and concerns regarding Section 1011 of the MMA with CMS, and looks forward to a continued dialogue on this issue. Please contact Margot Holloway with the California Hospital Association at (202) 488-4688 or mholloway@calhealth.org if you have any questions.

Sincerely,

C. Duane Dauner

President,

California Hospital Association

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CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

OCT 25

October 25, 2005

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2198-P, P.O. Box 8010
Baltimore, MD 21244-1850

Re: CMS-2198-P; Medicaid Program; Disproportionate Share Hospital Payments -- Proposed Rule.

Dear Dr. McClellan:

The California Hospital Association (CHA), on behalf of its nearly 500 member hospitals, health systems and ancillary providers, especially our 140 disproportionate share hospitals (DSH), respectfully submits comments regarding the proposed rule implementing the Medicaid Disproportionate Share Hospital (DSH) Payment reporting and auditing requirements found in Section 1001(d) of the Medicare Modernization Act of 2003 (MMA). In California, our safety net hospitals provide access to care for our most vulnerable citizens while shouldering the burden of critical community services such trauma care. The Medicaid DSH program provides the essential financial assistance to enable these hospitals to provide these necessary services. CHA strongly urges the Centers for Medicare & Medicaid Services (CMS) to rethink the approach adopted in this proposed rule.

California recently negotiated an 1115 waiver with CMS that addresses a number of the issues contained in the proposed rule while making significant changes to our DSH program. As such, CHA urges CMS to exempt California – and other states with similar recently negotiated 1115 waivers such as California's that are based on certified public expenditures (CPEs) for Medicaid and DSH payments – from this rule. Many of the provisions outlined in the proposed rule have been addressed or are significantly changed in California's waiver, which was approved in June 2005.

CHA has numerous concerns with the proposed rule and believes the rule as presently drafted will have a significant impact on our hospitals if the above exemption is not provided. California has operated its DSH program for a number of years in strict accordance with the prescriptive terms negotiated between the state and CMS.

Unfortunately CMS has chosen to use this proposed rule to establish DSH policy that reaches beyond the reporting and audit requirements outlined in Section 1001(d). For example, if a state fails to comply with the reporting and auditing requirements, CMS proposes to impose a penalty that would result in the loss of Federal matching Medicaid dollars. In addition to our concern that the proposed rule overreaches the original intent of Section 1001(d), CHA has concerns with:

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Corporate Members: Hospital Council of Northern and Central California, Hospital Association of Southern California, and Healthcare Association of San Diego and Imperial Counties

- CMS is proposing retroactive application of the auditing requirements to Fiscal Year (FY) 2005,
- The definition of uncompensated care,
- And an additional reporting burden being imposed on hospitals.

Auditing Requirements

Retroactive Audit
In the proposed rule, CMS proposes to apply the new reporting requirements to FY 2005 DSH programs. For California hospitals, the FY 2005 period has ended and this issue was addressed in California's 1115 waiver.

It should be pointed out that the MMA required CMS to implement the reporting and auditing requirements beginning in fiscal year 2004 but that CMS delayed such implementation beyond the specified date. The retroactive application of these new reporting and auditing requirements makes little sense now and will impose a hardship for state Medicaid programs as well as DSH hospitals. CHA is concerned that the imposition of the new and substantive reporting and auditing requirements will make it impossible for our state Medicaid program to comply because they would have to retroactively identify the requested data and to do so will have a significant impact on our state Medicaid DSH program. Additionally, California operated under two separate and very different waivers between 2005 and 2006. CHA believes that the new reporting requirements, for states that have not recently implemented an 1115 waiver, be implemented on a prospective basis, for example. As such, we strongly recommend that CMS remove this retroactive application provision from the final rule.

Audit
While it is clear that Section 1001(d) requires annual audits, in the proposed rule, CMS fails to provide clear direction as to how DSH payments and the actual calculation of a hospital's uncompensated care are to be reconciled. **California, as most state Medicaid programs, sets the hospital specific DSH limits based on estimates.** The reconciliation of payments and actual uncompensated care within the same year could be extremely difficult since most state Medicaid cost reports are open for longer than a year and in some cases years. The proposed rule imposes a significant auditing requirement on hospitals annually and there is no anticipation of payment for such audits. Again, the recent implementation of California's 1115 waiver completely changes the way DSH payments are calculated for California's hospitals, therefore, this requirement would be duplicative of many of the waiver requirements, bringing into question the purpose of including states such as California in this rule. In the absence of exempting states such as California, CHA recommends that before this provision can be implemented, CMS needs to provide clear and rational direction on how to reconcile actual cost with payments.

Reporting Requirements

Definition of Uncompensated Care (UCC)
The new definition of uncompensated care to both exclude bad debt and physician services are clear examples of the agency's attempt to substantively change long standing DSH policy without properly calling for direct public comment.

Bad Debt

The proposed rule includes language which states that uncompensated care does not include bad debt for purposes of setting the hospital specific DSH cap. This new definition of uncompensated care that excludes bad debt is not consistent with the statute, legislative history or long standing agency practice. The underlying statute (1923(g)(1)(A) permits the inclusion of the costs of services provided individuals with no health insurance or other source of third party coverage. The conference report language for the Omnibus Budget Reconciliation Act of 1993 (OBRA '93) provision, that originally established the hospital specific DSH limit, reveals Congress' intent in directing the agency on the various ways to determine the unreimbursed costs that hospitals bear. The report language states that the cost of providing services to uninsured patients would be net of any out of pocket payments received from uninsured individuals. CMS'1994 guidance letter to State Medicaid programs offered further guidance in the determination of unreimbursed costs by stating that the cost of services provided individuals with third party coverage, but whose third party coverage did not cover the hospital services the individual received, could be counted. The agency was clearly looking at the cost associated with the uninsured and the underinsured in implementing the hospital specific DSH limit. In 2002, the agency in its guidance to state Medicaid programs regarding the hospital specific DSH limit and the upper payment limit reaffirmed the 1994 DSH policy.

A number of state Medicaid programs include the costs of care provided uninsured individuals for which no payment is made and the costs associated with the nonpayment of copayments and deductibles for individuals with third party coverage in determining a hospital's qualifying costs for the hospital specific DSH limit. (Current Medicare policy requires that hospitals seek payment from individuals with the means to pay their copayments and deductibles.) The approaches adopted by these state Medicaid programs to establishing qualifying costs for setting the hospital specific DSH limit are consistent with the statute, legislative history, and long established agency DSH policy. A review of the legislative history of the MMA DSH reporting and auditing requirements does not reveal that Congress raised any concerns about how unreimbursed costs were determined for setting the hospital specific DSH limit by the agency or the individual state Medicaid programs. The explicit exclusion of bad debt from the definition of uncompensated care will be harmful to DSH hospitals that are struggling to meet the health care needs of the growing numbers of uninsured and underinsured. The recent growth of health plans that impose high deductibles or have exclusion limits as well as the proliferation of health savings account are putting new burdens on hospitals in terms of unreimbursed costs. CMS' new definition of uncompensated care, which includes the exclusion of bad debt, is inconsistent with the statute and long standing CMS DSH policy. This long-standing policy has been based on whether the individual has third party coverage, not whether the hospital has or has not treated the patient's account as bad debt.

CHA strongly recommends that CMS accurately capture all uncompensated costs and change its definition of uncompensated care by striking references to bad debt in 42 C.F.R. 447.299(c)(15) and in its place clarify that uncompensated care includes the costs of services furnished to individuals with no health care insurance, third party coverage, or third party payment and individuals with health savings accounts and includes the costs of services furnished insured individuals whose policies do not cover the services provided the individual due to their health plans exclusions, limits or deductibles.

Physician Services
The proposed rule states uncompensated care cost of physician services cannot be included in the calculation of the hospital specific DSH limit. This is new policy.

There is not statutory guidance on this question. CHA believes that uncompensated physician costs associated with hospital services must be included.

Section 1011
In the proposed rule, CMS clarifies that the receipt of a Section 1011 payment will not impact the calculation of a hospital's Medicaid DSH payment amount if the hospital has not reached its DSH cap. For hospitals receiving DSH payments at or near their DSH limit, States will need to consider a Section 1011 payment when determining the hospital's DSH limit, because the total DSH payments should not exceed the total amount of uncompensated care at the hospital.

CHA believes that this provision could have an adverse impact on the already vulnerable DSH-eligible hospitals. These hospitals are forced to rely on supplemental Medicaid payments in order to maintain access to care for all, but especially for low-income patients. Including Section 1011 payments as part of the DSH limitation could reduce the amount of supplemental payments these hospitals can receive without adequately covering the cost of health care provided to undocumented immigrants.

The hospital-specific DSH limit provides that the limit is equal to the costs of care provided to Medicaid or uninsured persons less Medicaid payments or payments by uninsured patients. Section 1011 payments are neither Medicaid payments nor payments by uninsured patients. Congress' intent in enacting Section 1011 was to provide new resources for hospitals providing volumes of uncompensated care to undocumented immigrants.

CHA urges CMS to withdraw the current proposal and in the final rule to adopt a policy where Section 1011 dollars do not affect the DSH limitation so eligible hospitals could continue to receive the same level of supplemental payments in addition to the Section 1011 funds.

Reporting of Transfer Payments
As a "condition of receiving any Medicaid payment or DSH payment," CMS proposes to require states to report annual amounts transferred by a hospital to the State or local governmental entity. The proposed rule does not, however, define what "as a condition of receiving ....payment" means. Considering the marked lack of detailed information to support how this proposal will ensure the appropriateness of DSH payments, CHA recommends that CMS withdraw this reporting requirement. If CMS should decide to proceed with implementing this provision, CHA requests that CMS, at a minimum, define the terms "as condition of receiving payment."

