CMS-2198-P-1

This comment was withdrawn.

Submitter :

Date: 09/19/2005

Organization :

Category : Health Care Industry

Issue Areas/Comments

GENERAL

GENERAL

1 ? Is the requirement that each State hire an auditor to look at each hospital?s uninsured calculations? Some are reading the audit requirement as being someone to look at how the State handles the DSH calculations and transactions and not a review of individual hospital records.

2 ? Is the expectation that hospitals that receive DSH funds that are subsequently passed on to other entities show the gross DSH payment as revenue and the payment to the external entity as an expense? We have different readings of the proposed regulations. One being that it is required that hospitals show gross revenue and expense any transfers out, the other that the regulation is addressing how the State handles the special DSH payments in computing available individual hospital DSH ceilings.

3 ? There is a provision of the regulations that speaks to using current year uninsured costs against the current year DSH payments. AT least one state has historically used two year old cost reports (e.g., FY 2003 for FY 2005 DSH) to determine the ceilings and trends the costs and payments from FY 2003 to the current year to determine the ceiling. Is that option no longer appropriate?

4 ? Can you help me identify whether the following items are uninsured? The issue seems directly related to Bad Debt which seems to be excluded per the new regulations.

Uncollected patient co-payments and deductibles ? Uninsured?
Claims denied by insurers as not covered ? Uninsured?
Claims denied by insurers for lack of medical necessity ? Uninsured?
Claims denied by insurers for lack of prior authorization or claims submitted too late ? Uninsured?
The argument is that the service is not reimbursed by the insurer and the amount is not a contractual allowance. Thus, the cost of that portion of the stay is uninsured.

5 ? The new regulations do not address the issue of other State or Local funded services for indigent patients and how that fits into uninsured. Some hospitals that have included in the ?uninsured ? state or local funded? things like county jail patients, public employee worker?s comp funded services, and services to juveniles referred from secure state facilities. Is there any guidance on items like these?

The regulation does not speak to the issue of state or local funded programs for indigents and the provision that specifies that these are uninsured costs without a need to offset the costs by the state or local payments. It seems useful to elaborate upon that issue in this rule.

CMS-2198-P-3 **DSH Hospital Payments**

Submitter : **Dr. Michael Zagnoev** **Date & Time:** **09/23/2005**

Organization : **Dr. Michael Zagnoev**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Please see attached

CMS-2198-P-3-Attach-1.DOC

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS
P.O. Box 8017
Baltimore, MD 21244-8017

Dear Dr. McClellan:

I am writing as an anesthesiologist at Long Beach Memorial Medical Center, to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.

Medicare's discriminatory payment arrangement, which applies only to anesthesiology teaching programs, has had a serious detrimental impact on the ability of programs to retain skilled faculty and to train the new anesthesiologists necessary to help alleviate the widely-acknowledged shortage of anesthesia providers -- a shortage that will be exacerbated in coming years by the aging of the baby boom generation and their need for surgical services.

Under current Medicare regulations, teaching surgeons and even internists are permitted to work with residents on overlapping cases and receive full payment so long as the teacher is present for critical or key portions of the procedure. Teaching surgeons may bill Medicare for full reimbursement for each of the two procedures in which he or she is involved. An internist may supervise residents in four overlapping office visits and collect 100% of the fee when certain requirements are met.

Teaching anesthesiologists are also permitted to work with residents on overlapping cases so long as they are present for critical or key portions of the procedure. However, unlike teaching surgeons and internists, since 1995 the teaching anesthesiologists who work with residents on overlapping cases face a discriminatory payment penalty for each case. The Medicare payment for each case is reduced 50%. This penalty is not fair, and it is not reasonable.

Correcting this inequity will go a long way toward assuring the application of Medicare's teaching payment rules consistently across medical specialties and toward assuring that anesthesiology teaching is reimbursed on par with other teaching physicians.

Please end the anesthesiology teaching payment penalty.

Name: Michael Zagnoev M.D

CMS-2198-P-4 **DSH Hospital Payments**

Submitter : **Mr. David Bergantino** **Date & Time:** **10/04/2005**

Organization : **Rhode Island Office of the Auditor General**

Category : **State Government**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment - Comments submitted to National State Auditors Association

CMS-2198-P-4-Attach-1.DOC

Date: October 4, 2005

To: Sherri Rowland
NSAA Association Manager
NASACT

From: Ernest A. Almonte, CPA, CFE
Auditor General
State of Rhode Island

Memo Re: *Comments and questions regarding the proposed rules for new auditing requirements for State Disproportionate Share Hospital (DSH) Payments*

Our comments and questions pertain specifically to Section 1923(j) which requires states to have DSH payment programs independently audited annually and to submit those certifications annually to the DHHS Secretary. In discussing this issue with officials from the RI Department of Human Services, there is significant confusion regarding how this requirement would be complied with. The following are comments, questions, and issues where we would like to see further guidance provided:

- ❑ Will this requirement be added to the A-133 Compliance Supplement for the Medical Assistance program?

- ❑ The Medicaid program already represents a huge audit task for our office, adding the additional responsibility of auditing hospital data for each hospital receiving a DSH payment would be an extremely large amount of additional work that would be nearly impossible to fit within required time frames.

- ❑ Further detail of the standards and/or procedures that CMS is requiring need to be clarified.

- ❑ In addition, questions regarding access to hospital records and other jurisdictional issues would also need to be discussed and decided.

- ❑ In our opinion, the most practical manner in which the State could meet this regulation is by requiring hospitals to have their uncompensated care data audited as part of their annual financial statement audit. Auditors of the Medicaid program (as part of the State's Single Audit) could then rely on these audited certifications and evaluate each State's DSH payment calculations and other information being reported by the State to the Secretary.

Please feel free to contact my office at (401) 222-2435 with any questions regarding our comments. Your coordinated efforts in regards to this very important issue are greatly appreciated.

Submitter : **Mr. Bryan Sperry** **Date: 10/14/2005**

Organization : **CHAT**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

October 14, 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

To Whom It May Concern:

On behalf of the Children?s Hospital Association of Texas (CHAT) I am commenting on the proposed rule on 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).

CHAT represents the not for profit freestanding children?s hospitals in Texas. These hospitals are essential providers of care for the sickest children in Texas, and Medicaid funding provides critical support to the mission of these hospitals including patient care and graduate medical education. In the aggregate, Medicaid covers more than half of all the inpatient days of service in CHAT hospitals. For children?s hospitals in South Texas, Medicaid covers more than 70 percent of inpatient days.

Texas has the fastest rate of child population growth in the country, and children?s hospitals are working to build the capacity to serve this population. At the same time, the Texas Medicaid program pays outpatient rates at about 85 percent of cost and has significantly under funded graduate medical education. Medicaid physician payment rates are so poor that low physician participation in the program is reducing access to care. Because Medicaid payments are below cost, children?s hospitals would be hard pressed to serve the growing number of children in Texas without Medicaid DSH payments. DSH payments enable children?s hospitals to provide access to pediatric specialty care.

CHAT offers the following comments on the proposed rules:

? The proposed rule exceeds the statutory authority of the MMA. Under the proposed rule, the uncompensated care costs of providing physician services cannot be considered in determining the hospital-specific DSH limit. Also, the rule requires a hospital receiving DSH payments to include Section 1011 payments, which HHS pays to hospitals for providing care to undocumented individuals, in calculating its DSH limit. MMA does not require these provisions.

? Some of the provisions are unclear. The proposed rule includes provisions that children?s hospitals find 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. With the growth of high deductible plans, this clarification is needed.

? 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. Hospitals submit accurate data on Medicaid and uncompensated care at a point in time. Data can change over time as claims and payment appeals are settled.

We appreciate the opportunity to present our comments.

Bryan Sperry
President
Children?s Hospital Association of Texas (CHAT)
823 Congress Ave.
Austin, TX 78701

Submitter : **Mr. David Bodoh** **Date: 10/20/2005**

Organization : **Mr. David Bodoh**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2198-P-6-Attach-1.RTF

Attachment #6

1725 Manley Street
Madison, WI 53704

October 19, 2005

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2198-P
Baltimore, MD

To Whom It Concerns:

I respectfully submit the following comments on proposed regulations CMS-2198-P.

42 CFR 455.204(c), mandating use of state fiscal year for UCC compliance test

The proposed regulations at 42 CFR 455.204(c)(1) and (2) mandate a state's fiscal year as the annual time period for which a state is to calculated the uncompensated care (UCC) test. That same paragraph requires measurement "against the actual uncompensated care cost in that same audited SFY."

The fiscal year of many DSH hospitals is not contiguous with a state's fiscal year. Hospitals will be burdened with preparing another annual cost report for an annual period that differs from their 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 state'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 a cost report for an annual fiscal period that differs from their fiscal year? From my experience, such a deviation from the established fiscal year 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 mandate the UCC test be based on a hospital's fiscal year that ends in the state's fiscal year. Since the UCC test is a hospital-by-hospital test, I do not think this would allow states to manipulate compliance to the UCC limit as could be done if the test was an 'in aggregate' test (such as the upper payment limit or the DSH annual target allowances).

42 CFR 455.204(c)(1), hospital reducing uncompensated claim cost

This specific audit verification requirement is meaningless as stated in the proposed regulation. More explanatory information is needed as to what it means.

42 CFR 447.299(c)(16), reporting unduplicated patients

Proposed 42 CFR 447.229(c)(16) mandates 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 accounting 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 a new accounting requirement in that it asks for unduplicated counts of Medicaid recipients receiving inpatient and outpatient hospital services for each specific DSH hospital. This added data is likely 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 not clear how this data serves to "ensure the appropriateness of the [DSH] payment adjustments" as is called-for in the MMA.

Thank you for the opportunity to comment on the proposed regulation CMS-198-P.

Sincerely,
David Bodoh

Submitter : Mr. EDWARD QUINLAN **Date:** 10/21/2005

Organization : Hospital Association of RI

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2198-P-7-Attach-1.DOC

HARI
The Hospital Association of Rhode Island
880 Butler Drive – Suite One
Providence. Rhode Island 02906

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

Submitter : Mr. Greg Gruman **Date:** 10/21/2005

Organization : Office of Health Care Financing-Office of Medicaid

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2198-P-8-Attach-1.DOC

Wyoming Department of Health

Dave Freudenthal, Governor

Brent D. Sherard, M.D., M.P.H.
Director and State Health Officer

October 21, 2005

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

Subject: Electronic Submission of Comments on Proposed Rules – CMS-2198-P
Disproportionate Share Hospital Reporting and Auditing Requirements

Dear Mr. Frizzera:

The State of Wyoming, Department of Health 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 State would like to enter the following comments for CMS' consideration related to the Proposed Rules in CMS-2198-P.

1. **General Comment**

   Given the State's historically low DSH allotment ($117,640 in Federal Fiscal Year 2004), the administrative costs of the proposed DSH reporting and auditing requirements are disproportionately onerous. The State requests that any state with a DSH allotment under $500,000 be exempted from the proposed reporting and auditing requirements and continue to report DSH payments under the DSH reporting requirements effective in Federal Fiscal Year 2005. If this exemption is not possible, the State requests that any state with a DSH allotment under $500,000 be allowed to use a hospital's independent auditor attestation to meet the audit requirements for hospital data used in DSH calculations.

2. **Hospital-Specific DSH Limits**

   If a hospital does not exceed its hospital-specific DSH limits solely based on its Medicaid costs, the State requests that the proposed reporting and auditing requirements regarding the costs of care for individuals with no source of third party coverage be waived for that hospital.

3. General Comment

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 State prior to completion of the Annual DSH Report. Therefore, CMS must allow sufficient time for the State to complete this process.

4. Medicaid Inpatient Utilization Rate

If a hospital is eligible for DSH based on its Medicaid inpatient utilization rate, is the hospital also required to submit information on its low income utilization rate? Federal regulations currently require that hospitals be given the option of qualifying for DSH based on either their Medicaid inpatient utilization rate or their low-income utilization rate, but does not require that hospitals submit information on both of these rates.

5. 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."*

Due to delays in receiving settled cost reports from Medicare Intermediaries, the State of Wyoming may distribute more than one year of DSH payments to hospitals in a given State Fiscal Year. Please confirm that the State should submit a separate Annual DSH Report for each year of DSH payments, regardless of the date of DSH payment.

6. DSH Payments

Per 70 FR 50263: *"Specifically, proposed paragraph (c) would require each State receiving an allotment under section 1923(g) of the Act, beginning with the first full State fiscal year (SFY) immediately after the enactment of section 1001(d) of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) and each year thereafter, to report to us the following information for each DSH hospital..."*

Per 70 FR 50264: *"...each State must obtain an independent certified audit, beginning with an audit of its State fiscal year 2005 DSH program."*

If a State makes DSH payments after SFY 2005 for dates of services prior to SFY 2005, are those DSH payments subject to the new auditing and reporting requirements? Currently, Wyoming makes DSH payments after receipt of settled cost report from the Medicare fiscal intermediary and applies the DSH allotment based on dates of service. For example, Wyoming made its DSH payment in SFY 2003 for dates of service in 2000 (using the 2000 Federal DSH allotment and settled Medicare cost reports). Applying the proposed Rule's requirements to dates of service prior to SFY 2005 would represent an undue administrative burden for both the State and hospitals.

7. DSH Payments

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 State 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. Does this mean that CMS is creating a cost-based DSH reimbursement system and will not allow States to move from a retrospective DSH payment system to a prospective payment system? If CMS will allow states to move to a prospective DSH payment system in the future, can the State satisfy the audit requirements by auditing the data used to make the prospective payments (i.e., the most recently available data at time of DSH payment calculation)?

8. Unduplicated 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."*

Collecting this information would be burdensome to both the State and the hospitals. Please explain why the number of unduplicated individuals is relevant to CMS' review of DSH payments and DSH limits. The State requests that this requirement be removed.

9. Section 1011 Payments

Per 79 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 total DSH payments should not exceed the total amount of uncompensated care at the hospital."*

The State 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 1011 Payments in DSH limit calculations.

10. Auditing Requirements and Federal Financial Participation

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 State until its Independent Audit of DSH Payments is completed and filed with CMS?

11. Auditing Requirements and Timing

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 State's fiscal year must the audit be completed?

12. Auditing Requirements and Hospital Independent Audits

To what extent could CMS' proposed DSH audit requirements be met by certifications from hospitals' independent auditors?

The State looks forward to viewing CMS' response to these comments. Please do not hesitate to contact me if you have any further questions.

Sincerely,

Greg Gruman
Medicaid Director

EqualityCare - Office of Medicaid
6101 Yellowstone Road, Suite 210 • Cheyenne WY 82002
FAX (307) 777-6964 • TTY (307) 777-5648 • **(307) 777-7531**

Submitter : Mr. Edward Quinlan **Date:** 10/21/2005

Organization : Hospital Association of RI

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2198-P-9-Attach-1.DOC

HARI **The Hospital Association of Rhode Island**
880 Butler Drive – Suite One
Providence. Rhode Island 02906

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

Submitter : Mr. Shane Roberts **Date:** 10/21/2005

Organization : St. Luke Community Hospital

Category : Critical Access Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter : Mr. Shane Roberts **Date:** 10/21/2005

Organization : St. Luke Community Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2198-P-11-Attach-1.DOC

St. Luke Community Healthcare Network

Attachment #11

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
Sent Via Electronic Submission

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

Dear Dr. McClellan:

The proposed rule in CMS- 2198-P is of great concern to St Luke Community Hospital and should be to Hospital's across rural America.

Two specific areas of concern are the proposed new definition of uncompensated care which excludes a hospital's bad debt and the proposed exclusion of uncompensated care for physician services from the hospital specific DSH limit.

The proposed rule, which excludes bad debt from the uncompensated care formula, is not consistent with the statute's intent, legislative history or long standing agency practice, including Medicare cost reports.

CMS proposed rule would reward hospitals whose liberal charity policies result in high charity care amounts. By not using their best efforts to collect on patient's accounts, these institutions pass on a greater financial burden to the Medicaid program under this proposal. Hospitals have a duty to make a reasonable effort when collecting accounts from patients who do not have insurance or in instances where insurance does not provide complete coverage.

The Heart of Healthcare in the Mission Valley
Phone (406)676-4441 ■ FAX (406) 676-0835 ■ 107 6th Ave. SW, Ronan, MT 59864
www.stlukehealthnet.org

In addition, a hospital can not force a patient to seek alternative resources, such as Medicaid, nor can a hospital force a patient to fill out all the necessary paper work required by charity policy guidelines. As a result, patients who fail to carry out these steps often fall on the Hospital as bad debt. Bad debt is part of uncompensated care.

Like many other rural hospitals across the United States, St. Luke finds itself in a position where it is necessary to employ physicians in order to ensure that patients of all payer classes have access to the primary and specialty care they require.

The proposed ruling to not allow uncompensated care for physician services penalizes hospitals, who employ physicians to ensure patient access, by not allowing them to capture the true costs associated with the care that they deliver.

St. Luke Community Hospital is located in an impoverished rural county in the middle of an Indian reservation. Access to care and the services we provide are crucial to the health of our patients.

MHA, An Association of Montana Health Care Providers, has also submitted a letter on the proposed rules, St. Luke concurs with sentiments of that letter.

The proposed rules would have a major impact on the financial stability of hospitals like St. Luke, who provide a much needed service to the impoverished and underinsured residents of rural areas across America. I respectfully request that you include bad debts within the definition of uncompensated care and that uncompensated care for physician services be included in the hospital specific DSH limit. Thank you for your consideration.

With Kindest Regards,

Shane H. Roberts
Chief Executive Officer

CC: Senator Conrad Burns
Senator Max Baucus
Representative Dennis Rehberg
Senator Charles Grassley

Submitter : Mrs. Karen Davis **Date:** 10/21/2005

Organization : Ventura County Medical Center

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter : Mr. Dave Mosley **Date:** 10/24/2005

Organization : Clifton Gunderson LLP

Category : Health Care Industry

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2198-P-13-Attach-1.DOC

CMS-2198-P-13-Attach-2.DOC

Attachment #13

Department of Health and Human Services

Centers for Medicare and Medicaid Services

Medicaid Program; Disproportionate Share Hospital Payments

Pages 50263-50264

III. Provisions of the Proposed Regulations

A. Reporting Requirements

The proposed rule requires that, "...each state receiving an allotment under section 1923 (f) of the Act.....to report to us the following information for each DSH hospital...." and the rule goes on to list specific data elements beginning with the hospital name and ending with the annual unduplicated number of individuals with no source of third party coverage for the inpatient hospital and outpatient hospital services they receive.

1. What level of audit and/or verification is CMS expecting regarding the various data elements for each hospital? For example, is CMS expecting a limited review of key data points by the state, a full audit of hospital cost report data, or some other form of audit? Since the nature of the DSH limitation is at the individual hospital level and the rule sets forth the reporting and documentation requirements at the state level, how does CMS expect that the state will obtain support for the component of the UCC calculation from each individual hospital receiving DSH funds?

2. Is it CMS' intent that the uninsured, their charges, their payments, and their costs be calculated and reported without regard to any income or asset threshold? Please explain CMS' intent regarding asset and income thresholds and the uninsured.

3. Is it CMS' intent to differentiate between indigent individuals without third party coverage and other, non-indigent individuals without third party coverage? If so, please explain how CMS expects this to be done.

4. There historically has been great difference in how uncompensated care costs have been calculated from state to state. Is it CMS' intent that there will now be uniform methodology among all states for calculating the uncompensated care costs for Medicaid eligible individuals and individuals with no source of third party coverage? If so, please provide a detailed explanation of how CMS intends to have this done.

5. Is it CMS intent that indigent care revenue, as defined, will also include any revenue received by the individual hospital associated with liens (or other such remedies) placed upon an uninsured individuals property or assets? If so, would it be CMS' intent that such revenues (collection from liens and other remedies) would reduce the claimed uncompensated care costs for uninsured individuals during the period in which the revenue is realized (funds received)? How has CMS previously audited indigent care revenue? Please explain CMS interpretation of the difference between "charity care" and care provided to the uninsured.

6. Please offer a definition or criteria for the classification of "non-state government owned" hospitals, as there has been great difference in how this classification has been used from state to state.

7. Will CMS allow states that utilize a Federal Fiscal Year (FFY) for their DSH payments calculations to report the aforementioned data items on a FFY basis?

8. Many states allow Medicaid providers up to a year to submit claims following the date of service. As such, there is often a significant lag in payments to Medicaid hospitals and uncompensated care figures would be overstated if only cost incurred and payments received during a SFY are considered. Please explain how you would expect states to appropriately take this into consideration.

9. Is it CMS' intent that each hospital's DSH payments be retrospectively settled against hospital-specific DSH limits using audited hospital data for the year in which payments are made? If so, will CMS consider allowing twenty-four (24) months from the end of the payment period (FFY or SFY) in order to allow auditors to use the best possible payment data? Further, is it CMS' intent that the retrospective settlement process, if required, would supersede any previously approved state plan language that allowed states to pay on a prospective basis without settlement?

10. Please explain the necessity of specifically defining physician fees as a cost not to be included.

Pages 50265-50264

III. Provisions of the Proposed Regulations

B. Audit Requirements

The proposed rule provides the submission of the independent audit report, "within one year of the independent certified audit."

11. Please explain CMS' intent regarding the SFY, audit performance requirement, and audit report requirement. Is there a reason for the report being required one year after the certified audit?

Pages 50264-50265

III. Provisions of the Proposed Regulations

B. Audit Requirements

The proposed rule states, "In the independent audit report, the auditor must verify whether the State's method of computing the hospital-specific DSH limit and the DSH payments made to the hospital comply with the following....."

12. Is it CMS' intent that the independent auditor will verify that the State is taking appropriate measures to insure that the data provided by hospitals is accurate, or is CMS simply referring to the mathematic formulas and methods the state is applying to "as reported" data from hospitals? If it is CMS' intent that the states use audited, verifiable data from hospitals as a component of acceptable methodology, is it CMS intent that each DSH hospital has cost, unduplicated headcounts, payments, charges, and other such required data elements audited by states each year? Would having the data audited by an independent audit firm engaged by the DSH hospitals satisfy this requirement, or would the states, as the party responsible for making computations and payments, be required to audit the data? What are CMS' expectations regarding the integrity of the hospital-specific data elements each state uses in making calculations for payments, limits, and settlements?

Page 50265

III. Provisions of the Proposed Regulations

B. Audit Requirements

The proposed rule sates, "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 cost in that same audited SFY, which for all states will begin with their respective SFY 2005."

13. Is it CMS' position that this language will require a retrospective, hospital-specific DSH settlement for SFY 2005 and for each subsequent year thereafter? Will the independent auditor be required to make such settlements, or will it satisfy CMS to have the independent auditor verify that the state, or its agent, is appropriately settling each hospital for each year? Will CMS' consider extending the deadline for any settlement and report thereon in order to allow for lagging claims and payment data from a state's fiscal agent?

Page 50266

III. Provisions of the Proposed Regulations

B. Audit Requirements

The proposed rule states, "We are proposing to add a new Sec 455.204 (c) (5) to reflect the requirement that the audit report include a determination that the state has collected, documented, and is retaining appropriate documentation for its DSH limits calculations and payments to qualified hospitals."

14. Is it CMS' intent that the term "appropriate" indicates documentation that has been verified and/or audited?

Page 50266

IV. Collection of Information Requirements
Section 447.299 Reporting Requirements

The proposed rule states, ".....submit to CMS information for each DSH for the most recently-completed state fiscal year beginning with the first full state fiscal year (SFY) after the enactment of section 1001 (d) of the MMA...."

15. Is it CMS' intent that SFY 2005 data, including all payments to hospitals, will be collected, audited, settled, and a report issued to CMS by June 30, 2006? If so, will CMS consider revising this language to address the fact that this timeframe appears inconsistent with the manner in which states pay hospitals, collect cost reports, and audit data contained therein?

Page 50266

V. Collection and Information Requirements
Section 447.299 Reporting Requirements

The proposed rule states, "We estimate that is will take each state approximately 30 minutes to prepare and submit the information for each of its DSHs."

16. Is this estimate based upon an assumption by CMS that states have historically been collecting and verifying the information required in the report to CMS? Please provide detail on how this estimate was calculated.

17. In FY 2003 total federal DSH allotments to states totaled just under $9 billion. Please provide a copy of the any audit findings and/or programs associated with CMS' historic and ongoing efforts to audit and/or verify the figures used by states to justify federal funds.

18. Is it CMS' intent to prevent an independent CPA firm, contracted by a state to audit Medicaid cost reports on the state's behalf, from being able to audit that same state's DSH program through the independence requirements of the Government Auditing Standards? If so, would any contract with a state's Medicaid agency impair the independence of a CPA firm in performing the DSH audit required in the rule?

19. Is it CMS' intent to prevent non-CPA firms, such as Medicaid fiscal agents contracted by a state to audit Medicaid providers on the state's behalf, from being able to audit that same state's DSH program through the requirement of adherence to the Government Auditing Standards?

20. Requiring the audits of the states to be performed under Generally Accepted Government Auditing Standards will insure that the reports are accurate and can be relied upon by third party users. We commend CMS for this requirement and recommend that it be retained in the final rules.

Submitter : Mr. Tom Marks **Date:** 10/24/2005

Organization : University of Michigan Health System

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2198-P-14-Attach-1.DOC

University of Michigan
Health System

Accounting and Reimbursement Services
2500 Green Road, suite 100
Ann Arbor, Michigan 48105
(734) 647-3321

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue
Washington, DC 20201

October 24, 2005

Re: Medicaid Program; Disproportionate Share Hospital Payments – Proposed Rule
Federal Register Dated August 26, 2005

File Code: CMS-2198-P

University of Michigan Hospitals and Health Centers (UMHHC) appreciates the opportunity to comment on the aforementioned proposed rule. Our comments are set forth in the following pages.

We appreciate your attention to these comments and recommendations, and would be pleased to provide any clarifications or additional information if you request. Please contact me at 734-647-3321, if you have questions about this letter.

Sincerely,

Thomas Marks
Interim Chief Financial Officer and
Director, Accounting & Reimbursement Services

Effective Date

The proposed regulations are effective for State Fiscal Year (SFY) 2005; however, the final regulations will not be known until well after the end of SFY 2005 for most states. States need time to review, understand, and comply with the final regulations. Also, hospitals will need time to modify their procedures to comply with State instructions for reporting made pursuant to the final regulations. We recommend that the regulations be effective prospectively, covering the first full SFY following issuance of the final DSH regulations. For example, States with fiscal years ending on September 30 would be required to comply with the new regulations in the SFY beginning October 1, 2006.

Uncompensated Care – Bad Debts and Payer Discounts

According to the proposed regulations, uncompensated care costs should not include bad debt or payer discounts. We disagree with this interpretation and do not believe that the definition of uncompensated care costs is workable.

For one, there is often no meaningful distinction between bad debt and charity (or indigent) care. There are many situations where uncollectible balances from uninsured patients are recorded by hospitals in bad debt expense. Generally accepted accounting principles limit the recognition of charity care to situations where the decision to provide free or discounted care is made in accordance with the hospital's charity care policy. The determination that the patient has no insurance or has no financial ability to pay is often made too late to record charity care. Such uncollectible balances are required to be recorded as bad debt regardless of the patient's financial status or whether there is any chance of collection.

Second, there are many situations where patients are uninsured for a portion of the hospital services (coinsurance, deductibles, non-covered services, etc). With the growing popularity of high deductible policies, the uninsured portion of a service to patients that have third party coverage may be large. These situations result in significant uncompensated care costs that would appear to fall outside of CMS' proposed definition, however there is often no practical difference between these losses and losses from patients that have no third party coverage at all.

Third, Michigan (and presumably other States) has many non-Medicaid indigent care programs. In many of these programs, the sponsoring government or agency provides a minimal payment to the hospital. The proposed regulations are not clear whether the loss on such programs/patients is includable in uncompensated care costs.

The proposed definition of uncompensated care costs is inconsistent with legislative intent and past 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, states that the cost of providing services to uninsured patients would be net of any out-of-pocket payments received from uninsured individuals. This clearly implies an intent to include accounts for which there was an attempt by the provider to collect. The agency's 1994 letter to state Medicaid programs offered additional guidance 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 included. In implementing the hospital-specific DSH limit, the agency took into consideration the cost associated with the uninsured and the underinsured populations. In 2002, the CMS issued a memo to state Medicaid programs regarding the hospital specific DSH limit and the upper payment limit and reaffirmed the 1994 DSH policy.

It is also noteworthy that CMS proposes to redefine uncompensated care costs in a very narrow fashion for DSH reporting, yet for reporting uncompensated care in the Medicare cost report, hospitals are instructed to include bad debts and non-Medicaid indigent care plans. We believe that a uniform definition should be in place for all hospital reporting.

We recommend that the definition of uncompensated care cost be modified to include all uncompensated care costs other than contractual allowances and third party insurance discounts given to plans other than indigent care plans.

Uncompensated Care – 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. In addition, in at least one communication to a state Medicaid program, the CMS allowed 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. Inclusion of physician costs is also vital since many hospital operations include physician clinics that focus on providing primary care to the underserved population and generally operate at a financial loss due to inadequate reimbursement rates. The MMA does not require exclusion of physician services.

We believe that physician costs associated with hospital services should be included. In addition, we recommend that references to excluding the physician costs in determining the hospital's uncompensated care costs should be deleted from the preamble.

Timing of Hospital Cost Data

The proposed regulations would require that DSH payments made in a given SFY be measured against actual hospital uncompensated care costs in the same SFY. This provision cannot be met without an extraordinary burden on hospitals and states.

First, hospitals frequently have different fiscal years than the state in which they reside. In Michigan, and presumably most states, the cost of services to Medicaid and other eligible patients is derived from the Medicare cost report, which is based on the hospital's fiscal year. In order to provide data on "actual hospital uncompensated care costs in the same SFY", hospitals would be required to prepare a second cost report covering the SFY. This would be an unreasonable, very costly, and completely unnecessary burden.

Second, States would not be able to make DSH payments based on actual uncompensated care data for the same SFY because the data is not available until several months after the SFY has ended. If hospitals are allowed 150 days after year-end to submit their cost data (the current Medicare due date), states would not even receive the actual data until 150 days after the SFY. The only way to comply with this provision is to estimate hospital DSH ceilings and retroactively adjust payments to account for estimation variances. This would add a significant administrative burden and uncertainty to states and hospitals.

CMS has allowed states to prospectively trend hospital cost data based upon information obtained from previous years to determine hospital-specific DSH ceilings. Reasonable trending based on the most recently filed hospital cost report data should be permissible in both determining and reconciling

hospital DSH ceilings and payments. Michigan has done this in the past and this has never been an issue.

We recommend that CMS modify its proposal to allow prospective trending of recent hospital cost report data, and to allow the calculations of hospital-specific DSH ceilings to be based on the hospital's fiscal year.

Reporting Medicaid and Uninsured Patient Counts

Under the proposed regulations, States would be required to provide an unduplicated count of Medicaid eligible beneficiaries and uninsured individuals by hospital. This information is not relevant in the calculations of DSH ceilings or uncompensated care costs, and it is not clear that this information has any value in terms of monitoring DSH payments and transfers. CMS has provided no rationale for reporting this information and no indication of what the information would be used for.

For this reporting requirement, identifying a distinct number of fee-for-service Medicaid eligible beneficiaries will be feasible due to the availability of data housed on the Medicaid eligibility and service utilization tracking system. However, the information is not available to report managed care Medicaid eligible persons and uninsured individuals receiving inpatient and outpatient hospital services. Hospitals do not report this information now, and may not even be able to readily extract it from its billing and patient management systems without incurring significant costs and effort.

This requirement should be eliminated, or changed to include an unduplicated count of only fee-for-service Medicaid eligible beneficiaries.

Audit Scope

Most of the requirements outlined in the proposed regulations require data that will be obtained from the hospital cost reports. It is not clear the extent to which the independent audit will require verification of the data supplied by hospitals. We are very concerned about the prospect of requiring independent auditors to test and validate the information at every hospital receiving DSH payments. This would be an enormous expense and yet another significant administrative burden to providers. We would appreciate if CMS would clarify its expectation for audit scope in the final regulations.

Submitter : **Mr. Michael Pelc** **Date: 10/24/2005**

Organization : **Detroit Medical Center Hospital's**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-2198-P-15-Attach-1.DOC

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.

Dear Dr. McClellan:

The Detroit Medical Center (DMC) on behalf of its six member hospitals- Children's Hospital of Michigan, Detroit Receiving Hospital, Harper-Hutzel Hospital, Huron Valley-Sinai Hospital, Rehabilitation Institute of Michigan and Sinai-Grace Hospital- welcomes this opportunity to comment to the Centers for Medicare & Medicaid Services regarding the proposed rule implementing the Medicaid Disproportionate Share Hospital (DSH) Payment reporting and auditing requirements included in the Medicare Modernization Act of 2003 (MMA), and which were recently published in the Aug. 26, 2005 *Federal Register*.

Funding from Medicaid DSH payments is critical to the financial viability of hospitals within our system. As the largest provider of Medicaid services in Michigan, we strongly support adequate and appropriate funding for services to Medicaid patients and those without insurance.

Our key concerns regarding the proposed DSH rule are:

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

As a result, the DMC strongly urges the CMS to reconsider the approach proposed in this rule.

A. Reporting Requirements

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

The revised definition of uncompensated care to exclude both bad debt and physician services are clear examples of the CMS' attempt to substantively change long standing DSH policy.

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 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 the agency on the various ways to determine the unreimbursed costs that hospitals incur. 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 additional 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 included. In implementing the hospital-specific DSH limit, the agency took into consideration the cost associated with the uninsured and the underinsured populations. In 2002, the CMS issued a memo to state Medicaid programs regarding the hospital specific DSH limit and the upper payment limit and reaffirmed the 1994 DSH policy.

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 individuals that have 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 CMS or state Medicaid programs.

Hospitals classify a charge as bad debt after they have exhausted all efforts to collect the funds from the patient. They'd rather collect the amount, which would improve their financial performance, rather then classify it as bad debt. These are uncompensated costs in the same sense as a patient that has **no** insurance coverage. 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 citizens. The recent growth of health plans that impose high deductibles and/or exclusion limits coupled with the growth of health savings account are further exacerbating the burden on hospitals in regard to unreimbursed costs. The DMC argues that CMS' new definition of uncompensated care to exclude bad debt is inconsistent with the statute and long-standing CMS DSH policy. As a result, **the DMC urges that the CMS modify its definition of uncompensated care by striking references to bad debt in 42 C.F.R. 447.299(c)(15). Instead, the DMC recommends that the CMS clarify that uncompensated care cost includes the cost associated with the following:**

- **services provided to individuals that have no health care insurance, third party coverage, or third party payment**
- **services provided to individuals that have health savings accounts, which due to health plan exclusions, limits or deductibles, are not covered.**

Section 1011 (Preamble)

The preamble in the proposed rule directs state Medicaid programs to consider Section 1011 payments for purposes of determining a hospital's 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. In enacting Section 1011, the Congressional intent was to provide additional resources rather than to merely substitute existing resources for hospitals that provide a high volume of uncompensated care to undocumented immigrants. This is 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 DSH dollars needed for hospitals serving high numbers of uninsured undocumented immigrants. **The DMC recommends that the CMS delete the language in the preamble that requires states to offset Section 1011 payments when establishing a hospital's individual DSH limit and to 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 (42 C.F.R. 447.299 (c)(16))

The proposal requires State Medicaid programs to report an unduplicated count of Medicaid eligible and uninsured patients for each hospital. 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, resulting in numerous questions as to how a hospital should classify certain patients. For example, how should a patient that has Medicaid coverage for a portion of the year, who due to increased earnings becomes ineligible for Medicaid coverage, which makes him uninsured for the remainder of the year be classified?

The DMC believes that this reporting requirement would be extremely and unnecessarily burdensome for hospitals and urges the CMS to delete it.

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

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 there is a concern that 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 additional audit costs. The DMC recommends that the CMS state affirmatively that the cost associated with 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 audit 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 DMC recommends that state Medicaid programs be allowed to use GAAP standards in the independent certified audits.

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

The proposed requirements would be effective for state fiscal year 2005, although fiscal year 2005 has ended for most states, including Michigan whose fiscal year ended Sept. 30. The proposed rule, which was not released until Aug. 25, 2005, would retroactively apply the new reporting and auditing requirements to fiscal year 2005. At this point, it would be impossible for Michigan and other state Medicaid programs to identify the data requested and meet the new and substantive reporting and auditing requirements on a retrospective basis. Although MMA provisions mandated the CMS to impose reporting and auditing requirements in fiscal year 2004, the CMS delayed implementation beyond the specified date, resulting in a significant hardship for state Medicaid programs and DSH hospitals due to the retroactive application of these new reporting and auditing requirements. **The DMC strongly believes that this retroactive application of the reporting and auditing requirements will be extremely problematic for both state Medicaid departments and DSH hospitals. The DMC recommends prospective application of these requirements upon each state's first fiscal year after finalization of the**

new DSH rule which would allow states time to review, understand, and comply with the final regulations.

