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MEMORANDUM

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DATE: January 12, 2009

TO: National Association of Public Hospitals and Health Systems

FROM: Ropes & Gray LLP

SUBJECT: Final Rule Regarding Medicaid DSH Reporting and Audit Requirements

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On December 19, 2008, the Centers for Medicare and Medicaid Services (CMS) published the long-anticipated Final Rule establishing new Medicaid disproportionate share hospital (DSH) reporting and audit requirements[1] which were mandated by Section 1001(d) of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA). The rule finalizes a proposal issued August 26, 2005. NAPH filed extensive comments to that proposed rule. This memorandum provides a summary of the Final Rule.

I. Executive Summary

As NAPH has stated in its comments to the proposed rule and elsewhere, NAPH generally supports reporting requirements that help ensure that state DSH payments comply with federal requirements and fulfill the statutory mandate to assist hospitals that serve a disproportionate share of low-income individuals. However, under the guise of implementing reporting requirements, CMS used the proposed rule to propose substantially narrowing the permissible scope of DSH payments.

Although somewhat improved relative to the proposed rule, the Final Rule continues to threaten harm to hospitals relying on DSH payments by narrowing the permissible scope of DSH payments. As a result, the Final Rule could reduce DSH payments to NAPH members. Although the reporting requirements are technically state requirements, the new Final Rule will impose a significant burden on hospitals, since states must rely on hospitals for much of the data. Finally, despite inclusion of a transition period, the Final Rule indicates the possibility that CMS will impose its substantive policy changes retroactively.

[1] 73 Fed. Reg. 77904 (Dec. 19, 2008).

Our greatest concerns result from the revised definition of the hospital-specific DSH limit.[2] In particular, with regard to the hospital-specific DSH limit, the Final Rule would require that states:

- Exclude from the hospital-specific DSH limit all uncompensated costs related to services furnished to underinsured patients. This is a significant retrenchment from CMS's 1994 guidance in which the agency authorized inclusion of costs for individuals with insurance if the insurance did not cover the service provided by the hospital.[3] Under the Final Rule, if an individual has "creditable coverage" of any sort, no uncompensated costs of care to that individual can be included in the DSH limit, even if the insurance provides no coverage for the hospital care provided.

- Exclude from the hospital-specific DSH limit costs related to physicians and pharmaceuticals, even if those costs are incurred by a hospital and are a necessary component of providing inpatient or outpatient hospital services. The Final Rule states that the hospital-specific DSH limit can only include inpatient and outpatient hospital services costs as defined in the state plan.[4] For outpatient hospital services, this interpretation incorporates the narrow definition included in the recent Medicaid outpatient hospital services regulation, which also excluded physician services and other services "covered under the scope of another Medical Assistance service category under the State Plan."[5]

- Calculate costs using the prescriptive cost calculation methodology contained in the "General DSH Audit and Reporting Protocol" issued at the same time as the Final Rule. This is a significant retrenchment from the CMS's 1994 guidance, which indicated that CMS generally "would permit the State to use the definition of allowable costs in its State plan, or any other definition ...."[6]

- Conduct retrospective reconciliations of DSH payments to the DSH limit for each year using actual costs and reduce payments that exceed the revised limit. Many states currently use prospective estimates of the hospital-specific DSH cap and do not conduct such subsequent reconciliations. In addition, unless the state plan specifically allows for reallocation of payments retroactively reduced as a result of exceeding the hospital-specific DSH limit, a state may not be able to reallocate these payments.

- Apply Section 1011 payments for inpatient and outpatient hospital services to undocumented uninsured immigrants as an offset against the unreimbursed cost of providing services to uninsured patients. This interpretation is not supported by statutory authority. As a result, in many states, the benefit of the Section 1011 payments will now accrue to states (whose DSH

[2] CMS uses the phrase "uncompensated care costs" to be synonymous with the hospital-specific DSH limit. CMS recognized, in response to NAPH comments, that this differs from the American Hospital Association's definition of uncompensated care costs as charity care and bad debt. 73 Fed. Reg. at 77914.
[3] Letter to State Medicaid Directors, Aug. 17, 1994, at page 4.
[4] 73 Fed. Reg. at 77924.
[5] 73 Fed. Reg. 66187, 66198 (Nov. 7, 2008) (42 C.F.R. § 440.20(a)(4)(iii)).
[6] Letter to State Medicaid Directors, Aug. 17, 1994, at page 3.

payment obligations will be offset by Section 1011 payments) rather than to providers, in direct contradiction to the clear intent of Congress in enacting Section 1011 as a direct payment to providers.

In addition, we continue to be concerned that CMS's insistence that its interpretations are not new policies leaves the door open regarding retroactive disallowances based on their new interpretations and about the administrative burden that this Final Rule could impose on NAPH members.