Reporting of Medicaid Eligible and Uninsured Individuals
The proposed rule requires the State Medicaid program to report for each hospital an unduplicated count of Medicaid eligible and uninsured patients receiving inpatient and outpatient hospital services. CHA is concerned that states will turn to hospitals to produce these patient counts. Because many of our hospitals in California do not have the reporting systems in place that would allow them to generate unduplicated counts of patients served throughout the year

that are Medicaid eligible or uninsured, this requirement is extremely burdensome and would prove difficult to fulfill. Additionally, this provision raises many questions regarding how a hospital would classify certain patients such as a patient that has Medicaid coverage for part of the year and are uninsured for part of the year. The proposed rule fails to provide justification of why this information is necessary. CHA encourages CMS to remove this provision from the final rule.

Reporting of Indigent Care Revenue
In the proposed rule CMS requires states to report total payments received by hospitals from individuals with no source of third party coverage. CHA is concerned that current accounting systems for many California hospitals do not allow them to match payments received from those individuals for which there was no third party coverage. CHA is concerned that this requirement would impose an excessive reporting burden on hospitals. In light of this concern, CHA strongly recommends that CMS remove this reporting requirement from the final rule.

Definition of Cost
CMS' 1994 guidance letter to state Medicaid directors makes it clear that the definition of costs should not exceed the amount that would allow "...a state to use the definition of allowable costs in its state Medicaid plan or any other definition as long as the costs determined under such a definition do not exceed the amounts that would be allowable under the Medicare principles of cost reimbursement." In keeping with this guidance, the proposed rule grants states some leeway in the definition of costs. CHA believes that the proposed rule should reaffirm this definition of allowable costs.

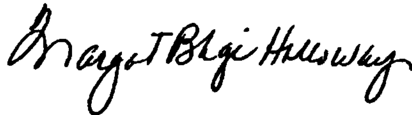
Reduce Uncompensated Care Costs by DSH Payments
The audit verification #1 requires that a state's audit report verify that each hospital receiving DSH payments has reduced its uncompensated care costs for furnishing inpatient hospital and outpatient hospital services during the state fiscal year (SFY) to Medicaid eligible individuals and individuals with no source of third party coverage for the services in order to reflect the total amount of claimed DSH expenditures. The DSH statute defines uncompensated care costs as the cost of serving Medicaid and uninsured patients net of Medicaid payments and payments made by uninsured individuals, excluding DSH payments. The statutory language is clear that uncompensated care costs are not offset by DSH payments. The first verification requirement that reduces a hospital's uncompensated care costs by claimed DSH expenditures is contrary to the statute. CHA recommends that verification #1 be changed to require that the total amount of claimed DSH expenditures for each hospital that qualifies for a DSH payment in the State is no more than the hospital's uncompensated care costs.

Same Year Actual Costs
The audit verification #2 requires that DSH payments comply with the hospital specific DSH limit by requiring that DSH payments made in the audited SFY be measured against the actual uncompensated care cost in the same audited SFY. This would require that states reconcile DSH payments to ensure such payments do not exceed actual costs. It is important to note that the MMA does not require that payments be based on actual audited costs. Current CMS DSH policy allows states to use a prospective methodology to estimate current year uncompensated care costs. This approach allows for adjustments in future years to reconcile DSH payments with

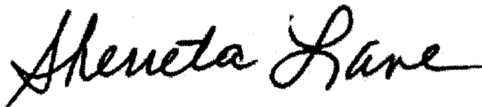
actual costs. The verification, through audit, of DSH payments with the same year actual uncompensated care costs will place an enormous burden on hospitals through new burdensome and costly audits as well as increase the administrative costs for each state Medicaid program. This is another example where the proposed rule substantively changes current Medicaid DHS policy. In addition, the proposed rule does not address the issue of how such additional audits will be paid for. We are concerned that the state will pass on the added costs for same year audits to the DSH hospitals. The cost for hospital audits can reach $50,000 or higher per hospital. This estimate clearly suggests that the economic impact of this one audit requirement will meet the test of a major rule under the Regulatory Flexibility Act and should require a regulatory flexibility analysis for small entities such as hospitals. CHA strongly recommends that this proposal requiring that audited DSH payments must be measured against actual uncompensated care cost in the same audited SFY be deleted from the final rule. Further, we recommend that CMS clarify that states be allowed to continue to use reasonable estimating methodologies to determine uncompensated care costs.

Thank you for the opportunity to provide comments on this proposed rule. The Medicaid DSH program is a lifeline to many safety net hospitals across the country. The proposed rule, as presently drafted, will have a significant negative impact on these institutions. If you have any questions or would like to discuss our comments, please contact Margot Holloway at (202) 488-4688 or mholloway@calhealth.org or Sherreta Lane at (916) 552-7536 or slane@calhealth.org.

Sincerely,



Margot Holloway
Vice President, Federal Regulatory Affairs



Sherreta Lane
Vice President, Reimbursement & Economic Analysis

Rec'd my TFM
OCT 24

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VIA HAND DELIVERY

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Jordan J. Cohen, M.D.
President

October 24, 2005

Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
Room 445-G
200 Independence Ave, S.W.
Washington, DC 20201

Attention: 2198-P

Dear Administrator McClellan:

The Association of American Medical Colleges (AAMC) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS or the Agency) proposed rule entitled *"Medicaid Program; Disproportionate Share Hospital Payments" 70* Fed. Reg. 50262 (August 26, 2005). The AAMC represents approximately 400 major teaching hospitals and health systems; all 125 accredited U.S. allopathic medical schools; 96 professional and academic societies; and the nation's medical students and residents. The Medicaid disproportionate share (DSH) program provides critical financial assistance to our teaching hospitals and academic clinical faculty, which serve as "safety net" providers for much of the nation's Medicaid population.

The proposed rule seeks to implement section 1001(d) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) which established new reporting and auditing requirements for state disproportionate share hospital payments. However, we believe there are a number of deficiencies in the proposal that, unless corrected, would go beyond the intent of section 1001(d) and have a serious detrimental impact on Medicaid DSH hospitals. These deficiencies include:

- Excluding bad debt in the calculation of uncompensated care costs,
- Excluding physician service costs in the calculation of the hospital-specific DSH limits,
- Including the receipt of 1011 payments in the calculation of the DSH limits, and
- The undue reporting burden that would be imposed on hospitals.

I. DEFINITION OF UNCOMPENSATED CARE COSTS

A. Bad Debt

One of the elements that states would be required to report to CMS is the level of uncompensated care costs incurred by each DSH hospital. The text of this proposed

requirement states, in part, that "Uncompensated care costs do not include bad debt or payer discounts." (proposed 42 C.F.R. § 447.299(c)(15)).

We strongly disagree that bad debt be excluded from the definition of uncompensated care costs. The statement is inconsistent with current law, which includes all costs related to individuals who "have no health insurance (or other source of third party coverage)" (42 U.S.C. §1396r-4(g)(1)(A)). In addition, the uncompensated costs associated with under-insured individuals and with patients having high deductibles or exclusion limits pose significant financial burdens on hospitals, burdens that historically have been recognized by state Medicaid programs. We urge CMS to rescind the exclusion of bad debt in the uncompensated care definition.

B. Physician Services

The preamble of the proposed rule states that uncompensated care costs of physician services cannot be included in the calculation of the hospital-specific DSH limit (70 Fed. Reg. 50265). We disagree strongly with this statement and urge the Agency to rescind it in the final rule.

There is nothing in either current law or the MMA that says physician costs cannot be included in the DSH limit calculation. The costs associated with securing physicians to serve the hospital's indigent patient population are legitimate unreimbursed costs and should be allowed. Inclusion of physician costs also is vital since many hospital operations include physician clinics that focus on providing primary care to underserved populations and generally operate at a financial loss due to inadequate medical reimbursement rates. The final rule should clarify that these costs <u>can</u> be included in the DSH limit calculation.

II. DSH LIMITS AND SECTION 1011 PAYMENTS

Under section 1011of the MMA, hospitals may be reimbursed for costs associated with emergency services provided to undocumented immigrants ("Section 1011 payments"). Although the preamble to the proposed rule states that the Agency believes receipt of Section 1011 payments will have no impact on DSH payments for hospitals that have not reached their DSH cap, it also states that for hospitals at or near their DSH limit "States will need to consider a section 1011 payment when determining the hospital's DSH limit, because the total DSH payments should not exceed the total amount of uncompensated care at the hospital." (70 Fed. Reg. at 50264).

Section 1011 payments should not be included in the reporting requirements. There is no statutory requirement to include them. The Medicaid statute requires only that uncompensated costs be offset by non-DSH Medicaid revenues or payments by uninsured patients--Section 1011 payments fall into neither of these categories.

III. HOSPITALS' ADMINISTRATIVE BURDEN

We believe that the proposed rule would place undue administrative burdens on hospitals. To help alleviate this burden, we urge the Agency to make the following changes in the final rule:

- Make the regulations effective prospectively (rather than FY 2005) so that states and hospitals have time to review, understand, and modify procedures to comply with the reporting instructions;

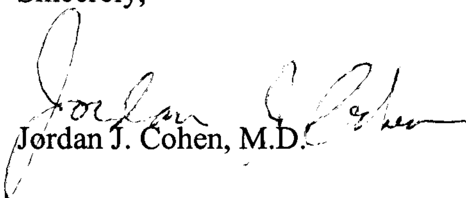
- Rescind the preamble requirement that audited DSH payments must be measured against actual uncompensated care costs in the same FY and continue to allow reasonable estimating methodologies to determine uncompensated care costs; and

- Delete the requirement that states must report, for each hospital, an unduplicated count of Medicaid eligible and uninsured patients because this reporting burden will likely fall to hospitals that do not have systems in place to generate these data.

* * * * * * * * * * *

If you have questions concerning these comments, please feel free to call Robert Dickler, Senior Vice President, Health Care Affairs, or Karen Fisher, Senior Associate Vice President. These individuals may be reached at (202) 828-0490.