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

Audit verification #2 requires that the DSH payments comply with the hospital specific DSH limit by requiring that DSH payments distributed during the state fiscal year (SFY) be compared to the actual uncompensated care cost for the same audited SFY. This would require states to reconcile DSH payments in order to ensure that such payments not exceed actual uncompensated care costs. However, the MMA does not require that payments be based on actual audited costs. The current CMS DSH policy allows states to employ a prospective methodology for estimating current year uncompensated care costs. This approach allows for adjustment during future years for reconciling DSH payments to actual costs. The verification, through audit, of DSH payments with the same year actual uncompensated care costs will create an enormous burden on hospitals due to burdensome and costly audits. These activities will also increase the administrative costs incurred by state Medicaid programs, making this another example where the proposed rule substantially revises the current Medicaid DSH policy. **The DMC strongly recommends that the CMS delete the requirement in the preamble and the regulatory language that audited DSH payments should be measured against actual uncompensated care cost for the same audited SFY. Instead, the DMC recommends that the CMS clarify that states be allowed to continue using reasonable estimation methodologies for determining uncompensated care costs. This would include data from the most recent filed cost report trended forward**

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

Audit verification #1 requires a state's audit report to verify that each hospital receiving DSH payments has reduced its uncompensated care costs for providing inpatient hospital and outpatient hospital services during the SFY to Medicaid eligible individuals and individuals with no source of third party coverage. For reflecting 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) excluding DSH payments, and payments made by uninsured individuals. The statutory language is clear that uncompensated care costs should **not** be 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. **The DMC recommends that verification #1 be revised to require that the total amount of DSH expenditures claimed for each hospital cannot exceed the hospital's uncompensated care costs.**

C. Other Issues/Concerns

Medicaid Eligible Individuals

Audit verification #3 required uncompensated care costs to include "only costs incurred for inpatient hospital and outpatient hospital services furnished to Medicaid eligible individuals and to individuals with no source of third party coverage..." "Medicaid individuals are the individuals that a state has determined to be eligible for its Federal Medicaid program in

accordance with applicable eligibility requirements.." (Federal Register pg 50265 August 26, 2005.

The DMC requests that these regulations provide specific guidance on what costs should be included as uncompensated care costs on the following specific issues:

a) Are uncompensated care costs to include the Medicaid eligible patients who have Medicare and Medicaid and for whom the only Medicaid liability is for the Medicare copayments and deductible amounts?

b) Are uncompensated care costs to include the Medicaid eligible patients who have other insurance coverage and where the Medicaid reimbursement is -0-?

In addition to the concerns identified above, we believe that the CMS should provide clarification regarding the following:

- Most of the data necessary to fulfill the requirements outlines in the proposed DSH regulations will be extracted from hospital cost reports. Since all hospitals do not have the same fiscal year as the state, it is important that the CMS specify the coverage periods for obtaining the required data elements.

- Most of the requirements outlines in the proposed regulations require data that will be obtained from hospital cost reports. Due to resources, during recent years, most states have scaled back cost report audits and perform only limited reviews of cost reports. Will the states be responsible for completing individual hospital audits in greater detail?

- If a patient has an ambulatory benefit, but does not have inpatient benefits, should he be considered as uninsured when inpatient hospital services are provided? Please define what is considered uninsured and what constitutes third party coverage.

Again, the DMC appreciates this opportunity to comment on the proposed rule that would implement the Medicaid DSH reporting and auditing requirements included in the MMA. The Medicaid DSH program is a vital lifeline to the DMC hospitals that play an integral role in providing care to a high volume of Medicaid and low income patients in the Detroit community. The proposed rule, in its current form, will have a significant negative impact on the DMC hospitals. Please refer any questions directly to me at 313-578-2820 or via e-mail at mpelc@DMC.org.

Sincerely,

Michael A. Pelc
Vice President, Finance

Submitter : Mr. R. Edward Howell **Date:** 10/24/2005

Organization : University of Virginia Medical Center

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2198-P-16-Attach-1.DOC

October 24, 2005

Via Electronic Filing

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 University of Virginia Medical Center (UVA Medical Center) submits these comments as part of the notice and comment rulemaking process for the above-referenced Proposed Rule.[1]

The UVA Medical Center is one of two academic medical centers in the Commonwealth of Virginia and as such is one of the largest providers of care to Medicaid and uninsured patients in Virginia. In fiscal year 2005, UVA Medical Center provided care to indigent and Medicaid patients at a cost of $138 million. In addition, the Medical Center's clinical faculty provided $22 million in care to indigent and Medicaid patients. As such, UVA Medical Center and its faculty rely on significant disproportionate share hospital (DSH) funding and have a direct interest in the subject of this Proposed Rule.

UVA Medical Center directs its comments to a single issue -- 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.[2]

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[1] 70 Fed. Reg. 50262 (Aug. 26, 2005), hereinafter "Proposed Rule."
[2] *Id.* at 50265.

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

UVA Medical Center believes that the preamble statement that physician services cannot be included in the calculation in Medicaid DSH payments to hospitals is improper for the following reasons[3]:

1. This is a rulemaking on reporting and auditing requirements. Discussion in the preamble on substantive issues relating to the computation of DSH payments is inapposite.
2. The statute permits inclusion in the calculation of Medicaid DSH payments of the cost of services furnished in hospitals by physicians.
3. Despite promising to do so as early as 1994, CMS has not issued rules interpreting the statutory Medicaid DSH provisions, and it may not properly use a backdoor mechanism of "clarifying" a policy not previously articulated and attempt to apply that policy retrospectively.
4. CMS policy has, in fact, been unclear on the agency's interpretation of what is a "hospital" service for purposes of Medicaid DSH payments, and clarification of that policy can occur only with notice and comment rulemaking that is applied prospectively.
5. Under CMS' Medicaid regulations, services furnished by physicians are expressly included within the definition of "hospital outpatient services" and are not excluded from the definition of hospital inpatient services.
6. The clear distinction between "hospital" and "physician" services that CMS implies to exist is not clear at all; hospital services and the services furnished by physicians to hospital patients are intertwined and inseparable.

I. The Cited Statutory Authority for the Proposed Rule Has No Bearing on Allowability of Costs in DSH Calculation, and There Is Inadequate Notice and Opportunity for Public Comment on CMS' Proposed Policy to Limit Hospital Costs Includable in the Medicaid DSH Calculation

CMS holds out the proposed rule as implementing Section 1001(d) of the Medicare Modernization Act ("MMA"). CMS cites no other law as the legal basis for this rule. Section 1001(d) of MMA is limited solely to reporting information and the auditing of that information. No portion of the

[3]UVA Medical Center considers these reasons to be representative only and does not hold out this list as being exhaustive.

proposed regulation addresses the issue of physician cost. The preamble language on hospital costs that may not be included in the Medicaid DSH calculation is inapposite to MMA § 1001(d) as well as the regulation text itself. By failing to give adequate notice to the public of the policy statement buried in the preamble, CMS' proposed new policy is not being proposed as it should be under the Administrative Procedure Act's rulemaking requirements. Moreover, if adopted, this new policy would be devoid of any claim for deference.

CMS may not argue that a rule on reporting and auditing may properly address substantive issues of what should be reported and audited. 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. Indeed, the text of the rule is properly limited to reporting and auditing issues. It would be improper for CMS to employ preamble language—much less the Rule itself—to alter substantive standards under the auspices of new statutory *reporting* requirements.

II. 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, dictate 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."[4] This provision does not require exclusion of hospitals' costs for the services of physicians from 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.[5] 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.[6] In contrast to the rural health clinic services which, while vital, are not a required service for a hospital to exist, physician services are a *sine qua non* for a hospital to operate. If

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

the services of a hospital-based rural health clinic must be included as hospital costs in the Medicaid DSH cap calculation, then hospital costs for services of physicians furnished to hospital patients surely must also be included in the Medicaid DSH cap calculation.

III. CMS Has Recognized That Substantive Rules Affecting the Medicaid DSH Calculation Should Be Published in Notice and Comment Rulemaking

CMS has previously distributed to State Medicaid Directors some informal interpretations of what may be included in the Medicaid DSH calculations. In at least one of those informal statements, CMS promised to publish its interpretation of the statute in a regulation:

> Attached for your information is a summary of the provisions of section 13621 of the 1993 Omnibus Budget Reconciliation Act. These provisions, effective for most States in the State fiscal year beginning on or after July 1, 1994, place new limits on the facilities which may qualify as disproportionate share hospitals (DSH), and the maximum payment adjustment such facilities may receive under the Medicaid program.
>
> **The Health Care Financing Administration is planning regulations to codify these new requirements in the Code of Federal Regulations.**[7]

Thus, CMS itself has recognized that notice and comment rulemaking is appropriate, particularly if it attempts to restrict the types of costs that may be included in the Medicaid DSH calculation. CMS not only promised to engage in such rulemaking, *it said more than 10 years ago that it would do so*. When CMS has dragged its feet and failed to give notice to the states of its policy, it may not attempt to create new policy in a single sentence buried in the preamble to a rulemaking on reporting and auditing requirements.

This is not just an issue of notice and comment rulemaking as required under the Administrative Procedure Act, it is an issue of federal-state comity. The Supreme Court has long recognized that the Federal government and the States enter into a voluntary "contract" when the Federal g overnment's s pending is c onditioned u pon federally i mposed conditions on the States. Pennhurst State School and Hospital v. Halderman, 451 U.S. 1, 17 (1981). Thus, "if Congress intends to impose a condition on the grant of federal moneys, it must do so unambiguously."

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

See also Mowbray v. Kozlowski, 914 F.2d 593, 598 (4th Cir. 1990) (citing to *Pennhurst* and finding that the terms of the Medicaid "contract" need to be clearly stated to be enforceable).

IV. The Wholesale Exclusion of Physician Costs Contradicts Existing CMS Guidance

The preamble language flatly contradicts existing CMS guidance. 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 Medicare allows for reimbursement to hospitals for the services of physicians in a number of circumstances,[9] the broad principle articulated in the 1994 letter to State Medicaid Directors allows for inclusion of the cost of these services in the calculation of the Medicaid DSH cap.

As a matter of public policy, 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.

Given the breadth of CMS' prior guidance and the indispensable role that physicians play in the delivery of hospital services, 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 UVA Medical Center's hospital and the Virginia Commonwealth University Health System Authority (VCU Health System).

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[8] 1994 Letter to State Medicaid Directors.

[9] For instance, teaching hospitals may elect to receive Medicare reimbursement for the reasonable costs of physician services provided at their facilities, provided that all the physicians furnishing services at the hospital agree not to bill Medicare for their services. 42 C.F.R. § 415.160.

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.[10] Nor would it be a legitimate means of strengthening the agency's litigation position.

It is problematic for CMS to effect 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.[11] CMS should therefore consider the utility and wisdom of employing unsupported preamble language to restrict the breadth of its 1994 State Medicaid Directors Letter. UVA Medical Center believes mere mention in a preamble is insufficient and improper. States are entitled to express notice on a prospective basis of any changes to the conditions of Federal funding, and not this "stealth regulation" that CMS has proposed here.[12]

V. The Plain Wording of CMS' Regulations Includes Physician Services within the Definition of Hospital Services

CMS defines "hospital outpatient services" as those services "furnished ***by*** or under the direction of a physician" to outpatients. 42 C.F.R. § 440.20 (emphasis added). There is nothing ambiguous or unclear about this definition. Thus, CMS' contention that hospital services do not include physician services flies in the face of its own Medicaid regulation that defines hospital outpatient services includes services "furnished by ... a physician." (The Medicaid definition of "inpatient hospital services" omits an express reference to services furnished by physicians but in no way

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[10] *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").

[11] *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).

[12] Pennhurst State School and Hospital v. Halderman, 451 U.S. 1, 17 (1981).

excludes services furnished to hospital inpatients from the scope of hospital services.)

VI. Physician Services in a Hospital are Inseparable from Other Services Furnished to Hospital Patients

Contending that hospital services do not include physician services is like arguing that a person can breathe without air. Under CMS' rules, a hospital cannot participate in the Medicaid program without a medical staff.[13] A hospital cannot admit a patient without a physician's order. No service can be furnished in the hospital without a physician's order. Indeed, Medicaid, Medicare and all other payers refuse to pay for services for which there is no documentation of a physician's order. Not only can there be no services furnished by a hospital without physicians, there cannot be a hospital under CMS' own definition, without there being physicians.

CMS' construct, condensed in an unsupported single sentence in the preamble to this proposed regulation, that implicitly presumes that physician services are not a part of hospital services is unsupportable both under CMS' regulations and in reality.

Conclusion

For the foregoing reasons, UVA Medical Center 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.

Sincerely,

R. Edward Howell
Vice President and Chief Executive Officer
University of Virginia Medical Center

[13] 42C.F.R. § 482.22.

Submitter : Mr. Michael Pelc **Date:** 10/24/2005

Organization : Detroit Medical Center Hospitals

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

"See Attachement"

CMS-2198-P-17-Attach-1.PDF

Attachment 17

Detroit Medical Center

Wayne State University

Reimbursement Division

Orchestra Place
3663 Woodward Ave.
Suite 200
Detroit, MI 48201-2403
313-578-2820 Phone

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.

Dear Dr. McClellan:

The Detroit Medical Center (DMC) on behalf of its six member hospitals- Children's Hospital of Michigan, Detroit Receiving Hospital, Harper-Hutzel Hospital, Huron Valley-Sinai Hospital, Rehabilitation Institute of Michigan and Sinai-Grace Hospital- welcomes this opportunity to comment to the Centers for Medicare & Medicaid Services regarding the proposed rule implementing the Medicaid Disproportionate Share Hospital (DSH) Payment reporting and auditing requirements included in the Medicare Modernization Act of 2003 (MMA), and which were recently published in the Aug. 26, 2005 *Federal Register*.

Funding from Medicaid DSH payments is critical to the financial viability of hospitals within our system. As the largest provider of Medicaid services in Michigan, we strongly support adequate and appropriate funding for services to Medicaid patients and those without insurance.

Our key concerns regarding the proposed DSH rule are:

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

As a result, the DMC strongly urges the CMS to reconsider the approach proposed in this rule.

A. Reporting Requirements

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

The revised definition of uncompensated care to exclude both bad debt and physician services are clear examples of the CMS' attempt to substantively change long standing DSH policy.

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 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 the agency on the various ways to determine the unreimbursed costs that hospitals incur. 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 additional 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 included. In implementing the hospital-specific DSH limit, the agency took into consideration the cost associated with the uninsured and the underinsured populations. In 2002, the CMS issued a memo to state Medicaid programs regarding the hospital specific DSH limit and the upper payment limit and reaffirmed the 1994 DSH policy.

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 individuals that have 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 CMS or state Medicaid programs.

Hospitals classify a charge as bad debt after they have exhausted all efforts to collect the funds from the patient. They'd rather collect the amount, which would improve their financial performance, rather then classify it as bad debt. These are uncompensated costs in the same sense as a patient that has **no** insurance coverage. 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 citizens. The recent growth of health plans that impose high deductibles and/or exclusion limits coupled with the growth of health savings account are further exacerbating the burden on hospitals in regard to unreimbursed costs. The DMC argues that CMS' new definition of uncompensated care to exclude bad debt is inconsistent with the statute and long-standing CMS DSH policy. As a result, **the DMC urges that the CMS modify its definition of uncompensated care by striking references to bad debt in 42 C.F.R. 447.299(c)(15). Instead, the DMC recommends that the CMS clarify that uncompensated care cost includes the cost associated with the following:**

- **services provided to individuals that have no health care insurance, third party coverage, or third party payment**
- **services provided to individuals that have health savings accounts, which due to health plan exclusions, limits or deductibles, are not covered.**

Section 1011 (Preamble)

The preamble in the proposed rule directs state Medicaid programs to consider Section 1011 payments for purposes of determining a hospital's 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. In enacting Section 1011, the Congressional intent was to provide additional resources rather than to merely substitute existing resources for hospitals that provide a high volume of uncompensated care to undocumented immigrants. This is 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 DSH dollars needed for hospitals serving high numbers of uninsured undocumented immigrants. **The DMC recommends that the CMS delete the language in the preamble that requires states to offset Section 1011 payments when establishing a hospital's individual DSH limit and to 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 (42 C.F.R. 447.299 (c)(16))

The proposal requires State Medicaid programs to report an unduplicated count of Medicaid eligible and uninsured patients for each hospital. 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, resulting in numerous questions as to how a hospital should classify certain patients. For example, how should a patient that has Medicaid coverage for a portion of the year, who due to increased earnings becomes ineligible for Medicaid coverage, which makes him uninsured for the remainder of the year be classified?

The DMC believes that this reporting requirement would be extremely and unnecessarily burdensome for hospitals and urges the CMS to delete it.

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

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 there is a concern that 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 additional audit costs. The DMC recommends that the CMS state affirmatively that the cost associated with 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 audit 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 DMC recommends that state Medicaid programs be allowed to use GAAP standards in the independent certified audits.

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

The proposed requirements would be effective for state fiscal year 2005, although fiscal year 2005 has ended for most states, including Michigan whose fiscal year ended Sept. 30. The proposed rule, which was not released until Aug. 25, 2005, would retroactively apply the new reporting and auditing requirements to fiscal year 2005. At this point, it would be impossible for Michigan and other state Medicaid programs to identify the data requested and meet the new and substantive reporting and auditing requirements on a retrospective basis. Although MMA provisions mandated the CMS to impose reporting and auditing requirements in fiscal year 2004, the CMS delayed implementation beyond the specified date, resulting in a significant hardship for state Medicaid programs and DSH hospitals due to the retroactive application of these new reporting and auditing requirements. **The DMC strongly believes that this retroactive application of the reporting and auditing requirements will be extremely problematic for both state Medicaid departments and DSH hospitals. The DMC recommends prospective application of these requirements upon each state's first fiscal year after finalization of the**

new DSH rule which would allow states time to review, understand, and comply with the final regulations.

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

Audit verification #2 requires that the DSH payments comply with the hospital specific DSH limit by requiring that DSH payments distributed during the state fiscal year (SFY) be compared to the actual uncompensated care cost for the same audited SFY. This would require states to reconcile DSH payments in order to ensure that such payments not exceed actual uncompensated care costs. However, the MMA does not require that payments be based on actual audited costs. The current CMS DSH policy allows states to employ a prospective methodology for estimating current year uncompensated care costs. This approach allows for adjustment during future years for reconciling DSH payments to actual costs. The verification, through audit, of DSH payments with the same year actual uncompensated care costs will create an enormous burden on hospitals due to burdensome and costly audits. These activities will also increase the administrative costs incurred by state Medicaid programs, making this another example where the proposed rule substantially revises the current Medicaid DSH policy. **The DMC strongly recommends that the CMS delete the requirement in the preamble and the regulatory language that audited DSH payments should be measured against actual uncompensated care cost for the same audited SFY. Instead, the DMC recommends that the CMS clarify that states be allowed to continue using reasonable estimation methodologies for determining uncompensated care costs. This would include data from the most recent filed cost report trended forward**

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

Audit verification #1 requires a state's audit report to verify that each hospital receiving DSH payments has reduced its uncompensated care costs for providing inpatient hospital and outpatient hospital services during the SFY to Medicaid eligible individuals and individuals with no source of third party coverage. For reflecting 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) excluding DSH payments, and payments made by uninsured individuals. The statutory language is clear that uncompensated care costs should **not** be 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. **The DMC recommends that verification #1 be revised to require that the total amount of DSH expenditures claimed for each hospital cannot exceed the hospital's uncompensated care costs.**

C. Other Issues/Concerns

Medicaid Eligible Individuals

Audit verification #3 required uncompensated care costs to include "only costs incurred for inpatient hospital and outpatient hospital services furnished to Medicaid eligible individuals and to individuals with no source of third party coverage..." "Medicaid individuals are the individuals that a state has determined to be eligible for its Federal Medicaid program in

accordance with applicable eligibility requirements.." (Federal Register pg 50265 August 26, 2005.

The DMC requests that these regulations provide specific guidance on what costs should be included as uncompensated care costs on the following specific issues:

a) Are uncompensated care costs to include the Medicaid eligible patients who have Medicare and Medicaid and for whom the only Medicaid liability is for the Medicare copayments and deductible amounts?

b) Are uncompensated care costs to include the Medicaid eligible patients who have other insurance coverage and where the Medicaid reimbursement is -0-?

In addition to the concerns identified above, we believe that the CMS should provide clarification regarding the following:

- Most of the data necessary to fulfill the requirements outlines in the proposed DSH regulations will be extracted from hospital cost reports. Since all hospitals do not have the same fiscal year as the state, it is important that the CMS specify the coverage periods for obtaining the required data elements.

- Most of the requirements outlines in the proposed regulations require data that will be obtained from hospital cost reports. Due to resources, during recent years, most states have scaled back cost report audits and perform only limited reviews of cost reports. Will the states be responsible for completing individual hospital audits in greater detail?

- If a patient has an ambulatory benefit, but does not have inpatient benefits, should he be considered as uninsured when inpatient hospital services are provided? Please define what is considered uninsured and what constitutes third party coverage.

Again, the DMC appreciates this opportunity to comment on the proposed rule that would implement the Medicaid DSH reporting and auditing requirements included in the MMA. The Medicaid DSH program is a vital lifeline to the DMC hospitals that play an integral role in providing care to a high volume of Medicaid and low income patients in the Detroit community. The proposed rule, in its current form, will have a significant negative impact on the DMC hospitals. Please refer any questions directly to me at 313-578-2820 or via e-mail at mpelc@DMC.org.

Sincerely,

Michael A. Pelc
Vice President, Finance

Submitter : Mr. Ryan Biles **Date:** 10/24/2005

Organization : The Ohio Hospital Association

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2198-P-18-Attach-1.DOC

OHIO HOSPITAL ASSOCIATION

Attachment #18

October 25, 2005

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and 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 Payments Proposed Rule

The Ohio Hospital Association (OHA), on behalf of its 170 member hospitals, would like to thank you for the opportunity to comment on the proposed Medicaid Disproportionate Share Hospital (DSH) Payments rule. In Ohio, the Medicaid DSH program, known as the Hospital Care Assurance Program (HCAP), is vital to the financial health and survival of many hospitals in Ohio's poorer urban and rural regions. Established in 1989 and expanded in 1992, many hospitals that remain open today owe their existence to the success of HCAP in the state of Ohio.

Today, Ohio is a state at a fiscal crossroads. The decline of American manufacturing has hit Ohio particularly hard, in terms of both falling wages and high unemployment. Eleven percent of the state's eleven million residents live with incomes at or below the federal poverty line, according to the US Census Bureau. Further, the state's economy has failed to generate sufficient funding for needed government programs, causing cuts to Medicaid—in particular, to eligibility and provider reimbursement. In this economically stagnant environment, many hospitals have not been able to continue providing needed services to the most distressed populations, with 17 hospital closures since 2000.

In the face of these tough times, HCAP has been a steadying source of funding for hospitals that provide a disproportionate share of care to Medicaid and uninsured patients. HCAP has been run ably and efficiently by Ohio's Department of Job and Family Services (ODJFS), prompting the Office of the Inspector General to comment, "Ohio's oversight and administration of DSH limits and payments were exemplary" in a 2004 audit. Now, though, unanticipated regulations proposed in CMS-2198-P have Ohio hospitals concerned about the future of HCAP and much higher administrative costs associated with the program. Specifically, the OHA requests that CMS amend or delete provisions in the proposed regulation pertaining to:

- Definitions of bad debt
- Section 1011 payments
- State audit requirements
- Reporting of unduplicated patient counts
- Actual year DSH limit reconciliations

Definitions of Bad Debt

Proposed Section 42 C.F.R. 447.299(c)(15) states, "Uncompensated care costs do not include bad debt for purposes of setting the hospital-specific DSH limit." The OHA has two concerns about this new provision. First, the DSH statute (1923(g)(1)(A)) permits the inclusion of the costs of providing services to

individuals with no health insurance or other source of third party coverage into hospital-specific DSH limits. This new provision would require that the costs of some services provided to individuals without health insurance not be included in specific DSH limits, only because of a financial accounting classification. However, that classification does not change the fact that a hospital incurred an un-reimbursed cost by providing services to an uninsured individual.

Second, Ohio hospitals are not currently required to segregate "bad debts" from uncompensated care delivered to uninsured patients on the Medicaid cost report. This provision would add administrative costs to hospitals. Adding administrative costs to services for which the hospital receives no reimbursement, while also penalizing hospitals with large amounts of bad debts through lowering specific DSH limits, seems to OHA not only unreasonable, but unfair.

CMS' new definition of uncompensated care, excluding bad debt, is both inconsistent with the governing statute and with long-standing CMS DSH policy. **The OHA strongly recommends that CMS delete references to bad debt in 42 C.F.R. 447.299(c)(15) and instead, 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 delivered to insured individuals whose policies do not cover the services provided due to exclusions, limits, or deductibles.**

Section 1011 Payments

The proposed regulation directs state Medicaid programs to consider Section 1011 payments in determining hospital-specific DSH limits. However, there is no statutory requirement for state Medicaid programs to do so. The proposed requirement actually seems to be in stark contrast to the Congressional intent behind the Section 1011 payments. While Section 1011 payments are a part of a federal program to reimburse hospitals for delivering care to a large population of uninsured, undocumented immigrants, this new regulation would penalize those same hospitals by lowering their hospital-specific DSH limits.

Data on Section 1011 payments are also currently not collected by the state Medicaid program in Ohio. Therefore, this regulation places a reporting and verification requirement on Ohio hospitals and the state for a federally administered program. **The OHA recommends that CMS delete the language that requires states to offset Section 1011 payments when calculating hospital-specific DSH limits.**

State Audit Requirements

The OHA has three concerns with the proposed regulation, relating to audit requirements foisted on the state. First, the proposed regulation, in Section 45.024 (b), requires that each state perform an independent certified audit of the DSH program, retroactive to state fiscal year 2005. Ohio's 2005 fiscal year ended on June 30th, and hospitals in the state have already completed and submitted Medicaid cost reports for fiscal year 2005. To require the state to go back and request additional data from Ohio hospitals in order to comply with a retroactive regulation would add, again, unreasonable administrative costs to both hospitals and the state. **The OHA recommends that CMS change the effective date of this requirement to state fiscal year 2006 at the earliest.**

The second concern with the audit requirements is the definition of the 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. Ohio hospitals are currently required to complete annual certified independent audits of their uncompensated care data, but they are only required to perform audits using generally accepted accounting principles (GAAP). **The OHA recommends that state Medicaid programs be allowed to use GAAP standards in the independent certified audits.**

Third, as noted above, Ohio hospitals already independently certify uncompensated care data submitted to the state. This proposed regulation would add a costly audit of HCAP at the state level, when the data is already being successfully certified at the hospital level. The OHA is concerned that any costs borne by the state in this extra audit will be shifted to hospitals in the form of administrative fees. While this requirement may be worthwhile in states that do not oversee and administrate DSH limits and payments in an "exemplary" fashion, as the OIG stated of Ohio in 2004, **the OHA would recommend that CMS exempt Ohio and other states with satisfactory independent certification programs already in place from this provision.**

Reporting of Unduplicated Patient Counts

Section 447.299(c)(16) requires states to collect and indicate the total annual Unduplicated Patient Count of Medicaid Eligibles and uninsured individuals served by hospitals. This provision requires that data to be collected for state fiscal year 2005, which again brings up the problem of retroactivity and the already completed 2005 cost reports. Additionally, many Ohio hospitals simply do not have the reporting systems in place that would allow them to generate unduplicated patient counts. This provision also requires hospitals to make definitive classifications of patients whose situations are not always easily classifiable. Many patients are covered by Medicaid for only a portion of a year, and many others have different insurance statuses by the month. This proposed regulation would add huge administrative costs to Ohio hospitals, and carries with it little to no expressed benefits. **The OHA recommends this provision be deleted.**

Actual Year DSH Limit Reconciliations

The proposed regulation requires that DSH payments not exceed hospital-specific DSH limits in any actual state fiscal year. However, as has long been the case, current CMS DSH policy allows states to use prospective methodology to estimate current year uncompensated care costs in order to set DSH limits. In Ohio, the most recent available data is used to calculate specific DSH limits, and this methodology has been allowed and even praised by CMS on multiple occasions.

The reason that a prospective methodology is just as effective as an actual year methodology for determining limits is because the prospective methodology allows for adjustments in future years to reconcile DSH payments with actual costs. However, the retrospective review of actual year costs to actual year DSH payments unnecessarily requires reviews of data. This provision adds even more administrative burden, cost, and complexity to a program that already carries with it great reporting burden, cost, and complexity. This provision is, furthermore, unnecessary in Ohio, as the federal DSH allocation to this state has consistently fallen short of Ohio's aggregate DSH limit by at least $200 million in each of the past five years.

Lastly, the audit verification #1 requires that each hospital receiving DSH payments reduce its uncompensated care costs by the amount of DSH payments received in any given year. The statute clearly

defines DSH limit 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. It is quite clear, then, that DSH payments should not be used to offset specific DSH limits. **Thus, the OHA recommends that CMS strike the requirement to offset DSH limits by DSH payments in audit verification #1.**

Again, the OHA appreciates this opportunity to comment on a proposed regulation that would unduly harm our 170 member institutions. The Medicaid DSH program carries such importance for our members that its administration, oversight, and validity are crucial to Ohio's hospital community as a whole. However, HCAP is currently being administered, overseen, and validated in a way that not only earns the praise of the Inspector General of the Department of Health and Human Services, but of hospital leaders and patient advocates around the state. The OHA respectfully asks that the newly proposed DSH regulation be amended to recognize the importance and effectiveness of our current DSH program, and that all undue burdens required of our members in this regulation be eliminated.

Sincerely,

Ryan Biles
Manager, Health Policy

cc. The American Hospital Association
The Ohio Hospital Association's Finance Committee
The Ohio Department of Job and Family Services

Submitter : **Denise Martin** **Date: 10/24/2005**

Organization : **CAPH**

Category : **Health Care Professional or Association**

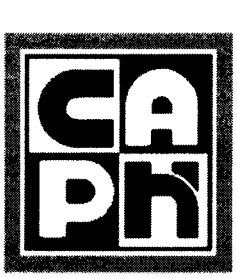
Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2198-P-19-Attach-1.DOC



CALIFORNIA ASSOCIATION OF PUBLIC HOSPITALS AND HEALTH SYSTEMS

Attachment #19

October 24, 2005

VIA HAND DELIVERY

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

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

Dear Dr. McClellan:

On behalf of the California Association of Public Hospitals and Health Systems ("CAPH"), I am writing in response to the Centers for Medicare & Medicaid Services' ("CMS") proposed rule regarding Medicaid program disproportionate share hospital ("DSH") payments. The proposed rule purports to implement section 1001(d) of the Medicare Prescription Drug Improvement and Modernization Act of 2003 ("MMA"), which establishes reporting and auditing requirements for state DSH programs. While much of the proposed rule is consistent with the statutory directive, it is clear that CMS intends to go beyond the implementation of the MMA provision and would impose significant policy changes in the guise of this audit and reporting rule. CAPH is concerned that these substantive changes in the federal DSH program requirements would jeopardize critical funding for California's public hospitals.

CAPH represents twenty-one hospitals, health care systems and academic medical centers in 16 counties throughout California. The geographic areas served by these hospitals and health systems account for 81 percent of the State's population. These providers are the core of California's health care safety net, and are uniquely committed to addressing the health care needs of the Medicaid, low-income, and other vulnerable populations. While our members account for 6 percent of the acute care hospitals in California, they consistently provide over 35 percent of hospital care to the State's Medicaid beneficiaries, 50 percent of the hospital care to California's uninsured, and over 80 percent of the State's hospital care to the medically indigent.

The financial viability of each of these public hospitals has depended on their receipt of Medicaid DSH payments, which, until State fiscal year ("SFY") 2004-05, have been paid in accordance with California's federally approved Medicaid state plan. As you know, under the terms of California's recently approved Medicaid Hospital / Uninsured Demonstration Project,

Medicaid reimbursement for the State's larger public hospitals will be based upon the certified public expenditures of the hospitals in lieu of the negotiated rate process that has been in place for more than 20 years. Critical to the success of the demonstration project is the payment of the full allotment of federal DSH funds to the public hospitals. DSH payments will be based on the hospitals' otherwise uncompensated Medicaid and uninsured costs that will be claimed as certified public expenditures. Any new policy interpretation that results in substantially lower DSH payments or affects prior year DSH payments will have a significant financial impact on these hospitals, and will put the State's entire health care safety net at risk.

GENERAL COMMENTS

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

Section 1001(d) of the MMA establishes annual reporting and audit requirements for states as a condition of receiving federal financial participation ("FFP") for DSH payments.[1] Neither the statutory language, nor the legislative history of the MMA suggest that Congress intended to adopt substantive changes to the DSH program through Section 1923(j). Thus, the audit and reporting requirements are predicated on the application of *existing* standards regarding DSH eligibility and DSH payment determinations. Notwithstanding the narrow scope of the statute, however, the proposed rule would impose new substantive requirements that are inconsistent with CMS-approved state plan provisions, which have governed the implementation of DSH programs for over a decade.

The core federal Medicaid statutory DSH requirements have been in place since 1987; and the hospital-specific DSH payment limits[2] since 1993. CMS has not promulgated implementing regulations for these statutory requirements, other than regulations regarding the state DSH allotments in 1992. California and other states have implemented and carried out their DSH programs pursuant to methodologies set forth in CMS-approved State plan amendments. These state plan methodologies were developed consistent with the DSH statute that provides states the flexibility to adopt procedures and methodologies tailored to each state's health care delivery system.

The proposed rule would impose new substantive requirements that would be implemented through third-party auditors applying standards that are at odds with existing state plan provisions. However, it is the approved Medicaid plan in each state plan that should provide the substantive basis for the independent audits and reports required under Section 1923(j). Because CMS approved the state plan provisions and has not implemented the statutory process that would be required to render them invalid,[3] they reflect current federal policy on the implementation of the Medicaid DSH program. The State plan *is* the standard by which FFP is available for state Medicaid expenditures.[4] There are existing administrative procedures for determining a state plan's compliance with federal Medicaid law, which include a notice and hearing process. Nothing in Section 1923(j) or its legislative history suggests that Congress

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[1] 42 U.S.C. §1396r-4(j); Soc. Sec. Act §1923(j). Referred to in this letter as "Section 1923(j)."
[2] 42 U.S.C. §1396r-4(g)(d); Soc. Sec. Act §1923(g)(D).
[3] 42 U.S.C. §1396c; Soc. Sec. Act §1904; 42 C.F.R. §430.60 et seq.
[4] 42 U.S.C. §1396b(a); Soc. Sec. Act §1903(a).

intended to circumvent these long-standing procedures through the audit and reporting requirements. Therefore, any attempt to do so in the guise of these implementing regulations would be invalid.

As discussed below, CAPH 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 receive adequate notice and have a meaningful opportunity to comment consistent with the rulemaking requirements of Administrative Procedure Act.[5]

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

The proposed rule provides that the reporting and independent certified audit provisions are effective as of SFY 2004-05 (retroactive for one year). Through SFY 2004-05, California's disproportionate share hospitals received DSH payment adjustments under a prospective methodology pursuant to the CMS approved state plan. In general, the methodology uses actual data for prior years that were the most complete and accurate data available at the start of each DSH payment year. The prospective determinations of DSH eligibility and DSH payment amounts, including the determination and application of the OBRA 1993 limit, are considered final determinations. This is to enable a hospital to accurately project, at the start of each SFY, the amount of DSH funding it will receive. This structure provides a degree of predictability and stability for financially distressed hospitals, and is particularly important for public hospitals that rely heavily on government funding.

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. CAPH suggests that the rule should be made effective with respect to the first full state fiscal year following the publication of the final rule.

[5] 5 U.S.C. §553 et seq.

SPECIFIC COMMENTS

1. 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.[6] While the proposed regulatory language is silent on this matter, this statement by CMS represents a new policy that is inconsistent with CMS' current policy as reflected in California's approved state plan. Such a substantive change could have a severe financial impact on California's public DSH facilities.

California public hospitals obtain physician services for their patients under a variety of arrangements. In many cases, the hospital (or its affiliated government entity) employs the physicians or contracts with physician groups. The physician services may be billed by the hospital under its own provider number, if the services are paid for under an all-inclusive rate, or billed separately under a different provider number for payment under the regulatory fee schedules. In either case, the costs of physician services are incurred and necessary to assure access to physician services for the hospital's predominately Medicaid and low-income populations. Without physicians, the hospital would be unable to provide its services. Indeed, Congress has expressed its expectation that disproportionate share hospitals are responsible for assuring access to physician services, as articulated in the requirement that a DSH facility have at least two obstetricians on its medical staff.[7]

The federal statute establishing the OBRA 1993 limit uses the general term "hospital services" and does not exclude the uncompensated costs of physician services provided to hospital patients.[8] Clearly, the reporting and audit requirements of Section 1923(j) do not address the treatment of physician services in the OBRA 1993 limit calculation. CMS cites no statutory support for the exclusion of physician services from this calculation. Although the preamble refers to existing regulatory definitions of "inpatient hospital services" and "outpatient hospital services," these definitions do not require the exclusion of physician services provided in the hospital setting.[9] Moreover, these regulations were promulgated independent of the DSH requirements. If these definitions are applied to exclude physician services, application to the DSH context now creates substantial unintended consequences.

Many financially distressed hospitals that rely on DSH funding need and expect this critical and significant component of their costs to be recognized in the determination of their uncompensated care costs. The language at issue should 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.

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[6] 70 Fed. Reg. at 50265.
[7] 42 U.S.C. §1396r-4(d)(1); Soc. Sec. Act §1923(d)(1).
[8] 42 U.S.C. 1396r-4(g); Soc. Sec. Act Section 1923(g).
[9] 42 C.F.R. §440.10; 440.20.

2. 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."[10] 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.

California public hospitals typically screen uninsured patients to determine the extent of their ability to pay for services rendered. The determination generally results in an allowance that is applied to reduce the amount due from the uninsured patient. CAPH recommends a revision to clarify that discounts for the uninsured are not applied to reduce the hospital's uncompensated care costs. The full cost should be recognized as uncompensated notwithstanding the discount or allowance process.