Sincerely,



Jordan J. Cohen, M.D.

cc: Robert Dickler, AAMC
Karen Fisher, AAMC

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OCT 25

Charles N. Kahn III
President

October 25, 2005

VIA EMAIL AND HAND-DELIVERY

Dr. Mark B. McClellan
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue S.W., Room 445-G
Hubert H. Humphrey Building
Washington, D.C. 20201

Re: CMS Proposed Rule with Comment Period, Medicare Program; Disproportionate Share Hospital Payments; 42 C.F.R Parts 447 and 455 (Federal Register August 26, 2005)

Dear Dr. McClellan:

The Federation of American Hospitals ("FAH") is the national representative of privately owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching, short-stay and long-term care hospitals in urban and rural America, and provide a wide range of ambulatory, acute and post-acute services. We appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services' ("CMS") proposed rule (the "Proposed Rule") regarding new and revised reporting and verification requirements applicable to the Medicaid program's disproportionate share hospital ("DSH") payment program.

I. General Comments

The FAH, in general, supports CMS' promulgation of the Medicaid DSH payment reconciliation reporting and verification requirements. Nevertheless, the FAH believes that it would be helpful to all providers and to the states charged with administering these requirements for CMS to clarify its position, as generally stated in the Proposed Rule, that "the receipt of a Section 1011 payment will not impact the calculation of a hospital's Medicaid DSH payment amount if the hospital has not reached its DSH cap." 70 Federal Register 50264 (August 26,

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2005). Although the FAH believes that this statement is clear on its face, other statements in the Proposed Rule inject at least some degree of ambiguity into this issue; thus, additional, unambiguous clarification would be greatly appreciated by providers nationwide, especially given the somewhat (as yet) undetermined process of distributing Section 1011 fund to providers that furnish emergency health services to undocumented aliens.

The FAH strongly believes, in apparent agreement with CMS, that the receipt of a Section 1011 payment by a provider should not impact the calculation of a hospital's Medicaid DHS payment amount unless the hospital has reached its DSH cap. The FAH wants to assure, however, that the state agencies which will be delegated substantial responsibility to report accurately and have audited Medicaid DSH payment information at the state and provider level, clearly understand what costs and payments are to be considered at each stage of the calculation for reporting and audit purposes. For example, in Texas Administrative Code, Title I, Part 15, Chapter 355, Subchapter L, Division 4, §355.8065(b)(5), the disproportionate share hospital ("DSH") regulation defines the cost of services to uninsured patients as "inpatient and outpatient charges" to patients who have no health insurance or other third party *payment* (emphasis added) for services provided during the year. It's possible this regulation could be interpreted by the Texas Medicaid state agency to mean that a Section 1011 payment received for the treatment of an undocumented alien is a third party *payment* thereby disqualifying the undocumented alien cost for inclusion in the hospital's DSH calculation. As such, this example illustrates why the FAH is requesting an unambiguous clarification of the proposed rule as it relates to Section 1011 payments and state Medicaid DSH payments.

Section 1923(g)(1)(A) of the Social Security Act indicates that a Medicaid DSH payment adjustment cannot exceed the costs incurred during the year of furnishing hospital services to individuals who either are eligible for medical assistance under a state plan (i.e., qualified for Medicaid) or who have no health insurance (or other source of third party coverage) for services provided during a given fiscal year. The undocumented aliens whose hospital services would be paid in part (and very likely, in small part) through the application of Section 1011 funds, would not have "health insurance" nor would such undocumented aliens have any "other source of third party coverage" for the services provided to them. Indeed, pursuant to Section 1011 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 ("MMA") (Pub. L. 108-173, enacted on December 8, 2003), the funds authorized under Section 1011 of the MMA do not offer undocumented aliens any type of "health insurance" or "health coverage." Rather, these funds are authorized to defray at least some of the costs incurred by providers in treating undocumented aliens to the extent the eligible provider is not "otherwise reimbursed" (through insurance or otherwise) for such services during fiscal years spanning a period from 2005 through 2008. See Section 1011 of MMA, Section (c)(1).

Section 1011, moreover, is a stand alone section, and was not incorporated into the Medicare or Medicaid Acts (Titles XVIII or XIX, respectively, of the Social Security Act) and Section 1011 funds do not constitute "health insurance" funds under the Medicaid Act. Thus, it should be made clear to the administering state agencies that Section 1011 payments will not be considered an "other source of third party coverage" under Section 1923(g) of the Social Security Act by states in determining the statutorily required individual hospital Medicaid DSH payment limitation (the "DSH cap").

The Proposed Rule states, in contrast, that uncompensated care costs of providing inpatient hospital and outpatient hospital services to Medicaid eligible individuals and uninsured individuals, as described in Section 1923(g)(1)(A) of the Medicaid Act, are included in the calculation of the hospital specific Medicaid DSH limits. Consequently, the FAH presumes that CMS intends for states to include the uncompensated care costs of providing hospital services to undocumented aliens (as "uninsured individuals" as described in Section 1923(g)(1)(A) of the Medicaid Act), in the calculation of the hospital specific Medicaid DSH limits stated in Sections 1923(f) and (g) of the Act. However, the FAH believes that some additional clarification by CMS in the final rule is necessary to confirm this understanding.

Likewise, the FAH wants to assure that states accurately report the various categories of costs and revenue identified under the proposed reporting requirement in the Proposed Rule. With respect to "indigent care revenue," states will be required to indicate the total annual payments received by each hospital from individuals with "no source of third party coverage" for inpatient hospital and outpatient hospital services they receive. The FAH encourages CMS to confirm that undocumented aliens seeking emergency services will not be deemed to have any source of third party coverage for hospital services they receive and that the only "indigent care revenue" associated with undocumented aliens that would be considered for DSH purposes under the Proposed Rule's reporting requirements would be monies actually received by hospitals from the undocumented aliens, themselves.

Also, with respect to " uncompensated care costs," states are required under the Proposed Rule to indicate separately the total annual amount of uncompensated care costs for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals and to individuals with no source of third party coverage for the inpatient hospital and outpatient services they receive. CMS indicates in its Proposed Rule that:

> The total annual uncompensated care cost equals the total cost of care for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals and to individuals with no source of third party coverage for the inpatient hospital and outpatient hospital services they receive, <u>less the sum of regular Medicaid rate payments, Medicaid managed care organization payments, supplemental/enhanced Medicaid payments and indigent care revenue</u>. ...[Emphasis added.]

70 Fed. Reg., 50264 (August 26, 2005).

Again, the FAH believes it would be helpful for CMS to state more explicitly that the cost of services provided to undocumented aliens by hospital providers does constitute uncompensated care cost, and that any Section 1011 funds received in partial compensation of such costs will not reduce a provider's Medicaid DSH allotment unless the provider has otherwise reached its Medicaid DSH cap as calculated under Sections 1923(f) and (g) of the Medicaid Act.

In the Proposed Rule, CMS also separately recognizes how the new reporting requirements will apply to "Medicare eligible and uninsured individuals." With respect to these

patients, states will be required under the Proposed Rule to "indicate the total annual unduplicated number of Medicaid eligible individuals receiving inpatient hospital and outpatient hospital services and the total annual unduplicated number of individuals with no source of third party coverage for the inpatient hospital and outpatient hospital services they receive." 70 Fed. Reg. at 50264 (August 26, 2005). The FAH believes, consistent with our comments above, that for purposes of this reporting calculation, states are to include undocumented aliens seeking emergency care among the individuals deemed to have no source of third party coverage for the inpatient hospital and outpatient hospital services they receive. Immediately below this language, in its explanation of the Proposed Rule, CMS states that the receipt of a Section 1011 payment will not impact the calculation of the hospital's Medicaid DSH payment if the hospital has not yet reached its DSH cap; however, patients for whose services Section 1011 funds are authorized are not specifically referenced in these other portions of the rule. Thus, the FAH requests such clarification.

II. Comments in Response to the Audit Requirements

The FAH supports the proposed imposition of audit requirements to assure that information concerning Medicaid DSH payments to hospitals is reported accurately on a nationwide basis. The FAH believes that the proposed audit requirements constitute a laudable effort to assure that DSH information is appropriately verified for all Medicaid DSH providers in all states. The FAH also wants to assure, however, that the burden of auditing the DSH information that has been delegated by CMS to the states, is not subsequently shifted to individual providers. While the FAH's members will be happy to comply with any reasonable reporting requirements imposed by states with respect to furnishing cost and payment information, the FAH believes that states should not be permitted to mandate that individual providers be required to arrange for a separate audit of the information to be submitted to the respective state agencies. This would constitute an additional burden on providers that is not contemplated by the governing statute or by CMS' Proposed Rule. The FAH would greatly appreciate clarifying language from CMS confirming that the newly proposed audit responsibility is delegated to the states, and that such responsibility should not be further delegated to individual providers.

With respect to the substance of the proposed audit requirements, much as it did in connection with the proposed reporting requirements, the FAH respectfully requests CMS to clarify its terms with respect to which costs and payments must be verified and included under which verification requirement.

For example, under "Verification 1," states must calculate the difference between (1) the costs incurred by each hospital for furnishing services to Medicaid beneficiaries and individuals without any other source of third party coverage, and (2) all Medicaid payments made to such hospital for such services and any payments made by uninsured individuals for such services. This difference, if any, then becomes the hospital's uncompensated care cost limit (or DSH cap). The FAH wants to assure that hospitals' incurred costs of furnishing services to undocumented aliens are includable in the costs incurred by hospitals for furnishing services to individuals with no source of third party coverage for the services they receive.

With respect to "Verification 2" and "Verification 3," the FAH also requests CMS to clarify that the costs of furnishing services to undocumented aliens will consistently be treated as an uncompensated care cost for purposes of calculating the total uncompensated care costs in excess of which no additional Medicaid DSH payment can be made.

Finally, with respect to "Verification 4," the FAH requests CMS to clarify for providers and states that only supplemental Medicaid payments (to the exclusion of Section 1011 funds, which are not Medicaid program payments) be included for purposes of counting which payments are deemed to have been paid to a hospital as part of the hospital specific DSH limit. The FAH wants to assure that, as stated in the Proposed Rule, the amount otherwise available to a hospital with respect to its Medicaid DSH cap remains available for purposes of paying any remaining uncompensated care costs of the hospital (including the costs of providing care to undocumented aliens), regardless of the hospital's receipt of some Section 1011 funds in that fiscal year. The Proposed Rule states in connection to this "Verification 4" that only a State's supplemental and/or enhanced Medicaid payments should be added to the regular Medicaid payments for purposes of determining the hospital's DSH cap; however, the FAH is concerned that administering state agencies may become confused on this point if CMS does not more explicitly exclude the Section 1011 funds from the "Verification 4" requirement.

* * * *

The FAH appreciates CMS' review and careful consideration of the comments in this letter, and would be happy to meet, at your convenience, to discuss them. If you have any questions, please feel free to contact Steve Speil, Sr. Vice President and Chief Financial Officer, at (202) 624-1529.

Respectfully submitted,

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American Hospital Association

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OCT 25

October 25, 2005

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, S.W.
Washington, DC 20201

Re: CMS-2198-P; Medicaid Program; Disproportionate Share Hospital Payment – Implementing the Medicare Modernization Act of 2003 Reporting and Auditing Requirements; Proposed Rule.

Dear Dr. McClellan:

The American Hospital Association (AHA), on behalf of our 4,800 member hospitals, health care systems, other health care organizations, and 33,000 individual members, appreciates the opportunity to comment on the proposed rule implementing the Medicaid Disproportionate Share Hospital (DSH) Payment reporting and auditing requirements found in the Medicare Modernization Act of 2003 (MMA). The Medicaid DSH program provides essential financial assistance to our nation's safety net hospitals. These hospitals care for our nation's most vulnerable populations – the poor, the disabled and the elderly. And, they shoulder critical community services such as trauma and burn care, high-risk neonatal care, and disaster preparedness resources. The AHA has numerous concerns with the presently drafted rule and believes it would have a significant negative impact on Medicaid DSH hospitals.

The Medicaid DSH program has operated with little written regulatory guidance since the publication of the program's initial regulations in 1992. Two communications sent to State Medicaid Directors in 1994 and 2002 address questions regarding the hospital-specific DSH limits. Much of the current DSH policy has been forged in negotiations between the Centers for Medicare & Medicaid Services (CMS) and individual state governments. The absence of consistent federal policy has been a source of frustration for hospitals. Unfortunately, CMS has chosen to use this proposed rule implementing the MMA reporting and auditing requirements to establish new DSH policy.

The AHA has four overriding concerns regarding the proposed rule:

- CMS' substantive changes to standard DSH policy not required by the MMA;
- CMS' definition of uncompensated care that excludes bad debt;
- CMS' proposed retroactive application of the auditing requirements to fiscal year 2005; and
- the reporting burden imposed on hospitals.

The AHA strongly urges CMS to rethink its approach adopted in this proposed rule.

REPORTING REQUIREMENTS

Uncompensated Care

The proposed rule represents the agency's attempt to substantively change long-standing DSH policy without properly calling for public comment and reaches beyond the statutory requirements of the MMA. The rule purports only to implement section 1001(d) of the MMA that establishes new reporting and auditing requirements for DSH payments. That provision of the MMA did not amend section 1923(g) of the Social Security Act, which establishes hospital-specific DSH limits for the costs of uncompensated care. A review of the legislative history of the MMA DSH reporting and auditing provision does not reveal that Congress raised any concerns about how CMS or state Medicaid programs were determining unreimbursed costs for setting the hospital-specific DSH limit.

The proposed rule would alter the definition of uncompensated care to exclude both bad debt and physician services, despite the fact that the MMA left the underlying law governing DSH limits in place, and that Congress expressed no concern about the calculation of uncompensated care costs. Interestingly, the proposed rule does not even acknowledge that it is proposing to alter the definition of uncompensated care. Rather, the new definition is simply included in the preamble and regulation text as though nothing is being substantively changed. The AHA has procedural and substantive concerns with the proposed rule.

As a procedural matter, CMS fails to acknowledge that it is changing the definition of a key term and inadequate notice has been provided to the public – violations of the Administrative Procedure Act. In addition, the changed definition raises the following substantive concerns.

Bad Debt. The proposed rule, in both the preamble and draft regulatory language, states that uncompensated care does not include bad debt for purposes of setting the hospital-specific DSH limit. This new definition of uncompensated care that excludes bad debt is inconsistent with the statute, legislative history and long-standing agency policy guidance and practice. The underlying statute (section 1923(g)(1)(A)) permits the inclusion of the costs of services provided to individuals with no health insurance or other source of third-party coverage. The legislative history of the Omnibus Budget Reconciliation Act of 1993 (OBRA) provision that originally established the hospital-specific DSH limit reveals Congress' intent regarding determining hospitals' unreimbursed costs. The report language states that the costs of providing services to uninsured patients would be net of any out-of-pocket payments received from uninsured individuals.

In a 1994 letter to state Medicaid programs implementing the OBRA 1993 provision, CMS stated:

> One of the key provisions in the [DSH] limit is the determination of which of a hospital's patients "have no health insurance or source of third-party payment for services provided." A number of States have asked about the meaning of this provision, and whether it includes, for example, individuals with indemnity policies, or individuals whose policies contain day limits that are exhausted.
>
> [CMS] believes it would be permissible for States to include in this definition individuals who do not possess health insurance which would apply to the service for which the individual sought treatment.

Thus, CMS determined that the cost of services provided to individuals with third-party coverage, but whose third-party coverage did not reimburse the hospital services the individual received, could be counted as uncompensated care costs. In making this determination, the agency was clearly looking at the costs associated with the uninsured and underinsured in implementing the hospital-specific DSH limit.

In 2002 guidance to state Medicaid programs regarding the hospital-specific DSH limit and the upper payment limit, CMS reaffirmed its 1994 DSH policy when it stated that the calculation of uncompensated care is "net of third party payments."

A number of state Medicaid programs include the costs of care provided to uninsured individuals for which no payment is made and the costs associated with the non-payment of copayments and deductibles for individuals with third-party coverage in determining a hospital's qualifying costs for the hospital-specific DSH limit. (Current Medicare policy requires that hospitals seek payment from all individuals – Medicare and non-Medicare – with the means to pay copayments and deductibles.) The approaches adopted by these state Medicaid programs to establish qualifying costs for setting the hospital-specific DSH limit are consistent with the statute, legislative history and established CMS DSH policy.

The explicit exclusion of bad debt from the definition of uncompensated care will be harmful to DSH hospitals that are struggling to meet the health care needs of the growing numbers of uninsured and underinsured. The recent growth of health plans and health savings accounts that impose high deductibles or have exclusion limits is putting new burdens on hospitals in terms of unreimbursed costs.

CMS' new definition of uncompensated care to exclude bad debt is inconsistent with the statute, legislative history and long-standing CMS DSH policy. **The AHA strongly recommends that CMS change its definition of uncompensated care by striking references to bad debt in 42 C.F.R. 447.299(c)(15) and in its place clarify that uncompensated care includes:**

- **the costs of services furnished to individuals with no health care insurance, third-party coverage or third-party payment;**
- **individuals with health savings accounts; and**

- **the costs of services furnished to insured individuals whose policies do not cover the services provided to the individual due to his/her health plan's exclusions, limits, copayments or deductibles.**

Physician Services. The proposed rule's preamble states that uncompensated care costs of physician services cannot be included in the calculation of the hospital-specific DSH limit. However, the statute does not specifically exclude physician services. In fact, the agency, in at least one communication to a state Medicaid program, allows for the inclusion of physician services in determining a hospital's unreimbursed costs. In this example, the costs associated with securing physicians to serve the hospital's Medicaid patient population are legitimate unreimbursed costs if the hospital does not separately bill for the services. The MMA does not require that CMS exclude physician services. This is another example of reaching beyond MMA statutory requirements to establish new CMS policy. **The AHA believes that physician costs associated with hospitals' services should be allowed and references to excluding physician costs in determining a hospital's uncompensated care costs in the preamble should be deleted.**

Section 1011

The preamble in the proposed rule directs state Medicaid programs to consider Section 1011 payments when determining a hospital's specific DSH limit. However, there is no statutory requirement to include Section 1011 payments when calculating the hospital's uncompensated care burden. Section 1011 payments are not Medicaid payments, health plan payments or payments from uninsured patients. Congressional intent, in enacting Section 1011, was to provide new resources rather than substitute existing resources for hospitals providing large volumes of uncompensated care to undocumented immigrants. Again, this reaches beyond statutory authority and sets new DSH policy. The consideration of Section 1011 payments would likely result in reducing needed DSH dollars to hospitals serving high numbers of undocumented immigrants. **The AHA recommends that CMS delete the language in the preamble that requires states to offset Section 1011 payments when establishing a hospital's DSH limit. In addition, CMS should clarify that Section 1011 payments should not factor into the calculation of the hospital-specific DSH limit regardless of whether the hospital is at or near its limit.**

Reporting Unduplicated Patient Count of Medicaid Eligibiles and Uninsured Individuals

State Medicaid programs are required to report for each hospital an unduplicated count of Medicaid-eligible and uninsured patients. The AHA is concerned that states will look to hospitals to produce these patient counts. Many hospitals do not have the reporting systems in place that would allow them to generate unduplicated counts of patients served throughout the year that are Medicaid eligible or uninsured. Further, many questions arise as to how a hospital would classify certain patients, such as a patient that has Medicaid coverage for part of the year and is uninsured for part of the year. The proposed rule also fails to make the case as to why this information is necessary. **The AHA recommends that this unnecessary and burdensome reporting requirement be deleted.**