Additionally, if an uninsured patient does not pay the amount he or she was expected to pay, that may be recorded by the hospital as bad debt. The OBRA 1993 limit as prescribed by section 1923(g) provides that the costs of furnished services are net of non-DSH payments under Medicaid and payments by uninsured patients. The statute does not authorize reductions to uncompensated care costs for amounts that patients were expected to pay, only for payments that are actually made. Similarly, with respect to Medicaid patients, the expected deductibles, copayments and share of cost payments that are ultimately unpaid should not be applied as a reduction in determining uncompensated care costs. The language suggesting that bad debt be applied as a reduction to costs should be eliminated.

Finally, we note that the "payer discount" exclusion is inappropriate with respect to both the uninsured and Medicaid beneficiaries. With respect to uninsured patients, no third party payer is involved. For services rendered to Medicaid patients, the difference between the Medicaid rates (or Medicaid managed care plan payments) and the costs of furnishing the services constitutes the Medicaid shortfall that is a component of uncompensated care costs. The language regarding payer discounts should be removed.

3. 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.[11] This statement represents another attempt to adopt new Medicaid policy in the guise of an audit and reporting rule. Section 1923(g) provides for only two reductions to costs: non-DSH Medicaid payments and payments by uninsured patients. The reduction for section 1011 payments that is suggested in the preamble (but not as a proposed

[10] Proposed 42 C.F.R. §447.299(c)(15); 70 Fed. Reg. at 50264.
[11] 70 Fed. Reg. at 50264.

rule) is unsupported by the statute. We further note that additional preamble language appears to suggest a similarly unsupportable expansion of the meaning of payments made by uninsured patients.[12]

For those hospitals at or near their limit, CMS' suggested treatment of section 1011 payments would merely supplant DSH payments with section 1011 funds, thereby eliminating the financial relief such payments are intended to provide. This result is inconsistent with the clear language of the Medicaid DSH provisions and with the purpose of section 1011, which was to provide financial relief to hospitals that provide emergency services to the undocumented population. CAPH 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.

4. 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.[13] 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.

Section 1923(g) does not require that the OBRA 1993 limits be recalculated and reapplied to reflect subsequently available year-of-service data, and CMS has never before imposed a reconciliation requirement. As described above, California has operated a prospective DSH payment program for many years under its CMS approved state plan. In 2003, CMS expressly acknowledged that a prospective reconciliation methodology based on historical cost data was appropriate.[14] Nothing in the MMA requires CMS to impose this dramatic shift in policy.

As discussed above, disproportionate share hospitals require finality with respect to their DSH payments. For California disproportionate share hospitals paid under the prospective state plan methodology, the proposed policy change will create unwarranted financial instability that will likely result in service disruptions. The proposed provision should be deleted.

5. 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 are required to report each hospital's low-income utilization rate as defined in Section 1923(b)(3).[15] This provision goes beyond the scope of the referenced statutory definition to require that the low-income utilization rate calculation "only includes individuals that have no source of third party coverage . . . ." This represents another attempt to adopt a substantive policy change in the context of these audit and reporting rules.

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[12] "Payments received from or on behalf of" uninsured patients; 70 Fed. Reg. at 50265.
[13] Proposed 42 C.F.R. §455.204(c)(2); 70 Fed. Reg. at 50265.
[14] California Transition Agreement between CMS and the State of California regarding the implementation of the Selective Provider Contracting Program, Feb. 4, 2003.
[15] Proposed 42 C.F.R. 447.299(c)(7); 70 Fed. Reg. at 50267.

Section 1923(b)(3) sets forth the calculation of the low-income utilization rate, which includes both a Medicaid component and a charity care component. The proposed rule would inappropriately limit the charity care component to only charity care rendered to the uninsured, thereby excluding charity care for the underinsured. While the lack of third-party coverage is an important factor in any hospital's charity care policy, it is not the only factor. Charity care is often appropriate, and should be recognized, when some third-party coverage exists, but it is inadequate given the financial circumstances of the patient. There is no indication that Congress intended to limit the charity care component by eliminating this type of care from the calculation.

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.[16] The language at issue should be retracted.

6. The Unduplicated Uninsured Patient Count Reporting Requirement is Unduly Burdensome for Many Hospitals

Section 1923(j) grants the Secretary broad authority to require states to report information "necessary to ensure the appropriateness of the {DSH} payment adjustments...." The proposed rule, however, appears to exceed this authority by requesting information that is irrelevant to DSH payment adjustment determination. The proposed rule would require that states report the total unduplicated number of Medicaid and uninsured individuals receiving hospital services. The preamble does not explain the relationship of this information to the DSH payment adjustment determination and we are aware of no rationale in support of collecting this information.

While states can likely provide the Medicaid count with little difficulty, it may be very difficult for many of the public hospitals to produce an accurate, unduplicated count of the uninsured. Hospitals are not currently required to report this information, so the requirement will impose a costly administrative burden on the hospitals. For a variety of reasons, many of the patients served by the safety net hospitals fail to provide accurate identifying information. As a result, the hospitals find that the kind of information sought under this rule is not likely to be reliable. In addition, collection of the data will be complicated by the fact that 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, CAPH recommends that CMS remove this requirement from the proposed rule.

[16] 42 U.S.C. §1396r-4(b)(4); Soc. Sec. Act §1923(b)(4).

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

The proposed rule requires an audit verification that each disproportionate share hospital in the state has reduced its uncompensated care costs in order to reflect the total amount of claimed DSH expenditures.[17] It is not clear how a hospital can demonstrate this, as costs generally are not reduced by expenditures.

We recognize that the statutory language is unclear with respect to this issue, but the regulation provides the opportunity to clarify what the auditors are expected to verify. Certainly, auditors will not be able to verify that costs that had been incurred in a prior time period were in some way eliminated when the DSH payments were subsequently made to the hospitals. The preamble suggests that the provision at issue is attempting to require that the auditors verify that both the nonfederal share of DSH expenditures, as well as the federal share of such expenditures, are compared against the hospital's OBRA 1993 limit.[18] If this is CMS' interpretation, the regulatory language should be modified accordingly.

We note however, that the language of Section 1923(j) requires the auditors to verify "the extent to which" the costs have been reduced. Thus, if costs have not been reduced at all, the auditor would verify that fact and the audit requirement would be met. The regulation appears to require a verification that the costs have *in fact* been reduced. The regulatory language should be revised to be consistent with the statutory requirement.

* * * *

In addition to these comments, CAPH endorses the comments submitted by the National Association of Public Hospitals and Health Systems in response to this proposed rule. CAPH appreciates the opportunity to submit these comments on the proposed rule. If you have any questions about these comments, please contact our counsel, Diane Ung at Foley & Lardner, 310-975-7818.

Sincerely,

Denise K. Martin,
President & CEO

[17] Proposed 42 C.F.R. §455.204(c)(1); 70 Fed. Reg. at 50268.
[18] 70 Fed. Reg. 50265.

Submitter : Mr. John Berta **Date:** 10/24/2005

Organization : Texas Hospital Association

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

Please see attached letter.

CMS-2198-P-20-Attach-1.DOC

TEXAS HOSPITAL ASSOCIATION

October 25, 2005

Mark McClellan, M.D. Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
P.O. Box 8010
Baltimore, MD 21244-1850

Regarding: CMS-2198-P; Medicaid Program; Disproportionate Share Hospital Payments

Dear Mr. McClellan:

On behalf of its more than 430 member hospitals and health systems, the Texas Hospital Association appreciates the opportunity to comment on the proposed Medicaid hospital disproportionate share payment rules published August 26, 2005 in the Federal Register. The proposed rules outline the necessary provisions associated with the Medicaid Disproportionate Share Hospital (DSH) Payment reporting and auditing requirements found in the Medicare Modernization Act of 2003 (MMA).

The Medicaid DSH program is critically important to Texas hospitals. Each year the Texas Medicaid DSH program distributes over $500 million in federal Medicaid funds to approximately 170 non-state DSH hospitals. Medicaid DSH funds are used by these safety net facilities to offset the tremendous levels of uncompensated care provided to the state's poor, disabled and the elderly. The THA has a number of concerns with the proposed rule.

Calculation of Uncompensated Care Costs

The THA disagrees with CMS about the inclusion of certain costs of care that should be considered in the calculation of a hospital's uncompensated care costs. CMS has taken a narrow view of the allowable costs, and has omitted some of the legitimate costs that should be included. Specifically, the proposed rule mandates that bad debt expense not be included in the calculation of hospital uncompensated care costs.

The THA recommends that CMS modify the agency's definition of uncompensated care costs to include the costs of bad debt. In addition, the definition should include any physician costs associated with hospital treatment, and the costs of services furnished to insured individuals whose policies do not cover the services provided to the individual due to their health plans exclusions, limits or deductibles.

Section 1011 Payments

The preamble in the proposed rule directs state Medicaid programs to consider Section 1011 payments (Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens) when determining a hospital's specific DSH limit. However, there is no statutory requirement to include Section 1011 payments when calculating a 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 of funds rather than substituting existing resources for hospitals providing large volumes of uncompensated care to undocumented immigrants. Inclusion of Section 1011 payments would likely result in reducing needed DSH dollars to hospitals serving high numbers of undocumented immigrants.

Therefore, the THA recommends that CMS modify the proposed rules allowing the inclusion of 1011 patients in the hospital specific DSH limit, without requiring hospitals to include the payments as an offset to that limit.

Unduplicated Patient Counts

State Medicaid programs are required to report for each hospital an unduplicated count of Medicaid eligible and uninsured patients. The THA 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 in 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 THA 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 or higher per hospital.

Texas' safety net hospitals are not in the financial position to absorb these added audit costs. Accordingly, the THA 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 THA recommends that state Medicaid programs be allowed to use GAAP standards in the independent certified audits.

Actual Costs Incurred in the Same Year

The audit verification #2 of the proposed rule 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.

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 as well as increase the administrative costs for each state Medicaid program.

The THA strongly recommends that CMS delete the requirement that audited DSH payments must be measured against actual uncompensated care cost in the same audited SFY. THA 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.

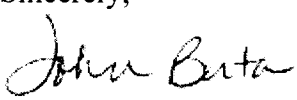
Reduce Uncompensated Care Costs by DSH Payments

The audit verification #1 of the proposed rule 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 THA 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.

Finally, the THA appreciates this opportunity to comment on the proposed rule to implement the Medicaid DSH reporting and auditing requirements of the MMA and looks forward to partnering with CMS on the successful implementation of this rule. The Medicaid DSH program is a much needed lifeline to many of the state's safety net hospitals and our association is concerned about the impact the current rules will have on these providers. If you have any questions about the comments, please contact me or Ernie Schmid, Senior Policy Analyst at 512-465-1000.

Sincerely,



John Berta
Senior Policy Analyst

Submitter : **Chris Underwood** **Date: 10/24/2005**

Organization : **Health Care Policy and Financing**

Category : **State Government**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment.

Chris Underwood
Manager, Safety Net Financing Section
Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

(303) 866-5177
Chris.Underwood@state.co.us

CMS-2198-P-21-Attach-1.DOC

Comments related to:
42 CFR Parts 447 and 455
Medicaid Program; Disproportionate Share Hospital Payments

File Code: CMS-2198-P

III. Provisions of the Proposed Regulation

A. Reporting Requirements

We are proposing to add a new paragraph (c) to the reporting requirements in Part 447.299.

Comment: This new annual reporting requirement should not be associated to the CMS 64 quarterly report. The DSH reporting should be submitted directly to CMS on the same day that the required independent certified audit is submitted.

Medicaid inpatient utilization rate. Indicate the hospital's Medicaid inpatient utilization rate, as defined in section 1923(b)(2) of the Act.

Comment: Currently the State calculates DSH eligibility on a calendar basis. Must now the State calculate the Medicaid Inpatient Utilization Rate on a State Fiscal Year basis to comply with the reporting requirements?

Type of Hospital Ownership.

Comment: Reporting on the type of hospital, type of ownership and the classification of operator is not required under Section 1001 of the MMA. Why does CMS propose such information is necessary to comply with the reporting requirements?

DSH Payments.

Comment: DSH payments are made on an accrual accounting basis. If a DSH payment is adjusted after the report has been filed, is the State expected to file a corrected report?

Regular Medicaid Payments.

Comment: Should these payments be reported on an accrual or cash accounting basis?

Comment: The State reconciles Outpatient Hospital payments to 72% of cost and those reconciliations may take several years to finalize. How should those reconciliation payments/recoveries be reported? If a Medicaid payment is adjusted after the report has been filed, is the State expected to file a corrected report?

Medicaid Eligible and Uninsured Individuals. 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.

Comment: Reporting the unduplicated number of patients that are Medicaid eligible and those with no source of third party coverage is a large reporting burden placed onto the providers. This reporting requirement is not directly specified under Section of 1001 of the MMA. Please explain the relevancy of this reporting requirement to DSH eligibility or payments.

Indigent Care revenue. Indicate 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: Please define Indigent Care Revenue. Would payments received under Section of 1001 of the MMA be included as Indigent Care Revenue?

Total cost of Care. Indicate separately the total annual costs incurred for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals and the 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: Most of the reporting requirements will require the hospital to report information directly to the State. Due to the variations in year end dates, many hospital financial audits would not be completed within the time frame that the State would request the financial data. What is the State's due-diligence responsibility for confirmation/assurance of the completeness and accuracy of the data provided by the hospital?

Sec. 455.201 Definitions. For the purposes of this subpart—Independent certified audit means an audit that is conducted in accordance with generally accepted government auditing standards, as defined by the Comptroller General of the United States.

Comment: Please confirm that the audit would be a Program Performance Audit of the State as defined in Government Auditing Standards, July 1999, Chapter 2, and as such would not require verification by a Certified Public Accounting firm as in the case of financial audits that lead to the expression of an opinion as defined in Chapter 3. Would states be allowed to utilize independent internal auditors or independent non-CPA firm external auditors to conduct the DSH verification?

IV. Collection of Information Requirements

The need for the information collection and its usefulness in carrying out the proper functions of our agency.

Comment: Per section 1001 (d)(1)(B) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. The State shall submit an annual report that includes...information as the Secretary determines necessary to ensure the appropriateness of the payment adjustments made under this section....Please clarify how the Reporting Requirement for Medicaid Eligible and Uninsured Individuals will ensure the appropriateness of payment adjustments. In talking to the hospitals in our state, we have been told that this would take a significant amount of time and may require adjustments to their reporting and tracking systems.

The accuracy of our estimate of the information collection burden.

Comment: As we already request data from providers for our annual report, adding new elements to our request does not place a significant additional burden on us, the State. However, the burden on hospitals that receive a DSH payment to report this additional data is significant. One hospital estimates that while current reporting requirements for quarterly and annual reporting takes approximately 128 hours per year, the new requirements may increase this to 512 hours per year.

Thank you for considering these comments.

Chris Underwood
Manager, Safety Net Financing Section
Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

(303) 866-5177
Chris.Underwood@state.co.us

Submitter : Mrs. Kim Carlstrom **Date:** 10/24/2005

Organization : Missouri Hospital Association

Category : Other Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2198-P-22-Attach-1.DOC

MISSOURI HOSPITAL ASSOCIATION

Marc D. Smith, Ph.D., President

October 24, 2005

Mark B. 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. 20201-0004

Re: **[CMS-2198-P] Medicaid Program; Disproportionate Share Hospital Payments**

Dear Dr. McClellan:

On behalf of our member hospitals, health care systems and individual members, the Missouri Hospital Association appreciates the opportunity to comment on the proposed rule on new reporting and auditing requirements for Medicaid state disproportionate share hospital payments found in the Medicare Modernization Act of 2003 (MMA). The proposed rule was published in the August 26, 2005, *Federal Register*.

MHA generally is supportive of reporting requirements that help ensure that state DSH payments comply with federal requirements; however, it appears that the proposed rule goes far beyond the procedural aspects of reporting and auditing to interpret the underlying substantive requirements of the hospital-specific DSH limit. In addition, these policy interpretations seem to go beyond Congress' direction in the MMA, which focused solely on auditing and reporting requirements. The proposed rule likely will have a direct financial impact on hospitals' DSH payments. Policy changes in this program, particularly changes with significant economic impacts, will directly affect the hospitals that provide essential access to healthcare for the poor and uninsured.

The Missouri Hospital Association has identified the following concerns with the proposed rule.

III. A. Reporting Requirements

Physician Costs

The language in the preamble to the proposed rule suggests that a hospital's physician costs cannot be included in the uncompensated care cost calculation. This is problematic for all hospitals since physician services are part of the services that hospitals routinely provide to the uninsured. 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. **MHA strongly recommends that CMS remove 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.**

Bad Debt

The definition of "uncompensated care costs" provided in the preamble to the proposed rule and in the proposed regulatory text contains the statement that "uncompensated care costs do not include bad debt or payer discounts." 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). 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. Missouri's state plan includes bad debt in uncompensated care costs that are eligible for DSH reimbursement. The current language excluding bad debt is misleading and should be clarified or eliminated.

MHA urges CMS to eliminate the reference to bad debt in proposed 42 CFR 447.299(c)(15) and clarify that uncompensated care costs include the following:

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

III. B. Audit Requirements

Definition of Independent Certified Audit

The proposed requirement that the audit must be conducted pursuant to the government auditing standards is unduly burdensome. Most of the auditors in the private sector use generally accepted accounting principles (GAAP) to audit hospitals' financial data. As a result, it would be inefficient to require these auditors to perform another audit of the same data using different auditing standards. **MHA recommends that CMS allow states to use either GAAP standards or the government auditing standards in meeting the audit requirements.**

Retroactive Audit

The proposed rule retroactively applies the new reporting and auditing requirements to state fiscal year 2005. Most state fiscal years for 2005 already have ended. The new reporting and auditing requirements would make it impossible for state Medicaid programs to comply because they would have to retroactively identify the requested data. It would impose a real hardship for state Medicaid programs and DSH hospitals. CMS already has delayed implementation of the reporting and auditing requirements beyond the date specified in the MMA. As a result, it makes little sense to require retroactive application of these requirements now. **MHA strongly recommends that retroactive application of the reporting and auditing requirements be deleted from the proposed rule. Rather, the reporting and auditing requirements should be tied to the first state fiscal year beginning after the rule is finalized.**

Same Year Actual Costs

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 have to be measured against the actual uncompensated care in the same audited state fiscal year. This would require that states reconcile DSH payments to ensure such payments do not exceed actual costs. CMS has never before required such a reconciliation and instead has allowed states flexibility to use estimates of current year uncompensated costs. Although placing 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. The proposed rule would place a significant strain on hospitals through new burdensome and costly audits as well as increase the administrative costs for each state Medicaid program. **MHA 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 state fiscal year. MHA also recommends that CMS clarify that states be allowed to continue to use reasonable methodologies for estimating uncompensated care costs in a given year.**

Reduction of Uncompensated Care Costs by DSH Payments

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 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. The first requirement, which reduces a hospital's uncompensated care costs by claimed DSH expenditures, is contrary to the statute. **MHA recommends that the first audit verification be changed to require that the total amount of claimed DSH expenditures for each hospital in the state does not exceed the hospital's uncompensated care costs.**

On December 9, 2002, the Centers for Medicare & Medicaid Services and the Missouri Department of Social Services signed the Missouri Medicaid Partnership Plan for the purpose of "establishing a stable funding mechanism for the state's Medicaid program that embodies accountability while assuring the availability of financial resources to provide needed health care to the program's beneficiaries." Prior to the agreement, Missouri's DSH program, as well as various other components of Missouri's Medicaid program, were closely scrutinized by federal authorities to ensure that Missouri was in compliance with federal regulations. The additional auditing and reporting requirements as addressed in the proposed regulation seem to be unduly burdensome and potentially costly to the state of Missouri and Missouri's hospitals.

The Missouri Hospital Association appreciates the opportunity to comment on the proposed rule. If you have any questions or if you need any additional information, please contact me at 573/893-3700, ext. 1345 or *kcarlstrom@mail.mhanet.com*. Thank you for your consideration of our comments.

Sincerely,

Kim Carlstrom

Kim Carlstrom
Vice President of Medicaid and FRA

kc/kh

Submitter :

Date: 10/24/2005

Organization :

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2198-P-23-Attach-1.DOC

Attachment #23

October 21, 2005

The Honorable Mark B. 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; Proposed Changes to the Disproportionate Share Hospital Payments; Proposed Rule (42 *Federal Register* 50262-50268).

Dear Administrator McClellan:

Thank you for the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule concerning Disproportionate Share Hospital Payments. Memorial Health University Medical Center (MHUMC) is a 530-bed teaching hospital with a Level I Trauma Center located in Savannah, Georgia.

This letter will focus on the calculation of uncompensated care costs and the retroactive application of the proposed changes.

Disproportionate Share Hospital Payments Background

Title XIX of the Social Security Act (the Act) authorizes Federal grants to States for Medicaid programs that provide medical assistance to low-income families, the elderly, and persons with disabilities. Section 1902(a)(13)(A)(iv) of the Act requires that States make Medicaid payment adjustments for hospitals that serve a disproportionate number of low-income patients with special needs. Section 1923(a)(2)(D) of the Act requires States to provide an annual report to the Secretary describing the payment adjustments made to each disproportionate share hospital (DSH).

Section 1923 of the Act also sets out certain limits on Federal financial participation for State DSH payments. Section 1923(f) of the Act defines, for each State, an aggregate annual limit on Federal financial participation for DSH payments. Section 1923(g)(1) of the Act also defines hospital-specific limits on Federal financial participation for DSH payments. Under the hospital-specific limits, a hospital's DSH payments must not exceed the costs incurred by that hospital in furnishing services during the year to Medicaid patients and the uninsured, less other Medicaid payments made to the hospital and payments made by uninsured patients ("uncompensated care costs").

"Uncompensated Care Costs"

Currently, under § 447.299, each State is required to report and maintain certain information about DSH program spending. One of the informational data elements outlined by the proposal to be reported by the State is Uncompensated Care Costs. The States would 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. 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 less the sum of regular Medicaid rate payments, Medicaid managed care organization payments, supplemental/enhanced Medicaid payments, and indigent care revenue. Uncompensated care costs do not include bad debt or payer discounts. Bad Debts represent an enormous uncompensated cost to providers. Although an individual may be eligible for Medicare, Medicaid, or some other third party coverage, that same individual may not have the financial ability to pay their out of pocket obligation. The Medicare program recognizes this reality and reimburses providers 70% of their Medicare bad debt write-offs. To exclude bad debts from Medicaid and other payors from the Medicaid DSH Program's calculation of uncompensated care costs is contradictory to Medicare Policy. Any calculation for uncompensated care costs that exclude bad debts is not reflective of the provider's true cost of uncompensated care.

In addition to changes to the reporting requirements, the proposal would also implement auditing requirements as required by Section 1001(d) of the MMA amended section of 1923(j)(2) of the Act. The Act is amended to require States to annually submit to CMS an independent certified audit report that verifies information about DSH payments to hospitals. The statute specifies five items that require verification by an independent audit. Collectively, these five items will provide independent verification that State Medicaid DSH payments comply with the hospital-specific DSH limit in section 1923(g) of the Act, and that such limits are accurately computed. Along with 4 other verification tests, the auditors are directed 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. Uncompensated care costs of providing physician services are excluded from the calculation of hospital-specific DSH limit. In order to provide patient care in the most efficient manner, employment agreements often exist between providers and physicians. That physician's compensation then becomes the provider's cost of providing patient care. In order to capture all of the providers uncompensated care costs, uncompensated costs for services provided by hospital employed physicians must be included in the hospital-specific DSH payment limit. In addition to hospital-employed physicians, consideration should also be given to any physician incurring cost for services for which he is uncompensated. CMS has approved the State of Alabama's plan to make UPL payments to physicians. If the State of Alabama and CMS both agree that physicians are deserving of UPL payments to offset their Medicaid losses, then it only stands to reason that the uncompensated costs of physician services should be included in the calculation of total uncompensated care costs.

"Retroactive Application of the Proposed Changes"

The proposal requires States to submit the required data elements 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 burden associated with this requirement is the time and effort for the States to prepare and submit the required information. It is estimated in the proposal that it will take each State approximately 30 minutes to prepare and submit the information for each of its DSH providers. It is unreasonable to expect that States are going to have readily available to them for State Fiscal Year (SFY) 2005, the data elements that you are just now requiring to be reported under this proposal. Applying the changes to the reporting requirements to SFY 2005 is a retroactive application and puts the States in the position of struggling to retrieve data that was not collected during SFY 2005. This would ultimately be to the detriment of the providers if the States are unable to capture all of the uncompensated care costs when they submit their reports. The proposed changes in the reporting and auditing requirements should begin with SFY 2006, which would allow the States to adequately prepare for the collection of the required data elements.

Thank you for considering our remarks on the proposed rule. If you have any questions about our comments, please feel free to contact me.

Sincerely,

Bob Colvin
President and CEO

Cc: Suzanne Heck, CFO, MHUMC
Margaret Gill, VP Finance, MHUMC
Amy Hughes, VP Government Affairs, MHUMC

Submitter :

Date: 10/24/2005

Organization :

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2198-P-24-Attach-1.DOC

RIVERSIDE COUNTY
REGIONAL MEDICAL CENTER

OFFICE OF THE DIRECTOR

October 24, 2005

Attachment #24

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

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

Dear Dr. McClellan:

On behalf of Riverside County Regional Medical Center, 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. Riverside County Regional Medical Center is concerned that substantive changes to the federal DSH program proposed in the rule would jeopardize critical funding for our hospital and all public hospitals in California.

Riverside County Regional Medical Center's patient population mix consists of 22.2 percent uninsured, 16.4 percent indigent, and 35.2 percent Medicaid. Riverside County Regional Medical Center provides substantial hospital health care support to the vulnerable population in Riverside County.

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.

Riverside County Regional Medical Center 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. Riverside County Regional Medical Center objects to many of the proposed

26520 Cactus Avenue, Moreno Valley, California 92555
Phone: 951-486-4450 • FAX: 951-486-4475 • TDD: 951-486-4397

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.**

Riverside County Regional Medical Center 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. Riverside County Regional Medical Center 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, Riverside County Regional Medical Center 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.

****

Riverside County Regional Medical Center appreciates the opportunity to submit these comments on the proposed rule. If you have any questions about these comments, please contact Mr. Bagley.

Sincerely,

Douglas D. Bagley
Chief Executive Officer

26520 Cactus Avenue, Moreno Valley, California 92555
Phone: 951-486-4450 • FAX: 951-486-4475 • TDD: 951-486-4397

Submitter : Mrs. Cherie Taylor **Date:** 10/24/2005

Organization : Northern Rockies Medical Center, Inc.

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2198-P-25-Attach-1.DOC

Attachment #25

Northern Rockies Medical Center, Inc.
802 2nd St. SE
Cut Bank, MT 59427

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:

Northern Rockies Medical Center, a Critical Access Hospital in Montana, 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 hospital. Without the DSH financial assistance for the past two years, our hospital may not have been open today. Medicaid payments, especially payments from the DSH program, provide an extremely important resource to assure continued access to care for Glacier County residents.

NRMC is a not-for-profit community institution that provides access to care for Glacier County, one of the poorest counties in Montana, and surrounding communities. Montana has one of the highest percentages of uninsured residents and one of the lowest average incomes among all the states. Glacier County has a higher percentage of uninsured residents and a lower average income than the Montana average.

NRMC is greatly concerned about the proposed rule. Adoption of the rule would greatly reduce the DSH payments to our hospital; which would eliminate in the future some of the services we provide. The largest burden would be on the impoverished community of ours since those people could not travel to receive those services elsewhere.

NRMC endorses the comments provided by the American Hospital Association, which notes that 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 caps. Much of the current DSH policy has been forged in negotiations between the Centers on Medicare and Medicaid (CMS) and individual state governments.

It appears to me that CMS is choosing to use this proposed rule that implements the MMA reporting and auditing requirements to establish new DSH policy. NRMC is currently required to report both charity and bad debt costs to the Medicaid program to assure that it will not receive 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.

NRMC believes CMS is changing the definition of uncompensated care. The changed definition of uncompensated care to both exclude bad debt and physician services I believe is the agency's attempt to substantively change long-standing DSH policy.

UNCOMPENSATED CARE (42 C.F.R. 447.299(C)(15))

NRMC would like to know why CMS seems to be ignoring past practice and original intentions of the legislative body as outlined by in a MHA letter as stated 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 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 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 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 co-payments 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. NRMC 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.

NRMC requests the same recommendation as MHA 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. NRMC employs physicians and other practitioners in order to assure access to services in Glacier County, which is an underserved area with a HPSA of 14. The hospital bears all the risk for nonpayment for the providers' services while it incurs the cost of employment and other support. It is unreasonable to exclude provider services in the calculation for uncompensated care for Medicaid. The MMA does not require that CMS exclude physician services; therefore, I want to know why this is being proposed.

AHA has stated, MHA concurs, and NRMC 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 the state will ask our hospital to produce these patient counts. It would be very difficult for my system to produce the reports that would be mandated. I have no idea how our system could handle patients that are Medicaid for part of the year and uninsured for the other part. NRMC needs to know why this information is necessary and I do not get that understanding by what is written in the proposed rule.

NRMC recommends that this reporting requirement 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. It would be extremely labor intensive for my hospital to match payments received from individuals to payments received for individuals for which there was no third party coverage because it does not currently do that automatically.

The reporting burden on Critical Access Hospitals like NRMC would distract from needed resources to provide services to the uninsured. I concur with AHA's recommendation that this reporting requirement be deleted.

REPORTING TOTAL COSTS (42 C.F.R. 447.299(C)(14))

The definition of allowable costs in the State Medicaid plan should be consistent with the allowable costs under the Medicare principles of reimbursement.

NRMC concurs with the MHA belief 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. Imposing these new and substantive reporting and auditing requirements would be very difficult to be done retroactively. I do not believe it is unreasonable for CMS to retroactively impose a rule that is very burdensome to small businesses such as rural hospitals. The state would have to apply a new standard to NRMC that is inconsistent with its current state plan and administrative rules. NRMC could not repay large 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 could impose a substantially large hardship on our hospital.

MHA recommends and NRMC concurs 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. The state has made adjustment prospectively due to the difficulties of matching state and hospital fiscal year ends. I do not see how it can be done without an additional audit that would tie the hospital costs to the state year-end versus hospital year-end. Our critical access hospital does not have the excess manpower and resources to accomplish this additional audit. I believe 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.

NRMC strongly agrees with MHA's following recommendations:

- **CSM deletes 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.**
- **CMS clarifies that states are allowed to continue to use reasonable estimating methodologies to determine uncompensated care costs.**

I request that CMS seriously considers the above stated recommendations on the proposed rule to implement the Medicaid DSH reporting and auditing requirements of the MMA. NRMC is not against measuring compliance with federal regulations, or to the plain meaning of the provisions of MMA. The proposed rule, as presently drafted, could negatively impact our facility over $300,000 from the last estimation on a 9 million dollar operation.

Please contact me with any questions or to further discuss my comments. I can be reached at 406-873-2251 or e-mail at nrmcomt@theglobal.net.

Sincerely,

Cherie Taylor
Chief Executive Officer

Submitter : Mr. Peters Willson **Date:** 10/24/2005

Organization : National Association of Children's Hospitals

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2198-P-26-Attach-1.DOC

Attachment #26

National Association of
Children's Hospitals

401 Wythe Street
Alexandria, VA 22314
(703)684-1355 Fax (703)684-1589

N • A • C • H •

October 24, 2005

Centers for Medicare and 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 Share Hospital Payments

Dear CMS:

On behalf of the National Association of Children's Hospitals (N.A.C.H.), 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).

N.A.C.H. represents more than 130 children's hospitals nationwide, including virtually all independent children's hospitals, as well as most children's hospitals within larger hospitals and medical centers. In almost all states, independent children's hospitals are among the leading DSH hospitals, in terms of the proportion of their patient care devoted to Medicaid recipients and uninsured patients. In addition, most children's hospitals within larger medical centers serve as the pediatric departments of the nation's leading medical centers, which are often major DSH providers. In fact, in many states, it is not unusual for a children's hospital to devote a larger proportion of its patient care to Medicaid assisted patients than any other hospital. On average, an independent children's hospital receives about $5 million annually in state Medicaid DSH payments; often this amount can be much higher.

DSH payments play such a large role in children's hospitals that they affect not only the hospitals' ability to serve low-income patients; they also affect their ability to serve all children, and, in turn, to touch the lives of virtually every child in the country. That is because of the extraordinarily large role children's hospitals play in the nation's pediatric health care infrastructure.

Although they represent less than 5 percent of all hospitals, children's hospitals—both independent and within larger institutions—provide more than 40 percent of all inpatient care to children and most of the inpatient care to children with serious medical conditions. They train the majority of the nation's

pediatricians and the large majority of its pediatric subspecialists, including pediatric researchers. They house the nation's premier pediatric research centers, and they are leading advocates for the public health and well-being of all children in their communities.

Independent children's hospitals alone—which represent only about one percent of all hospitals and are direct recipients of DSH payments—deliver about half of the nation's inpatient care required by very sick children and train nearly half of the nation's pediatric subspecialists.

N.A.C.H. Response

In response to CMS's invitation for comments, N.A.C.H. expresses concern with the proposed rule for the following reasons:

1) The proposed rule exceeds the statutory authority of the MMA. The proposed rule creates new reporting and auditing requirements that are not included in the MMA's authority. For example, under the proposed rule, the uncompensated care costs of providing physician services could not be considered in determining the hospital-specific DSH limit.

Also, the rule would require hospitals receiving DSH payments at or near their DSH limit to include Section 1011 payments, which HHS pays to hospitals for providing care to illegal aliens, in calculating their DSH limit. Neither of these provisions is required by the MMA, but they could significantly reduce DSH payments for children's hospitals. Furthermore, the proposed rule requires reporting of transfer payments and supplemental payments; this provision also is not mandated by the MMA.

2) Some of the provisions are unclear. The proposed rule includes provisions that children's hospitals find 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.

The MMA requires an annual certified public audit, but 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.

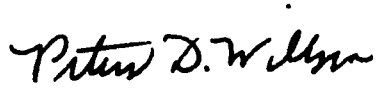
3) The auditing and reporting requirements are excessively burdensome to DSH hospitals. The proposed rule requires the state to report the number of non-duplicated Medicaid eligibles and uninsured receiving inpatient and outpatient health services, as well as total payments to hospitals from individuals with no source of third party coverage. These requirements would place an excessive burden on DSH hospitals that would have to provide this information.

In addition, the proposed rule applies new auditing and reporting requirements retroactively. Auditing and reporting requirements begin in state fiscal year 2005, which many states will be unable to meet because their fiscal year has already ended.

Also, the proposed rule requires that for each audited year DSH payments made for that year must be compared with the actual uncompensated care costs for the same year. However, states cannot determine the actual uncompensated care costs prior to or during the year that DSH payments are made.

We appreciate the opportunity to present our comments and would be pleased to discuss them further. For additional information, please contact me at 703/797-6006 or pwillson@nachri.org. Thank you for your consideration of our comments.

Sincerely,



Peters D. Willson
Vice President for Public Policy

Submitter : **Ms. Barbara Edwards** **Date: 10/24/2005**

Organization : **Ohio Department of Job and Family Services**

Category : **State Government**

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-2198-P-27-Attach-1.DOC

Bob Taft
Governor

Barbara Riley
Director

OHIO Job & Family SERVICES

30 East Broad Street • Columbus, Ohio 43215-3414
www.state.oh.us/odjfs

Attachment #27

October 25, 2005

To: Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services,
Department of Health and Human Services,
O. Box 8010, Baltimore, Maryland 21244-1850

From: Barbara Coulter Edwards, Deputy Director, Office of Ohio Health Plans
(Ohio Medicaid)

Attention: CMS-2198-P

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

The State of Ohio appreciates the opportunity to comment, and submits 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 (August 26, 2005).

The Medicaid DSH program provides essential financial assistance to Ohio hospitals that provide the disproportionate share of care to indigent Ohioans. The State of Ohio has operated it's DSH program over the last ten years with guidance from CMS through annual state plan approvals, where Ohio has consistently demonstrated its compliance with applicable DSH regulations, including instituting certified public auditor certifications of hospitals uncompensated care data, followed by the Ohio Auditor of State's annual single state audit of Ohio's DSH program. In addition, Ohio voluntarily designed and has for two years reported information suggested by MPDIMA, to CMS during the state plan approval process.

Ohio has numerous concerns with the proposed regulations and believes the regulations, as presently drafted, would place significant additional administrative/financial burdens on the state.

Ohio has four overriding concerns regarding the proposed rule: 1) the retroactive application of the auditing requirements to Fiscal Year 2005 and the requirement that state's conduct "independent certified audits"; 2) the substantive changes to standard DSH policy not required by the MMA - the definition of uncompensated care that excludes bad debt; 3) the reporting burden imposed on hospitals, which the state must collect and verify; and 4) Section 1011 (Preamble).

1. Auditing Requirements

Timing of Audits

Proposed Section 45.024 (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.

Comment: The proposed regulation 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 the state would have to retroactively identify some of the requested data. The regulation should be clarified to permit the required report to be based on a hospital's as-filed cost report, and time should be allowed for states to collect the additional data needed to meet the reporting requirements. For example, Ohio's SFY 2005 ended on June 30, 2005. Hospitals have already filed this years cost report, hence, the earliest Ohio can modify it's hospital cost report to capture information like Medicaid Managed Care payments or hospital revenues from uninsured individuals will be the SFY 2006 cost report, which are due to be filed, June 2006.

Audit Requirements

Proposed Section 455.201 requires that states obtain independent certified audits, ...