AUDIT REQUIREMENTS

The MMA requires that state Medicaid programs have their DSH programs independently audited and submit this independent certified audit to the Secretary on an annual basis. The proposed rule does not address how the audits will be paid for and there is a concern that the state Medicaid programs will pass on these additional costs to DSH hospitals. The cost for hospital audits can reach as high as $50,000 per hospital. This estimate clearly suggests that the economic impact, if audit costs are passed on to hospitals as expected, will trigger the test of a major rule under Executive Order 12866 (September 1993 Regulatory Planning and Review) and should require a regulatory impact analysis. These safety net hospitals are not in the financial position to absorb these added audit costs. **The AHA recommends that CMS state affirmatively that the cost of the audits should not be passed on to hospitals.**

Definition of Independent Certified Audit

The proposed rule defines an independent certified audit as an audit conducted with generally accepted government auditing standards as defined by the Government Accountability Office. Most private sector audits use generally accepted accounting principles (GAAP) to audit hospital financial data. Applying a different set of auditing standards than GAAP to hospital financial data will result in an unnecessary burden on the hospitals trying to comply with information requests from the auditors. **The AHA recommends that state Medicaid programs be allowed to use GAAP standards in the independent certified audits.**

Retroactive Audit

The proposed rule retroactively applies the new reporting and auditing requirements to each state's fiscal year (FY) 2005. Most state fiscal years for 2005 have ended. The imposition of the new and substantive reporting and auditing requirements would make it impossible for state Medicaid programs to comply because they would have to retroactively identify the requested data. While the MMA required that CMS impose reporting and auditing requirements beginning in FY 2004, CMS has delayed implementation beyond the date specified in the MMA. The retroactive application of these new reporting and auditing requirements makes little sense now and will impose a hardship for state Medicaid programs and DSH hospitals. **The AHA strongly recommends that retroactive application of the reporting and auditing requirements be deleted from the rule and that the reporting and auditing requirements be tied to the first state fiscal year beginning after the rule is finalized.**

Reduce Uncompensated Care Costs by DSH Payments

The audit verification #1 requires that a state's audit report verify that each hospital receiving DSH payments has reduced its uncompensated care costs for furnishing inpatient and outpatient hospital services to Medicaid eligible individuals and individuals with no source of third-party coverage for the services in order to reflect the total amount of claimed DSH expenditures during the SFY. The DSH statute defines uncompensated care costs as the cost of serving Medicaid and uninsured patients net of Medicaid payments and payments made by uninsured individuals, excluding DSH payments. The statutory language is clear that uncompensated care costs are not offset by DSH payments. Verification #1 requirement, which reduces a hospital's

uncompensated care costs by claimed DSH expenditures, is contrary to the statute. **The AHA recommends that verification #1 be changed to require that the total amount of claimed DSH expenditures for each DSH hospital in the state is no more than the hospital's uncompensated care costs.**

Same Year Actual Costs

The audit verification #2 requires that the DSH payments comply with the hospital-specific DSH limit by stating that the DSH payments made in the audited state fiscal year (SFY) be measured against the actual uncompensated care cost in the same audited SFY. This would require that states reconcile DSH payments to ensure such payments do not exceed actual costs. However, the MMA does not require that payments be based on actual audited costs. Current CMS DSH policy allows states to use a prospective methodology to estimate current year uncompensated care costs for purposes of establishing the hospital's specific DSH limit (*the maximum amount that a hospital may receive in DSH payments*). The verification, through an audit, of DSH payments with the same year actual uncompensated care costs will place an enormous strain on hospitals through new burdensome and costly audits and increase the administrative costs for each state Medicaid program. This is another example of where the proposed rule substantively changes current Medicaid DSH policy, without statutory authority.

The AHA strongly recommends that CMS delete the requirement in the preamble and the regulatory language that audited DSH payments must be measured against actual uncompensated care cost in the same audited SFY. The AHA further recommends that CMS clarify that states be allowed to continue to use reasonable estimating methodologies to determine uncompensated care costs for purposes of establishing the hospital's specific DSH limit.

Conclusion

The AHA appreciates this opportunity to comment on the proposed rule to implement the Medicaid DSH reporting and auditing requirements of the MMA. While the AHA has long advocated for greater transparency in the operation of the Medicaid DSH program and more consistent federal standards, the proposed rule fails to achieve these goals and makes substantive policy changes that clearly exceed congressional intent. The Medicaid DSH program is a lifeline to many safety net hospitals across the country. The proposed rule, as presently drafted, will have a significant negative impact on these institutions. The AHA stands ready to provide any assistance to remedy the concerns outlined. If you have any questions about our comments, please contact me or Molly Collins Offner, senior associate director of policy, at (202) 626-2326 or mcollins@aha.org.

Sincerely,

Rick Pollack
Executive Vice President

Hospital Association of Rhode Island
100 Midway Road – Suite 21
Cranston, Rhode Island 02920
(401) 946-7887 Fax (401) 946-8188

Edward J. Quinlan
President

October 21, 2005

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Re: CMS-2198-P; Medicaid Program; Disproportionate Share Hospital Payments -- Implementing the Medicare Modernization Act of 2003 Reporting and Auditing Requirements; Proposed Rule.

Dear Dr. McClellan:

The Hospital Association of Rhode Island (HARI), on behalf of our member hospitals, appreciates the opportunity to comment on the proposed rule implementing the Medicaid Disproportionate Share Hospital (DSH) Payment reporting and auditing requirements found in the Medicare Modernization Act of 2003 (MMA). Since there is no public acute care hospital in Rhode Island, the Medicaid DSH program provides essential financial assistance to our state's safety net hospitals. It is these hospitals that provide access to care for our most vulnerable populations -- the poor, the disabled and the elderly. They also shoulder critical community services such as trauma and burn care, high-risk neonatal care, and disaster preparedness resources. HARI has numerous concerns with the proposed rule and believes the rule, as presently drafted, would have a serious negative impact on our Medicaid DSH hospitals.

The Medicaid DSH program has operated with little written regulatory guidance since the publication of the program's initial regulations in 1992. There have been two communications to the State Medicaid Directors in 1994 and 2002 that address questions regarding the hospital specific DSH limits. Much of the current DSH policy has been forged in negotiations between the Centers for Medicare and Medicaid (CMS) and individual state governments. The lack of consistent federal policy has been a source of frustration for hospitals. Unfortunately, it appears CMS is using this proposed rule implementing the MMA reporting and auditing requirements to establish new DSH policy.

HARI has four concerns regarding the proposed rule: 1. the definition of uncompensated care that excludes bad debt; 2. the substantive changes to standard DSH policy not required by the MMA; 3. the retroactive application of the auditing requirements to Fiscal Year 2005; and 4. the reporting burden imposed on hospitals. HARI requests that CMS rethink the approach described in this proposed rule.

A. Reporting Requirements

Uncompensated Care (UCC) (42 C.F.R. 447.299(c)(15))

The definition of uncompensated care, excluding both bad debt and physician services, substantively changes long standing CMS DSH policy without properly calling for direct public comment.

Bad Debt The proposed rule states that uncompensated care does not include bad debt for purposes of setting the hospital specific DSH limit. This statement is not consistent with the statute, legislative history, or long standing CMS practice. The underlying statute (1923(g)(1)(A)) permits the inclusion of the costs of services provided to individuals with no health insurance or other source of third party coverage. The conference report language for the Omnibus Budget Reconciliation Act of 1993 (OBRA '93) provision that originally established the hospital specific DSH limit reveals Congress' intent in directing CMS on the various ways to determine the unreimbursed costs that hospitals bear. The report language states that the cost of providing services to uninsured patients would be net of any out-of-pocket payments received from uninsured individuals. In its 1994 letter to state Medicaid Directors, CMS offered further guidance in the determination of unreimbursed costs by stating that the cost of services provided to individuals with third party coverage, but whose third party coverage did not cover the hospital services the individual received, could be counted. CMS was clearly looking at the cost associated with the uninsured and the underinsured in implementing the hospital specific DSH limit. In 2002, CMS, in its guidance to state Medicaid Directors regarding the hospital specific DSH limit and the upper payment limit, reaffirmed the 1994 DSH policy.

Thus, it is clear that the proposed rule's treatment of bad debt would result in major change in policy. However, nothing in the MMA DSH reporting and auditing requirements justifies this proposed policy shift. A review of the legislative history reveals no concern raised by Congress about how CMS or state Medicaid programs determined uncompensated care costs.

Neither is the change justified on policy grounds. The explicit exclusion of bad debt from the definition of uncompensated care will be harmful to DSH hospitals that are struggling to meet the health care needs of the growing numbers of uninsured and underinsured. The recent growth of health plans that impose high deductibles or have exclusion limits as well as the growth of health savings accounts are putting new burdens on hospitals in terms of unreimbursed costs.

HARI believes that CMS' new definition of uncompensated care which excludes bad debt is inconsistent with the statute and is a dramatic and unjustified shift in long-standing CMS DSH policy. Hospitals should not be denied DSH payments for uncollectible copays and deductibles for patients eligible for charity care based on a hospital's policy or for bad debts that in fact are true charity care but cannot be accounted for as such because the patient would not or could not fill out a hospital's charity care application.

Therefore, HARI strongly recommends that CMS change its definition of uncompensated care by striking references to bad debt in 42 C.F.R. 447.299(c)(15) and in its place clarify that uncompensated care include (1) the costs of services furnished to individuals with no health care insurance, third party coverage, or other third party payment and (2) the costs of services furnished to insured individuals, including those with health savings

accounts, whose policies do not cover the services provided to the individual due to their health plans exclusions, limits, or deductibles.

Physician Services The preamble of the proposed rule states uncompensated care costs associate with physician services cannot be included in the calculation of the hospital specific DSH limit. This, too, represents a proposed policy shift that has no basis in the MMA. CMS, in at least one communication to a state Medicaid Director, has allowed for the inclusion of physician services in determining a hospital's unreimbursed costs. As that decision suggested, the costs associated with securing physicians to serve the hospital's indigent patient population are legitimate unreimbursed costs and should be allowed. Thus, this is another instance of CMS' attempt to reach beyond MMA statutory requirements to establish new policy. **HARI believes that costs associated with hospital-employed physician services should be included and references to excluding the physician costs in determining the hospital's uncompensated care costs in the preamble should be deleted.**

Reporting Unduplicated Patient Count of Medicaid Eligibiles and Uninsured Individuals (42 C.F.R. 447.299 (c)(16))

State Medicaid programs are required to report for each hospital an unduplicated count of Medicaid eligible and uninsured patients. HARI is concerned that states will turn to hospitals to produce these patient counts, thus imposing an expensive administrative burden on already struggling hospitals. Many of our hospitals do not have the reporting systems in place that would allow them to generate unduplicated counts of patients served throughout the year that are Medicaid eligible or uninsured. Also, questions arise as to how a hospital would classify certain patients such as a patient that has Medicaid coverage for part of the year and is uninsured for part of the year. The proposed rule also fails to make the case why this information is necessary.

HARI recommends deleting this reporting requirement because it imposes an unnecessarily burden on hospitals and produces little, or no, discernable benefit.

Reporting Total Costs (42 C.F.R. 447.299(c)(14))

The 1994 guidance to State Medicaid Directors allows a state to use the definition of allowable costs in its State Medicaid plan or any other definition as long as the costs determined under such a definition do not exceed the amounts that would be allowable under the Medicare principles of cost reimbursement. This pronouncement was consistent with the principle that Medicaid is a federal-state partnership and should be continued.

HARI believes that since this is a Medicaid DSH program, the state should be permitted to determine the definition of allowable costs as either not exceeding amounts allowable under Medicare principles of cost reimbursement or amounts that would be consistent with the state's existing Medicaid program.

B. Auditing Requirements (42 C.F.R 455.201 and 204)

Definitions. (42 C.F.R. 455.201)

The proposed rule defines *Independent certified audit* as one conducted in accordance with generally accepted government auditing standards, as defined by the Comptroller General of

the United States. Most, if not all, hospital auditors use auditing standards generally accepted in the United States of America when auditing hospitals financial data. Thus, the proposed rule would subject hospitals to two separate auditing standards. Having certain data audited under one set of principles and other data audited under another will create confusion in representing the financial condition of the hospitals. Moreover, requiring that the data be re-audited using differing principles may result in variances in data and create more inconsistencies in an industry striving to present consistent data.

HARI strongly recommends that the definition be changed so that audits may be performed under those principles already in place for a hospital's audited financial data.

Retroactive Audit (42 C.F.R. 455.204(b))

The proposed rule retroactively applies the new reporting and auditing requirements to the state's 2005 fiscal year (FY). Rhode Island's 2005 FY has ended. Imposing the new and substantive reporting and auditing requirements would make compliance virtually impossible because state Medicaid programs would have to retroactively identify the requested data. While the MMA required that CMS impose reporting and auditing requirements beginning in fiscal year 2004, CMS delayed implementation beyond the date specified in the MMA. Retroactive application of these new reporting and auditing requirements will impose a hardship for state Medicaid programs as well as DSH hospitals.

HARI strongly recommends that this retroactive application of the reporting and auditing requirements be deleted from the rule and that the reporting and auditing requirements be tied to the first state fiscal year beginning after the finalization of the rule.

Same Year Actual Costs (42 C.F.R. 455.204(c))

The audit verification #2 requires that the DSH payments agree with the hospital specific DSH limit, requiring that DSH payments made in the audited state fiscal year (SFY) be measured against the actual uncompensated care cost in the same audited SFY. This would require that the state reconcile DSH payments to ensure such payments do not exceed actual costs. The verification, through audit, of DSH payments with the same year actual uncompensated care costs is excessively burdensome and impracticable because Medicare and Medicaid cost report audits themselves are years in arrears.

HARI recommends that the time for filing an audit be extended until underlying Medicare/Medicaid audits are performed so that an accurate cost number can be recognized.

Reduce Uncompensated Care Costs by DSH Payments (42 C.F.R. 455.204(c)(1))

The audit verification #1 requires that a state's audit report verify that each hospital receiving DSH payments has reduced its uncompensated care costs for furnishing inpatient hospital and outpatient hospital services during the SFY to Medicaid eligible individuals and individuals with no source of third party coverage for the services by the total amount of claimed DSH expenditures for that hospital. The DSH statute defines uncompensated care costs as the cost of serving Medicaid and uninsured patients net of Medicaid payments and payments made by uninsured individuals, excluding DSH payments. The statutory language is clear that uncompensated care costs are not offset by DSH payments. Yet, the first verification

requirement, as written, reduces a hospital's uncompensated care costs by claimed DSH expenditures is contrary to the statute.

HARI recommends that the language of verification #1 be revised to require that the total amount of claimed DSH expenditures for each hospital that qualifies for a DSH payment in the State is no more than the hospital's uncompensated care costs, exclusive of DSH payments.

Economic Impact

The audit process will place an enormous burden on hospitals through additional and costly audits, as well as increase the administrative costs for each state Medicaid program. As the proposed rule also does not consider how such additional audits will be paid for, HARI is concerned that the added costs will be passed on to the DSH hospitals. It is estimated that the cost for hospital audits may be approximately $800,000 or higher. **This estimate clearly suggests that the economic impact of this one audit requirement meets the test of a major rule under the Regulatory Flexibility Act and requires a regulatory flexibility analysis for small entities such as hospitals.**

Post-Audit Adjustments

The proposed regulation is silent on the question of post-audit adjustments. In some cases, audits will reveal actual costs that were not included in the estimated uncompensated care costs provided. In such cases, provided there are funds remaining in the state's DSH allotment or other money available for such purposes, states should be permitted to compensate hospitals.

HARI recommends that the proposed rule be revised to expressly permit states, upon receipt of an audit showing additional actual cost not included in estimated uncompensated care costs, to compensate hospitals through post-audit adjustments.

HARI appreciates this opportunity to comment on the proposed rule to implement the Medicaid DSH reporting and auditing requirements of the MMA. While HARI supports transparency in the operation of the Medicaid DSH program and appreciates the value of more consistent federal standards, the proposed rule has not achieved these goals. Moreover, the proposed rule makes substantive policy changes that clearly exceed Congressional intent. Finally, because the Medicaid DSH program is a lifeline to the safety net hospitals in Rhode Island, the proposed rule, as presently drafted, will have a significantly negative impact on these institutions.

HARI is happy to provide any assistance to remedy the concerns outlined. Please refer any questions directly to my staff, Pat Moran at 401-946-7887x103 or e-mail at patm@hari.org.

Sincerely,

Edward J. Quinlan

State of California—Health and Human Services Agency

Department of Health Services

California
Department of
Health Services

SANDRA SHEWRY
Director

ARNOLD SCHWARZENEGGER
Governor

October 25, 2005

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2198-P
P.O. Box 8010
Baltimore, MD 21244-1850

Dear Sir or Madam:

CMS PROPOSED REGULATIONS
NEW REPORTING AND AUDIT REQUIREMENTS FOR DISPROPORTIONATE SHARE HOSPITAL PROGRAM **(CMS-2198-P)**

The California Medicaid Program appreciates this opportunity to comment on the proposed regulation changes in the Notice of Proposed Rule Making (CMS-2198-P) published at 70 Fed. Reg. 50262 (August 26, 2005).

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) and the proposed regulations require states to provide additional information and obtain an independent certified audit. The proposed regulations establish new reporting requirements and require an independent certified audit report beginning with the state's fiscal year 2005 Disproportionate Share Hospital (DSH) program. The audit reports are to be submitted within a year after the completion of the State Fiscal Year (SFY) beginning with 2005, and for all subsequent years. California's comments on the proposed regulations are set forth below.

Retrospective Reconciliation to Actual

The proposed regulations appear to require a retrospective reconciliation to actual costs, rather than an audit to confirm that the approved estimating methodology was properly applied. Retrospective implementation would result in timing issues and changes in methodology for California. As part of its approved Medicaid State Plan, the Centers for Medicare & Medicaid Services (CMS) has authorized California to use a prospective estimate of a hospital's uncompensated care costs (UCC) for a given year based on the hospital's costs in prior years. Many states use data from a prior period

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to estimate UCC for purposes of the DSH program, because no data exist for the current state fiscal year costs. In accordance with its state plan, California used a prospective system for SFY 2004-05, where the data for calculation of UCC was based largely on calendar year 2002 data. California's State Plan does not require any kind of retrospective reconciliation to actual costs.

The difficulties of applying retrospective audits to prospective systems implemented in the past cannot be overemphasized. A retrospective audit to determine the accuracy of the estimates used to determine UCC based on the approved prospective methodology would require changing the State Plan. In order to ensure timely payments to providers, states should be allowed to continue to use prospective systems to determine UCC. Implementing the audit requirement effective in a state's fiscal year ending 2005 is not feasible because of unanticipated impacts on payments already made to the hospitals.

California requests clarification that the proposed regulations do not require retrospective reconciliation for states using a CMS-approved prospective methodology. California also requests that CMS begin full implementation of the audit requirement no sooner than state fiscal years ending in 2006, to allow a transition period for states to obtain data and implement procedures. Because CMS does not allow a state to retroactively change it's state plan, CMS should not impose retroactive regulations that have the affect of changing approved state plans for years that have already been completed.

The DSH reporting and auditing requirements contained in MMA were intended only to ensure compliance with the DSH requirements, not to change the DSH requirements themselves. Nothing in the MMA either requires or encourages a change in CMS's long-standing policy that DSH payments can be based on a prospective estimate of a hospital's uncompensated care costs.

Performing the Independent Audit

Each state is required to obtain an independent audit of its DSH program. The proposed regulations define an "independent audit" as an audit conducted according to the standards specified in the generally accepted government auditing standards issued by the Comptroller General of the United States. However, it is not clear what constitutes "independent."