Comment: The proposed requirement for the independent certified audits is unduly burdensome. The State of Ohio has had in place for three years a requirement that hospitals submit certified public auditor certifications of hospitals uncompensated care data. This is followed by the Ohio Auditor of State's annual single state audit of Ohio's DSH program. This single state audit tests and verifies all of the elements that are currently required by our DSH state plan and state law requirements. To impose an additional layer of auditing at considerable expense to the state is unnecessary.

Reconciliation of DSH payment to same year uncompensated care costs

Proposed Section 455.204(c) requires DSH payments comply with the hospital specific DSH limit by requiring that DSH payments made in the audited SFY have to be measured against the actual uncompensated care costs in the same audited SFY. 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. It is important to note that the MMA does not require that payments be based on actual audited costs. The verification, through audit, of DSH payments with the same year actual uncompensated care costs will place an enormous burden on Ohio through new burdensome and costly audits and thereby increase our administrative costs. This policy is unnecessary, as Ohio's federal DSH allotments have resulted in total DSH funding that has consistently fallen short of Ohio's aggregate DSH limit by about $200 million in each of the past five years. For this reason, Ohio's DSH payments to hospitals are driven by the ratio of each hospitals provision of uncompensated care to the statewide provision of uncompensated care

2. Changes to Standard DSH Policy

Uncompensated Care

Proposed Section 42 C.F.R. 447.299(c) (15) provides, "Uncompensated care costs do not include bad debt for purposes of setting the hospital specific DSH limit".

Comment: This new definition of uncompensated care that excludes bad debt 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. Does an unpaid hospital bill by an uninsured patient which a hospital classifies as bad debt for financial accounting purposes not constitute an un-reimbursed cost from an uninsured individual per statute? In addition, CMS's 1994 letter to state Medicaid programs offered further guidance in the determination of un-reimbursed 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.

3. The Reporting Burden Imposed on Hospitals

Section 447.299 (c)(16) requires states to collect and indicate the total annual Unduplicated Patient Count of Medicaid Eligibiles and Uninsured Individuals served by hospitals.

Comment: This requirement leaves state's no choice but to again amend their hospital cost reports to capture this information (note timing issues outlined earlier), which in turn requires hospitals to produce these patient counts. We believe 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. This would also force hospitals to essentially create eligibility tracking systems. This further raises many questions as to 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, and how the state would verify the accuracy of hospital's reported information.

4. Section 1011 (Preamble) Federal Reimbursement For Emergency Health Services Furnished to Undocumented Aliens.

The preamble in the proposed regulation 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 and are actually federal payments. We would argue that 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 regulation places a reporting and verification requirement on the state for a federally administered program. We would suggest that CMS should offset Medicare DSH payments with these payments.

Ohio appreciates the opportunity to comment on the proposed regulation to implement the Medicare Modernization Act of 2003 Reporting and Auditing Requirements for the Medicaid Program's; Disproportionate Share Hospital Payment. If you have any questions or need further clarifications, please contact Ogbe Aideyman or Debbie Clement in the Bureau of Health Plan Policy at (614) 466-6420 or via email at aideyo@odjfs.state.oh.us or clemed@odjfs.state.oh.us.

Submitter : Mr. Gary Sherman **Date:** 10/24/2005

Organization : Missouri Department of Social Services

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

The Missouri Department of Social Services has reviewed the proposed rule for the Medicaid Program, Disproportionate Share Hospital Payments, 42 CFR Parts 447 and 455 published in the Federal Register, Volume 70, Number 165. We are pleased to offer the attached comments.

CMS-2198-P-28-Attach-1.DOC

MISSOURI
DEPARTMENT OF SOCIAL SERVICES

Matt Blunt
GOVERNOR

K. Gary Sherman
DIRECTOR

P. O. BOX 1527
BROADWAY STATE OFFICE BUILDING
JEFFERSON CITY
65102-1527
TELEPHONE: 573-751-4815, FAX: 573-751-3203

RELAY MISSOURI
for hearing and speech impaired
TEXT TELEPHONE
1-800-735-2966
VOICE
1-800-735-2466

October 20, 2005

Attachment #28

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

The Missouri Department of Social Services has reviewed the proposed rule for the Medicaid Program, Disproportionate Share Hospital Payments, 42 CFR Parts 447 and 455 published in the Federal Register, Volume 70, Number 165. We are pleased to offer the following comments.

A. Reporting Requirements

State of Missouri comments: Section 1001(d) of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 requires the following data to be reported to the Centers for Medicare and Medicaid Services (CMS): the identification of each disproportionate share hospital (DSH) receiving a payment adjustment; the amount of payment adjustment made to each hospital for the preceding fiscal year; and information necessary to ensure appropriateness of payment adjustments. The proposed 447.299(c) lists 16 items as additional reporting requirements. Items (c)(1) through (c)(5) identify each hospital. Item (c)(8) pertains to the payment adjustments to be reported. The other 10 items under (c) attempt to ensure appropriateness of payment adjustments.

The exhaustive list of data to be reported under (c), however, will be of little use without the methodology to show how the reported data yielded DSH payments. If states perform calculations with the requested data to determine DSH payments, why not discard (c)(6) through (c)(16), and instead request a copy of DSH payment calculations for all hospitals in a particular fiscal year? Each hospital's payment calculation could appear on separate pages or worksheets. If needed, states could highlight the items requested in (c)(6) through (c)(16) whenever they appear on the pages or worksheets. Putting the requested data in the context of a calculation should help CMS more quickly determine the appropriateness of payment adjustments, as required in the MMA, while simplifying the reporting requirements for the states.

In its description of Uncompensated Care Costs, the proposed 447.299(c)(15) concludes by stating "Uncompensated care costs do not include bad debt or payer discounts." Missouri disagrees with this categorization of bad debt. Missouri's state plan includes bad debt in uncompensated care costs that are eligible for DSH reimbursement. Missouri defines bad debt so that it is not confused with contractual adjustments, write-downs, or discounts. Missouri requests that the last sentence in (c)(15) be either deleted or modified so we may continue to include bad debts in uncompensated care costs.

In accordance with its state plan, Missouri uses hospital cost report data to determine prospective reimbursement. DSH payments made in state fiscal year (SFY) 2005, for example, were calculated from 2001 cost report data. This "lag" is necessary to allow providers time to submit their cost reports; to allow the state time to review, audit, and finalize the cost reports; and to permit the state to complete DSH payment calculations prior to the start of the fiscal year in which the payments are made.

We are not sure which FY 2005 data are being requested for this proposed rule - the data from 2005 cost reports or the data used to calculate 2005 DSH payments. If the former is being required, states will have two significant problems with compliance. First, most hospitals have a December 31 fiscal year end and states like Missouri who follow the Medicare cost report submission deadlines won't receive those cost reports until late May of the following year. States with a June 30 fiscal year end would only have 30 days to gather data for CMS from the December 31 cost reports. Second, demanding 2005 cost report data for SFY 2005 also means that most, if not all, of the cost report data forwarded to CMS will be as submitted by the hospitals because the states will not be able to review and audit the cost reports before the reporting deadline.

CMS' estimate of the time needed for the proposed 447.299(c) reporting requirements (Federal Register, Volume 70, Number 165, p. 50266) is another cause for concern. CMS admits the proposed requirements, on average, will require the equivalent of one full-time employee working nearly a whole week just to fulfill these new demands. Missouri has almost twice as many disproportionate share hospitals as the 75 per-state average, so we could look forward to one full-time employee spending about two weeks just on these new requirements. The estimated time needed to comply with the proposed reporting requirements is a signal that these requirements should be reconsidered for possible consolidations or deletions.

B. Audit Requirements

State of Missouri comments: The proposed 455.204(b) would require that Missouri's independent certified audit for its fiscal year ending June 30, 2005 be submitted to CMS by June 30, 2006. This strikes us as impossible to achieve. If this rule took effect immediately, Missouri would have less than nine months to: solicit bids for the audit and award the audit to an independent firm; help the audit firm to understand Missouri's DSH methodology so it could plan an audit; allow the firm sufficient time to review Missouri's methodology, gather data from the individual hospital cost reports, test the cost report data against DSH payment calculations, and form initial audit conclusions; meet with the firm to discuss its initial audit findings; and review the firm's report prior to submission to CMS. Since this rule won't take effect immediately, the audit deadline for SFY 2005 is even more onerous.

The proposed 455.204(c)(1) is interpreted to require that each hospital's uncompensated care cost be reduced for any DSH payments received. Rule 455.204(c)(2) is interpreted to require that each hospital's DSH payments not exceed its uncompensated care cost. Missouri understands that the (c)(1) and (c)(2) requirements are in response to specific provisions of Section 1001(d) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. The proposed requirements, however, are more confusing than clarifying. They ought to be consolidated into a single requirement that the independent audit certify that hospitals' DSH payments do not exceed their unreimbursed costs of services to Medicaid and uninsured patients.

Missouri hospitals submit audited financial statements along with their annual cost reports. The information in the cost reports comes from the hospitals' accounting systems that have been independently audited. The cost report data are first reviewed by independent auditors, and later reviewed by Missouri Medicaid auditors, before being used in DSH payment calculations. With respect to the data submitted by hospitals, the independent audit called for in the proposed 455.204 is a duplication of auditing effort even if the efforts of Missouri's auditors are not counted. We suggest that data submitted by a hospital which has had its own independent audit be considered "certified" for the independent audit requirements of this rule.

We appreciate the opportunity to comment on the proposed rule changes to 42 CFR Parts 447 and 455. Please contact Q. Michael Ditmore, M.D., Director, Division of Medical Services, at (573) 751-6922 if you have any questions.

Sincerely,

K. Gary Sherman
Director

KGS:pl

Submitter : Mr. Nick Hinch **Date:** 10/24/2005

Organization : Northern Rockies Medical Center

Category : Critical Access Hospital

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-2198-P-29-Attach-1.DOC

Northern Rockies Medical Center, Inc.
802 2nd St. SE
Cut Bank, MT 59427

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 impact on NRMC by limiting the *Disproportionate Share Hospital Payments* for 2005 through new definitions of uncompensated care.

Dr. McClellan:

Montana has 42 Critical Access Hospitals, including *Northern Rockies Medical Center*, located in rural settings and serving a smaller base of patients. The patients who utilize these hospitals travel many miles from small communities for their basic healthcare and emergency healthcare needs. In short, Montana is a very big state with a small population and a small number of hospitals. The smaller hospitals in this state have a hard time collecting enough payment from a poor population to keep the hospitals in business. These smaller organizations have become dependent on other sources of funding.

For the year 2004, *Northern Rockies Medical Center* received around $404,000 from the *Disproportionate Share Hospital Payments* program. The proposed changes to the program would limit the amount of disproportionate payment a hospital can receive at the amount of charity care a hospital has given. If the $350,000 we have conservatively budgeted for were to suddenly be capped at the amount of charity care we have given over the course of a year (charity care for the year is estimated to be around $133,000) it would be a severe blow. This blow would be enough to cause some Montana hospitals to close I believe.

It is mentioned twice in the proposed legislation that rule changes would not hurt small hospitals, but that is not the case in Montana. Most of the hospitals in Montana budget for and count on receiving this money. It would be unfair to remove bad debt from the *DSH* payment equation for all of 2005, when the proposed recommendation wasn't made until June of 2005. If this proposal were passed now, *Northern Rockies Medical Center* would not be given the opportunity to reduce bad debt and increase charity care for 2005, because much of 2005 has passed by.

Furthermore, *NRMC* currently lacks the ability to provide Medicaid with an unduplicated count of patients served that are Medicaid eligible or uninsured. It would not be entirely impossible to track this information in the future, but would be prohibitively time consuming and costly to determine this for prior periods of time.

Northern Rockies Medical Center has steadily increased the amount of charity care it has given over the last three years. FY2003's charity was $17,000, 2004 was $41,000, and 2005 is

projected to be $133,000. Charity is a priority for NRMC; however, it is limited by human resources that are directly related to financial resources available.

Sincerely,

Nick Hinch
Chief Financial Officer
(406) 873-2251 ex. 6819
nrmcfo@theglobal.net

Submitter :

Date: 10/25/2005

Organization :

Category : **State Government**

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter :

Date: 10/25/2005

Organization :

Category : **State Government**

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-2198-P-31-Attach-1.DOC

October 24, 2005

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

The State of Alaska DHSS (DHSS) submits the following additional comments on the proposed regulations implementing the disproportionate share hospital auditing and reporting regulations contained in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, 70 FR 50262 (Aug. 26, 2005).

A. Reporting Requirements

- Type of Hospital Ownership. Type of hospital ownership does not appear to be a standard addressed in relevant sections of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, or a factor for consideration in the determination of the propriety of Medicaid DSH payments. DHSS questions the need for this information in the context of these regulations.
- Medicaid Eligible and Uninsured Individuals. Proposed regulations would require states to "...indicate the total annual unduplicated number of Medicaid eligible individuals receiving inpatient and outpatient hospital services...". Identifying these Medicaid eligible individuals who have received services not covered by Medicaid has proven, in the Medicare DSH process, to be a very difficult, resource intensive, and subjective process since Medicaid is often not billed for Medicaid non-covered services. DHSS recommends that if CMS requires this type of information, it should require the information only for Medicaid covered services to Medicaid eligible individuals.

B. Audit Requirements

- Verification 1: DHSS interprets the CMS explanation of the requirement for verifying "The extent to which hospitals in the state have reduced their uncompensated care costs to reflect the total amount of payment adjustments under this section.", and the new 455.204(c)(1), to mean verifying that obligations of the qualifying DSH hospital to fund the non-Federal share of a DSH payment or any other Medicaid payment are not included as uncompensated care costs for purposes of the hospital-specific DSH limit, as described in your analysis. In order to make the requirement clearer to the federal government, state governments, and independent auditors, the regulation should clearly state the requirement is to verify that obligations of the qualifying DSH hospital to fund the non-Federal share of a DSH payment or any other Medicaid payment are

not included as uncompensated care costs for purposes of the hospital-specific DSH limit.

- Verification 2: CMS states that "...payments made in the audited State fiscal year (SFY) must be measured against the actual uncompensated care costs in that same audited SFY...". Due to circumstances particular to any individual state (budget/appropriation processes in particular) it may not be possible for the state to actually make payment during the specific SFY DSH period. DHSS recommends alternative language to the effect that "...payments related to the audited State fiscal year (SFY) must be measured against the actual uncompensated care costs in that same audited SFY...".

  The proposed regulations are not clear as to the required state procedures for making DSH payments during a SFY when the state has to audit facilities for that same SFY in order to make the DSH payment. Are states to perform a prospective Facility Specific Limit calculation to make the DSH payment and a retrospective calculation after the end of the SFY when facility information is audited and available to prove the estimate was correct? Would states then be required to recover excess DSH payments made under the estimate? DHSS recommends states be allowed to continue to utilize historical information to perform prospective DSH limit calculations.

- Verification 2 and Verification 3: Neither the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 nor the explanation provided with this Federal Register clearly state if the independent auditor is providing an opinion on whether the state's calculation formula includes "Only uncompensated care costs of furnishing inpatient and outpatient hospital services to Medicaid eligible individuals and individuals with no source of third party coverage...", or whether the intent is for the independent auditor to perform an in depth annual audit of the hospitals records and cost reports in order to verify the hospital reporting processes as well as audit the state's methodology. Requiring a separate independent audit of each hospital each state fiscal year, especially when hospital fiscal years many times do not match state fiscal years, seems unduly burdensome to the nation's healthcare system when state cost finding systems associated with Medicaid rate setting processes generally already have systems identifying hospital costs in approved state plans. Requiring 5,000 individual hospital audits nationwide based on state fiscal years, even at $30,000 per audit would require $150,000,000 in annual expenditures to meet a requirement to perform an independent audit of all hospitals. DHSS recommends that the requirement be to verify that the state's calculation formula provides for including only uncompensated care costs of furnishing inpatient and outpatient hospital services to Medicaid eligible individuals and individuals with no source of third party coverage.

  If an independent audit of each facility is required, would State Medicaid program auditors be considered independent to perform the hospital portion of the work?

- Verification 3: CMS states "The uncompensated care costs of providing physician services cannot be included in the calculation of hospital specific DSH limit." Alaska's tribal providers are many times paid for services through the use of Federal published per diem and encounter rates. These rates may include payment for physician costs. A strict ban on the inclusion of physician costs in the calculation of facility specific limits for tribal providers could unfairly limit authorized DSH payments if payment rates include physician payments, but allowed costs do not include physician costs. DHSS recommends CMS not implement a strict ban on the inclusion of physician costs in the calculation of uncompensated care costs.

Respectfully Submitted,

Jack Nielson
Alaska Department of Health and
Social Services
Office of Rate Review
PO Box 240249
Anchorage, AK 99524-0249

Submitter : Mr. James Fredyma **Date:** 10/25/2005

Organization : NH Dept. of Health and Human Services

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

See Attachment. The attached letter from Commissioner John A. Stephen, NH Department of Health and Human Services, offers comments about the proposed rule for reporting and auditing of disproportionate share hospitals.

CMS-2198-P-32-Attach-1.DOC

October 25, 2005

Attachment #32

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)

Submitter : **Ms. Ellen Kugler** **Date: 10/25/2005**

Organization : **National Association of Urban Hospitals**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2198-P-33-Attach-1.DOC

NATIONAL ASSOCIATION OF URBAN HOSPITALS

Private Safety-Net Hospitals Caring for Needy Communities

Attachment #33

October 25, 2005

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

Subject: File Code CMS-2198-P

To Whom it May Concern:

I am writing on behalf of the National Association of Urban Hospitals (NAUH) in response to the proposed regulation governing the reporting of Medicaid disproportionate share hospital payments (DSH) as proposed by the Centers for Medicare & Medicaid Services (CMS) on August 26, 2005 (File Code CMS-2198-P; *Federal Register*, Vol. 70, No. 165, p. 50262; 42 CFR Parts 447 and 455).

The following are comments that fall into four general categories: areas in which we respectfully disagree with the path that CMS has proposed; issues that we do not entirely understand, as presented in the proposed regulation, and that we believe would benefit from further clarification; data requested under the proposed regulation that we believe is unrelated to the calculation of Medicaid DSH payments and does not contribute to determining the accuracy or appropriateness of those payments; and technical matters that we hope will be considered before the regulation officially takes effect.

We address each of these categories individually below.

Areas of Disagreement

NAUH respectfully disagrees with the approach that CMS has proposed in five areas and requests that you consider our views on these issues of vital importance to urban safety-net hospitals.

The Use of Audits as an Enforcement Mechanism

NAUH wishes to express our disagreement with the manner in which the proposed regulation would employ audits to determine whether states are making their Medicaid DSH payments in appropriate amounts. While audits are excellent tools for measuring performance against clear, known standards, this approach appears to be relying on audits to introduce new standards. While Congress and CMS in the past have provided general guidelines for the calculation of Medicaid DSH payments and hospital-specific DSH payment limits, they have never developed and implemented specific formulas for such calculations and directed the states to use those formulas and only those formulas. As such, states have been free to exercise some discretion in the manner in which they calculate these figures.

21351 Gentry Drive • Suite 210 • Sterling, VA 20166 • (703) 444-0989 • Fax: (703) 444-3029
www.nauh.org

Now, it appears as if the proposed regulation is asking auditors to determine whether DSH is being calculated "correctly" by the states in a context in which there has never been a single, true, definitive definition of exactly what "correct" means. In other words, the regulation proposes counting on auditors to help impose a standard that does not currently exist. From NAUH's perspective, this appears to be the introduction of a new, definitive standard for calculating DSH payments and limits – a standard that we do not believe was mandated or authorized in the enabling legislation.

NAUH is concerned that the results of audits may be used to attempt to take back money from states and/or hospitals for failing to meet standards that they never knew existed. To be fair, neither the background information accompanying the regulation nor the regulation itself indicate how audit results will be used, but this understandably fuels our concern. The regulation is clear about the penalty for failing to provide audit results in a timely manner but is silent on the question of what happens if CMS looks unfavorably on the results themselves.

NAUH also is concerned that the reporting requirements, as stated in the proposed regulation, suggest that there is only one way to calculate DSH payments and hospital-specific DSH payment limits when, in reality, federal guidelines give states some leeway in making these calculations. NAUH is concerned that auditors will interpret their mandate very literally – too literally, we fear.

For these reasons, NAUH wishes to express its opposition to this aspect of the proposed regulation. While we recognize the need for audits, we believe that the audits should fulfill only the following three objectives: they should determine whether individual states are following their own formulas for the calculation of DSH payments and hospital-specific DSH payment limits; they should verify the accuracy of states' calculations; and they should determine whether individual states are making good-faith efforts to make those calculations in compliance with federal guidelines. NAUH also hopes that CMS will instruct auditors that there are, in fact, various ways for states to make these calculations while remaining in compliance with federal guidelines.

Use of Same Fiscal Periods for Costs and Payments

Many states make their Medicaid DSH payments prospectively, estimating current needs based on recent past experience. In a state that makes quarterly DSH payments, for example, the data used to calculate hospitals' first-quarter payments does not come from that quarter, or even the previous quarter, because it is nearly impossible to collect and compute such data in such a short period of time. Consequently, DSH payments and hospital-specific DSH payment limits often are calculated with data that can be more than a year old. Requiring DSH payments to correspond to data from that same year, and calculating individual hospitals' DSH payment limits in the same manner, would be practically impossible and extremely burdensome for both the states and hospitals.

Currently, there is no law requiring that DSH payments made in a fiscal year correspond to costs from that same fiscal year, nor does the Medicare Modernization Act of 2003 call for such a requirement. For these reasons, NAUH opposes the proposed regulation's provision calling for this change in Medicaid DSH policy and respectfully requests that CMS allow states to make good-faith efforts to estimate hospital-specific DSH payment limits so long as states are using the most recently available data. This modification to the proposed approach would help prevent situations in which states would need to attempt to take back past DSH payments to hospitals – a situation that would be especially burdensome for the very kinds of hospitals that DSH payments are intended to help.

Bad Debt and the Definition of "Uncompensated Care Costs"

NAUH disagrees with how one portion of the proposed regulation defines "uncompensated care costs" – and with its exclusion of bad debt as a type of uncompensated care.

Specifically, §447.299(c)(15) states that:

> The total annual uncompensated care cost equals the total cost of care for furnishing inpatient hospital services to Medicaid eligible individuals and to individuals with no source of third party coverage for the hospitals services they receive less the sum of regular Medicaid rate payments, Medicaid managed care organization payments, supplemental/enhanced Medicaid payments, and indigent care revenue. **Uncompensated care costs do not include bad debt or paper discounts**. (emphasis added)

NAUH urges CMS to remove the reference to "bad debt" in this definition. Bad debt, in our view, is virtually indistinguishable from charity care: it arises when patients cannot afford to pay for medically necessary services for which they are not insured. This can be because the patient is medically indigent; has health insurance that does not cover the service in question; or cannot afford a required co-payment or deductible. Such costs, when incurred by hospitals, are truly "uncompensated care costs."

We believe that a definition of "uncompensated care costs" that does not encompass bad debt is inconsistent with the statute, the legislative history, and long-standing federal practice. This view is supported by language in the Omnibus Budget Reconciliation Act of 1993 conference report as well as by the Health Care Financing Agency's 1994 written guidance to state Medicaid agencies – guidance reaffirmed by CMS in 2002. Based on this history and this guidance, many states now include bad debt in their uncompensated care costs, and changing the federal position on this matter could cause significant financial problems for state Medicaid programs and countless DSH hospitals.

Third-Party Coverage

NAUH is concerned that the regulation lacks a clear and appropriate definition of "third-party coverage." In particular, we believe that third-party coverage should explicitly be defined in a manner that makes clear that third-party coverage does not include state and local programs to pay for care for indigent and uninsured individuals and that "lack of third-party coverage" also encompasses patients who lack coverage for the service provided, not necessarily any coverage at all. Among those who lack such coverage are patients who are medically indigent, patients whose health insurance does not cover the medical service or services in question, and patients who have insurance but cannot afford their co-pays or deductibles. While some may attempt to differentiate this "bad debt" from other forms of uncompensated care, their origins are the same: an inability to afford to make the payment in question. NAUH believes that in this context, uncompensated care and bad debt are indistinguishable and actually are one and the same and that a more explicit definition of "third-party coverage" in this regulation would clarify and reinforce this very important point.

Section 1011 Payments

Section 1011 payments are available to hospitals that provide significant amounts of emergency care to uninsured, undocumented residents. They were created to reflect the federal government's recognition that some hospitals, because of where they are located, shoulder an unusual burden in caring for uninsured, undocumented residents. When the legislation authorizing §1011 payments was

enacted and the regulations needed to implement the program were first issued, there was a good deal of public discussion about whether §1011 funds would count against hospitals' individual DSH payment limits. During this discussion, members of Congress indicated that they did not believe it should count against those limits.

Under the regulation now proposed, however, §1011 payments would count against hospitals that are at or near their hospital-specific DSH payment limits, neutralizing the effect of the §1011 funds. NAUH respectfully requests that CMS reconsider this approach.

Technical Issues

In the course of reviewing the proposed regulation, NAUH has identified several technical issues that we hope CMS will address in the final, official version of the regulation.

Definition of "Uncompensated Care Costs"

NAUH believes that different parts of the regulation define "uncompensated care costs" differently.

Specifically, §447.299(c)(15) states that:

> The total annual uncompensated care cost equals the total cost of care for furnishing inpatient hospital services to Medicaid eligible individuals and to individuals with no source of third party coverage for the hospitals services they receive less the sum of regular Medicaid rate payments, Medicaid managed care organization payments, supplemental/enhanced Medicaid payments, and indigent care revenue. Uncompensated care costs do not include bad debt or paper discounts.

In contrast, §455.204(c), describing the audit requirement, states that the audit must verify that:

> Each hospital that qualifies for a DSH payment in the State 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.

NAUH believes these definitions of "uncompensated care costs" are contradictory and should be modified to make them more consistent. We also believe that the definition in §455.204(c) is very complicated and could easily be misinterpreted. For these reasons, we recommend that in the §455.204(c) definition, the words "has reduced" be replaced with "does not receive total DSH payments in excess of." In addition, we recommend that the §455.204(c) sentence cited above should end with the phrase "coverage for the services" and that the phrase "in order to reflect the total amount of claimed DSH expenditures" be eliminated. These changes, NAUH believes, would eliminate the contradiction between the two definitions, make them more compatible, and more

accurately reflect the intent of the statute. (As noted earlier in this letter, NAUH also recommends that CMS remove the reference to "bad debt" in the 447.299(c)(15) definition.)

Definition of "Low Income Utilization Rate"

According to §1923(b) of the Social Security Act, the low income utilization rate is the sum of two ratios:

1. $\frac{\text{Total Medicaid revenue + cash subsidies from state and local governments}}{\text{total revenue for patient services}}$

2. $\frac{\text{charity care charges-certain related cash subsidies}}{\text{total inpatient charges}}$

The proposed regulation, however, states that the low income utilization rate only includes uninsured individuals who do not have third-party coverage for hospital services. NAUH believes that the low income utilization rate is clearly defined in §1923(b) of the Social Security Act and that this proposed regulation should use that same definition.

NAUH believes that the second sentence in §447.299(c)(7) ("The low income utilization rate calculation only includes individuals that have no source of third party coverage for the inpatient and/or outpatient hospital services they receive") is inaccurate and hopes it will be deleted in the final version of the regulation.

Physician Services

The background section of the proposed regulation states that physician services do not count as hospital costs. NAUH believes that certain physician services, such as clinic services, currently do count toward hospitals' costs and that they should continue to do so.

Citation

The proposed §447.299(c)(8) reads as follows:

> Disproportionate Share Payments. Indicate total annual payment adjustments made to the hospital under §1923(g).

Section 1923(g) refers to the hospital-specific DSH payment limit and does not provide for payment adjustments; we believe that the citation should be to the entire §1923, not to this subsection.

Requested Data That is Unrelated to DSH Reporting

NAUH believes that in certain areas, the proposed regulation calls for states to provide data that is unrelated to CMS's need to determine the appropriateness of DSH payments to hospitals. Below is a brief summary of the data elements in question.

- *Annual unduplicated number of Medicaid and uninsured patients receiving treatment.* We do not believe these figures are needed to determine the appropriateness of DSH payments. In addition, collecting this data would be extremely burdensome for hospitals.
- *Transfer money.* In NAUH's view, transfer money has nothing to do with the appropriateness of Medicaid DSH payments to hospitals.
- *"Regular Medicaid payments" and "Medicaid managed care organization payments" and "enhanced/supplemental Medicaid payments."* While we recognize the importance of the sum of these three figures in determining hospital eligibility for Medicaid DSH payments and in calculating the hospital-specific limits for such payments, we do not understand why these figures need to be reported separately because those separate figures, in and of themselves, do not contribute to CMS's ability to determine the appropriateness of DSH payments.

Issues That Would Benefit From Additional Clarification

NAUH believes that selected aspects of the proposed regulation would benefit from further explanation and clarification. We outline these issues below.

- *Audit outcomes.* As noted previously, the proposed regulation states the penalty for failure to provide the required information by the stipulated deadline but does not address the question of how CMS intends to use the data that it collects. How will this data affect the distribution of Medicaid funds to the states? If CMS is unhappy with the information gathered in the audits, will it attempt to take money back from the states? Will it require the states to take Medicaid DSH funds back from hospitals? While we recognize that it is possible that these questions have not been addressed because this is not part of CMS's plans, NAUH hopes that CMS can elaborate on its intentions and clarify them for the hospital community.
- *"Regular Medicaid payments."* This is a new term that would benefit from more explicit definition. Does it refer only to Medicaid fee-for-service payments or does it have other applications as well?
- *"Regular Medicaid payments" and "Medicaid managed care organization payments."* We do not understand, based on the proposed regulation, whether these categories are mutually exclusive.
- *"Supplemental and enhanced Medicaid payments."* The regulation does not specifically define these terms, leaving them subject to interpretation. In addition to increasing the likelihood of discrepancies in how different states and even different hospitals choose to define these terms, this lack of specificity also may increase the likelihood that hospitals and states will be held accountable, in a potentially damaging way, for failing to define the term as the regulation's authors envisioned.
- *Medicaid waiver programs.* The proposed regulation does not address how states that operate their Medicaid programs under federal waivers would do their Medicaid DSH reporting. Some of the requirements delineated in the regulation are irrelevant to some of these states, leaving a potential gap in understanding in these places.

About the National Association of Urban Hospitals

The National Association of Urban Hospitals (NAUH) advocates for adequate recognition and financing of private, non-profit, urban safety-net hospitals that serve America's needy urban communities. These private, urban safety-net hospitals differ from other hospitals in a number of key ways: they serve communities whose residents are much older and poorer; they are far more reliant on Medicare and Medicaid for revenue; they provide far more uncompensated care; and unlike public safety-net hospitals, they have no statutory entitlement to local or state funds to underwrite their costs.

NAUH's role is to ensure that when federal officials make policy decisions, they understand the implications of those decisions for these distinctive private, urban safety-net hospitals. NAUH pursues its mission through a combination of vigorous, informed advocacy, data-driven positions, and an energetic membership with a clear stake in the outcome of public policy debates.

* * *

We appreciate your attention to the issues raised above and welcome any questions you may have about any of these matters. Please feel free to contact me for further information at 703-444-0989.

Sincerely,

Ellen Kugler, Esq.
Executive Director

Submitter : Mr. James Kirkpatrick **Date:** 10/25/2005

Organization : Massachusetts Hospital Association

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

Please find attached comments on Medicaid DSH rule.

CMS-2198-P-34-Attach-1.DOC

MHA

Massachusetts Hospital
Association

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 Massachusetts Hospital Association (MHA), on behalf of our member hospitals and health care systems, offers these comments 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 are concerned that the proposed rule goes beyond Congressional intent and we are certain that Massachusetts hospitals would be negatively impacted. MHA respectfully requests that CMS withdraw this proposed rule and reconsider the intentions of Medicaid DSH reporting requirements found in the MMA as well as the consequences of modifying this essential financial mechanism for care provided to low-income and uninsured patients.

MHA finds it troubling that CMS has elected to make substantial changes to national DSH policy not required by the MMA but under its banner. The only reference to new rules governing the Medicaid DSH program found in the MMA relate to increased reporting and an independent certified audit. We are very concerned that CMS has used this platform to dramatically change the financing of the Medicaid DSH program that would have serious implications for hospitals that care for the low-income and uninsured. While we are open to increased transparency on the funds associated with this care in order to ensure that state governments and hospitals comply with federal law, we must object to the unwarranted dramatic changes.

MHA is particularly concerned with CMS's decision to redefine hospital uncompensated care. Besides our underlying belief that CMS has overstepped its mandate, we do not agree with proposed redefined terms of uncompensated care. With regards to bad debt, this new definition is inconsistent with the statute and long-standing agency policy. It also does not recognize the reality that many patients do not pay or cannot afford to pay for their care and therefore the hospital is not compensated for those services. In order to remain viable, hospitals make every effort to collect payments from patients, insurers, and other sources including state and federal governments. This effort is an exhaustive and expensive process but one that hospitals remain

committed to since it is critical to the fulfillment of their mission. At the end of day, however, many services will go unpaid for, especially by those who have limited resources. Congress has recognized this reality and through statute established the DSH program to alleviate this burden. Medicaid DSH statute clearly permits the inclusion of the costs of services provided to individuals with no health insurance. CMS through its letters and rules has also maintained that costs associated with patients who do not pay or whose insurance coverage does not reimburse is uncompensated care qualifying for DSH. MHA requests that the proposed exclusion of bad debt from hospital uncompensated care be retracted.

The new rule also proposes to redefine hospital uncompensated care so that it does not include physician services. Again, while we believe CMS has overstepped its mandate in the MMA, we also object to this new definition. Though uncompensated care costs are restricted to inpatient and outpatient hospital services, physician services that are on a hospital license are indeed hospital services and should not to be confused with physician services provided in a physician's office. Federal Medicaid regulations clearly states that the services in question are indeed hospital services. 42 CFR § 440.10 and 440.20 define inpatient and outpatient hospital services, respectively, as services that are furnished to inpatient and outpatients and that "(2) are furnished by or under the direction of a physician or dentist;". To no longer recognize these physician services as hospital services would be the opposite of reality. Even Medicare recognizes these physician services as *hospital* services. MHA requests that the proposed exclusion of physician services from hospital uncompensated care be retracted.

MHA is also concerned with the added burden that these new rules would impose on hospitals. We ask that the CMS be mindful of the additional financial costs that hospitals would incur and compensate hospitals accordingly. Further, we believe it is not feasible without major increases in administrative burden to expect retrospective review under new rules of costs incurred and reported prior to adoption and publication of those rules. Therefore we urge CMS to move forward with the MMA requirement of independent audits on the current and future years rather than retrospective application. Many hospitals that receive DSH funding are financially fragile and every dollar and resource allocation counts in their mission to run a healthy and stable hospital.

MHA appreciates the opportunity to comment on the proposed rule to implement the Medicaid DSH reporting and auditing requirements of the MMA. The Medicaid DSH program is a critical support mechanism to our safety net hospitals and we hope that major policy changes are done cautiously and reasonably. While we are open to transparency with this program to protect its credibility, we hope that CMS will reconsider its proposed policies that we believe go beyond Congressional intent and will negatively impact hospitals and low-income and uninsured patients.

Sincerely,

James T. Kirkpatrick

Submitter : Mr. Tim Burgess **Date:** 10/25/2005

Organization : Georgia Department of Community Health

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2198-P-35-Attach-1.DOC

GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

Tim Burgess, Commissioner

Sonny Perdue, Governor

2 Peachtree Street, NW
Atlanta, GA 30303-3159
www.dch.georgia.gov

Attachment #35

October 25, 2005

Mark B. McClellan, M.D., Ph. D.
Administrator, Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Subject: CMS-2198-P

Dear Dr. McClellan:

The Georgia Department of Community Health administers our state's Medicaid program, and our agency welcomes the opportunity to comment on the proposed rule regarding Medicaid Disproportionate Share Hospital (DSH) Payments. The continued availability of DSH funding is an extremely important factor in our efforts to assure access to medically necessary services for Georgians with limited financial resources. We commend the Centers for Medicare & Medicaid Services (CMS) for this public effort to clarify your agency's expectations for states to access these needed funds.

In presenting our comments for the proposed rule, the following information provides a brief description of an item followed by our agency's recommendation:

1. Type of hospital – The proposed rule states: "The State would indicate if the hospital is an acute, long-term care, psychiatric, teaching, children's, rehabilitation or other facility.

   Comment – It is possible that an individual hospital could be classified in multiple categories; for example, a hospital could be considered both an acute care hospital and a teaching hospital. CMS should clarify whether a State should identify all categories that may be applicable for a hospital or, if not, whether there are any expectations regarding the single category that may be selected."

2. Type of ownership – The proposed rule states: "The State would indicate whether the hospital is a privately-owned, State government-owned, non-State government owned or a facility owned by the Indian Health Service or a tribal government. The State would also indicate whether the hospital is privately operated, State government operated, non-State government operated or a facility operated by the Indian Health Service, or a tribal government."

   Comment – CMS should clarify that it acceptable for the State to report for this item based on information available at the time of submittal. From ongoing discussions with CMS representatives, the Department understands that CMS is currently considering guidelines regarding the identification of non-State government owned facilities; depending on the outcome of such a process, changes in the classification of a facility could occur. Because the provider classification is an important consideration for both DSH and potential Upper Payment

Limit policies, the Department would also encourage CMS to allow for public comment before finalizing its reporting expectations regarding type of ownership.

3. Reporting of Medicaid rate payments and Medicaid managed care organization payments

   Comment - The proposed rule requires that a State report the payment elements that can be used to determine each hospital's DSH limit payment. In order to avoid undue delays in disbursing needed DSH funds on a timely basis, it should be acceptable for a State to identify the Medicaid payment amounts based on data collected for a recent prior period, with appropriate adjustments for expected changes between the data collection period and the DSH reporting period. CMS should clarify that such a practice would be acceptable. In the absence of such a clarification, in order to obtain an acceptable audit opinion for its DSH report, a State might be required to wait for an extended period after a fiscal year ends to determine allowable payment amounts. Such a delay would cause extreme and unnecessary financial distress for DSH hospitals.

4. Reporting of indigent care revenue

   Comment – The CMS description for this data element states that a State should report the amount of payments received from individuals with no source of third party payments. It would avoid misunderstanding if CMS clarified whether the required data element refers to gross revenue (full charges for services) or net revenue (expected collections after revenue adjustments.) Also, CMS should clarify why the data element is limited to services provided for uninsured patients only. Many Georgia hospitals provide indigent care or charity care to patients who may have limited third party coverage, so CMS should address its basis for its interest in services provided to uninsured patients only, without regard to the patient's indigency status. CMS should clarify whether the required data element refers to services provided to patients whose third party coverage makes no payment to the hospital; for example, the patient may have exhausted benefits coverage, the hospital may have failed to properly bill for the service, or the service provided may not be a covered benefit. Finally, CMS should clarify that it is acceptable to report data for a recent prior period, with appropriate adjustments for expected changes between the data collection period and the DSH reporting period.

5. Medicaid eligible and uninsured patients

   Comment – There has not previously been a reporting requirement for a State or DSH hospital to identify the unduplicated number of Medicaid patients and uninsured patients that received services from a DSH hospital. In order to allow sufficient time for reporting procedures to be developed so that accurate data can be obtained, if this data element should be necessary, it should not be required until a fiscal year that begins after the proposed rule is finalized. Also, similar to the preceding items, CMS should clarify that it is acceptable to report data for a recent prior period, with appropriate adjustments for expected changes between the data collection period and the DSH reporting period.

6. Audit Requirement Verification 3, Physician Services

   The proposed rule states: "The uncompensated care costs of providing physician services cannot be included in the calculation of hospital-specific DSH limit." In meeting EMTALA

obligations or when responding to the needs of their communities by providing services to patients without regard for the patients' financial resources, hospitals can incur costs for required physician services and other medical needs, such as pharmacy costs, that might not be meet a limited definition of hospital services. Rather than attempting to clarify precise limitations, CMS should consider expanding the definition of DSH-limit services to include all costs that a hospital incurs in providing services to uninsured patients.

7. Audit Requirement Verification 5, Documentation

   Comment (with underlining added for emphasis) – Section 1923(j)(2)(E) states that an independent audit should verify that: "The State has separately documented and retained a record of all of **its** costs under this title, claimed expenditures under this title, uninsured costs in determining payment adjustments under this section, and any payments made on behalf of the uninsured from payment adjustments under this section." By contrast, the proposed rule appears to have greatly expanded the required scope by requiring that: "The State has collected, documented and is retaining appropriate documentation for its DSH limit calculation and payments to the qualified hospital." Particularly with regard to services to uninsured patients or some components of cost of care calculations, DSH limit calculations are dependent on hospital-reported data that a Medicaid program would not otherwise have available. The proposed rule requiring a State to retain appropriate documentation could possibly be interpreted to make the State responsible for retaining documentation of patient-specific data. Assuming that CMS does not intend to place such a reporting burden on the states, CMS should clarify that the documentation requirement for hospital-reported data is limited to collecting, documenting and retaining State data and does not include documentation for data that a hospital might otherwise have available.

8. Audit Requirement Verification 5, Methodology

   Comment (with underlining added for emphasis) – The proposed rule presents a requirement that: "The audit report include a determination that each State employs an appropriate methodology for calculating the hospital-specific DSH limit." A determination of appropriateness is exceedingly broad and may be subject to individual judgments. The vagueness of the term may also make it difficult for an independent auditor to provide an opinion. As an alternative, and assuming that all other requirements will be clearly defined, the Department recommends that CMS consider an alternative that a State employs a methodology for calculating the hospital-specific DSH limit that is permissible under federal rules.

If you should have any questions about these comments or should need any clarification, please contact Ms. Carie Summers, Chief Financial Officer, at (404) 657-4859 or at csummers@dch.state.ga.us.

Sincerely,
Tim Burgess

Submitter : Mr. Lloyd Myers **Date:** 10/25/2005

Organization : Greenville Hospital System

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2198-P-36-Attach-1.DOC

GREENVILLE HOSPITAL SYSTEM
UNIVERSITY MEDICAL CENTER

October 25, 2005

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

Re: C MS-2198-P; M edicaid P rogram; D isproportionate S hare H ospital P ayments - - Implementing the Medicare Modernization Act of 2003 Reporting and Auditing Requirements; Proposed Rule.

Dear Dr. McClellan:

Thank you for the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) proposed rule implementing the Medicaid Disproportionate Share Hospital (DSH) Payment reporting and auditing requirements found in the Medicare Modernization Act of 2003 (MMA). I am the Manager of Reimbursement for Greenville Hospital System (GHS) located in Greenville, South Carolina. Our largest hospital, Greenville Hospital Center (Medicare Provider Number 42-0078) is one of many hospitals in the nation which serve as a safety net hospital for the poor, disabled, and elderly population. We at GHS have many concerns with this proposed rule. We believe that this rule could have a significant negative impact on Greenville Hospital Center, as well as all of the hospitals in our system.

We are primarily concerned with four aspects of the proposed rule: 1. the exclusion of bad debts from the definition of uncompensated care, 2. the provision to require the offset of Section 1011 payments when calculating the DSH limit, 3. the requirement for reporting of unduplicated patient count of Medicaid eligible and uninsured patients, and 4. the retroactive application of audit requirements to each state's fiscal year 2005. Our specific concerns with each enumerated area are outlined below:

1. Exclusion of Bad Debts (42 CFR 447.299 (c) (15)

The proposed rule, states that uncompensated care should not include bad debt for purposes of setting the hospital specific DSH limit. With the proposed language as it is written, hospitals would not be allowed to include the costs related to patients who have no insurance, but whose balances end up in bad debts because they do not qualify for charity. We believe such a change would be an irresponsible shift of the costs of caring for uninsured patients to the hospitals. A significant portion of the DSH payments for our hospitals relates to charges for uninsured patients that end up in bad debts. It is hard to believe that CMS is even considering not allowing hospitals to include bad debts related to uninsured individuals.

The effect of this exclusion on our system would be disastrous. In effect, GHS would lose DSH reimbursement for a significant portion of its uninsured population, retaining it only for the portion qualifying for charity. On the most recent DSH calculations which our System submitted to the state, a large portion of the uninsured charges used in calculating our DSH payments related to patients who have no insurance but do not qualify for charity. Much of the charges included in this category end up in bad debt status. CMS's proposal, as it currently reads would cause us to lose reimbursement for the costs related to these charges.

We believe that this new definition is not consistent with the underlying statute governing DSH payments. The Social Security Act, 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. By proposing to exclude bad debts, CMS is effectively attempting to shut off DSH reimbursement for a significant portion of the population fitting the description of "...individuals with no health insurance or other source of third party coverage." This provision will be harmful to DSH hospitals that are charged with meeting the health care needs of the uninsured population in their communities and it would be contrary to the intent of Congress. **We strongly recommend that CMS change the language in the proposed rule to eliminate the reference to excluding bad debts in 42 CFR 447.299 (c)(15).**

2. Offset of Section 1011 Payments (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. When Congress enacted Section 1011, it intended to create a new source of funding for the cost of caring for undocumented aliens, not to replace already existing DSH funding. There is no requirement in the statute to consider Section 1011 payments when determining a hospital's uncompensated care costs. This requirement would result in a reduction of much needed DSH dollars to hospitals that serve a high number of uninsured undocumented aliens. **We recommend that CMS remove from the preamble the requirement to offset Section 1011 payments when establishing a hospital's DSH**

limit. Furthermore, CMS should add language that states that Section 1011 payments should in no way be a part of the calculation of DSH limits.

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

As part of this proposed rule, State Medicaid programs are required to report for each hospital an unduplicated count of Medicaid eligible and uninsured patients. The states will doubtless ask the hospitals to supply this information. We have concerns as to how we would go about obtaining this information. It is not clear how we are to count patients who are eligible for Medicaid but who have third party insurance – should these patients be included in this count? We do not understand why this information is necessary. There will be a significant additional burden placed upon us to provide this information to the State. **We recommend that this requirement be deleted from the proposed rule.**

4. Retroactive Audit to Each State's Fiscal Year 2005 (42 C.F.R. 455.204(b))

The proposed rule retroactively applies the new reporting and auditing requirements to each state's FY 2005. This is an unreasonable provision, given that most state fiscal years for 2005 have ended. The reporting and auditing requirements of this proposed rule are not insignificant and to apply them retroactively is completely unnecessary and will create an undue burden on states and hospitals alike. The MMA required that CMS impose reporting and auditing requirements beginning in fiscal year 2004; however, CMS has delayed beyond that implementation date and would now penalize hospitals for its delay. **We recommend that the reporting and auditing requirements be applied prospectively, beginning with the first state fiscal year beginning after the finalization of the rule.**

I appreciate this opportunity to comment on the proposed rule to implement the Medicaid DSH reporting and auditing requirements of the MMA. Greenville Hospital System depends on Medicaid DSH money to enable it to provide for the health care needs of the most vulnerable portion of the population in our community. The proposed rule, as presently drafted, will have a significantly negative financial impact on our system as well as placing a significant administrative burden on our system. Please give careful consideration to these comments in drafting the final rule. Again, thank you for the opportunity to provide input. If you have any questions, give me a call at 864-454-2484.

Sincerely,

Lloyd E. Myers, Jr.
Manager of Reimbursement

Submitter : Ms. Kathryn Kuhmerker **Date:** 10/25/2005

Organization : NYS Department of Health, Medicaid Mgmt

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

See attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter : Mr. Tommy Cockrell **Date:** 10/25/2005

Organization : SC Hospital Association

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2198-P-38-Attach-1.DOC

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 its ninety plus member hospitals, the South Carolina Hospital Association (SCHA) 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 South Carolina Medicaid DSH program provides essential financial assistance to our state's hospitals that treat a disproportionate share of poor, disabled and elderly population groups in South Carolina. The SCHA has numerous concerns with the presently drafted rule and believes it would have a significant negative impact on Medicaid DSH hospitals.

A. 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. 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. In addition, 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. The proposed definition of uncompensated costs is inconsistent with long-standing Federal and State policy.

SCHA recommends the definition of uncompensated care as proposed by the AHA to include:

- **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 their health plans exclusions, limits or deductibles.**

B. 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. SCHA believes that Congressional intent when enacting Section 1011 payments was to provide additional sources of funding – not replacement of existing funds – for hospitals providing large volumes of uncompensated care services to undocumented immigrants. Requiring state Medicaid programs to consider the Section 1011 payments places an additional burden on already financially strained hospitals that are providing services to this population group.

> **SCHA recommends that CMS delete the language that requires States to offset Section 1011 payments when establishing a hospital's Disproportionate Share limit.**

C. 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 SCHA 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 in 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 SCHA recommends that this unnecessary and burdensome reporting requirement be deleted.**

D. 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. Again, should this cost be passed on to already financially burdened hospitals, this will adversely impact the hospital's ability to provide needed services to the poor, disabled and elderly populations.

> **The SCHA recommends that CMS state affirmatively that the cost of the audits should not be passed on to hospitals.**

In addition to the general comments above regarding the cost of the audit process, SCHA also expresses concern over several other provisions:

1. Definition of Independent Certified Audit: **SCHA recommends that state Medicaid programs be allowed to use GAAP standards in the independent audit process.**

2. Retroactive Audit: The proposed rule retroactively applies the new reporting and auditing requirements to each state's fiscal year 2005. South Carolina's state fiscal year ended June 30, 2005. To impose retroactive reporting now, of yet to be determined final rules, will make it terribly burdensome on hospitals and state Medicaid programs to comply. **SCHA recommends that retroactive implementation of the reporting and auditing requirements be deleted from the proposed rule. Any new reporting and auditing requirements should be linked to the first full state fiscal year following the finalization of the rule.**

3. Same Year Actual Costs: The South Carolina Medicaid program uses a prospective payment methodology to estimate current year uncompensated care costs. The verification, through an audit process, of DSH payments with the same year actual uncompensated care costs will place another undue burden on hospitals and the South Carolina Medicaid program. **SCHA recommends CMS delete the requirement in the proposed rule that audited DSH payments must be measured against actual uncompensated care costs in the same audited state fiscal year.**

Again, the South Carolina Hospital Association appreciates the opportunity to comment on the proposed rule regarding Medicaid DSH reporting and auditing requirements. As previously noted, the Medicaid DSH program provides essential financial assistance to South Carolina hospitals treating the most vulnerable population groups. The proposed rule as currently drafted will have a significant adverse financial impact on these hospitals.

Please feel free to contact me at 803-744-3510 or tcockrell@scha.org should there be questions.

Sincerely,

Thomas D. Cockrell, FHFMA
Vice President

Submitter : Mr. Jason Jorkasky **Date:** 10/25/2005

Organization : Michigan Medical Services Administration

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2198-P-39-Attach-1.DOC

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
Medical Services Administration

MEMORANDUM

To: Centers for Medicare & Medicaid Services **Date:** October 20, 2005

From: Paul Reinhart, Director
Medical Services Administration
Michigan Department of Community Health

Re: Proposed rule; Disporportionate Share Hospital Payments
CMS-2198-P

The State of Michigan would like to thank you for providing the opportunity to review and respond to the proposed Disproportionate Share Hospital regulations implementing reporting and auditing requirements, issued on August 26, 2005, and found at the Federal Register, Volume 70, Number 165, 50262. Please find our comments, questions and requests for clarification below.

General Comments

1. The proposed regulations are effective for SFY 2005; however, the proposed regulations were not issued until August 26, 2005, and comments are not due until October 25, 2005, well after the end of SFY 2005 for most, if not all, states. The DSH regulations should be effective prospectively, covering the first full SFY following issuance of the final DSH regulations, so that all states have time to review, understand, and comply with the final regulations.

2. If states are not found to be in compliance with all verifications required as part of the audit (§455.204 (c)), what action will be taken against the states?

3. Most of the requirements outlined in the proposed regulations require data that will be obtained from the hospital cost reports. Will the states be responsible for completing audits of individual hospital cost report data prior to completing the DSH report?

4. If an individual has an ambulatory benefit, but does not have an inpatient benefit, this individual should be considered uninsured when inpatient hospital treatment is provided. The costs a hospital incurs for the provision of care to these individuals should be included in determining the cost of uncompensated care. Please provide a definition of what is considered uninsured and what constitutes 3rd party coverage.

5. As noted, Michigan strongly opposes an interpretation of the law that would require retrospective calculation of DSH limits. However, if CMS takes the untenable position that states cannot continue their legal and legitimate prospective calculation of DSH limits,

then states will have serious problems implementing the audit requirements outlined in the federal register. This can be demonstrated in two specific ways. First, the proposed regulations indicate that states are required to submit their report and audit information to CMS within one year of the end of the measured SFY. Hospital cost reports would be the most accurate source for the data reporting requirements. These reports will not be available in time to complete the audit requirements within the specified one year time period. Secondly, all hospitals do not share the same fiscal year begin and end dates as the state, and therefore would contain data for different fiscal periods within the audited SFY.

Reporting Requirements

6. According to §447.299 (c)(15), uncompensated care costs should not include bad debt or payer discounts. It is often difficult to distinguish between bad debt and charity care. The situation of an individual who is believed to have insurance upon admission to a hospital but who is later found to be uninsured will often be carried as bad debt. There are also situations in which persons with 3rd party coverage are unable to meet deductible and/or co-payment amounts. In these situations, the provision of care is either fully or partially uncompensated. These costs should be allowed in the uncompensated care calculation because they are truly for uncompensated care. To appropriately account for such circumstances, contractual allowances and payer discounts for persons with 3rd party coverage should be the only items not permissible on this line, and the language in the last line of this requirement should be changed to: "Uncompensated care costs do not include contractual allowances or payer discounts."

   The same concern related to what constitutes uncompensated care costs is renewed in Verification 3 (§455.204 (c)(3)) of the auditing requirements, which requires that only uncompensated care costs for Medicaid eligible persons and persons with no 3rd party coverage be included in the calculation of the hospital-specific DSH ceiling.

7. According to §477.299 (c)(16), states will provide an unduplicated count of Medicaid eligible beneficiaries and uninsured individuals by hospital. For this reporting requirement, a distinct number of Medicaid eligible beneficiaries and uninsured persons will be extremely difficult to obtain. Hospitals would have the most accurate data for each of these populations; however, these data are currently not required on hospital cost reports or any other reports of which we are aware. Requiring supplemental reporting of this data element would impose additional administrative reporting requirements and costs on each DSH hospital and is unlikely to yield complete or fully accurate results. There are numerous definitional issues where patients have multiple coverages so this will get fairly complicated in addition to the extra work. The Medicaid agency would have a more straight forward ability to run these numbers for Medicaid beneficiaries but would not have complete data for a variety of reasons. In any case, this new requirement is problematic.

Auditing Requirements

8. Verification 1 (§455.204 (c)(1)) requires hospitals to reduce their uncompensated care costs to reflect the total amount of claimed DSH expenditures. Does this imply that hospitals' uncompensated care costs should be reduced, on a 1:1 ratio, for every dollar a hospital receives from the DSH program? For example, if a hospital receives a $1,000 DSH payment, is it expected that their uncompensated care costs would be reduced by exactly $1,000? No payments made to hospitals through a DSH program will reduce uncompensated care costs, as these costs will continue to be incurred by the hospitals regardless of DSH or other similar payments made to offset them. Uncompensated care

costs will only be reduced when more people are covered by healthcare insurance. Please provide clarification regarding the intent behind this language.

9. Prior to the issuance of the draft regulations, CMS has allowed states to prospectively trend hospital cost data based upon information obtained from previous years to determine hospital-specific DSH ceilings. However, Verification 2 (§455.204 (c)(2)) requires payments made in the audited SFY be measured against the actual uncompensated care costs in the same audited SFY. This implies that the new audit regulations require a retrospective audit.

   The data source, hospital cost reports, from which data can be extracted to calculate current DSH ceilings are not available for the audited SFY until well after the end of the audited SFY. Because of this delay, states should be able to use data from the most recently filed cost report and trend uncompensated care costs forward to the current year. Reasonable trending based on the most recently filed hospital cost report data should be permissible in both determining and reconciling hospital DSH ceilings and payments. Michigan has done this in the past and this has never been an issue.

   If it is the intent of the federal government to recover the federal share of funding where actual DSH ceilings fall short of projections, Michigan strenuously objects. States should not be at risk two years after the claiming period waiting for retrospective cost report data. States should be held to an appropriate trending methodology that meets professional standards and that should be considered sufficient. After the fact exposure is untenable for states with balanced budget requirements. Please provide clarification regarding this issue.

Submitter : Mr. Sean J. Hopkins **Date:** 10/25/2005

Organization : New Jersey Hospital Association

Category : Other Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2198-P-40-Attach-1.DOC

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 New Jersey Hospital Association (NJHA), on behalf of our 109 member hospitals, health care systems and other health care organizations, appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule implementing the Medicaid Disproportionate Share Hospital (DSH) Payment reporting and auditing requirements established by 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. NJHA has several concerns with the presently drafted rule and believes it would have a significant negative impact on Medicaid DSH hospitals.

I. REPORTING REQUIREMENTS

Uncompensated Care

The proposed rule represents CMS's attempt to 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. According to the American Hospital Association (AHA), 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. 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 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. **NJHA 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. **NJHA 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

NJHA appreciates the extensive effort that CMS has invested in MMA Section 1011 to date. However, we would like to express our concerns with CMS's proposed clarification regarding the receipt of Section 1011 payments and the new DSH reporting and auditing proposals.

During the course of numerous discussions with CMS, the "Coalition for Fair Payment to Healthcare Providers Treating Undocumented Immigrants" – of which NJHA is a member – had made it clear that they oppose any offset of Section 1011 payments for establishing DSH payment limits. The Coalition requested clarification as to whether Section 1011 payments would offset Disproportionate Share Hospital funds dispersed through state Medicaid programs.

In response to the Coalition's request for clarification, CMS is directing state Medicaid programs to consider Section 1011 payments when determining hospital-specific DSH limits, which set 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 a 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.

NJHA 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 continue to provide access to health care services for all, and 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.

NJHA 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 if 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. NJHA 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. **NJHA recommends that this unnecessary and burdensome reporting requirement be deleted.**

II. 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. **NJHA 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. **NJHA 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. **NJHA 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. **NJHA 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.

NJHA 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. NJHA 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.

NJHA appreciates the opportunity to share our thoughts and concerns regarding the proposed rule to implement the Medicaid DSH reporting and auditing requirements of the MMA, particularly as they pertain to Section 1011 payments, and looks forward to a continued dialogue on theses issues. The Medicaid DSH program is a lifeline to many New Jersey safety net hospitals. The proposed rule, as presently drafted, will have a negative impact on these institutions. If you should have any questions, please contact Sean Hopkins, senior vice president, Health Economics at (609) 275-4022 or shopkins@njha.com.

Sincerely,

Sean Hopkins
Senior Vice President

Submitter : Mr. Thomas Moser **Date:** 10/25/2005

Organization : Community Medical Center

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment.

CMS-2198-P-41-Attach-1.DOC

COMMUNITY
MEDICAL CENTER

2827 Fort Missoula Road ▪ Missoula, MT 59804
(406) 728-4100 ▪ www.communitymed.org

Attachment #41

October 16, 2005

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

As President an CEO of Community Medical Center in Missoula, Montana, I 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). The Medicaid DSH program provides essential financial assistance to our Hospital, and without these funds, we would be severely constrained in our ability to respond to the needs of our community. As a not-for-profit community hospital, we provide access to care for all who utilize our facilities, including the poor, disabled and elderly. As you may be aware, Montana 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.

We at Community Medical Center are very concerned about the proposed rule. Adoption of the rule would greatly reduce the DSH payments to our facility, especially recognizing the patients we treat from the Salish-Kootenai Indian Reservation.

Community Medical Center endorses the comments provided by the American Hospital Association, which notes that 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 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. 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. It is our belief that the proposed rule is inconsistent with Congressional intent, and actually works to weaken the statute's purpose. **We recommend 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. **We believe 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. **We believe 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. **We recommend 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. **We 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 in the same audited SFY. We further recommend that CMS clarify that states be allowed to continue to use reasonable estimating methodologies to determine uncompensated care costs.**

Again, I appreciate this opportunity to comment on the proposed rule to implement the Medicaid DSH reporting and auditing requirements of the MMA. Community Medical Center 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 our hospital. Please contact me with any questions or to further discuss our comments. I can be reached at 406-327-4002 or e-mail at tmoser@communitymed.org.

Sincerely,

Thomas A. Moser, FACHE
President & CEO

CC: Robert Phillips, Board Chair- Community Medical Center

Submitter : Mr. Stephen Frayne **Date:** 10/25/2005

Organization : Connecticut Hospital Association

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2198-P-42-Attach-1.PDF

Attachment #12

CHA CONNECTICUT HOSPITAL ASSOCIATION

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; Medicaid Program; Disproportionate Share Hospital Payment – Implementing the Medicare Modernization Act of 2003 Reporting and Auditing Requirements; Proposed Rule.

Dear Sir or Madam:

Please accept these comments from the Connecticut Hospital Association (CHA) on behalf of its thirty not-for-profit acute care hospital members, regarding the Centers for Medicare and Medicaid Services (CMS) proposed rule: Medicaid Program; Disproportionate Share Hospital Payment – Implementing the Medicare Modernization Act of 2003 Reporting and Auditing Requirements; Proposed Rule [CMS-2198-P]. The CMS proposed rule sets forth numerous operational and policy changes to the Disproportionate Share Hospital (DSH) Payment system. These comments explain the significant negative effect a number of the proposed operational and policy changes will have on Connecticut's hospitals.

COMMENT SUMMARY

- CHA opposes the exclusion of bad debt and physician services from the definition of uncompensated care.
- CHA opposes the reduction of uncompensated care costs by DSH payments and Section 1011 payments.
- CHA opposes retroactive application of the rule to fiscal year (FY) 2005.
- CHA opposes the changes to the definition of allowable costs.
- CHA opposes expanding and/or imposing a reporting burden on hospitals.

COMMENT DETAIL

- **CHA Opposes the Exclusion of Bad Debt and Physician Services in the Definition of Uncompensated Care**

  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 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 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. 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.

Connecticut's DSH program includes the costs of care provided to uninsured individuals for which no payment is made and the costs associated with the non-payment of co-payments and deductibles for individuals with third-party coverage in determining a hospital's qualifying costs for the hospital-specific DSH limit. CMS has approved Connecticut's inclusion of bad debt in its DSH program since 1992; such approval was and is consistent with the statute, legislative history, and historical agency DSH policy.

The explicit exclusion of bad debt from the definition of uncompensated care will be harmful to Connecticut hospitals, their communities' safety net providers for the uninsured and underinsured. Consistent with statute, legislative history, agency guidance, and long-standing agency practice, the definition of uncompensated care should be modified to include bad debt.

Physician Services. The proposed rule's preamble states 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. Connecticut's DSH program includes the costs of unreimbursed hospital billed physician services in determining a hospital's qualifying costs for the hospital-specific DSH limit. CMS has approved Connecticut's inclusion of the unreimbursed cost of physician services in its DSH program since 1992; such approval was and is consistent with the statute, legislative history, and historical agency DSH policy. The explicit exclusion of physician services will be harmful to Connecticut. Therefore, physician costs associated with hospital services should be allowed, and references to excluding the physician costs in determining the hospital's uncompensated care costs in the preamble should be deleted.

- **CHA Opposes The Reduction Of Uncompensated Care Costs By DSH Payments And Section 1011 Payments.**

  Reducing Uncompensated Care Costs by DSH Payments. The audit verification 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. Therefore, this requirement for offset 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. The explicit inclusion of Section 1011 payments will be harmful to Connecticut. Therefore, the language in the preamble that requires states to offset Section 1011 payments when establishing a hospital's DSH limit should be deleted.

- **CHA Opposes Retroactive Application Of The Rule To Fiscal Year (FY) 2005**

  The proposed rule retroactively applies the new reporting and auditing requirements to each state's FY 2005. Connecticut's state fiscal year for 2005 ended on June 30, 2005. The imposition of the new and substantive changes to what is allowable and required to be reported and audited would make it impossible for Connecticut to comply because the year is already over. Therefore, the retroactive application of the substantive changes to what is allowable and required to be reported and audited should be deleted from the rule. Any changes should not be applicable until at least the first state fiscal year beginning after the rule is finalized.

- **CHA Opposes The Changes To The Definition Of Allowable Costs**

  The 1994 guidance to State Medicaid Directors required a state to define allowable costs under their state plan. As drafted, the proposed rule could be interpreted as establishing a new standard for the definition of allowable costs. Application of such new standard would inevitably require Connecticut to review its existing state plan and to test it to see if it meets the standard. As proposed, this rule discounts and discards existing and deployed definitions of allowable costs. This proposed rule should be modified to codify, not call into question, Connecticut's existing definition of allowable costs.

- **CHA Opposes Expanding And/Or Imposing A Reporting Burden On Hospitals**

  Reporting Unduplicated Patient Count of Medicaid Eligibles and Uninsured Individuals. State Medicaid programs are required to report for each hospital an unduplicated count of Medicaid eligible and uninsured patients. CHA is concerned that the state of Connecticut will look to hospitals to produce these patient counts. Connecticut 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. In addition, it is unclear how this information would be used. Therefore, this unnecessary and burdensome reporting requirement should be deleted.

  Audit Requirement. The MMA requires that state Medicaid programs have their DSH programs independently audited and submit the independent certified audit to the Secretary on an annual basis. The proposed rule does not specify, however, who will bear the cost of the audit. For years Connecticut hospitals have had to shoulder the burden of doing DSH agreed upon procedures reports and covering the cost of such reports. The work is very time consuming and expensive. Migrating such work to the level required to certify in an audit will exponentially increase the work and cost. In Connecticut, such a level of effort was required one year and then abandoned because the average hospital out-of-pocket expense was approximately $100,000. The audit requirement should be deleted, but if it must remain it should be clear that the effort and the cost is to be borne by the State and is not permitted to be passed to the hospital.

  Same Year Actual Costs. The proposed audit verification 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. However, the MMA does not require that payments be based on actual audited costs. Current CMS DSH policy allows states to

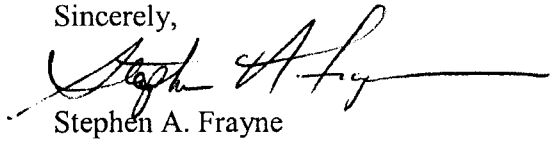
use a prospective methodology to estimate current year uncompensated care costs for purposes of establishing the hospital's specific DSH limit.

The 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 as well as increase the administrative costs for each state Medicaid program. In addition, and more importantly, it will undermine the current predictability of DSH payments, i.e., once set for a year, the hospital knows and can plan for what it will receive. Imposition of a "settle-up" destroys predictability. For years Connecticut imposed a "settle-up" process that had to be abandoned for this very reason. Therefore, 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 should be deleted. It is further recommended 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

We appreciate the opportunity to offer comments and thank you for your consideration.

Sincerely,



Stephen A. Frayne
Sr. Vice President, Health Policy

SAF:kas
By electronic submission

Submitter : **Mr. Michael Hill** **Date: 10/25/2005**

Organization : **NH Hospital Association**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2198-P-43-Attach-1.DOC

Attachment #43

New Hampshire Hospital Association

125 Airport Road
Concord, NH 03301
(603)225-0900

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 New Hampshire Hospital Association, (NHHA) on behalf of our 28 acute care and specialty care participating 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 NHHA has three primary concerns regarding the proposed rule:

- 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 NHHA strongly urges CMS to rethink its approach put forth in this proposed rule.

REPORTING REQUIREMENTS

Uncompensated Care

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 NHHA 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.

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 NHHA 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 NHHA 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.

Reporting Unduplicated Patient Count of Medicaid Eligibiles and Uninsured Individuals

According to the proposed rule, the New Hampshire Medicaid program is required to report for each hospital an unduplicated count of Medicaid-eligible and uninsured patients. The NHHA is concerned that the state 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 NHHA 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 program 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 NHHA 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 other 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 NHHA 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. The New Hampshire state fiscal year for 2005 has ended. The imposition of the new and substantive reporting and auditing requirements would make it impossible for the New Hampshire State Medicaid program 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 both the New Hampshire State Medicaid program and DSH hospitals. **The NHHA 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.**

Conclusion

The NHHA appreciates this opportunity to comment on the proposed rule to implement the Medicaid DSH reporting and auditing requirements of the MMA. The proposed rule, as presently drafted, will have a significant negative impact on both the State of New Hampshire and its hospitals. If you have any questions about our comments, please contact me or Paula Minnehan at (603) 225-0900 or pminnehan@nhha.org.

Sincerely,

Michael Hill
President

Submitter : Dr. Thomas L. Garthwaite **Date:** 10/25/2005

Organization : Los Angeles County Department of Health Services

Category : Local Government

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

CMS-2198-P-44-Attach-1.PDF

#44

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

FRED LEAF
Chief Operating Officer

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES
313 N. Figueroa, Los Angeles, CA 90012
(213) 240-8101

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)

Submitter : Michele DeSmet **Date:** 10/25/2005

Organization : Oakwood Healthcare, Inc.

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2198-P-45-Attach-1.DOC

CMS-2198-P-45-Attach-2.DOC

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.

Dear Dr. McClellan:

Oakwood Healthcare, Inc. welcomes this opportunity to comment to the Centers for Medicare & Medicaid Services regarding the proposed rule implementing the Medicaid Disproportionate Share Hospital (DSH) Payment reporting and auditing requirements included in the Medicare Modernization Act of 2003 (MMA), and which were recently published in the Aug. 26, 2005 *Federal Register*. Oakwood Healthcare, Inc., located in Dearborn, Michigan, operates four not-for profit acute care hospitals with 1,307 licensed beds.

The Medicaid DSH program provides essential financial assistance to our nation's safety net hospitals which provide access to care for our nation's most vulnerable populations -- the poor, the disabled and the elderly. In addition, these hospitals shoulder critical community services such as trauma and burn care, high-risk neonatal care and disaster preparedness resources. As a result, Oakwood Healthcare, Inc. is concerned with the proposed rule and believes the rule, as proposed, would have a significant negative impact on Medicaid DSH hospitals.

Since initial implementation in 1992, the Medicaid DSH program has operated with minimal written regulatory guidance. Subsequently, there have been two communications to the State Medicaid Directors, in 1994 and 2002, to address questions regarding hospital-specific DSH caps. Much of the current Medicaid DSH policy has been determined based upon negotiations between the Centers on Medicare and Medicaid (CMS) and state governments, resulting in inconsistent application of federal policy and a constant source of frustration for state government and hospitals. Unfortunately, the CMS has opted to use this proposed rule that was to implement the MMA reporting and auditing requirements as an opportunity to establish a new DSH policy. Oakwood Healthcare, Inc. believes this is contrary to original intent of the MMA provision.

Our key concerns regarding the proposed DSH rule are:

- the definition of uncompensated care that excludes bad debt and physician services
- the retroactive application of the auditing requirements to Fiscal Year 2005; and
- the substantive changes to standard DSH policy that were not required by the MMA.
- the significant reporting burden imposed on hospitals;

As a result, Oakwood Healthcare, Inc. strongly urges the CMS to reconsider the approach proposed in this rule.

A. Reporting Requirements

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

The revised definition of uncompensated care to exclude both bad debt and physician services are clear examples of the CMS' attempt to substantively change long-standing DSH policy.

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 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 the agency on the various ways to determine the unreimbursed costs that hospitals incur. 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 additional 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 included. In implementing the hospital-specific DSH limit, the agency took into consideration the cost associated with the uninsured and the underinsured populations. In 2002, the CMS issued a memo to state Medicaid programs regarding the hospital specific DSH limit and the upper payment limit and reaffirmed the 1994 DSH policy.

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 individuals that have 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 CMS or state Medicaid programs.

Hospitals classify a charge as bad debt after they have exhausted all efforts to collect the funds from the patient. They'd rather collect the amount, which would improve their financial performance, rather then classify it as bad debt. These are uncompensated costs in the same sense as a patient that has **no** insurance coverage. 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 citizens. The recent growth of health plans that impose high deductibles and/or exclusion limits coupled with the growth of health savings accounts are further exacerbating the burden on hospitals in regard to unreimbursed costs. Oakwood Healthcare, Inc. argues that CMS' new definition of uncompensated care to exclude bad debt is inconsistent with the statute and long-standing CMS DSH policy. As a result, **Oakwood Healthcare, Inc. urges that the CMS modify its definition of uncompensated care by striking references to bad debt in 42 C.F.R. 447.299(c)(15). Instead, Oakwood Healthcare, Inc. recommends that the CMS clarify that uncompensated care cost includes the cost associated with the following:**

- **services provided to individuals that have no health care insurance, third party coverage, or third party payment**
- **services provided to individuals that have health savings accounts, which due to health plan exclusions, limits or deductibles, are not covered.**

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. In addition, in at least one communication to a state Medicaid program, the CMS allowed 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. Inclusion of physician costs is also vital since many hospital operations include physician clinics that focus on providing primary care to the underserved population and generally operate at a financial loss due to inadequate medical reimbursement rates. The MMA does not require that the CMS exclude physician services, making this another example of the CMS' reach beyond statutory requirements to establish new policy. **Oakwood Healthcare, Inc. believes that physician costs associated with hospital services should be included. In addition, Oakwood Healthcare, Inc. recommends that references to excluding the physician costs in determining the hospital's uncompensated care costs should be deleted from the preamble.**

Section 1011 (Preamble)

The preamble in the proposed rule directs state Medicaid programs to consider Section 1011 payments for purposes of determining a hospital's 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. In enacting Section 1011, the Congressional intent was to provide additional resources rather than to merely substitute existing resources for hospitals that provide a high volume of uncompensated care to undocumented immigrants. This is 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 DSH dollars needed for hospitals serving high numbers of uninsured undocumented immigrants. **Oakwood Healthcare, Inc. recommends that the CMS delete the language in the preamble that requires states to offset Section 1011 payments when establishing a hospital's individual DSH limit and to 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 Eligible and Uninsured Individuals (42 C.F.R. 447.299 (c)(16))

The proposal requires State Medicaid programs to report an unduplicated count of Medicaid eligible and uninsured patients for each hospital. 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, resulting in numerous questions as to how a hospital should classify certain patients. For example, how should a patient be classified who has Medicaid coverage for a portion of the year, but due to increased earnings, becomes ineligible for Medicaid coverage and consequently becomes uninsured for the remainder of the year? **Oakwood Healthcare, Inc. believes this reporting requirement would be extremely and unnecessarily burdensome for hospitals and urges the CMS to delete it.**

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

The proposed rule requires hospitals to report total payments received from individuals that do not have third party coverage. The current accounting systems at most hospitals would not allow them to accurately segregate payments received from individuals with third party coverage from payments received from individuals without third party coverage. **This requirement would impose an excessive reporting burden on hospitals. As a result, Oakwood Healthcare, Inc. recommends that the CMS delete this reporting requirement.**

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 that definition do not exceed the amounts allowable based upon Medicare principles of cost reimbursement. **To ensure greater consistency among all states and Medicaid DSH**

programs, Oakwood Healthcare, Inc. believes that the CMS should reaffirm the definition of allowable costs in the proposed rule.