The Audits and Investigations program (A&I) of CDHS conducts audits following generally accepted government accounting standards. Staff from A&I are very familiar

with California's large and complex county and University of California hospitals and are familiar with the practices and history of each individual hospital. Additionally, A&I staff are very familiar with government auditing standards and have always been considered "independent" of any influences from individual hospitals or the hospital industry as a whole. While A&I is independent of the hospitals, A&I is not a private sector auditing firm independent of the State of California.

CDHS has experienced numerous difficulties when contracting with external auditing firms. The State contracting process itself is very time consuming, usually taking well over a year to complete. CDHS has had some very unfortunate experiences as a result of contracts with private sector auditing firms. For example, a very large audit contract with a well-known private sector auditing firm was extremely costly and resulted in numerous problems. The firm was not familiar with the complex infrastructure of local agencies in California and the intricacies of the Medi-Cal Program, resulting in a protracted auditing process. Also, the firm appeared to exhibit some "conflicts of interest" because it did not want to alienate future contracts with local agencies in California.

Some states, such as California, regularly conduct hospital audits and have auditors competent to perform these audits in an efficient as well as independent manner. As a result of experiences with private-sector contracted audits, California proposes that CMS provide that "independent audit" means an audit independent of the hospital and does not require the state to contract with a private-sector auditing firm to complete and certify the "independent audits" required by the proposed regulations.

Physician Service

The preamble to the proposed regulations states that the "uncompensated care costs of providing physician services cannot be included in the calculation of hospital-specific DSH limit."

Prohibiting the costs attributable to physician services from counting towards a hospital's uncompensated care costs is not consistent with the wording or purpose of the DSH statute. The definition of the hospital-specific DSH limit contained in Section 1923(g) states that DSH payments in a given year must not exceed "the costs incurred during the year of furnishing hospital services." If the hospital bears the costs of the physicians, the costs are necessarily part of the "costs incurred...of furnishing hospital services." Uncompensated care costs should include *all* unreimbursed costs incurred by the hospital in serving the uninsured. Otherwise, the purposes of the DSH statute -- to assist safety net hospitals and other hospitals to meet *their* costs of serving the uninsured -- would be thwarted.

CMS has articulated no policy reason why physician services costs borne by hospitals for uninsured patients should be treated any differently than other costs of serving those patients. In fact, the absolute bar on including hospital-incurred physician services costs in the calculation of uncompensated care costs is a departure from other statements from CMS on this issue. CMS has previously recognized that States *may* include the uncompensated costs of physician services in the calculation of the hospital-specific DSH limit if hospitals do not separately bill for these services when provided to Medicaid patients.

Section 1011 Payments

In the preamble to the proposed regulations, CMS states that payments under Section 1011 of the MMA, which provides for federal payments directly to hospitals for otherwise unreimbursed costs of providing services to aliens, "will not impact the calculation of a hospital's Medicaid DSH payment amount if the hospital has not reached its DSH cap," but that these payments should be considered if a DSH hospital is at or near its DSH limit.

There is no basis in the Social Security Act for requiring that a hospital's uncompensated care costs must be offset by Section 1011 payments. Under Section 1923(g) of the Act, the DSH limit for an individual hospital is equal to the costs of care provided to Medicaid or uninsured individuals "net of payment under [Title XIX], other than under [Section 1923], and by uninsured patients." A Section 1011 payment is neither a payment under Title XIX or a payment by an uninsured patient. As a result, these payments should not be included in any calculation of a hospital's uncompensated care costs.

Bad Debt

The description of uncompensated care costs in proposed 42 C.F.R. § 447.299(c)(15) provides, "Uncompensated care costs do not include bad debt or payer discounts."

Bad debt should be included in the calculation of uncompensated care costs. Bad debt represents the portion of revenue treated as received for accounting purposes, but not actually received, due to the fact that some payers do not pay even though they are obligated to do so. Bad debt is thus an allowable cost, as recognized by generally accepted accounting principles. Not including bad debt would understate uncompensated care costs (or overstate revenue, which is deducted to determine uncompensated care costs).

Number of Eligibles

Proposed Section 447.299(c)(16) requires States to report, for each DSH hospital, the unduplicated number of Medicaid eligible individuals and uninsured individuals receiving inpatient and outpatient services.

CMS should eliminate this reporting requirement. Hospitals are currently not required to report the number of uninsured individuals receiving services, and we do not believe routinely compile data in this manner. Moreover, the regulations and preamble provide no guidance on how States are supposed to identify whether individuals have been double-counted as both a Medicaid recipient and an uninsured individual. Trying to establish an unduplicated number may be burdensome and confusing: how are States supposed to count individuals who have Medicaid coverage for part of a year, but are uninsured for the remainder of the year? Moreover, the purpose of this reporting requirement is not clear, as the total number of unduplicated Medicaid and uninsured individuals seems to have only a minimal relationship to a hospital's uncompensated care costs or the payments they receive for these costs.

If you have any questions, please contact me at (916) 440-7800.

Sincerely,

Stan Rosenstein
Deputy Director

cc: Mr. Toby Douglas
Assistant Deputy Director
Medical Care Services
California Department of Health Services
1501 Capitol Avenue, MS 4000
P.O. Box 997413
Sacramento, CA 95899-7413

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Minnesota Department of **Human Services**

October 25, 2005

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2198-P
P.O. Box 8010
Baltimore, MD 21244-1850

Re: Medicaid Program; Disproportionate Share Hospital Payments Proposed Rule

To Whom It May Concern:

Thank you for the opportunity to comment on CMS' August 26, 2005 proposed rule establishing additional reporting and auditing requirements for disproportionate share hospital (DSH) payments.

Provisions of the Proposed Regulations

A. Reporting Requirements

Since 1997, §1923(a)(2)(D) of the Social Security Act (the Act) has required states to submit annual reports describing disproportionate share payments to each disproportionate share hospital. Medicaid regulations at 42 CFR §447.299 require states to submit "the quarterly aggregate amount" of DSH payments. Added by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, §1923(j) of the Act also requires annual reports identifying: 1) each DSH and the amount of the "payment adjustment" each received in the preceding fiscal year; and 2) such other information CMS determines is necessary to ensure appropriateness of the payment adjustments. The proposed amendments to the regulation would add new requirements under CMS' authority to require "such other information."

As a general comment, we understand CMS's goal to instill additional program integrity into state DSH payments. However, this particular method, as drafted in the proposed regulation, is impossible for both states and hospitals from an operational standpoint. Because this methodology uses actual costs and payments, and because of the deadlines for the audits and reports, neither Medicaid payments nor audited cost information are available. We sincerely hope that CMS rethinks the overall timing.

1. CMS is proposing that states report information (and conduct audits) on a state fiscal year basis, rather than on a federal fiscal year basis. We urge you to consider a change to a federal fiscal year basis because the federal DSH allotment is made on the basis of federal fiscal years. Because CMS' stated purpose is to ensure that hospitals are paid no more in DSH than what is allowable under the state's aggregate allotment and the hospital's individual limit, it is appropriate to calculate the allotment and the hospital-specific DSH limits on the basis of federal fiscal years.

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If it is not possible to require the reports based on a federal fiscal year basis, the regulation should be revised to clarify that states must adjust their annual DSH allotments to the relevant state fiscal year.

In addition, the regulation should clarify the source for the information to be provided, particularly as it pertains to the payments made for the services. Is the information to be provided for discharges during a state fiscal year (Medicare pays based on discharges), admissions during a state fiscal year (Minnesota pays based on admissions), or actual payments made during the state fiscal year regardless of when the services were provided?

2. Some hospitals report costs related to all of their uninsured patients, including patients from outside Minnesota. We believe it is reasonable that hospitals need not record their Medicaid payments for treating the uninsured in different accounts depending on the state in which their residents reside.

There is nothing in the proposed amendments addressing this situation. Will CMS require a state to include in the report information on patients from another state?

3. Type of hospital (42 CFR §447.299(c)(4)). One of the indicators is whether the hospital is a "teaching hospital." Please clarify what qualifies a hospital as such.

Minnesota uses cost reports for establishing its DSH payments and compliance to the aggregate annual limit on the Medicaid match for DSH payments. The hospital types that can be selected under the Medicare cost reporting system are based on the type of service predominately provided by a hospital (for example, general short term, general long term, children's, or rehabilitation) and not on whether the hospital provides "teaching." Minnesota teaching hospitals are either general short term or children's hospitals. Therefore, if a hospital provides teaching, please clarify how to appropriately report the hospital, by type.

4. Low income utilization rate (42 CFR §447.299(c)(7)). The proposed change requires states to report both the Medicaid inpatient utilization rate and the low-income utilization rate of all disproportionate share hospitals. Section 1923(b) of the Act permits a state to qualify hospitals as eligible for DSH using one of two methodologies, the Medicaid inpatient utilization rate or the low-income utilization rate. Only the data from the method that is used should be required.

5. Regular Medicaid rate payments (42 CFR §447.299(c)(9)). Please define this term.

Payments are not known at the end of any given state fiscal year. Hospitals have up to 12 months after the date of service to submit a claim for payment. In addition, hospitals dissatisfied with their payment have an appeals process that could extend the period of time before the final payment is known.

The audit report is due within one year after the end of a state fiscal year, at which time not all payments have been paid. The only way to report accurate payments made during a state fiscal year and meet this submission deadline is to report actual payments made during a state fiscal year, even if the services were provided and the related costs incurred in a prior fiscal year – in which case, payments will not be accurately matched to the related costs.

6. Supplemental/enhanced Medicaid payments (42 CFR §447.299(c)(11)). Please define this term.

7. Indigent care revenue (42 CFR §447.299(c)(12)). This is defined as total annual payments received by a hospital from individuals with no source of third party coverage for inpatient and outpatient hospital services they receive. Section 1923(g)(1)(A) of the Act provides that "payments made to a hospital for services provided to indigent patients made by a State . . . shall not be considered to be a source of third party payment." The regulation should contain that language as well, in order to avoid confusion.