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

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 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 additional audit costs. Oakwood Healthcare, Inc. recommends that the CMS state affirmatively that the cost associated with 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 audit 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. Oakwood Healthcare, Inc. recommends that state Medicaid programs be allowed to use GAAP standards in the independent certified audits.

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

The proposed requirements would be effective for state fiscal year 2005 even though fiscal year 2005 has ended for most states, including Michigan, whose fiscal year ended September 30, 2005. The proposed rule, which was not released until August 25, 2005, would retroactively apply the new reporting and auditing requirements to fiscal year 2005. At this point, it would be impossible for Michigan and other state Medicaid programs to identify the data requested and meet the new and substantive reporting and auditing requirements on a retrospective basis. Although MMA provisions mandated the CMS to impose reporting and auditing requirements in fiscal year 2004, the CMS delayed implementation beyond the specified date, resulting in a significant hardship for state Medicaid programs and DSH hospitals due to the retroactive application of these new reporting and auditing requirements. **Oakwood Healthcare, Inc. strongly believes that this retroactive application of the reporting and auditing requirements will be extremely problematic for both state Medicaid departments and DSH hospitals. Oakwood Healthcare, Inc. recommends prospective application of these requirements upon each state's first fiscal year after finalization of the new DSH rule which would allow states time to review, understand, and comply with the final regulations.**

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

Audit verification #2 requires that the DSH payments comply with the hospital specific DSH limit by requiring that DSH payments distributed during the state fiscal year (SFY) be compared to the actual uncompensated care cost for the same audited SFY. This would require states to reconcile DSH payments in order to ensure that such payments not exceed actual uncompensated care costs. However, the MMA does not require that payments be based on actual audited costs. The current CMS DSH policy allows states to employ a prospective methodology for estimating current year uncompensated care costs. This approach allows for adjustment during future years for reconciling DSH payments to actual costs. The verification, through audit, of DSH payments with the same year actual uncompensated care costs will create an enormous burden on hospitals due to burdensome and costly audits. These activities will also increase the administrative costs incurred by state Medicaid programs, making this another example where the proposed rule substantially revises the current Medicaid DSH policy. **Oakwood Healthcare, Inc. strongly recommends that the CMS delete the requirement in the preamble and the regulatory language that audited DSH payments should be measured against actual uncompensated care cost for the same audited SFY. Instead, Oakwood Healthcare, Inc. recommends that the CMS clarify that states be allowed to continue using reasonable estimation methodologies for determining uncompensated care costs. This would include data from the most recent filed cost report trended forward**

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

Audit verification #1 requires a state's audit report to verify that each hospital receiving DSH payments has reduced its uncompensated care costs for providing inpatient hospital and outpatient hospital services during the SFY to Medicaid eligible individuals and individuals with no source of third party coverage. For reflecting 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) excluding DSH payments, and payments made by uninsured individuals. The statutory language is clear that uncompensated care costs should **not** be 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. **Oakwood Healthcare, Inc. recommends that verification #1 be revised to require that the total amount of DSH expenditures claimed for each hospital cannot exceed the hospital's uncompensated care costs.**

In addition to the concerns identified above, we believe that the CMS should provide clarification regarding the following:

- Most of the data necessary to fulfill the requirements outlined in the proposed DSH regulations will be extracted from hospital cost reports. Since all hospitals do not have the same fiscal year as the state, it is important that the CMS specify the coverage periods for obtaining the required data elements.

- Most of the requirements outlined in the proposed regulations require data that will be obtained from hospital cost reports. Due to limited resources during recent years, most states have scaled back cost report audits and perform only limited reviews of cost reports. Will the states be responsible for completing individual hospital audits in greater detail?

- If a patient has an ambulatory benefit, but does not have inpatient benefits, should he be considered as uninsured when inpatient hospital services are provided? Please define what is considered uninsured and what constitutes third party coverage.

Again, Oakwood Healthcare, Inc. appreciates this opportunity to comment on the proposed rule that would implement the Medicaid DSH reporting and auditing requirements included in the MMA. Although the AHA, the MHA, and other state associations have long advocated for increased consistency in federal standards, the proposed rule makes substantive policy changes that negate Congressional intent. The Medicaid DSH program is a vital lifeline to many safety net hospitals across the country that play an integral role in providing care to a high volume of Medicaid and low income patients in their communities. The proposed rule, in its current form, will have a significant negative impact on these institutions.

Thank you for your review and consideration of these comments. If you have any questions, please contact me at 313-586-5717 or via email at michele.desmet@oakwood.org.

Sincerely,

Michele DeSmet
Reimbursement Manager
Oakwood Healthcare, Inc.

F:\Medicare\FY2006\Comment on DSH 10-05.doc

Submitter : Michele DeSmet **Date:** 10/25/2005

Organization : Oakwood Healthcare, Inc.

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2198-P-46-Attach-1.DOC

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.

Dear Dr. McClellan:

Oakwood Healthcare, Inc. welcomes this opportunity to comment to the Centers for Medicare & Medicaid Services regarding the proposed rule implementing the Medicaid Disproportionate Share Hospital (DSH) Payment reporting and auditing requirements included in the Medicare Modernization Act of 2003 (MMA), and which were recently published in the Aug. 26, 2005 *Federal Register*. Oakwood Healthcare, Inc., located in Dearborn, Michigan, operates four not-for profit acute care hospitals with 1,307 licensed beds.

The Medicaid DSH program provides essential financial assistance to our nation's safety net hospitals which provide access to care for our nation's most vulnerable populations -- the poor, the disabled and the elderly. In addition, these hospitals shoulder critical community services such as trauma and burn care, high-risk neonatal care and disaster preparedness resources. As a result, Oakwood Healthcare, Inc. is concerned with the proposed rule and believes the rule, as proposed, would have a significant negative impact on Medicaid DSH hospitals.

Since initial implementation in 1992, the Medicaid DSH program has operated with minimal written regulatory guidance. Subsequently, there have been two communications to the State Medicaid Directors, in 1994 and 2002, to address questions regarding hospital-specific DSH caps. Much of the current Medicaid DSH policy has been determined based upon negotiations between the Centers on Medicare and Medicaid (CMS) and state governments, resulting in inconsistent application of federal policy and a constant source of frustration for state government and hospitals. Unfortunately, the CMS has opted to use this proposed rule that was to implement the MMA reporting and auditing requirements as an opportunity to establish a new DSH policy. Oakwood Healthcare, Inc. believes this is contrary to original intent of the MMA provision.

Our key concerns regarding the proposed DSH rule are:

- the definition of uncompensated care that excludes bad debt and physician services
- the retroactive application of the auditing requirements to Fiscal Year 2005; and
- the substantive changes to standard DSH policy that were not required by the MMA.
- the significant reporting burden imposed on hospitals;

As a result, Oakwood Healthcare, Inc. strongly urges the CMS to reconsider the approach proposed in this rule.

A. Reporting Requirements

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

The revised definition of uncompensated care to exclude both bad debt and physician services are clear examples of the CMS' attempt to substantively change long-standing DSH policy.

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 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 the agency on the various ways to determine the unreimbursed costs that hospitals incur. 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 additional 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 included. In implementing the hospital-specific DSH limit, the agency took into consideration the cost associated with the uninsured and the underinsured populations. In 2002, the CMS issued a memo to state Medicaid programs regarding the hospital specific DSH limit and the upper payment limit and reaffirmed the 1994 DSH policy.

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 individuals that have 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 CMS or state Medicaid programs.

Hospitals classify a charge as bad debt after they have exhausted all efforts to collect the funds from the patient. They'd rather collect the amount, which would improve their financial performance, rather then classify it as bad debt. These are uncompensated costs in the same sense as a patient that has **no** insurance coverage. 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 citizens. The recent growth of health plans that impose high deductibles and/or exclusion limits coupled with the growth of health savings accounts are further exacerbating the burden on hospitals in regard to unreimbursed costs. Oakwood Healthcare, Inc. argues that CMS' new definition of uncompensated care to exclude bad debt is inconsistent with the statute and long-standing CMS DSH policy. As a result, **Oakwood Healthcare, Inc. urges that the CMS modify its definition of uncompensated care by striking references to bad debt in 42 C.F.R. 447.299(c)(15). Instead, Oakwood Healthcare, Inc. recommends that the CMS clarify that uncompensated care cost includes the cost associated with the following:**

- **services provided to individuals that have no health care insurance, third party coverage, or third party payment**
- **services provided to individuals that have health savings accounts, which due to health plan exclusions, limits or deductibles, are not covered.**

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. In addition, in at least one communication to a state Medicaid program, the CMS allowed 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. Inclusion of physician costs is also vital since many hospital operations include physician clinics that focus on providing primary care to the underserved population and generally operate at a financial loss due to inadequate medical reimbursement rates. The MMA does not require that the CMS exclude physician services, making this another example of the CMS' reach beyond statutory requirements to establish new policy. **Oakwood Healthcare, Inc. believes that physician costs associated with hospital services should be included. In addition, Oakwood Healthcare, Inc. recommends that references to excluding the physician costs in determining the hospital's uncompensated care costs should be deleted from the preamble.**

Section 1011 (Preamble)

The preamble in the proposed rule directs state Medicaid programs to consider Section 1011 payments for purposes of determining a hospital's 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. In enacting Section 1011, the Congressional intent was to provide additional resources rather than to merely substitute existing resources for hospitals that provide a high volume of uncompensated care to undocumented immigrants. This is 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 DSH dollars needed for hospitals serving high numbers of uninsured undocumented immigrants. **Oakwood Healthcare, Inc. recommends that the CMS delete the language in the preamble that requires states to offset Section 1011 payments when establishing a hospital's individual DSH limit and to 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 Eligible and Uninsured Individuals (42 C.F.R. 447.299 (c)(16))

The proposal requires State Medicaid programs to report an unduplicated count of Medicaid eligible and uninsured patients for each hospital. 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, resulting in numerous questions as to how a hospital should classify certain patients. For example, how should a patient be classified who has Medicaid coverage for a portion of the year, but due to increased earnings, becomes ineligible for Medicaid coverage and consequently becomes uninsured for the remainder of the year? **Oakwood Healthcare, Inc. believes this reporting requirement would be extremely and unnecessarily burdensome for hospitals and urges the CMS to delete it.**

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

The proposed rule requires hospitals to report total payments received from individuals that do not have third party coverage. The current accounting systems at most hospitals would not allow them to accurately segregate payments received from individuals with third party coverage from payments received from individuals without third party coverage. **This requirement would impose an excessive reporting burden on hospitals. As a result, Oakwood Healthcare, Inc. recommends that the CMS delete this reporting requirement.**

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 that definition do not exceed the amounts allowable based upon Medicare principles of cost reimbursement. **To ensure greater consistency among all states and Medicaid DSH**

programs, Oakwood Healthcare, Inc. believes that the CMS should reaffirm the definition of allowable costs in the proposed rule.

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

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 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 additional audit costs. Oakwood Healthcare, Inc. recommends that the CMS state affirmatively that the cost associated with 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 audit 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. Oakwood Healthcare, Inc. recommends that state Medicaid programs be allowed to use GAAP standards in the independent certified audits.

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

The proposed requirements would be effective for state fiscal year 2005 even though fiscal year 2005 has ended for most states, including Michigan, whose fiscal year ended September 30, 2005. The proposed rule, which was not released until August 25, 2005, would retroactively apply the new reporting and auditing requirements to fiscal year 2005. At this point, it would be impossible for Michigan and other state Medicaid programs to identify the data requested and meet the new and substantive reporting and auditing requirements on a retrospective basis. Although MMA provisions mandated the CMS to impose reporting and auditing requirements in fiscal year 2004, the CMS delayed implementation beyond the specified date, resulting in a significant hardship for state Medicaid programs and DSH hospitals due to the retroactive application of these new reporting and auditing requirements. **Oakwood Healthcare, Inc. strongly believes that this retroactive application of the reporting and auditing requirements will be extremely problematic for both state Medicaid departments and DSH hospitals. Oakwood Healthcare, Inc. recommends prospective application of these requirements upon each state's first fiscal year after finalization of the new DSH rule which would allow states time to review, understand, and comply with the final regulations.**

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

Audit verification #2 requires that the DSH payments comply with the hospital specific DSH limit by requiring that DSH payments distributed during the state fiscal year (SFY) be compared to the actual uncompensated care cost for the same audited SFY. This would require states to reconcile DSH payments in order to ensure that such payments not exceed actual uncompensated care costs. However, the MMA does not require that payments be based on actual audited costs. The current CMS DSH policy allows states to employ a prospective methodology for estimating current year uncompensated care costs. This approach allows for adjustment during future years for reconciling DSH payments to actual costs. The verification, through audit, of DSH payments with the same year actual uncompensated care costs will create an enormous burden on hospitals due to burdensome and costly audits. These activities will also increase the administrative costs incurred by state Medicaid programs, making this another example where the proposed rule substantially revises the current Medicaid DSH policy. **Oakwood Healthcare, Inc. strongly recommends that the CMS delete the requirement in the preamble and the regulatory language that audited DSH payments should be measured against actual uncompensated care cost for the same audited SFY. Instead, Oakwood Healthcare, Inc. recommends that the CMS clarify that states be allowed to continue using reasonable estimation methodologies for determining uncompensated care costs. This would include data from the most recent filed cost report trended forward**

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

Audit verification #1 requires a state's audit report to verify that each hospital receiving DSH payments has reduced its uncompensated care costs for providing inpatient hospital and outpatient hospital services during the SFY to Medicaid eligible individuals and individuals with no source of third party coverage. For reflecting 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) excluding DSH payments, and payments made by uninsured individuals. The statutory language is clear that uncompensated care costs should **not** be 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. **Oakwood Healthcare, Inc. recommends that verification #1 be revised to require that the total amount of DSH expenditures claimed for each hospital cannot exceed the hospital's uncompensated care costs.**

In addition to the concerns identified above, we believe that the CMS should provide clarification regarding the following:

- Most of the data necessary to fulfill the requirements outlined in the proposed DSH regulations will be extracted from hospital cost reports. Since all hospitals do not have the same fiscal year as the state, it is important that the CMS specify the coverage periods for obtaining the required data elements.

- Most of the requirements outlined in the proposed regulations require data that will be obtained from hospital cost reports. Due to limited resources during recent years, most states have scaled back cost report audits and perform only limited reviews of cost reports. Will the states be responsible for completing individual hospital audits in greater detail?

- If a patient has an ambulatory benefit, but does not have inpatient benefits, should he be considered as uninsured when inpatient hospital services are provided? Please define what is considered uninsured and what constitutes third party coverage.

Again, Oakwood Healthcare, Inc. appreciates this opportunity to comment on the proposed rule that would implement the Medicaid DSH reporting and auditing requirements included in the MMA. Although the AHA, the MHA, and other state associations have long advocated for increased consistency in federal standards, the proposed rule makes substantive policy changes that negate Congressional intent. The Medicaid DSH program is a vital lifeline to many safety net hospitals across the country that play an integral role in providing care to a high volume of Medicaid and low income patients in their communities. The proposed rule, in its current form, will have a significant negative impact on these institutions.

Thank you for your review and consideration of these comments. If you have any questions, please contact me at 313-586-5717 or via email at michele.desmet@oakwood.org.

Sincerely,

Michele DeSmet
Reimbursement Manager
Oakwood Healthcare, Inc.

F:\Medicare\FY2006\Comment on DSH 10-05.doc

Submitter : Mr. Joe Martin **Date:** 10/25/2005

Organization : AnMed Health

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

AnMed Health agrees with the AHA comments regarding CMS-2198-P DSH Hospital Payments as referenced below.

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

Bad Debt. AnMed Health requests 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. AnMed Health believes that physician costs associated with hospital services should be included and references to excluding the physician costs in determining the uncompensated care costs in the preamble should be deleted.

Section 1011 (Preamble)
AnMed Health requests that CMS delete the language in the preamble that requires states to offset Section 1011 payments when establishing a 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))

AnMed Health believes that this reporting requirement would be unnecessarily burdensome and requests that it be deleted.

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

This would be an excessive reporting burden AnMed Health requests that this reporting requirement be deleted.

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

AnMed Health 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))

AnMed Health requests 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))

AnMed Health requests 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. AnMed Health requests 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))
AnMed Health requests 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.

Submitter : **Date: 10/25/2005**

Organization :

Category : **State Government**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2198-P-48-Attach-1.DOC

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

Submitter : Mr. Jeffrey White **Date:** 10/25/2005

Organization : Beaufort Memorial Hospital

Category : Hospital

Issue Areas/Comments

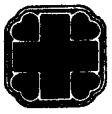
GENERAL

GENERAL

See attachment

CMS-2198-P-49-Attach-1.PDF

#49



BEAUFORT MEMORIAL HOSPITAL

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:

Beaufort Memorial Hospital appreciates the opportunity to comment on the above referenced proposed rule. The Medicaid DSH program provides essential financial assistance to our organization for the care of the poor, the disabled and the elderly. We do have concerns with the proposed rule and believes the rule, as presently drafted, would have a tremendously negative impact on our Hospital and the care we can provide.

The proposed rule includes a new definition of uncompensated care, which excludes bad debt. For CMS to exclude bad debts from its calculations for Medicaid DSH directly contradicts the governments recognition and philosophy of costs associated with providing uninsured and underinsured healthcare services, as is evidenced by the Medicare's recognition and compensation of bad debts through the annual Medicare cost report.

We provide a substantial amount of care to individuals who are uninsured for which we receive no payment. We provide our patients with the opportunity to receive financial assistance. However, not all patients comply with the procedures to be qualified for indigent care. In these cases, our established collection procedures are followed and the account ultimately, if not paid, becomes a bad debt. This process is necessary in order to properly value our accounts receivable as required by Generally Accepted Accounting Principals. We make every effort to qualify all individuals as appropriate. We do not believe it has ever been the intent of CMS to exclude bad debts from the complete determination of costs associated with providing health care to needy populations, and would therefore request this be excluded from the Proposed Rule.

We concur with the AHA recommendation 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.

955 Ribaut Road · Beaufort, SC 29902-5454
(843) 522-5200 · Web www.bmhsc.org

Furthermore, the proposed rule retroactively applies the new reporting and auditing requirements to each state's FY 2005. Retroactive application of the reporting and auditing requirements will be burdensome for our organization to implement. Prospective reporting and auditing would be our recommendation.

Should you require any addition information, please feel free to contact me at 843-522-5142.

Sincerely,

Jeffrey L. White
Senior Vice president & CFO

Submitter : **Ms. Patricia Andersen** **Date: 10/25/2005**

Organization : **Oklahoma Hospital Association**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See attached comment letter regarding proposed DSH rules from the Oklahoma Hospital Association

CMS-2198-P-50-Attach-1.DOC

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 Oklahoma Hospital Association (OHA), 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)*. The Medicaid DSH program which has been implemented in Oklahoma in a very conservative manner provides critical financial assistance to our state's safety net hospitals. These provide critical community services such as trauma services, burn care, high-risk neonatal care, obstetrical services and other high cost services for which payments do not cover the cost of care. The OHA has numerous concerns with the presently drafted rule and believes it would have a significant negative impact on Medicaid DSH hospitals in Oklahoma.

The Medicaid DSH program has operated with little written regulatory guidance since the publication of the program's initial regulations in 1992. Current DSH policy has been developed on a state-by-state basis as state Medicaid agencies have worked with the Centers for Medicare & Medicaid Services (CMS). This has resulted in significant variations in how DSH programs have been developed and evolved and the absence of consistent federal policy has been a source of frustration for hospitals. It appears to us that CMS has chosen to use this proposed rule implementing the MMA reporting and auditing requirements to establish new DSH policy.

The OHA has four significant concerns about the proposed rule implementing the *Medicaid Disproportionate Share Hospital (DSH) Payment reporting and auditing requirements found in the Medicare Modernization Act of 2003 (MMA)*:

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

The OHA strongly urges CMS to reconsider the approach presented in the proposed rule.

CMS' substantive changes to standard DSH policy not required by the MMA

The proposed rule would 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.

- 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.
- Congress has not raised any concerns about how CMS or state Medicaid programs were determining unreimbursed costs for setting the hospital-specific DSH limit.

CMS' definition of uncompensated care that excludes bad debt is contrary to direction to CMS provided by Congress

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 OHA 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 which we believe are violations of the Administrative Procedure Act. In addition, the changed definition raises the following substantive concerns.

Bad Debts from Services to Uninsured or Underinsured Patients
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."

The Oklahoma Medicaid program includes the costs of care provided to uninsured individuals for which no payment is made and the costs associated with the non-payment of co-payments 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 co-payments and deductibles.) This approach to establishing 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 continuing to add new burdens on hospitals in terms of unreimbursed costs of providing care.

CMS' new definition of uncompensated care to exclude bad debt is inconsistent with the statute, legislative history and long-standing CMS DSH policy. **The OHA 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:**

1. **The costs of services furnished to individuals with no health care insurance, third-party coverage or third-party payment;**
2. **Individuals with health savings accounts; and**
3. **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, co-payments 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. The OHA 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 Funds

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. This addition to regulation 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. Congress has provided these funds because hospitals must provide care to people regardless of their immigration status. **The OHA 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.**

Unnecessary reporting burden imposed on hospitals

Reporting Unduplicated Patient Count of Medicaid Eligibles and Uninsured Individuals
State Medicaid programs are required to report for each hospital an unduplicated count of Medicaid-eligible and uninsured patients. The OHA 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 OHA recommends that this unnecessary and burdensome reporting requirement be deleted.**

Audit Requirements

Cost of auditing DSH data should not be passed on to DSH hospitals
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 be very high. 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 OHA 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 OHA recommends that state Medicaid programs be allowed to use GAAP standards in the independent certified audits.**

CMS' proposed retroactive application of the auditing requirements to fiscal year 2005

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 OHA 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.**

Inappropriate to require that uncompensated care costs be reduced 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 OHA 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 proposed rule change substantively changes current Medicaid DSH policy, without statutory authority**.

The OHA 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 OHA 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 OHA appreciates this opportunity to comment on the proposed rule to implement the Medicaid DSH reporting and auditing requirements of the MMA. While the OHA 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 in Oklahoma and across the country. The proposed rule, as presently drafted, will have a significant negative impact on these institutions. The OHA stands ready to provide any assistance to remedy the concerns outlined. If you have any questions about our comments, please contact me.

Sincerely,

OKLAHOMA HOSPITAL ASSOCIATION
Patricia D. Andersen, CPA
Vice-President – Finance & Information Services
pandersen@okoha.com
405-427-9537

Submitter : Mr. Andrew Carter **Date:** 10/25/2005

Organization : Ohio Children's Hospital Association

Category : Hospital

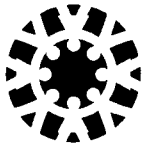
Issue Areas/Comments

GENERAL

GENERAL

See attachment.

CMS-2198-P-51-Attach-1.DOC



Ohio Children's Hospital Association

Progress is a healthy child

Attachment #51

October 25, 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

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

To Whom It May Concern:

The Ohio Children's Hospital Association (OCHA) appreciates the opportunity to submit comments on the above-named proposed rule for the federal Disproportionate Share Hospital program, which in Ohio is implemented as the "Hospital Care Assurance Program," or HCAP.

Eight children's hospitals in Ohio with their own Medicaid provider number participate in HCAP, with payments to them accounting for approximately 13-14% of total DSH payments in Ohio. Moreover, DSH payments to children's hospitals, net of the assessments paid, accounted for roughly 15% of total direct Medicaid payments to children's hospitals. Changes to the program, therefore, have a significant impact on Ohio's children's hospitals, and are of deep concern to us. We are pleased to have been part of a program that has won federal plaudits for its efficiency and program integrity.

In response to the proposed rules, OCHA offers the following comments:

1. **The scope of the rule is overly broad.** The proposed rule includes several provisions that create new requirements that exceed CMS statutory authority granted by Congress either in longstanding statutes or in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). The rule places new federal limits on costs that may be included in the calculation of hospital-specific DSH limits, such as physician costs. Whether or not Ohio currently includes such costs in its own limit calculations is less important than retaining the flexibility to do so if it determines the costs are a meaningful reflection of a hospital's efforts to provide essential health care to all patients regardless of ability to pay.

2. **Bad debt definitions are overly proscriptive.** States should have flexibility to define uncompensated care in a manner that is administratively feasible while observing the spirit of the DSH program to help offset the cost of providing care to the uninsured. OCHA recommends removal of language addressing bad debt definitions.

155 East Broad Street Columbus, Ohio 43215 614/228-2844 fax 614/228-3772 www.ohiochildrenshospitals.org

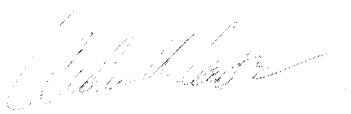
Children's Hospital Medical Center of Akron | Children's Hospital Medical Center, Cincinnati | Rainbow Babies and Children's Hospital, Cleveland | Children's Hospital, Columbus | The Children's Medical Center, Dayton | Toledo Children's Hospital

3. **Proposed treatment of Section 1011 payments undercuts Congressional intent.** The Section 1011 program payments are designed to offset costs incurred treating undocumented immigrants. Including those payments in the calculation of DSH limits could potentially negate their effect by (depending on a hospital's own limit) reducing DSH payments dollar for dollar of 1011 payments. That outcome was not envisioned by Congress and is not required by MMA. Moreover, it creates new and potentially costly reporting and verification processes.

4. **New state audit and reporting requirements are unclear and potentially burdensome.** The rule establishes a new audit process that would duplicate in Ohio a hospital audit requirement. Moreover, the rule requires retroactive application of the new audit requirement back to SFY 2005, potentially requiring some hospitals to re-open cost reports to provide new data and incur unbudgeted costs. The rule also requires states (and thus hospitals) to produce unduplicated counts of Medicaid eligible and uninsured individuals. This requirement would create new and unwarranted reporting requirements for hospitals. Finally, the rule includes new requirements for reconciling DSH payments to uncompensated care data for the same periods, disturbing an effective and efficient system in Ohio that already meets federal standards for program integrity.

Thank you for the opportunity to comment. For additional information, please contact me at 614-228-2844 or acarter@ohiochildrenshospitals.org.

Sincerely,



Andrew Carter
President

cc: Ohio Hospital Association
National Association of Children's Hospitals
Ohio Department of Job and Family Services

Submitter : Mr. Mark Moody **Date:** 10/25/2005

Organization : Wis Division of Health Care Finance

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter : Mr. Michael Chirieleison **Date:** 10/25/2005

Organization : Safety-Net Association of Pennsylvania

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2198-P-53-Attach-1.DOC

Safety-Net Association of Pennsylvania
112 Walnut Street • Harrisburg, PA 17101 • 717-234-6970 • 717-234-6971 fax • www.pasafetynet.org

Attachment #53

October 25, 2005

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

Subject: File Code CMS-2198-P

To Whom it May Concern:

I am writing on behalf of the Safety-Net Association of Pennsylvania (SNAP) in response to the proposed regulation governing the reporting of Medicaid disproportionate share hospital payments (DSH) as proposed by the Centers for Medicare & Medicaid Services (CMS) on August 26, 2005 (File Code CMS-2198-P; *Federal Register*, Vol. 70, No. 165, p. 50262; 42 CFR Parts 447 and 455).

The following are comments that fall into four general categories: areas in which we respectfully disagree with the path that CMS has proposed; issues that we do not entirely understand, as presented in the proposed regulation, and that we believe would benefit from further clarification; data requested under the proposed regulation that we believe is unrelated to the calculation of Medicaid DSH payments and does not contribute to determining the accuracy or appropriateness of those payments; and technical matters that we hope will be considered before the regulation officially takes effect.

We address each of these categories individually below.

Areas of Disagreement

SNAP respectfully disagrees with the approach that CMS has proposed in five areas and requests that you consider our views on these issues of vital importance to Pennsylvania's safety-net hospitals.

The Use of Audits as an Enforcement Mechanism

SNAP wishes to express our disagreement with the manner in which the proposed regulation would employ audits to determine whether states are making their Medicaid DSH payments in appropriate amounts. While audits are excellent tools for measuring performance against clear, known standards, the proposed approach appears to be relying on audits to introduce new standards. While Congress and CMS in the past have provided general guidelines for the calculation of Medicaid DSH payments and hospital-specific DSH payment limits, they have never developed and implemented specific formulas for such calculations and directed the states to use those formulas and only those formulas. As such, states have been free to exercise some discretion in the manner in which they calculate these figures.

Now, it appears as if the proposed regulation is asking auditors to determine whether DSH is being calculated "correctly" by the states in a context in which there has never been a single, true, definitive definition of exactly what "correct" means. In other words, the regulation proposes counting on auditors to help impose a standard that does not currently exist. From SNAP's perspective, this appears to be the introduction of a new,

definitive standard for calculating DSH payments and limits – a standard that we do not believe was mandated or authorized in the enabling legislation.

SNAP is concerned about the implications of auditors concluding that Pennsylvania has not correctly calculated DSH payments and hospital-specific DSH payment limits and that the state should return DSH money to the federal government, necessitating the return of DSH money to the state by hospitals. This would be extremely burdensome for Pennsylvania's hospitals, which undoubtedly would already have spent that money serving their low-income and uninsured patients. Equally troubling is the regulation's call for such audits to begin for the 2004 fiscal year. This is well in the past and would involve auditors attempting to impose standards that did not exist at the time that year's DSH payments and limits were calculated. This is especially troubling for Pennsylvania and its hospitals because Pennsylvania has long concluded that there is no meaningful difference between bad debt and charity care because both have the same origins: patients too poor to pay their hospital bills, co-payments, and deductibles. If CMS does not allow Pennsylvania to continue including bad debt in its uncompensated care calculations, this could result in a devastating financial blow to the state and its safety-net hospitals. To be fair, neither the background information accompanying the regulation nor the regulation itself indicate how audit results will be used, but this understandably fuels our concern. The regulation is clear about the penalty for failing to provide audit results in a timely manner but is silent on the question of what happens if CMS looks unfavorably on the results themselves.

SNAP also is concerned that the reporting requirements, as stated in the proposed regulation, suggest that there is only one way to calculate DSH payments and hospital-specific DSH payment limits when, in reality, federal guidelines give states some leeway in making these calculations. SNAP is concerned that auditors will interpret their mandate very literally – too literally, we fear.

For these reasons, SNAP wishes to express its opposition to this aspect of the proposed regulation. While we recognize the need for audits, we believe that the audits should fulfill only the following three objectives: they should determine whether individual states are following their own formulas for the calculation of DSH payments and hospital-specific DSH payment limits; they should verify the accuracy of states' calculations; and they should determine whether individual states are making good-faith efforts to make those calculations in compliance with federal guidelines. SNAP also hopes that CMS will instruct auditors that there are, in fact, various ways for states to make these calculations while remaining in compliance with federal guidelines.

Use of Same Fiscal Periods for Costs and Payments

Pennsylvania makes its Medicaid DSH payments prospectively, estimating appropriate payments based on recent past experience. The state makes quarterly DSH payments, and the data it uses to calculate eligible hospitals' quarterly DSH payments does not come from that quarter, or even the previous quarter, because it is nearly impossible to collect and compute such data in such a short period of time. Requiring DSH payments to correspond to data from that same year, and calculating individual hospitals' DSH payment limits in the same manner, would be practically impossible and extremely burdensome for both the states and hospitals.

Changing this system would have significant implications for Pennsylvania's safety-net hospitals. First, changing the system from prospective payments to retrospective payments raises the possibility of CMS concluding that it needs to take back Medicaid DSH funds from the state, which in turn would necessitate the state taking money back from DSH hospitals. This would be extremely difficult for hospitals, which almost certainly would have spent that money on patient care and would have difficulty finding the money to return to the state. Second, changing the system from prospective to retrospective would make it impossible for

hospitals to anticipate Medicaid DSH money in their revenue projections, resulting in significant budget challenges and problems for hospitals that already are typically operating on very slim margins.

Currently, there is no law requiring that DSH payments made in a fiscal year correspond to costs from that same fiscal year, nor does the Medicare Modernization Act of 2003 call for such a requirement. For these reasons, SNAP opposes the proposed regulation's provision calling for this change in Medicaid DSH policy. Instead, we believe that the states should be required to use the most recently available data to make such calculations – a way to ensure that states are not relying on old, outdated data or using more favorable data to maximize their federal funding. Pennsylvania has a history of making good-faith estimates of DSH payments and hospital-specific DSH payment limits, and SNAP believes the state should be allowed to continue in this manner so long as it uses the most recent data available for its estimates. For these reasons, we ask CMS to reconsider this aspect of the proposed regulation.

Bad Debt and the Definition of "Uncompensated Care Costs"

SNAP disagrees with how one portion of the proposed regulation defines "uncompensated care costs" – and with its exclusion of bad debt as a type of uncompensated care.

Specifically, §447.299(c)(15) states that:

> The total annual uncompensated care cost equals the total cost of care for furnishing inpatient hospital services to Medicaid eligible individuals and to individuals with no source of third party coverage for the hospitals services they receive less the sum of regular Medicaid rate payments, Medicaid managed care organization payments, supplemental/enhanced Medicaid payments, and indigent care revenue. **Uncompensated care costs do not include bad debt or payer discounts**. (emphasis added)

SNAP urges CMS to remove the reference to "bad debt" in this definition. Bad debt, in our view, is virtually indistinguishable from charity care: it arises when patients cannot afford to pay for medically necessary services for which they are not insured. This can be because the patient is medically indigent; has health insurance that does not cover the service in question; or cannot afford a required co-payment or deductible. Such costs, when incurred by hospitals, are truly "uncompensated care costs." Pennsylvania has long viewed bad debt, along with charity care, as indistinguishable components of uncompensated care costs.

We believe that a definition of "uncompensated care costs" that does not encompass bad debt is inconsistent with the statute, the legislative history, and long-standing federal practice. This view is supported by language in the Omnibus Budget Reconciliation Act of 1993 conference report as well as by the Health Care Financing Agency's 1994 written guidance to state Medicaid agencies – guidance reaffirmed by CMS in 2002. Based on this history and this guidance, many states now include bad debt in their uncompensated care costs, and changing the federal position on this matter could cause significant financial problems for state Medicaid programs and countless DSH hospitals.

Third-Party Coverage

SNAP is concerned that the regulation lacks a clear and appropriate definition of "third-party coverage." In particular, we believe that third-party coverage should explicitly be defined in a manner that makes clear that third-party coverage does not include state and local programs to pay for care for indigent and uninsured individuals and that "lack of third-party coverage" also encompasses patients who lack coverage for the service provided, not necessarily any coverage at all. Among those who lack such coverage are patients who

are medically indigent, patients whose health insurance does not cover the medical service or services in question, and patients who have insurance but cannot afford their co-pays or deductibles. While some may attempt to differentiate this "bad debt" from other forms of uncompensated care, their origins are the same: an inability to afford to make the payment in question. SNAP believes that in this context, uncompensated care and bad debt are indistinguishable and actually are one and the same and that a more explicit definition of "third-party coverage" in this regulation would clarify and reinforce this very important point.

Technical Issues

In the course of reviewing the proposed regulation, SNAP has identified several technical issues that we hope CMS will address in the final, official version of the regulation.

Definition of "Uncompensated Care Costs"

SNAP believes that different parts of the regulation define "uncompensated care costs" differently.

Specifically, §447.299(c)(15) states that:

> The total annual uncompensated care cost equals the total cost of care for furnishing inpatient hospital services to Medicaid eligible individuals and to individuals with no source of third party coverage for the hospitals services they receive less the sum of regular Medicaid rate payments, Medicaid managed care organization payments, supplemental/enhanced Medicaid payments, and indigent care revenue. Uncompensated care costs do not include bad debt or payer discounts.

In contrast, §455.204(c), describing the audit requirement, states that the audit must verify that:

> Each hospital that qualifies for a DSH payment in the State 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.

SNAP believes these definitions of "uncompensated care costs" are contradictory and should be modified to make them more consistent. We also believe that the definition in §455.204(c) is very complicated and could easily be misinterpreted. For these reasons, we recommend that in the §455.204(c) definition, the words "has reduced" be replaced with "does not receive total DSH payments in excess of." In addition, we recommend that the §455.204(c) sentence cited above should end with the phrase "coverage for the services" and that the phrase "in order to reflect the total amount of claimed DSH expenditures" be eliminated. These changes, SNAP believes, would eliminate the contradiction between the two definitions, make them more compatible, and more accurately reflect the intent of the statute. (As noted earlier in this letter, SNAP also recommends that CMS remove the reference to "bad debt" in the 447.299(c)(15) definition.)

Definition of "Low Income Utilization Rate"

According to §1923(b) of the Social Security Act, the low income utilization rate is the sum of two ratios:

1. Total Medicaid revenue + cash subsidies from state and local governments

total revenue for patient services

2. charity care charges-certain related cash subsidies
   total inpatient charges

The proposed regulation, however, states that the low income utilization rate only includes uninsured individuals who do not have third-party coverage for hospital services. SNAP believes that the low income utilization rate is clearly defined in §1923(b) of the Social Security Act and that this proposed regulation should use that same definition.

SNAP believes that the second sentence in §447.299(c)(7) ("The low income utilization rate calculation only includes individuals that have no source of third party coverage for the inpatient and/or outpatient hospital services they receive") is inaccurate and hopes it will be deleted in the final version of the regulation.

Physician Services

The background section of the proposed regulation states that physician services do not count as hospital costs. SNAP believes that certain physician services, such as clinic services, currently do count toward hospitals' costs and that they should continue to do so.

Citation

The proposed §447.299(c)(8) reads as follows:

> Disproportionate Share Payments. Indicate total annual payment adjustments made to the hospital under §1923(g).

Section 1923(g) refers to the hospital-specific DSH payment limit and does not provide for payment adjustments; we believe that the citation should be to the entire §1923, not to this subsection.

Requested Data That is Unrelated to DSH Reporting

SNAP believes that in certain areas, the proposed regulation calls for states to provide data that is unrelated to CMS's need to determine the appropriateness of DSH payments to hospitals. Below is a brief summary of the data elements in question.

- *Annual unduplicated number of Medicaid and uninsured patients receiving treatment.* We do not believe these figures are needed to determine the appropriateness of DSH payments. In addition, collecting this data would be extremely burdensome for hospitals.
- *Transfer money.* In SNAP's view, transfer money has nothing to do with the appropriateness of Medicaid DSH payments to hospitals.
- *"Regular Medicaid payments" and "Medicaid managed care organization payments" and "enhanced/supplemental Medicaid payments."* While we recognize the importance of the sum of these three figures in determining hospital eligibility for Medicaid DSH payments and in calculating the hospital-specific limits for such payments, we do not understand why these figures need to be reported separately because those separate figures, in and of themselves, do not contribute to CMS's ability to determine the appropriateness of DSH payments.

Issues That Would Benefit From Additional Clarification

SNAP believes that selected aspects of the proposed regulation would benefit from further explanation and clarification. We outline these issues below.

- *Audit outcomes.* As noted previously, the proposed regulation states the penalty for failure to provide the required information by the stipulated deadline but does not address the question of how CMS intends to use the data that it collects. How will this data affect the distribution of Medicaid funds to the states? If CMS is unhappy with the information gathered in the audits, will it attempt to take money back from the states? Will it require the states to take Medicaid DSH funds back from hospitals? While we recognize that it is possible that these questions have not been addressed because this is not part of CMS's plans, SNAP hopes that CMS can elaborate on its intentions and clarify them for the hospital community.
- *"Regular Medicaid payments."* This is a new term that would benefit from more explicit definition. Does it refer only to Medicaid fee-for-service payments or does it have other applications as well?
- *"Regular Medicaid payments" and "Medicaid managed care organization payments."* We do not understand, based on the proposed regulation, whether these categories are mutually exclusive.
- *"Supplemental and enhanced Medicaid payments."* The regulation does not specifically define these terms, leaving them subject to interpretation. In addition to increasing the likelihood of discrepancies in how different states and even different hospitals choose to define these terms, this lack of specificity also may increase the likelihood that hospitals and states will be held accountable, in a potentially damaging way, for failing to define the term as the regulation's authors envisioned.

About the Safety-Net Association of Pennsylvania

The Safety-Net Association of Pennsylvania represents the interests of private, acute-care hospitals that play the leading role in caring for the poor, the disadvantaged, and the uninsured residents of the commonwealth. Safety-net hospitals are the 25 percent of hospitals in Pennsylvania that care for the highest combined proportion of uninsured patients, Medical Assistance recipients, and Medicare SSI recipients and that therefore constitute the state's health care safety net. As a result of the patients they serve, Pennsylvania's safety-net hospitals face a significant, continuing, disproportionate challenge to their financial health.

* * *

We appreciate your attention to the issues raised above and welcome any questions you may have about any of these matters. Please feel free to contact me for further information at 717-234-6970.

Sincerely,

Michael Chirieleison
Executive Director

Submitter : Mr. Ebenezer Erzuah **Date:** 10/25/2005

Organization : Sparrow Health System

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

Please See Attachment

CMS-2198-P-54-Attach-1.DOC

[VIA ELECTRONIC FILING]

Attachment #54

October 23, 2005

The Honorable Mark McClellan, M.D., PhD
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.

Dear Dr. McClellan:

On behalf of Sparrow Hospital, we wish to take this opportunity to comment on the Centers for Medicare & Medicaid Services regarding the proposed rule implementing the Medicaid Disproportionate Share Hospital (DSH) payment reporting and auditing requirements included in the Medicare Modernization Act of 2003 (MMA) and which were recently published in the August 26, 2005 *Federal Register.*

Sparrow Hospital believes that the most pressing issue facing healthcare providers is the inadequate funding of government health care programs. This condition is even more critical for safety net hospitals throughout the country, such as Sparrow Hospital, which is the Lansing, Michigan area's only disproportionate share hospital (DSH) and level I Trauma Center.

Last year, Medicare and Medicaid payments to Sparrow Hospital fell substantially short of covering the operating costs associated with Sparrow Hospital caring for Medicare and Medicaid beneficiaries. The number of uninsured and underinsured patients has also been creeping up. Sparrow Hospital recorded a net uncompensated care amount of over $49 million in fiscal year 2004. This number goes up to $55 million when Medicare DSH payments are excluded.

Clearly, there is an inadequacy of Medicare and Medicaid payments to DSH hospitals and Level I Trauma Centers to account for the substantial increase in both healthcare cost and uninsured patients.

Sparrow Hospital offers the following comments in an effort to assist CMS in modifying the proposed rules implementing the Disproportionate Share Hospital (DSH) payments and auditing requirements included in the Medicare Modernization Act of 2003:

A. Reporting Requirements

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

The reporting requirement is for the State to indicate separately the total annual amount of uncompensated care cost for furnishing only inpatient hospital and outpatient hospital services to Medicaid eligible individuals and to individuals with no source of third party coverage for those services.

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 longstanding practice. The proposed rule states that "only 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 Act are included in the calculation of the hospital-specific limits." The agency's 1994 letter to state Medicaid programs offered additional guidance in the determination of un-reimbursed 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 included. In implementing the hospital-specific DSH limit, the agency took into consideration the cost associated with the uninsured and the underinsured populations. In 2002, the CMS issued a memo to state Medicaid programs regarding the hospital specific DSH limit and the upper limit and reaffirmed the 1994 DSH policy.

A substantial number of admissions and visits to Sparrow are made by uninsured individuals for which no payment is made and the costs associated with the non-payment of co-payments and deductibles for individuals with third party coverage in determining Sparrow Hospital's qualifying costs for the hospital specific DSH limit. In 2004, uncompensated care accounted for 6% of total patient days at Sparrow Hospital. Last year Sparrow Hospital incurred $22.7 million on net bad debt expense. Uninsured patients generated the majority of this amount. *(Current Medicare policy requires that hospitals seek payment from individuals that have the means to pay their co-payments and deductibles. Medicare qualifying bad debt is reimbursed at a 30% discount if beneficiaries are unable to pay).*

Sparrow Hospital classifies a charge as bad debt only after it has exhausted all efforts to collect the funds from the patient. The proposed exclusion of bad debt expense in the uncompensated care amount is troubling and comes at the worse time because of the recent growth of health plans that impose high deductibles and /or exclusion limits coupled with the growth of health savings accounts.

This condition is gradually shifting the healthcare burden from a share corporate or national responsibility to individuals.

Sparrow Hospital recommends that the CMS modify its definition of uncompensated care by including bad debt or unpaid deductibles and coinsurance. The section of the proposed rule defining uncompensated care should include the following:

- **Unpaid portion of services provided to individuals that have no health care insurance, third party coverage, or third party payment.**
- **Unpaid portion of services provided to individuals that have health savings accounts, which is due to health plan exclusions, limits or deductibles.**

Physician Services - The proposed rule states that the total annual uncompensated care for furnishing inpatient hospital and outpatient 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 less the sum of regular Medicaid rate payments, Medicaid managed care organization payments, supplemental/enhanced Medicaid payments, and indigent care revenue. This definition of uncompensated care excludes the cost incurred by hospitals to secure physicians that serve indigent patients should be allowed in the establishment of the hospital specific DSH limit. Sparrow Hospital operates physician clinics that focus on providing primary care to the underserved population mostly at a loss because of reduced reimbursement rates for these services. The statute that created the DSH provision does not specifically exclude physician services.

We recommend that the physicians' costs associated with hospital services should be included in the determination of the uncompensated care cost. The reference to the exclusion of physician costs in determining the hospital's uncompensated care costs should be deleted from the preamble.

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 cost in its state Medicaid Plan or any other definition as long as the costs determined under that definition do not exceed the amounts allowable based upon Medicare principles of cost reimbursement.

Sparrow Hospital would like to recommend that the CMS reaffirm the definition of allowable cost in the proposed rule in order to ensure a greater level of consistency among all states and Medicaid DSH programs. A reference to the cost determination method via the Medicare cost report would be beneficial.

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

Section 1001(d) of the MMA amended section 1923(j)(2) of the Act to require States to annually submit to CMS an independent certified audit report that verifies information about DSH payments to hospitals. Section 1923 (j)(2)(A) of the Act requires that the independent audit verifies whether total claimed DSH expenditures for each hospital, including the non-Federal share, are included as revenues when determining whether DSH payments are less than or equal

to each hospital's UCC. The cost of this audit would be passed on to DSH hospitals since the state currently uses employed auditors to review Hospital specific cost report and uncompensated care data. The cost to each hospital could be as high as $50,000. DSH hospitals are currently not in the financial position to absorb this cost.

Sparrow Hospital would like to recommend that the CMS accept the current audit processes of the State of Michigan and if the CMS decides to implement the independent audit rule that it be funded by a special appropriation to the States for such purpose. We would also like the CMS to state affirmatively that the cost associated with the audit should not be passed on to the DSH hospitals.

Sparrow Hospital is committed as part of its mission statement, to provide quality, compassionate, cost effective care to all patients in the Lansing area irrespective of their ability to pay. We continually strive to meet this mission but on an annual basis payment adjustments are implemented by both the Federal government and the State of Michigan that substantially reduce our ability to deliver health care services to all patients. The burden of taking care of the health care needs of the uninsured and underinsured is getting unbearable for DSH hospitals like Sparrow Hospitals, thus we implore you to strongly consider our comments and recommendations stated above.

If you have any questions comments about the stated issues above, please contact me at (517) 364-6020 or at ebbie.erzuah@sparrow.org.

Thank you for your attention to these matters.

Sincerely,

EBBIE N. ERZUAH
Finance Director – Government Programs
Edward W. Sparrow Hospital Association

Submitter : Ms. Mark Moody **Date:** 10/25/2005

Organization : Wisconsin Division of Health Care Financing

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2198-P-55-Attach-1.DOC

Jim Doyle
Governor

Helene Nelson
Secretary

State of Wisconsin

Department of Health and Family Services

DIVISION OF HEALTH CARE FINANCING

1 WEST WILSON STREET
P O BOX 309
MADISON WI 53701-0309

Telephone: 608-266-8922
FAX: 608-266-1096
TTY: 608-261-7798
dhfs.wisconsin.gov

Attachment #55

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

MBM:kjd
HP10033.RP
J-20-1-05

Submitter :

Date: 10/25/2005

Organization :

Category : **State Government**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment.

CMS-2198-P-56-Attach-1.DOC

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

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,

Charles A. Miller
Kelly C. Blevins
Covington & Burling
1201 Pennsylvania Ave, N.W.
Washington, D.C. 20004-2401

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

Submitter : Ms. Christine Bronson **Date:** 10/25/2005

Organization : Minnesota Department of Human Services

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

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 ? signature //
Medicaid Director

Submitter : Ms. Christine Bronson **Date:** 10/25/2005

Organization : Minnesota Department of Human Services

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2198-P-58-Attach-1.RTF

Minnesota Department of **Human Services**

Attachment #58

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.

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 – signature //
Medicaid Director

Submitter : Mr. Auston Johnson **Date:** 10/25/2005

Organization : National State Auditors Association

Category : Other Association

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2198-P-59-Attach-1.PDF

#5-9

National State Auditors Association

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

The National State Auditors Association (NSAA) is pleased to provide the following comments in response to the proposed regulations implementing section 1001(d) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) which establishes new reporting and auditing requirements for state Disproportionate Share Hospital (DSH) payments.

Apparent circumvention of Single Audit Act

We are unclear about how the proposed certified independent audit of the state's DSH payments would impact a state's Single Audit. The proposed rules appear to require a separate audit, especially since there is no reference to the Single Audit Act. This seems to be an obvious circumvention of the act. We believe these audit requirements should be included in the existing framework for audits of federal programs under the Single Audit Act and include the five items requiring verification in the OMB Circular A-133 Compliance Supplement. Specifically, we believe the most practical and effective manner for these proposed requirements to be met is to:

1. Require hospitals to expand their current financial audits to include the appropriate hospital-related compliance issues.

2. Revise OMB Circular A-133 Compliance Supplement to require the state Medicaid program's auditor test this reporting requirement by ensuring the Medicaid program received the information and audit assurances from the hospitals, accumulated the information, and properly reported the results to the Centers for Medicare and Medicaid Services.

Clarification needed if separate audit requirements remain

1. The proposed rule defines an independent audit as one conducted in accordance with *Government Auditing Standards*. However, it is not clear whether this audit is intended to follow the financial audit standards or attestation engagement standards of *Government Audit Standards*. Further, if attestation standards are to be used, the regulations need to describe whether auditors are expected to follow the examination, review, or agreed-upon procedures type of engagement. Obviously the objectives of each of these four possible audits, and the resultant reports will yield quite different scopes and results. CMS should add the necessary guidance to make explicit which of the *Government Auditing Standards* should be used here.

2. The proposed rule does not specify, and there seems to be much confusion over, who is responsible for obtaining the independent audit and ensuring the requirements are met. From our perspective, there are several possible alternatives for performing this function. For example, it could be presumed that these audit requirements are the responsibility of the state's auditor, the state Medicaid program's auditor, the Medicaid agency's staff or their agent, or the hospital's auditor. Therefore, the guidance in the proposed regulation should be clarified.

2401 Regency Road, Suite 302, Lexington, Kentucky 40503-2914, Telephone (859) 276-1147, Fax (859) 278-0507
444 N. Capitol Street, NW, Suite 234, Washington, DC 20001, Telephone (202) 624-5451, Fax (202) 624-5473
www.nasact.org

3. We also believe there are several impediments to ensuring that this proposed audit requirement is met.
   a) It appears that verifying each hospital's proper treatment of uncompensated care costs can only be accomplished by the auditor performing audit procedures at ***each*** hospital. At best, this means in some states, dozens or more hospitals will have to be audited for compliance with this requirement. At worst, hospitals will not be cooperative. In addition, state auditors may not have jurisdiction to audit private hospitals.
   b) The extent of testing is not established by this rule, and without such clarification, will most certainly result in inconsistent and inadequate audit coverage.
   c) It is not clear if audit procedures applied in any other audits the hospital has undergone would be sufficient to rely upon in this verification.

   CMS should revise the proposed rule to clearly describe the level of verification expected (i.e., the extent of audit procedures).

4. We are concerned about the timing of this audit requirement. Our understanding is that the proposed rules will require the audit work to be as of the end of state fiscal year 2005. Given that the fiscal year is already over, the proposed rules are not yet in effect, and the significant number of entities (hospitals, states, auditors) impacted, it will be very difficult, or near to impossible, to meet the requirement as of the end of the year.

We appreciate the opportunity to provide our comments. Should you have any questions or need additional information regarding our response, please contact Sherri Rowland of NSAA at (859) 276-1147 or me at (801) 538-1360.

Sincerely,

Auston G. Johnson
President, NSAA

Submitter : Mr. Reginald Ballantyne **Date:** 10/25/2005

Organization : Vanguard Health Systems, Inc.

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2198-P-60-Attach-1.DOC

Attachment #60

VANGUARD
HEALTH SYSTEMS

October 25, 2005

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

Reference: File Code CMS – 2198 P

Re: Comments in Response to Proposed Rule to implement section 1001(d) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) which establishes new reporting and auditing requirements for State Disproportionate Share Hospital Payments

Centers for Medicare and Medicaid Services:

The purpose of this filing is to register the strong opposition of Vanguard Health Systems to that part of Section III (A) of the proposed rule (Provisions of the Proposed Regulations – Reporting Requirements) addressing "Medicaid Eligible and Uninsured Individuals." Specifically, Vanguard protests the proposed treatment of payments to hospitals under Section 1011, Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens, of the MMA. The proposed rule provides:

> "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 payment should not exceed the total amount of uncompensated care at the hospital ..."

We understand that this proposed treatment of Section 1011 payments could operate to count such payments against a hospital's DSH limit. The enactment of Section 1011 was intended as a new source of funding to help cover the costs of federally mandated – but uncompensated – services to undocumented aliens. No statutory basis has been provided to support this portion of the proposed rule, nor does one exist.

When Senator Jon Kyl, author of Section 1011, spoke to the congressional intent of the provision, no mention was made of utilizing the additional authorized funds as a substitute for DSH payments already made to hospitals, to wit:

> "Because emergency rooms now are faced with treating illegal immigrants under this requirement and because the federal government has not been able to enforce the law to prevent those people from coming into the country illegally in the first instance, we believed it was important for the federal government to at least help these hospitals defray some of the expenses they are incurring, which in some cases are so severe, it is forcing hospitals to consider closing down and certainly shutting down emergency room care." (*108th Congress, Congressional Record at S15524 [November 22, 2003]*)

Based on our ongoing work with the senatorial author of Section 1011, we know that the proposed rule is manifestly contrary to congressional intent. That intent is clarified in section 1002 of S. 1033, the Secure America and Orderly Immigration Act of 2005, which states:

> **SEC. 1002. PROHIBITION AGAINST OFFSET OF CERTAIN MEDICARE AND MEDICAID PAYMENTS.**
>
> Payments made under section 1011 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (42 U.S.C. 1395dd note)--
>
> (1) shall not be considered `third party coverage' for the purposes of section 1923 of the Social Security Act (42 U.S.C. 1396r-4); and
>
> (2) shall not impact payments made under such section of the Social Security Act.

To adopt the proposed rule would be to: violate clearly expressed congressional intent; invite and require statutory correction; unnecessarily result in future administrative proceedings; and, most important, immediately deprive health care providers of the full benefit of Section 1011. Accordingly, Vanguard Health Systems respectfully requests CMS to amend the proposed rule so that is comports with congressional intent, as reflected in Section 1002 of S. 1033 cited above.

Sincerely,

Reginald M. Ballantyne, III
Senior Corporate Officer

Submitter : Mr. Edwin Stephens **Date:** 10/25/2005

Organization : The Agency for Health Care Administration

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2198-P-61-Attach-1.DOC

CMS-2198-P-61-Attach-2.DOC

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

JEB BUSH, GOVERNOR

ALAN LEVINE, SECRETARY
Attachment #61

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: Proposed rule implementing section 1001(d) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) which establishes new reporting and auditing requirements for State Disproportionate Share Hospital payments.

File code: CMS-2198-P

Via electronic submission to http://www.cms.hhs.gov/regulations/ecomments

Dear Sir/Madam:

The State of Florida Agency for Health Care Administration (AHCA), Division of Medicaid, in collaboration with AHCA's Disproportionate Share Council (DSH Council), submits the following comments regarding the above rule:

1. Amount paid to Managed Care Organizations: The Centers of Medicare & Medicaid Services (CMS) proposes that each state report the total annual amount paid to hospitals by Medicaid managed care organizations of hospital services furnished to Medicaid eligible individuals. Because these payments to hospitals are paid by the managed care plans and not AHCA, AHCA has no first hand knowledge, and no claims documentation regarding these payments. However, AHCA does require hospital financial information that references these payments in total.

   Additionally, CMS has criticized AHCA's use of this information (Florida Hospital Uniform Reporting System (FHURS)) for its hospital inpatient upper payment limit calculation. Therefore, AHCA has concerns whether CMS would find this source of information acceptable for managed care payments to hospitals. If not, additional reporting and documentation would be required for AHCA to obtain this data.

   Furthermore, AHCA requests clarification as to how CMS proposes that such information, including regular Medicaid rate payments, be documented. If AHCA

must request managed care information from each participating hospital, is it acceptable to request their reporting of regular Medicaid rate payments? If not (e.g. using an alternative source such as the Florida Medicaid Management Information System (FMMIS)), AHCA requests clarification regarding why self-reported hospital data is sufficient for one purpose (managed care payments) but not another (regular rate payments).

2. Indigent Care Revenue: The rule indicates that for Indigent Care Revenue, "The State would indicate the total annual payments received by the hospital from individuals with no source of third party coverage for inpatient hospital and outpatient hospital services they receive."

   The phrasing of this requirement implies that the State should report all payments unrelated to third party coverage. As some individuals can pay for certain hospital bills privately, these payments would be included within this definition. Therefore, private pay amounts would be included as Indigent Care Revenue. If this is correct, then bad debts should be included in uncompensated care. If this is incorrect, CMS should clarify what amounts are to be included as revenue from the indigent, and how the indigent and their revenues are to be identified.

3. Low Income Utilization Rate & Indigent Care: CMS requests the states to report the hospital's low income utilization rate as defined in section 1923(b)(3) of Title XIX of the Social Security Act (the Act). CMS further states that "the low income utilization rate determination should only include those individuals that have no source of third party coverage." In section 1923(b)(3) of the Act there is no reference that individuals with no source of third party coverage are to be excluded. This section does state that the calculation include "the total amount of the hospital's charges for inpatient hospitals services which are attributable to charity care..."

   Charity care is defined in the Title XIX Florida Inpatient Hospital Reimbursement Plan and the FHURS manual. Charity care (uncompensated care) is the portion of hospital charges reported for which there is no compensation. The qualifications include documentation that the individual's income is within a certain percentage of the federal poverty level. Florida Medicaid requires audits of the hospital's charity data by First Coast Service Options, Inc., the Florida fiscal intermediary.

   An individual could qualify for charity care and still have third party coverage. An example would include an individual whose primary coverage is auto insurance. The individual's stay is lengthy as are the charges incurred. The auto coverage is limited to personal injury protection (PIP) which is exhausted within the first few days of stay. The balance due is the individual's responsibility. If the individual was unable to pay the balance and qualified within the stated federal poverty guidelines, the remaining charges may be classified as charity care. The unpaid balance is documented in the hospital accounts as uncompensated care. Similar scenarios can exist with commercial insurance where the benefits are extremely low (e.g. $200 per

diem with the individual responsible for all remaining charges). These situations are examples of the underinsured.

Uncompensated costs exist for individuals with third party coverage as well as those who have no third party coverage. In addition, bad debt exists for individuals with third party coverage as well as those who have no third party coverage. CMS should clarify what amounts (revenue charges and costs) are to be included in uncompensated care, and how the indigent are to be identified.

4. Costs for individuals with no third party coverage: CMS requests that States report the "...costs incurred for furnishing those services provided to individuals with no source of third party coverage for the inpatient hospital and outpatient hospital services they receive." However, CMS does not indicate how such costs for these services are to be identified.

   Florida currently calculates such costs using a Medicaid cost to charge ratio applied to charges associated with the indigent and uninsured. However, these charges are only reported to the State in the aforementioned FHURS reports. Medicare cost reports, CMS 2552-96, do not include this information. If CMS requests such information, but has concerns regarding how the State currently gathers and computes this information, CMS should provide clarification regarding acceptable methods for computing the cost of care for these services. CMS should clarify the difference between "third party coverage" and "indigent care revenue."

5. Bad debt: CMS states that bad debt is not to be included as uncompensated care costs. If a low income individual has employer sponsored coverage with a high deductible, a hospital may be left with a large unpaid balance if the individual's deductible is applicable to the hospital services. Conversely, an individual may have sufficient income to not be considered indigent, but have no health insurance. Under that scenario, a hospital may bill the individual for services, and the individual may pay a fraction of the charge, leaving the balance unpaid. The remaining charges, or cost as determined, does represent costs to the hospital for services to the uninsured or underinsured, but have been classified as bad debt due to accounting technicalities. CMS should clearly define the criteria for determining when a bad debt can be included as uncompensated care costs, and should not insist on prohibiting all bad debt from inclusion in this category.

6. Undocumented aliens: CMS proposes that States need to consider payments made under section 1011, Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens, of the Medicare Modernization Act (MMA) in determining the hospital's DSH limit. Florida requests clarification as to how CMS proposes that such information be considered. If Florida is required to rely on self-reported hospital data then Florida also requests clarification regarding why self-reported hospital data is sufficient for one purpose (section 1011 payments or managed care payments mentioned in item 1 above) but not another (regular rate payments).

7. General revenue: AHCA receives state legislative authority to make distribution to hospitals from general revenue. Florida requests confirmation from CMS that these payments, unmatched by federal funds, are excluded from the hospital's DSH limit calculations.

8. Florida raises the following concerns regarding the requirement of an independent certified audit report:

    a. The initial period to be audited is defined as the period "...beginning with an audit of its State fiscal year 2005 DSH program." For Florida, that would be the fiscal year ending 6/30/05. Auditing a historic period for specific information that was not required at the time of the payments sets up the program for negative audit comments. Florida suggests that no audit be required for a period for which the requirements have not been clearly identified.
    b. CMS requests verification that the hospital's DSH payments for a given fiscal year are within the calculated DSH limit of that fiscal year. The current calculation of a hospital's DSH limit is through use of the FHURS reports in conjunction with the Medicare cost report, CMS 2552-96, including the Medicaid schedules. The cost data used to calculate hospital's DSH limit is reported by the provider's fiscal year end which often is not the same as the State's fiscal year end. The hospital DSH limit is created using historical data. Florida proposes to continue using historical information to determine current DSH limits.
    c. Using an independent auditor would add administrative costs to the Medicaid program. Florida request CMS to confirm if DSH funds can be used to fund the cost of the audit, and if the State can claim FFP at the DSH matching rate.
    d. CMS proposes that the audit must verify that the uncompensated care costs of providing physician services are not included in the calculation of the hospital-specific DSH limit. Florida hospitals are constantly striving to maintain a sufficient supply of physicians to treat Medicaid and indigent patients. Many hospitals and health systems incur additional costs to address the physician shortage. These costs should not be excluded as part of the hospital's DSH limit calculation as they represent hospital's efforts to provide continued quality care to Medicaid and indigent patients.
    e. Without clarification of the other issues discussed in these comments, the State may find itself disagreeing with its auditor over the definitions of certain requirements and methodologies. Without additional CMS clarification, the auditor may revert to a reasonableness test when clarification is lacking, which may not meet the objectives of CMS in promulgating these rules.

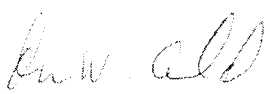
9. Uninsured: CMS should further clarify what costs may be included in the costs of services for the uninsured. For example, provider based clinics may provide physician services to the uninsured, but are not allowable costs in the Medicare cost report for determining allowable outpatient costs. Should such costs be included when such services are provided to the uninsured? Similar issues regarding ancillary and pharmacy services should be addressed.

10. Without CMS clarification, many of these requirements will require additional reporting by participating hospitals. Lacking additional guidance, each State will create its own reporting mechanisms, adding to the reporting burden under which hospitals currently operate under. Several requirements, such as an unduplicated count of uninsured individuals, may not be possible within current billing systems.

    Furthermore, even if hospitals are able to submit unduplicated counts to AHCA, AHCA will have to complete additional analysis to determine the unduplicated count of Medicaid and the uninsured to cross match data from different hospitals.

Thank you for accepting Florida's comments on proposed rule (file code) CMS -2198-P. We appreciate the opportunity to provide feedback on the proposed changes in the Disproportionate Share Hospital Program.

Sincerely,



Thomas W. Arnold,
Deputy Secretary,
Florida Medicaid

cc: Tony Carvalho, Chairman, Disproportionate Share Council
Paul Belcher, Senior Vice President, Florida Hospital Association

Submitter : **Carolyn Ingram** **Date: 10/25/2005**

Organization : **HSD-Medical Assistance Division**

Category : **State Government**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2198-P-62-Attach-1.WPD

New Mexico Human Services Department

Medical Assistance Division
PO Box 2348
Santa Fe, NM 87504-2348
Phone: (505) 827-3103; Fax: (505) 827-3185

Bill Richardson, Governor
Pamela S. Hyde, J.D., Secretary

October 25, 2005

Attachment #62

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

To whom it may concern:

Please consider the following as official comments to CMS Proposed Rule 2198-P from the New Mexico Medical Assistance Division:

Retroactive Application. The proposed rule addresses reporting requirement that apply retroactively to State Fiscal Year 2005. Certain information and data was not previously collected on the cost reports.

Reporting Based on State Fiscal Year. The establishment of a State Fiscal Year reporting timeline may prove problematic. New Mexico currently distributes DSH payments to providers on a federal fiscal year basis. Also, New Mexico requires providers to submit Medicaid cost reports to the audit agent 150 days from the end of their fiscal year. The audit agent then has 150 days to complete the audit of the report and submit the report to New Mexico. This time frame provides the state with a narrow window of time to complete and submit the newly required independent certified audit.

Direct Matching. It appears that the draft regulation appears to require a direct matching between payments and the costs incurred. Due to the timeline of the cost reporting process stated above, this requirement could be difficult to meet.

Unduplicated Number of Medicaid and Uninsured Individuals. The proposed regulations require that states report by hospital the total unduplicated number of Medicaid and uninsured individuals. The Medical Assistance Division keeps a report of the total number of Medicaid individuals however has never collected this information by hospital therefore there would not be data for State Fiscal Year 2005 and State Fiscal year 2006. Policy changes would need to be put in place to require hospitals to report this data.

Exclusion of Physician Costs. Currently, physician services are part of the services that hospitals routinely provide to the uninsured. The draft regulation does not address how physician costs should be treated for DSH purposes for public teaching hospitals that have elected to receive cost-based reimbursement for their physicians as provided for at 42 CFR 415.160.
Definition of Inpatient Hospital. The proposed regulation does not reference 42 CFR 441.40 which provides the definition of an Institution for Mental Disease (IMD) which are currently entitled to participate in Medicaid DSH Programs. New Mexico currently makes DSH payments to such facilities.

For the above concerns and comments, New Mexico would need to make several regulation changes

that would need to be retroactive to July 1, 2005. New Mexico currently does not have a procedure to change regulations retroactively.

If you have any questions regarding these comments, please feel free to call me at 505-827-3106. Thank you.

Sincerely,

/ s /

Carolyn Ingram, Director
Medical Assistance Division

Submitter : **Ben Pully** **Date: 10/25/2005**

Organization : **Virginia Hospital**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2198-P-63-Attach-1.DOC

4200 INNSLAKE DRIVE, GLEN ALLEN, VIRGINIA 23060-6712
PO BOX 31394, RICHMOND, VIRGINIA 23294-1394
(804) 965-1227 FAX (804) 965-0475

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

Subject: CMS-2198-P

Dear CMS:

The Virginia Hospital & Healthcare Association (VHHA) 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 Virginia's safety net hospitals. VHHA, however, has numerous concerns with the presently drafted rule and believes CMS should reconsider several key components outlined below.

42 C.F.R. 477.229(c)(6): Report Medicaid inpatient utilization rate as defined in 1923(b)(2).
42 C.F.R. 477.229(c)(7): Report low income utilization rate as defined in 1923(b)(3).

Virginia's DSH methodology defines Medicaid inpatient utilization differently than does 1923(b)(2). Therefore, the state does not utilize the hospital data required under these provisions of the proposed rule. As neither of these reporting requirements is specifically required in the MMA and neither contributes to compliance with the hospital-specific DSH limitation, we feel they place an unnecessary reporting burden on Virginia hospitals and recommend this requirement be removed.

42 C.F.R. 477.229(c)(12): Report indigent care revenue.

The proposed rule requires reporting of total payments received by hospitals from individuals with no source of third party coverage. VHHA 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 we recommend this requirement be removed.

42 C.F.R. 477.229(c)(14): Report the cost of inpatient and outpatient services provided to Medicaid and uninsured patients.

In Virginia, DSH payments are less than Medicaid uncompensated care alone, which is calculated for each hospital on the Medicaid cost reporting forms. Thus, most DSH hospitals are not required to report costs of uninsured patients on the cost reporting forms. Requiring hospitals to do so would be an unnecessary and significant reporting burden. VHHA recommends that the proposed rule be amended to grant states the option to not report uninsured costs for some or all hospitals where Medicaid losses justify the DSH payment made.

42 C.F.R. 477.229(c)(15): Report separately the uncompensated care of Medicaid and of uninsured patients.

VHHA does not believe existing law and regulation supports the new definition of uncompensated care to exclude both bad debt and physician services. We feel CMS should change its definition of uncompensated care by striking the reference to bad debt in 447.299(c)(15) and in its place clarify that it includes the costs of services furnished to individuals with no health care insurance, third party coverage, or third party payment. The definition should also include individuals with health savings accounts and include the costs of services furnished to insured individuals whose policies do not cover the services provided the individual due to their health plans exclusions, limits, or deductibles. The definition of uncompensated care should include physician costs as well.

42 C.F.R. 477.229(c)(16): Separately report the unduplicated number of Medicaid eligible individuals and uninsured individuals receiving inpatient and outpatient hospital services.

VHHA feels the proposed rule fails to make the case why this information is necessary. The Virginia Medicaid program does not currently capture data that would support an effort to count unduplicated uninsured individuals receiving inpatient and outpatient hospital services. Therefore, Medicaid would turn to the hospitals to produce these patient counts, many of which do not have the reporting systems necessary to allow them to generate unduplicated counts of patients that are Medicaid eligible or uninsured. This reporting requirement would be unnecessarily burdensome for hospitals and should be removed from the rule.

42 C.F.R. 455.204(b): Audit is required for SFY2005 and subsequent fiscal years no later than 1 year after the completion of each state fiscal year.

The proposed rule retroactively applies the new reporting and auditing requirements to each state's fiscal year 2005, which has already ended for Virginia and will not be finalized until much later in fiscal year 2006. The retroactive application of these new reporting and auditing requirements makes little sense now and will impose a hardship for the Medicaid program as well as DSH hospitals. VHHA 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.

42 C.F.R. 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.

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

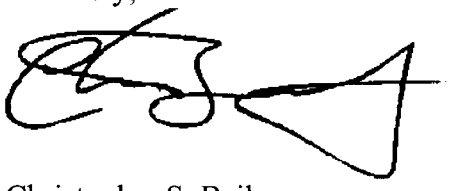
42 C.F.R. 455.204(c)(2): The audit must verify that DSH Payments made in each audited SFY must be measure against he actual uncompensated care cost in that same audited SFY.

The regulation 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 and not necessarily the year in which the funds were dispersed. The regulation should be amended to state that the DSH payment needs to be compared to the uncompensated care cost of the year to which the DSH payment truly applies.

VHHA appreciates this opportunity to comment on the proposed rule to implement the Medicaid DSH reporting and auditing requirements of the MMA. While we understand CMS' desire to better understand state DSH programs, the proposed rule as written represents an overly burdensome approach beyond what is required under the MMA. 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 about our comments, please contact me at (804) 965-1207 or at cbailey@vhha.com. Thank you for your time and consideration

Sincerely,



Christopher S. Bailey
Senior Vice President

Submitter : Mr. Robert Kerr **Date:** 10/25/2005

Organization : South Carolina Dept. of Health

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2198-P-64-Attach-1.DOC

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Robert M. Kerr
Director

October 25, 2005

Attachment #64

Mark McClellan, M.D., Ph.D.
Administrator
Center for Medicare and 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 South Carolina Department of Health and Human Services wishes to make the following comments on the Proposed Rule which implements section 1001(d) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 that establishes new reporting and auditing requirements for State Medicaid Disproportionate Share Hospital Payments.

Reporting Requirements (Including the excel spreadsheet):

1. **Excel Spreadsheet** - Please clarify what is expected in the **Definition of Uncompensated Care** block? The definition is included in the proposed rule. Are you looking for a description of the sources of data used in the calculation as well as a description of the methodology used to calculate Uncompensated Care cost by the state?
2. **Excel Spreadsheet - Column D**: There is only one column for Type of Hospital Ownership. In the proposal, you are asking States to indicate the type of ownership of the hospital (e.g. privately-owned, State government-owned, etc.) and how the hospital is operated (e.g. privately operated, state-government operated, etc.). It appears that you are requesting asset ownership as well as licensee ownership. Is CMS going to define a public versus private entity? Also, will CMS identify the sources of information that can be used and acceptable to CMS to determine public versus private entities? As an example, how would CMS classify the operating type of a non-State government-owned hospital that has a management contract with a privately owned corporation? Would this be considered a non-State government-owned operated hospital or a privately operated hospital?
3. **E xcel Spreadsheet - Column O:** It appears that you are looking for one amount for Medicaid Eligible & Uninsured Individuals for all DSH hospitals. Please clarify what you are expecting in light of the following comments. In one reporting period some patients can receive hospital services as Medicaid and uninsured. Do you want an unduplicated list that includes all Medicaid eligible and uninsured patients receiving hospital services in a period? Also, you mention that the information contained on the excel spreadsheet is requested for each DSH hospital. Could CMS clarify that the information contained in the spreadsheet is required on all DSH hospitals even though the unreimbursed Medicaid fee for service cost may be paid outside of the DSH Program? For example, there are Medicaid eligible patients who receive inpatient/outpatient services whose hospital claims are paid by other payers (not Medicaid).
4. **Audit Requirements** It is stated that each State must obtain an independent certified audit, beginning with an audit of its State fiscal year 2005 DSH program. While we have been aware of the general audit

Office of the Director
P.O. Box 8206 Columbia, South Carolina 29202-8206
(803) 898-2504 Fax (803) 898-4515

requirements of MMA, some of the details included in this proposed rule are new. Since we have operated our 2005 DSH program in accordance with an approved State Plan amendment it does not seem fair that the 2005 DSH plan would be audited by new rules. Therefore, we recommend that the rules be finalized and applied prospectively.