8. Transfers (42 CFR §447.299(c)(13)). Please define this term. To our knowledge, "transfer" is undefined in federal statute and regulation. CMS should also distinguish a "transfer" from an "intergovernmental transfer" if the two terms are different, and from provider taxes and other payments made to the state or local government.

Furthermore, CMS continues to require states to report all intergovernmental transfers in conjunction with new State plan amendments. If CMS continues to require such reporting, then the requirement in this regulation appears to be duplicative and should be deleted.

9. Total cost of care (42 CFR §447.299(c)(14)). The regulation should provide more specificity about the level of precision expected in calculating the total cost of care. Due to the timing lag for reporting and auditing, Minnesota uses a hospital's latest available Medicare cost report to calculate that hospital's overall cost-to-charge ratio (total cost per Worksheet B, Part I, Column 25, divided by total charges per Worksheet C, Part I, Column 6 as adjusted to exclude non-hospital services). The state converts the Medicaid and uninsured charges to cost using the hospital's overall cost-to-charge ratio. Relatively few hospitals have a cost reporting period that is the same as the state fiscal year and, therefore, there would be two cost reporting periods during a state fiscal year. Would applying a hospital's latest available cost-to-charge ratio to that hospital's federal fiscal year Medicaid and uninsured charges be an acceptable and reasonable method to calculate that total cost of care? If so, the regulation should specify.

10. Uncompensated care costs (42 CFR §447.299(c)(15)). This definition does not include bad debt. It is unreasonable to exclude those costs if the anticipated revenue has been included. Bad debt should count as a loss to the extent that payment is not received by the hospital and costs are incurred.

11. Medicaid eligible and uninsured individuals (42 CFR §447.299(c)(16)). This information has no effect on the formulas and required audits and should be deleted.

B. Audit Requirements.

Pursuant to §1923(j) of the Act, CMS proposes adding a Subpart C to 42 CFR Part 455.

1. As in item A, above, the regulation should clarify the source for the information to be provided for the audit, particularly as it pertains to the payments made for the services. Is the information to be

provided for discharges during a state fiscal year (Medicare pays based on discharges), admissions during a state fiscal year (Minnesota pays based on admissions), or actual payments made during the state fiscal year regardless of when the services were provided?

2. Proposed 42 CFR §455.204(b) provides that, beginning, with "FY 2005," the state must submit an audit report not later than one year after the completion of its fiscal year. If CMS intends that the first audit must govern state fiscal year 2005, and that the audit report related to state fiscal year 2005 is due within one year after the close of state fiscal year 2005, this should be made clear. We note that CMS does have a definition in proposed 42 CFR §455.201 of "State fiscal year."

We strongly object to the retroactive nature of this audit requirement, which appears to have the effect of revising state calculations of hospital-specific DSH limits for years already passed. States that made DSH payments for state fiscal year 2005 correctly based on allowable methodologies in the current law and regulation should not be required to return federal Medicaid funding, if the results are different under the new, retroactive methodology.

Furthermore, a requirement that states file the audit report within one year from the close of the audit year does not allow for enough time because hospitals have up to 12 months after the date of service to submit a claim for payment. As noted in item A, #5, above, hospitals dissatisfied with their payment have an appeals process that could lengthen the period of time before the final payment is known. To permit enough time for billing, payment processing, hospital-specific DSH reporting, *and auditing*, the deadline should be extended to at least two years after the end of the audit period.

The only way to report accurate payments made during a state fiscal year and meet this submission deadline is to report actual payments made during a state fiscal year, even if the services were provided and the related costs incurred in a prior fiscal year – in which case, payments will not be accurately matched to the related costs.

In addition, because all federal DSH limits are based on federal fiscal years, a federal fiscal year should be used. Furthermore, given the timing of the publication of the proposed and final regulations, the state is likely to have six months or less to complete the first audit, which is simply not enough time. For these reasons, the first audit period should be changed to federal fiscal year 2006, with the audit report due two years later.

3. A financial threshold of DSH payments should be created before an in-depth audit pursuant to 42 CFR 455, new Subpart C is triggered. Many small hospitals have little in DSH payments. It is not cost effective to audit these hospitals.

4. The proposed payment and audit model is one that requires states to make estimated DSH payments, and then adjust to actual information reported long after the close of the payment year. This makes it difficult for states to budget, and for hospitals to predict revenue, and produces unnecessary administrative costs in conducting the settle-up. It is reasonable to allow states to estimate limits based on reasonable and reliable information, which CMS could define by regulation. This would achieve

CMS' goal of program integrity without the added administrative burden of making adjustments years after the fact, and would allow states and hospitals some predictability. Furthermore, if a state finds, after the cost reporting and the audit, that it did not fully use its DSH allotment, the state may have lost the ability to claim the DSH allotment due simply to the passage of time. States only have 24 months to claim matching funds for a Medicaid expenditure. In sum, there is a way to achieve program integrity without loss to the state of allowable claims, and without the added administrative burden and loss of predictability.

5. The financial effectiveness of the audits would be enhanced if the Medicare fiscal intermediaries were available to do the audits. Intermediaries provide services at a lower cost than private accounting firms. Time would be saved because the intermediaries have all the necessary information. This may also be helpful to states that require a lengthy procurement bidding process.

6. To assure compliance with the rule when promulgated and to avoid disputes after payments have been made, a detailed audit manual should be prepared by CMS.

Again, thank you for the opportunity to comment. If you have any further questions, please contact Stephanie Schwartz, of my staff, at (651) 431-2187.

Sincerely,

Christine Bronson
Medicaid Director

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OCT 1 4 2005

111 Michigan Avenue, N.W.
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October 17, 2005

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attn: CMS-2198-P
P.O. Box 8010
Baltimore, MD 21244-1850

Attn: CMS-2198-P
Medicaid Disproportionate Hospital Payments

Dear CMS:

On behalf of Children's National Medical Center (CNMC), I am submitting comments on the proposed rule on new reporting and auditing requirements for Medicaid state Disproportionate Share Hospital (DSH) payments, published in the *Federal Register* on August 26, 2005. The proposed rule would implement section 1001(d) of the "Medicare Prescription Drug, Improvement, and Modernization Act of 2003" (MMA).

CNMC is a 279-bed pediatric inpatient facility that has provided care to children in the greater Washington area, as well as children around the world, for more than 130 years. In addition to our main campus hospital, we also operate a network of specialty outpatient clinics, pediatric practices, primary care health centers, and mobile vans. More than 50 percent of the patients at CNMC are Medicaid recipients. We are the single largest provider of pediatric care to children in the District of Columbia, and the second largest provider in Maryland. We are the safety net for the children of this region.

Under the proposed rule, the uncompensated care costs associated with physician services may not be considered in determining the hospital-specific DSH limit. In response to CMS's invitation for comments, CNMC expresses strong concern with this section of the proposed rule and the unintended consequences that would result.

First, this proposed rule threatens the health care safety net for children. CNMC is a safety net hospital. Without our facilities and services, many Medicaid children would have nowhere to go. The purpose of DSH is to provide additional support to safety net hospitals. CNMC, unlike most hospitals, employs its physicians within the Hospital entity. We cannot function as a health care institution without our employed physicians. Thus any uncompensated care provided by our employed physicians directly effects the bottom line of the

Hospital in the same manner as any non-physician uncompensated care goods or services (e.g., tests and medical procedures provided to patients while receiving services at the hospital). Our DSH calculation would be significantly altered and impacted by this rule. In fact, any hospital that directly employs their physicians as part of their Hospital entity would be impacted negatively by this rule.

Secondly, this rule would adversely affect access to health care for all children—not just Medicaid beneficiaries. If our bottom line is negatively impacted by this proposed rule, then CNMC might be forced to close programs or clinics in order to cover the loss. A closed program would limit access to care for all children, not just Medicaid beneficiaries. If access to healthcare services is limited, then children and their families would be forced to seek care in emergency rooms, which is a more expensive visit for Medicaid, too. This will invariably result in ever more crowded emergency rooms, which affects care for all children.

Third, this requirement exceeds the scope of the Medicare Modernization Act (MMA). This provision is not mandated in the MMA, and is therefore not necessary to include. If Congress had intended for this provision to be included, they could have included it in the law.

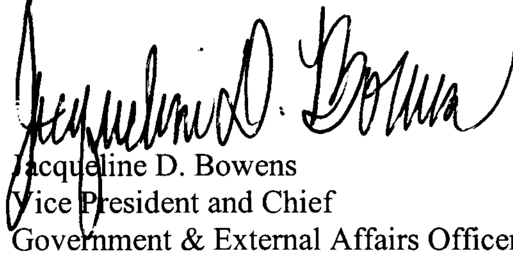
It is our understanding that the American Hospital Association, the National Association of Children's Hospitals, and the Association of American Medical Colleges all share our concerns regarding this provision. We strongly urge you to amend the proposed regulation to allow the uncompensated care costs of ***hospital salaried*** physician services to be included in the calculation of the hospital-specific DSH limit.

In addition, some of the other provisions in the proposed rule are unclear and difficult to interpret. For example, the proposed rule fails to clarify how bad debt would be calculated and whether non-payment of beneficiaries' deductibles and co-payments would be considered bad debt. In another example, although the MMA requires an annual certified public audit, the proposed rule is unclear about how the audit will reconcile DSH payments and the hospitals' calculation of actual compensated care. Also, it is unclear who must pay for the audit, and how overpayments and underpayments will be reconciled.

Finally, the reporting requirements are excessively burdensome to DSH hospitals. The proposed rule requires the states to report the number of non-duplicated Medicaid eligibles and uninsured receiving inpatient and outpatient health services, as well as total payments to hospitals from individuals with no source of third party coverage. These requirements would place an excessive burden on DSH hospitals that would have to provide this information.

We appreciate the opportunity to present our comments and would be pleased to discuss them further. For additional information, please contact me at 202-884-4933 or jbowens@cnmc.org. Thank you for your consideration of our comments.

Sincerely,



Jacqueline D. Bowens
Vice President and Chief
Government & External Affairs Officer