Verifications:

5. **Under Verification 2 it is stated that DSH payments made in the audited SFY must be measured against the actual uncompensated care costs in the same audited SFY** . . . South Carolina employs a prospective DSH payment methodology using desk audited base year cost report data inflated to the payment period to represent the unreimbursed cost for DSH purposes. We keep the base year as current as possible and use the CMS Market Basket Forecasts for inflation trending. Medicaid revenue is adjusted to the payment period in the event that inpatient or outpatient rate increases are implemented during or after the base year. We also adjust Medicaid revenue to take into account any supplemental Medicaid payments that are made. We feel our prospective payment is the most reasonable and feasible approach. CMS has always approved the prospective DSH payment methodology via state plan amendments. It would be an administrative burden to perform retrospective reviews and adjust each year' s DSH payments. Therefore, we request that CMS audit the data used by the state to determine the prospective DSH payments paid during the state fiscal year based upon the CMS approved DSH state plan payment methodology to determine the actual uncompensated care costs in the same audited SFY . Also, in SFY 2004-05, our DSH UPL for public hospitals was set at 175% of cost as allowed by federal law. Therefore, we request that CMS acknowledge that the SFY 2005 DSH payments can be set at 175% of unreimbursed costs and not at actual uncompensated care costs . In addition, we question the use of SFY 2005 as the first year to conduct the audits because of the 175% DSH plan. We could not make payments at this level because the total unreimbursed cost significantly exceeded the state DSH allotment. It would seem that the additional administrative burden this would add would not reap the outcomes to make it worth the effort.
6. **U nder Verification 5 the State has collected and continues to maintain appropriate documentation for its calculation of hospital-specific DSH limits** . . . We survey the hospitals in order to get the data required to determine DSH eligibility and payment. We have an authorized hospital representative sign the survey to certify that the data is accurate and in accordance with hospital records. We require that hospitals maintain the supporting documentation for potential audits. Is this sufficient or will we be required to have all the supporting documentation housed at the Medicaid agency?

Thank you for the opportunity to comment on the proposed regulations. We look forward to working with CMS on this important issue.

Sincerely,

/s/

Robert Kerr
Director

RMK/wsw

Submitter : Mr. Stan Rosenstein **Date:** 10/25/2005

Organization : California Department of Health Services

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

See Attachments - A Microsoft Word version and an Acrobat PDF version are attached for your convenience. Thank you.

CMS-2198-P-65-Attach-1.DOC

CMS-2198-P-65-Attach-2.PDF

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

Attachment #65

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

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,

/s/ ***Stan Rosenstein***

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

Submitter : Mr. Matthew Gutwein **Date:** 10/25/2005

Organization : The Health and Hospital Corporation of Marion Coun

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter : **Mr. Jerry Friedman** **Date: 10/25/2005**

Organization : **American Public Human Services Association**

Category : **Other Association**

Issue Areas/Comments

GENERAL

GENERAL

October 25, 2005
Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
Room 445-G
200 Independence Avenue, S.W.
Washington, DC 202010

Attention: CMS-2198-P

Re: Proposed Rule?Medicaid Program; Disproportionate Share Hospital Payments

Dear Dr. McClellan:

The American Public Human Services Association (APHSA) and its affiliate the National Associatio of State Medicaid Directors (NASMD) is pleased to submit comments on the proposed rule establishing new reporting and auditing requirements for state Disporportionate Share Hospital (DSH) payments as set forth in section 1001(d) of the Medicare Modernization Act of 2003. APHSA and NASMD is commenting on the proposed rule described in the August 26, 2005, Federal Register (70 FR 50262) for the Centers for Medicare and Medicaid Services (CMS). APHSA and NASMD represents human service agencies in all states and many counties throughout the United States.

As representatives of human services officials and organizations, APHSA and NASMD support federal and state efforts to monitor and ensure appropriate use of public funding, including DSH payments. We also recognize that DSH policy has evolved over a number of years as CMS and states have negotiated individually on different issues rather than through a preferable formal and transparent rule making process. However, we are troubled that CMS seems to have exceded Congressional intent by using MMA?s DSH provisions to implement new DSH policies. We encourage you to request CMS leadership to reconsider a number of aspects of the DSH reporting and auditing proposed rule, including the following major issues:

? changes to DSH policy that exceed MMA requirements;
? exclusion of bad debt from the uncompensated care definition; and
? burdensome administrative and reporting.
1. Changes to DSH Policy that Exceed MMA Requirements

With this DSH audit proposed rule CMS may be circumventing the transparent rule-making process that provides for public stakeholder discussion of substantive policy changes as are embodied in within the proposal. APHSA and NASMD believe that CMS is exceeding the requirements of MMA and is introducing significant policy changes by re-defining uncompensated care definitions as well as implementing a more extensive DSH audit requirement and reporting process than required by MMA. MMA?s Section 1011(d) did not amend section 1923(g) of the Social Security Act, which establishes hospital-specific DSH limits for the costs of uncompensated care. However, the DSH audit proposed rule revises the uncompensated care definition to exclude both bad debt and physician services.

CMS-2198-P-67-Attach-1.DOC

APHSA
American Public Human Services Association

Attachment #67

October 25, 2005

Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
Room 445-G
200 Independence Avenue, S.W.
Washington, DC 202010

Attention: CMS-2198-P

Re: Proposed Rule—Medicaid Program; Disproportionate Share Hospital Payments

Dear Dr. McClellan:

The American Public Human Services Association (APHSA) and its affiliate the National Associatio of State Medicaid Directors (NASMD) is pleased to submit comments on the proposed rule establishing new reporting and auditing requirements for state Disporportionate Share Hospital (DSH) payments as set forth in section 1001(d) of the Medicare Modernization Act of 2003. APHSA and NASMD is commenting on the proposed rule described in the August 26, 2005, *Federal Register* (70 *FR* 50262) for the Centers for Medicare and Medicaid Services (CMS). APHSA and NASMD represents human service agencies in all states and many counties throughout the United States.

As representatives of human services officials and organizations, APHSA and NASMD support federal and state efforts to monitor and ensure appropriate use of public funding, including DSH payments. We also recognize that DSH policy has evolved over a number of years as CMS and states have negotiated individually on different issues rather than through a preferable formal and transparent rule making process. However, we are troubled that CMS seems to have exceded Congressional intent by using MMA's DSH provisions to implement new DSH policies. We

encourage you to request CMS leadership to reconsider a number of aspects of the DSH reporting and auditing proposed rule, including the following major issues:

- changes to DSH policy that exceed MMA requirements;
- exclusion of bad debt from the uncompensated care definition; and
- burdensome administrative and reporting.

1. Changes to DSH Policy that Exceed MMA Requirements

With this DSH audit proposed rule CMS may be circumventing the transparent rule-making process that provides for public stakeholder discussion of substantive policy changes as are embodied in within the proposal. APHSA and NASMD believe that CMS is exceeding the requirements of MMA and is introducing significant policy changes by re-defining uncompensated care definitions as well as implementing a more extensive DSH audit requirement and reporting process than required by MMA. MMA's Section 1011(d) did not amend section 1923(g) of the Social Security Act, which establishes hospital-specific DSH limits for the costs of uncompensated care. However, the DSH audit proposed rule revises the uncompensated care definition to exclude both bad debt and physician services.

2. Exclusion of Bad Debt From the Uncompensated Care Definition

Both the proposed rule and proposed rule's preamble assert that uncompensated care excludes bad debt for purposes of setting hospital-specific DSH limits. This definition deviates from accepted practices and is inconsistent with the statute. The authorizing legislation and statute permits inclusion of costs of services provided to individuals with no health insurance or other source of third-party coverage.

CMS determined in a 1994 state Medicaid letter 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.

The agency reaffirmed the 1994 position again in 2002 guidance to state Medicaid programs when the current hospital-specific DSH limit and the upper payment limit were established 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. APHSA and NASMD encourage CMS to re-evaluate the changes in the uncompensated care definition:

3. Burdensome Administrative and Reporting Requirements

APHSA and NASMD believe that the reporting burden estimates for states of 38 hours vastly under estimates states reporting burden. In order to submit an independent certified audit as outlined in Section 455.202 states will need to retain audit contractors. Activities to retain contractors, monitor, and review audit contractors alone will require substantially more than 38 hours of state Medicaid staff time. In addition, these burden estimates do not account for the potential cost of independent certified audits for disproportionate share hospitals. States are likely to require DSHs to submit independent audits, essentially passing audit costs on to facilities, but these additional costs could pose a hardship on these important safety-net providers that states rely on in some cases as providers of last resort. APHSA and NASMD suggest that CMS consider evaluating whether the cost associated with detailed audits are justified and whether an audit that reviews a sample of hospitals annually might be just as effective and considerably less costly.

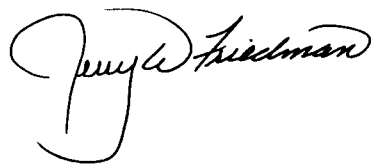
The proposed rule defines an independent certified audit as an audit conducted with generally accepted government auditing standards as defined by the Government Accountability Office. Most private sector audits use generally accepted accounting principles (GAAP) to audit hospital financial data. Applying a different set of auditing standards than GAAP to hospital financial data will increase the burden on hospitals and administration and cost to states in contracting for independent certified audits.

The proposed rule retroactively applies the new reporting and auditing requirements to each states' 2005 fiscal years, however, most states' fiscal years have ended. Imposition of these new reporting and auditing requirements will make it difficult for state Medicaid programs to comply because they would have to retroactively identify data for FY 2005. While the MMA required that CMS impose reporting and auditing requirements beginning in FY 2004, CMS delayed implementation beyond 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.

In addition, states will have difficulty confirming their audit reports that hospital-specific DSH payments to hospitals were made in the audited state fiscal year (SFY) and were measured against actual uncompensated care cost in the same audited SFY. This provision 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 require states and hospitals to implement new costly audits and increase the administrative costs for each state Medicaid program.

In summary, would be pleased to meet with you at any time on these matters. Thank you for considering our comments. If you have any questions, please do not hesitate to contact me or Elaine Ryan, at (202) 682-0100, ext. 235.

Sincerely,



Jerry Friedman,
Executive Director

Submitter : Ms. Bettye Sledge **Date:** 10/25/2005

Organization : Ms. Bettye Sledge

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

Is this "independent audit" intended to be a financial audit, or is it instead an audit of agreed-upon procedures? And if it is an audit of agreed-upon procedures, will the audit program and procedures clarification be provided by CMS? Under the definition of "independent audit" as an audit conducted according to the standards specified in the generally accepted government auditing standards, no specification is made regarding what entities may perform the audit. Can it be performed by the State audit agency?

The distinction between the two audit types underlies the following questions:

Verification 1 proposes to require that the audit report include a determination that qualifying hospitals in States have properly reduced their uncompensated care costs to reflect the total amount of claimed DSH expenditures. Unless this requirement can be met through the acceptance of evidentiary documentation from the qualifying hospitals, further verification can only be made by the auditors' actual observation of the hospitals' records. Sending auditors to physically visit every qualifying hospital is onerous and expensive. Is an extensive drill-down the intent of this section?

Verification 3 proposes verification 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. As with Verification #1, unless evidentiary documentation is acceptable to meet this requirement, actual observation of hospitals' records will be necessary. Here again, the question is whether or not an investigation of this intensity is intended.

Submitter : Ms. Beth Waldman **Date:** 10/25/2005

Organization : Massachusetts EOHHS - Office of Medicaid

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

See Attachments

CMS-2198-P-69-Attach-1.DOC

CMS-2198-P-69-Attach-2.DOC

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

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 Sir/Madam:

The Commonwealth of Massachusetts appreciates the opportunity to submit comments on proposed rule CMS-2198-P. The Commonwealth has substantial concerns regarding the proposed rule.

In general, the State endorses the comments submitted by The National Association of Public Hospitals and Health Systems (NAPH). We attached the draft of the document that we reviewed. We also have a number of additional comments on the proposed rule.

Reporting and Audit Requirements:

- Where the regulations refer to a State Fiscal Year cycle for reporting, Massachusetts asserts that states should be given the option to report on a state or federal fiscal year basis, particularly where DSH allotments and hospital rate years line up with the federal and not state fiscal year.

- In regards to the application of these regulations to State Fiscal Year 2005, Massachusetts believes that the detailed reporting and audit requirements contained in this regulation should be applied prospectively. This is of particular importance where the regulations impose reporting of certain data, or data in a form that states were not required to maintain, and where these regulations are not yet final and reporting elements could still change.

- Given the recent approval of Massachusetts' new 1115 waiver, the Commonwealth suggests the regulation should specify that the DSH reporting and audit requirements do

not apply to states that do not make DSH payments or are not required to comply with DSH requirements pursuant to federal waivers of DSH requirements.

- In reference to the spreadsheet that will be supplied to states to assist in uniform reporting, the Commonwealth notes that the form does not recognize that the type of hospital categories listed can overlap (e.g. a hospital can be both a children's and a teaching hospital, which is the case for at least one hospital in Massachusetts).

- 'Indigent care revenue' and 'third party payments' are not defined, and should explicitly exclude payments to a hospital made by a state or local government (see 42 USC 1396r-4(g)(A), since those payments do not count against DSH limits).

- The regulation specifies how Medicaid MCO payments to hospitals are treated, but does not appear to contemplate how payments from other managed care entities' that are not solely Medicaid MCOs. The regulations should clarify how all revenues from managed care entities for hospital services should be treated.

- 42 CFR §455.204 (c)(5) is confusing and unclear and needs to be clarified in the final rule.

Thank you for considering the Commonwealth's comments.

Sincerely,

Beth Waldman
Medicaid Director

Submitter : Mr. Matthew Gutwein **Date:** 10/25/2005

Organization : The Health and Hospital Corporation of Marion Coun

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2198-P-70-Attach-1.DOC

Attachment #70

The Health and Hospital Corporation of
Marion County
3838 North Rural Street, 8th Floor
Indianapolis, IN 46205-2930

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

VIA Electronic Filing at www.cms.hhs.gov/regulations/ecomments

Re: **CMS-2198-P**: Comments to Proposed Rules Implementing Section 1001(d) of the Medicare Modernization Act of 2003.

Dear Dr. McClellan:

The Health and Hospital Corporation of Marion County ("HHC") and its Division of Public Hospitals d/b/a Wishard Health Services ("Wishard" or "Hospital"), located in Indianapolis, IN, respectfully submits these comments to the Centers for Medicare & Medicaid Services ("CMS") regarding the proposed rule set forth at 70 FR 50262 (August 26, 2005), that would 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. HHC, a municipal corporation, is a governmental entity which has a statutory mission of furnishing "medical care to the indigent of the county." See Indiana Code Section 16-22-8-34(a)(6). Wishard Hospital is specifically required to "be for the benefit of the residents of the county and of every person who becomes sick, injured or maimed within the county." See Indiana Code Section 16-22-39(a). Therefore, Medicaid disproportionate share payments and the legal basis for them are of particular concern to HHC and crucial to the HHC's ability to fulfill its mission.

In particular, these comments are in reference to 42 CFR 447.299(c)(15) entitled *Uncompensated care costs*. With respect to those costs that can be included under this section, we believe that the costs to the hospital for physician services for medical care of the uninsured and for bad debt should be included as uncompensated care costs that can be included in the calculation of the hospital's hospital-specific limit, and that to include these costs in hospital-specific limits is consistent with federal statute, the legislative history of the statute, and the purpose of the Medicaid Disproportionate Share Hospital Program.

First, we are opposed to CMS changing what costs can be included as "inpatient hospital services and outpatient hospital services". At 70 FR 50265, the commentary states that under the proposed rule "uncompensated care costs of providing physician services cannot be included in the calculation of hospital-specific DSH limit[s]." We believe that such a change in policy would be devastating, contrary to past policy and practice, as well as, contrary to law. We emphasize that the disproportionate share

statute does not specifically exclude physician services from being included in the calculation of hospital-specific limits and that, in Indiana, past policy has specifically permitted the inclusion of such physician costs.

As the largest public hospital system in Indiana, Wishard's patient population is approximately 36% uninsured. Wishard's uninsured population consists of both persons who are self-pay (patients above 200% of federal poverty rates who do not qualify for Wishard Advantage) and persons who qualify for Wishard's innovative Wishard Advantage program, which is not an insurance product. The uninsured must meet income limits to receive medical treatment through the Wishard Advantage program. Wishard, which has the highest low-income utilization rate of any large, public acute care hospital system in Indiana, has implemented the Wishard Advantage program to provide medical care for the uninsured in Marion County, Indiana, through a "managed-care" like system. The purpose of Wishard Advantage is to apply preventative, managed care principles to the uninsured population. This system provides medical care to uninsured patients through neighborhood health centers and Wishard Memorial Hospital, allowing persons enrolled in the Wishard Advantage program to schedule appointments with Wishard Advantage physicians in office settings. Individuals enrolled in the Wishard Advantage program see a primary care physician, who serves as a gatekeeper to specialists. As a result, uninsured patients can receive timely medical care in office settings rather than seeking care through Wishard's Emergency Department.

Wishard is able to provide this unique and innovative program in large part due to its effective and efficient use of Medicaid disproportionate share dollars. Wishard contracts with Indiana University faculty physicians to provide services and pays the physicians to provide care for these uninsured patients. The costs of providing appropriate and quality physician services to the uninsured are included in the calculation of Wishard's hospital-specific limit. Without receiving disproportionate share dollars to help pay for these physicians, Wishard may be unable to maintain the Wishard Advantage program in future years and most certainly could not maintain it at its present cost to participants and HHC. We ask that instead of excluding from the calculation of a hospital's hospital-specific limit all uncompensated care costs of providing physician services to the uninsured, that the proposed rule be changed to specifically allow for such appropriately documented costs to be included in the calculation of a hospital's hospital-specific limit. By allowing such costs to be included in the calculation of hospital-specific limits, CMS will help ensure that Wishard's innovative Wishard Advantage program and programs like it, which provide managed care-like medical coverage to the poor and uninsured, will continue to thrive, which will allow the poor and uninsured to obtain both primary and specialty medical care in appropriate, non-emergency settings.

Second, we are also opposed to CMS' proposed blanket exclusion of bad debt from uncompensated costs. We believe that not only is this exclusion of bad debt from uncompensated costs inconsistent with past practice, but that it is also inconsistent with federal law and the legislative history of the disproportionate share program. Section 1923(g)(1)(A) of the Social Security Act [42 USC 1396r-4(g)(1)(A)] provides for the calculation of a hospital's hospital specific-limit, and specifically states that the costs to be included in the calculation are, "the costs incurred during the year of furnishing hospital services (as determined by the Secretary and net of payments under this title, other than under this section, and by uninsured patients) by the hospital to individuals who either are eligible for medical assistance under the State plan **or have no health insurance (or other source of third party coverage) for services provided during the year**." (Emphasis added).

A large portion of the cost of care provided to uninsured persons is reflected in Wishard's bad debt. This is because the costs incurred by uninsured patients who complete the "IndeApp" paperwork to determine if they are eligible for the Wishard Advantage program, but who are ineligible because they earn over 200% of the federal poverty level, are put into bad debt when such patients do not pay for their medical care. Therefore, it is only after it is documented that patients are uninsured and meet specific income limitations that persons are eligible for Wishard Advantage. It has been past practice to include this type of bad debt in Wishard's hospital-specific limit because of past guidance from the legislature and CMS. For example, the legislative history of the Omnibus Budget Reconciliation Act of 1993, which established the hospital-specific limit, required any out-of-pocket payments, or cash receipts, received from uninsured persons to be excluded from the amount that hospitals could include in their costs for providing medical care to uninsured patients. Further, a 1994 letter from CMS to state Medicaid programs allowed for unpaid amounts of persons with third party coverage to be included in hospitals' uncompensated care amounts. This CMS policy was reaffirmed in 2002 in a memo from CMS to state Medicaid programs regarding the hospital-specific limit and upper payment limits.

The State of Indiana makes an effort to require all disproportionate share hospitals to consistently document charity care and bad debt by requiring independent certifications from accounting firms. Indiana's audit requirements ensure that hospitals qualifying for Medicaid disproportionate share payments correctly calculate both their uncompensated costs for Medicaid patients (including offsetting any special Medicaid adjustments or supplemental payments the qualifying hospital may receive) and their uncompensated costs of care for uninsured patients (costs minus cash receipts from those patients). Recently, Indiana's Office of Medicaid Policy and Planning has been working on new guidelines (Agreed Upon Procedures) for the independent accounting firms with the purpose of ensuring consistency in hospital-specific limit calculation methodology amongst accounting firms. This will ensure that there is consistency in hospital-specific limit calculations and appropriate testing of data that is both fair and economical.

In conclusion, Medicaid DSH payments were created to help qualifying hospitals with the cost of providing medical treatment to the poor and uninsured in order to preserve the hospital safety net. Congress recognized that hospitals having either very high Medicaid utilization rates or low-income utilization rates not only have extraordinary amounts of uncompensated costs because of the socio-economic conditions with which their patients present, but also have more limited ability to cost shift to insured patients. This problem is especially bad for those hospitals, like Wishard, qualifying under the low-income utilization rate. We believe that if the definition of uncompensated costs is changed to exclude costs for physician services and all bad debt, the safety-net system that Medicaid DSH payments were created to help would be jeopardized. For all of the above reasons, we ask that you reconsider and that you continue to allow a hospital's costs for physician services for care of the uninsured and a hospital's bad debt due to nonpayment by uninsured and underinsured patients to be included in the calculation of hospital-specific limits.

Thank you for the opportunity to submit these comments. We appreciate that you are attempting to protect the integrity of the Medicaid Disproportionate Share Hospital program and to curb abuses which have taken place. However, we believe that these proposed regulations are both inconsistent with the legal basis of the Medicaid Disproportionate Share Hospital Program and have the potential to harm the very safety-net hospitals that the Disproportionate Share Hospital program was designed to protect.

Very truly yours,

/s/ Matthew R. Gutwein
Matthew R. Gutwein, President and CEO
The Health and Hospital Corporation of Marion County

/s/ Daniel E. Sellers
Daniel E. Sellers, Treasurer
The Health and Hospital Corporation of Marion County

KD_IM-650742_2.DOC

Submitter : Mr. Santiago Munoz **Date:** 10/25/2005

Organization : University of California Office of the President

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2198-P-71-Attach-1.PDF

#71

UNIVERSITY OF CALIFORNIA

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OFFICE OF THE PRESIDENT --
CLINICAL SERVICES DEVELOPMENT

OFFICE OF THE PRESIDENT
1111 Franklin Street
Oakland, CA 94607-5200
Phone: (510) 987-9071
Fax: (510) 763-4253
http://www.ucop.edu

October 25, 2005

Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building, Room 443-G
200 Independence Ave, SW
Washington, DC 20201

SUBJECT: **CMS-2198-P** – Proposed Rule Relating to Medicaid Disproportionate Share Hospital Payments

Dear Administrator McClellan:

On behalf of the University of California (UC), Office of the President, Clinical Services Development Division, and the UC's five academic medical centers (AMCs) located in Davis, Los Angeles, Irvine, San Diego, and San Francisco, I am writing to express our concerns with proposed rule CMS-2198-P related to Medicaid Disproportionate Share Hospital (DSH) payments. This rule is designed to implement provisions contained in the Medicare Prescription Drug Improvement and Modernization Act (MMA) of 2003 (MMA), which established reporting and auditing requirements for state DSH programs. The University is extremely concerned that the proposed rule goes beyond implementation of the MMA provisions and imposes significant policy changes that could jeopardize critical DSH funding to the UC and other California hospitals.

Together, the UC AMCs are the fifth largest healthcare delivery system in California, the leading provider of certain specialty services and medical procedures, and one of the state's largest providers of care to Medicaid patients. Annually, the AMCs provide patient care services valued at over $3.5 billion. In alignment with their patient care work, the AMCs also play a critical role in a number of broad public-policy goals, including the education of health professionals and the advancement of medical science through cutting-edge research. Specifically, UC medical centers offer services that are essential to the health and well being of Medicaid beneficiaries including a broad-array of highly specialized services, such as cancer centers, geriatric and orthopedic centers of excellence, organ transplant programs, and world class primary and preventive care.

We are particularly concerned with this proposed rule given the role of Medicaid DSH payments in helping to ensure the financial survival of the UC Davis, UC Irvine, and UC San Diego Medical Centers. Like many hospitals throughout the state, these facilities have been heavily dependant on Medicaid DSH payments. Further, under California's recently approved Medicaid Hospital / Uninsured Demonstration Project we fully anticipate that all five UC hospitals will begin receiving DSH payments.

We are concerned that the proposed rule shifts interpretation of existing policies and may substantially lower DSH payments or affect prior year DSH allocations to UC hospitals and thereby threaten our ability to continue to serve our community. **Our comments are limited to the provisions that we believe exceed the statutory requirements of the MMA. Further, it is essential that any substantive DSH policy changes that occur through rulemaking process that identifies and acknowledges the changes so that all interested parties will have a meaningful opportunity to comment.**

- 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 fiscal year (FY) be compared against the hospital's actual uncompensated care costs in that same FY. 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 FY months or even years after the year has ended.

Section 1923(g) does not require that the OBRA 1993 limits be recalculated and reapplied to reflect subsequently available year-of-service data; CMS has never before imposed a reconciliation requirement. California has operated under a prospective DSH payment program under its long-standing CMS approved state plan. An essential element of the program is that it is structured as a prospective system, in which DSH eligibility and payment amounts are determined at the start of each State fiscal year. The purpose of using a prospective structure is to provide predictability and stability to DSH funding, which is critical to hospitals such as the UC AMCs. Because the fundamental structure of this cost-finding methodology is to make prospective determinations of the DSH limits, the State Plan does not provide for retrospective adjustments. Thus, hospitals receive DSH payments with the expectation that the payments comply with federal Medicaid requirements. California's system has ensured stable, predictable funding to hospitals, allowing for appropriate budgeting and expenditures.

CMS accepted the California's OBRA '93 hospital-specific DSH limit methodology in 1994. Additionally, in 2003, CMS expressly acknowledged that a prospective reconciliation methodology based on historical cost data was appropriate. This expressed acknowledgment was provided in the Transition Agreement between CMS and the State of California regarding the implementation of the Selective Provider Contracting Program, Feb. 4, 2003.

For California disproportionate share hospitals paid under the prospective state plan methodology, the proposed policy change will create unwarranted financial

instability that will likely result in service disruptions. The proposed provision should be deleted. Nothing in the MMA requires CMS to impose this dramatic shift in policy.

- New Medicaid Hospital / Uninsured Demonstration Project

As you know, under the terms and conditions of California's recently approved Medicaid Hospital / Uninsured Demonstration Project, Medicaid payments to UC AMCs will be based upon the certified public expenditures of the hospitals in lieu of the negotiated rate process that has been in place for more than 20 years. Critical to the success of the demonstration project is payment of California's full federal DSH allotment, including payments to all five UC AMCs. Medicaid payments, including DSH payments, will be based on the hospitals' otherwise uncompensated Medicaid and uninsured costs that will be claimed as certified public expenditures. This new system is predicated on the hospitals need for certainty with respect to prior year DSH determinations. If hospitals lose DSH funding from prior years it would cause financial instability and place at risk key services we provide to our community.

Any changes made to Medicaid DSH payments should be made only on a prospective basis. Any new interpretation of existing policy that results in substantially lower DSH payments or affects prior year DSH payments will have a significant financial impact on our hospitals and put the State of California's entire health care safety net at risk.

- Exclusion of Physician Costs from the Determination of Uncompensated Care Costs is Inappropriate

CMS states in the preamble of the proposed rule 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. Quite simply, our patients care cannot be provided without physician services and excluding the costs of these services from the determination of uncompensated care costs would have a significant negative impact on our hospitals. **We recommend that the proposed language excluding physician services 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 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 and the creation of MMA Section 1011. For our hospitals, CMS' suggested treatment of Section 1011 payments would supplant DSH payments with section 1011 funds, thereby eliminating any financial relief such payments were intended to provide. 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. **We recommend 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.**

- The Proposed 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 are required to report each hospital's low-income utilization rate as defined in Section 1923(b)(3). This provision goes beyond the scope of the referenced statutory definition to require that the low-income utilization rate calculation "only includes individuals that have no source of third party coverage . . . ."

Section 1923(b)(3) sets forth the calculation of the low-income utilization rate, which includes both a Medicaid component and a charity care component. To the extent the proposed rule attempts to limit the "charity care" component, there is no statutory language that supports such a limitation. California has calculated the low-income utilization rates for many years pursuant to its state plan methodology that is tailored to our 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. **We recommend that the language at issue be retracted.**

- Verification Regarding the Reduction of Uncompensated Care Costs is Ambiguous

The proposed rule requires audit verification that each disproportionate share hospital in the state has reduced its uncompensated care costs in order to reflect the total amount of claimed DSH expenditures. It is not clear how a hospital can demonstrate this, as costs generally are not reduced by expenditures. We recognize that the statutory language is unclear with respect to this issue, but the regulation provides the opportunity to clarify what the auditors are expected to verify. Certainly, auditors will not be able to verify that costs that had been incurred in a prior time period were in some way eliminated when the DSH payments were subsequently made to the hospitals. The preamble suggests that the

provision will require auditors to verify both the nonfederal share of DSH expenditures, as well as the federal share of such expenditures, as compared to the hospital's OBRA 1993 limit. If this is CMS' interpretation, the regulatory language should be modified accordingly.

Thank you for the opportunity to comment on the proposed rule. If there are questions or if I can provide any additional information or input, please contact me at 510-987-9062 or santiago.munoz@ucop.edu.

Sincerely,

Santiago Muñoz, Executive Director
Clinical Services Development

Submitter : Mr. Robert Sillen **Date:** 10/25/2005

Organization : Santa Clara Valley Medical Ctr

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

CMS-2198-P-72-Attach-1.PDF

CMS-2198-P-72-Attach-2.DOC

72

Dedicated to the Health of the Whole Community

SANTA CLARA VALLEY HEALTH & HOSPITAL SYSTEM

Robert Sillen
Executive Director
645 South Bascom Avenue, Suite #221
San Jose, California 95128
Tel. (408) 885-4030
Fax. (408) 885-4051

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

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

Dear Dr. McClellan:

On behalf of Santa Clara Valley Medical Center (VMC)], 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. **VMC** is very concerned that substantive changes to the federal DSH program proposed in the rule would jeopardize critical funding for our hospital and all public hospitals in California

VMC is *the* safety net provider for the South San Francisco Bay region of California, and the largest provider in the Santa Clara County. VMC provides a full spectrum of inpatient and outpatient services, including: the region's *only* burn center; nationally recognized rehabilitation services for spinal cord and traumatic brain injuries; pediatric intensive care; regional level III neonatal intensive care; regional high-risk pregnancy program; comprehensive emergency department; Level I trauma center; and the regions only psychiatric emergency service. VMC is and always has been the major provider of care to Medi-Cal, Health Families and Healthy Kids beneficiaries, the medically indigent and other low-income individuals, and California Children's Services (CCS) beneficiaries in the County. This commitment to indigent care is clearly demonstrated through publicly available data - in 2004 VMC provided 20.1% of the total patient days in the County, but 50% of all county Medi-Cal fee-for-service days. VMC's market share of charity patients is even greater - VMC provides over 80% of the charity care in the county. DSH funding has been a critical source of revenue for VMC to be able to provide these services. 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.

VMC 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. VMC 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.**

VMC and all public safety net hospitals 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 integral to our 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. **VMC** 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, VMC 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.

Santa Clara Valley Medical Center appreciates the opportunity to submit these comments on the proposed rule. If you have any questions about these comments, please contact me at 408-885-4030.

Sincerely,

Robert Sillen
Executive Director
Santa Clara Valley Health and Hospital System

Submitter : Mr. Doug Porter
Organization : Department of Social
Category : State Government
Date: 10/25/2005

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2198-P-73-Attach-1.DOC

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

P.O. Box 45080, Olympia, Washington 98504-5080

October 25, 2005

Attachment #73

****ELECTRONIC SUBMISSION****

Centers for Medicare and Medicaid Services
Department of Health and Human Services
http://www.cms.hhs.gov/regulations/ecomments

RE: CMS-2198-P

Dear Sirs:

Washington State's Department of Social and Health Services (DSHS), Health and Recovery Services Administration (HRSA), is responding to the Centers for Medicare and Medicaid Services' (CMS) proposed rule regarding disproportionate share hospital (DSH) payments.

These comments are in addition to the response submitted by Covington and Burling on behalf of several states, including Washington. We are hopeful that CMS will recognize our concerns and work with states and hospital providers to make the final rule less burdensome and more workable.

Thank you for this opportunity to comment. Please direct any questions to Susan Lucas at (360) 725-1828.

Sincerely,

Heidi Robbins Brown for

Douglas Porter, Assistant Secretary
Health and Recovery Services Administration

Enclosure

cc: Susan Lucas
Charles Miller

Washington State Department of Social and Health Services
RE: CMS-2198-P

On August 26, 2005, the Centers for Medicare and Medicaid Services (CMS) published a proposed rule (CMS-2198-P) implementing section 1001(d) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). This MMA provision establishes new reporting and auditing requirements for state Disproportionate Share Hospital (DSH) payments.

The comments below are in addition to comments submitted by Covington and Burling on behalf of several states, including Washington.

A. Reporting requirements

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. It will be difficult, if not impossible, for states to retroactively identify data that CMS is now requesting.

In Washington State, providers have up to one year to submit a claim for payment, and up to 36 months to adjust a claim. Total payments for the year cannot be determined until all claims are received and paid. We also currently have no way of verifying payments to hospitals by Medicaid managed care organizations for inpatient and outpatient hospital services furnished to Medicaid eligible individuals. The one year period for reconciliation does not allow sufficient time for complete data collection.

DSHS is concerned with the requirement that states indicate for each DSH hospital an unduplicated count of Medicaid-eligible and uninsured individuals. The states will have to rely on hospitals for these data, and many hospitals have difficulty tracking this information in a claim-driven system. Not all hospitals collect this information. For some it may be burdensome to begin collecting it. Further, the 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? At what point is an individual coded as self-pay? We are also concerned over the fact that this requirement does not appear to bear any relation to any DSH requirement.

Because there is no clear relationship between the DSH program and these data, and because the requirement is unduly burdensome on hospitals, DSHS requests that this data element be removed from the reporting requirements.

Given the delay in CMS' issuance of the regulation, CMS should make the new reporting and audit requirements prospective, beginning with the fiscal year after the final rule is adopted.

B. Audit requirements

CMS historically has allowed states to make a prospective estimate of a hospital's uncompensated care costs for a given year, based on the hospital's costs in prior years. One of the major advantages associated with a prospective system is the sense of certainty it gives hospitals. This is particularly important to small hospitals, especially small rural hospitals which make up half of the hospital providers in Washington State.

The proposed rule seems to require a retrospective audit. This changes DSH policy in several areas. Requiring a retrospective audit to be submitted within a year after the end of the fiscal year is not feasible, given that most hospitals' cost reports are not finally settled for one or more years. A retrospective audit raises the specter of recoupments long after a hospital's fiscal year is over.

This retrospective audit could significantly affect already approved programs. Washington's approved State Plan states that we pay prospectively. We ask that CMS clarify that states can continue to use the method in their approved State Plan to determine hospitals' DSH payments.

Further, requiring the use of government auditing standards imposes an undue burden on states and hospital providers. Why not use generally accepted accounting principles, which all parties use and understand? Many of our hospital providers are private entities not familiar with government auditing standards. Any requirement outside a provider's normal practice adds to the complexity and time involved in complying with the rule. If adopted, the requirement to use government auditing standards will further hinder states' ability to complete and report audits in a timely manner.

Individual hospitals should be allowed to make the required verification for their own financial data. Hospitals typically use independent auditors to audit and certify hospitals' financial information. The independent auditors can do the verifications required by CMS at the same time as the hospital audit. There is no added value in duplicating the effort by requiring states to do one statewide audit on the same set of data. A separate additional audit at the state level is not a good use of states' limited resources.

DSHS 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.

DSHS urges CMS to revise the regulation to reduce to reduce the paperwork burden associated with the new audit and reporting requirements and avoid imposing unnecessary additional administrative costs on states and hospital providers.

Submitter : Gene O'Connell **Date:** 10/25/2005

Organization : San Francisco General Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2198-P-74-Attach-1.DOC

City and County of San Francisco

Department of Public Health

San Francisco General Hospital Medical Center

Gene Marie O'Connell
Chief Executive Officer

Gavin Newsom
Mayor

October 25, 2005

Attachment #74

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

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

Dear Dr. McClellan:

On behalf of San Francisco General Hospital, I am writing to express concern regarding the CMS proposed rule implementing section 1001(d) of the Medicare Prescription Drug Improvement and Modernization Act of 2003, which impacts Medicaid disproportionate share hospital ("DSH") payments. The substantive changes to the federal DSH program proposed in the rule would jeopardize critical funding for our hospital and all public hospitals in California.

San Francisco General Hospital provides the vast majority of uncompensated care in the City and County of San Francisco. Approximately 26 percent of patients receiving inpatient services at San Francisco General are uninsured. The proportion of outpatient services provided to patients without health coverage is even higher at 36 percent. San Francisco General is also the largest provider of both inpatient and outpatient services to Medicaid-eligible San Franciscans.

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, threatening the hospital's ability to continue to serve the San Francisco community.

San Francisco General Hospital endorses the comments submitted by the California Association of Public Hospitals and Health Systems in their letter to CMS dated October 24, 2005.

Thank you for the opportunity to comment on the proposed rule. If you would like additional information about San Francisco General Hospital, please contact Iman Nazeeri-Simmons at 415.206.3455.

Sincerely,

Gene Marie O'Connell
Chief Executive Administrator
San Francisco General Hospital

Hospital Administration
San Francisco General Hospital Medical Center
1001 Potrero Avenue ◦ Suite 2A5 ◦ San Francisco, CA 94110
Telephone (415) 206-3517 ◦ Fax (415) 206-3434