CMS did make some generally positive changes to the Final Rule, including some urged by NAPH in its October 25, 2005 comment letter (available at http://www.naph.org/NAPH/Policy/DSH_Proposed_Rule_Comments_2005.pdf). For example:

- The Final Rule does not require that states and hospitals report (and thus classify) each DSH hospital's ownership status, type of hospital, and the total annual amount of intergovernmental transfers, which could have resulted in additional scrutiny of Medicaid financing issues.
- The Final Rule does not require an unduplicated patient count of Medicaid eligible and uninsured individuals served by each hospital, which NAPH argued was substantially burdensome.
- The Final Rule generally allows states three years, rather than one, after the close of the state plan rate year to complete audits. Audit reports and the state reporting are due no later than 90 days after the completion of the audit.
- The regulatory language of the Final Rule indicates that findings of State reports and audits for Medicaid state plan years 2005 through 2010 generally will not be given weight, except as they impact estimates used for calculating DSH payments after 2011. However, CMS does not preclude retrospective review of DSH payments "independent of the State audit process."
- The Final Rule requires each state to verify that each hospital is allowed to retain its DSH payments "so that the payment is available to offset its uncompensated care costs."[7]
- The Final Rule clarifies a few issues concerning the calculation of the Medicaid inpatient utilization rate (MIUR) and the low income utilization rate (LIUR) used for determining DSH eligibility.

We advise NAPH members to take a number of actions in response to this Final Rule:

1. Review their current hospital-specific DSH calculations in light of the Final Rule to determine the magnitude of the financial impact on DSH payments.

2. Review their state's Medicaid state plan to determine the impact of likely revisions and work with their state to ensure that any DSH payments determined to be in excess of the hospital-specific DSH limit can be reallocated.

[7] 73 Fed. Reg. 77904, 77951.

3. Because the Final Rule requires hospitals to track costs associated with uninsured persons, determine the extent to which accounting systems may be adjusted to comply.

4. Evaluate whether CMS is likely to assert that current DSH payments do not comply with the policies of the Final Rule.

5. Inform NAPH so that the association may develop appropriate policy responses, particularly to the extent that either the financial or administrative burden is excessive.

Questions or concerns may be directed to Charles Luband (202-508-4762 or charles.luband@ropesgray.com) or Barbara Eyman (202-508-4760 or barbara.eyman@ropesgray.com) at NAPH Counsel Ropes & Gray, LLP.

The Final Rule becomes effective on January 19, 2009. Under the transition period provided in the Final Rule, audit reports for the 2005 and 2006 rate years must be completed by September 30, 2009 and submitted to CMS by December 31, 2009. The audit for the 2007 rate year must be completed September 30, 2010 and the audit report is due 90 days after completion of the audit. The text of the Final Rule is available at http://edocket.access.gpo.gov/2008/pdf/E8-30000.pdf. The reporting protocol is available at http://www.cms.hhs.gov/MedicaidGenInfo/Downloads/CMS2198FRptProtocol.pdf.

II. Background

The Medicaid statute establishes a variety of guidelines for the receipt of DSH funds. In addition to state-by-state spending allotments, a key limitation on DSH spending is the hospital-specific DSH cap set forth in Section 1923(g) of the Social Security Act.[8] The hospital-specific DSH cap limits the amount of DSH payments that a hospital can receive to the unreimbursed cost of providing care to its Medicaid patients and to its patients without insurance. CMS oversight has not been particularly intensive since the enactment of the limit in 1993, although in the past several years, CMS has looked more closely at state calculations of the limit and the HHS Office of Inspector General (OIG) has audited calculations in several states. Aside from State Medicaid Directors letters issued in 1994 and 2002, CMS has not provided substantial guidance to states on how the limit is to be calculated, and has not publicly clarified its views of the recommended approaches to calculating the limit adopted by the OIG in its several reports. Regulations governing Medicaid DSH have not been revised since 1992 and do not include any regulatory language regarding the hospital-specific DSH cap or even the current methodology for calculating state DSH allotments.[9]

Prior to the MMA, states were required to report and maintain certain information about DSH spending, but the requirements were only loosely enforced.[10] In the 1997 Balanced Budget Act, Congress mandated that states submit annual reports on DSH spending per hospital.[11] In 1998

[8] 42 U.S.C. §1396r-4(g)(1).
[9] *See* 42 C.F.R. 447.296-447.299.
[10] *See* 42 C.F.R. 447.299.
[11] 42 U.S.C. §1396r-4(a)(2)(D).

and again in 2004, CMS issued Federal Register notices regarding the format for submitting these reports.[12] Among the items required in these annual reports were the hospital name and Medicaid provider number, the type of hospital, hospital ownership, total uncompensated care and total Medicaid revenue. Not all states have complied in each year, and CMS generally has not undertaken steps to ensure the quality and consistency of the data reported.

The reporting requirements included in the MMA and outlined in this Final Rule are more detailed than previous requirements and the audit requirements are entirely new. Furthermore, the MMA made state receipt of matching payments related to Medicaid DSH contingent upon state submission of an annual DSH report and an independent certified audit. Thus, states are much more likely to comply with these reporting and audit requirements than prior requirements. The definitions in the preamble of the Final Rule are likely to be viewed by states and independent auditors as extremely significant.

III. Reporting and Audit Requirements

At the core of the Final Rule are the reporting and audit requirements. The MMA required only an annual report including identification of each hospital receiving a DSH payment and the amount of the payment and "such other information as the Secretary determines necessary to ensure the appropriateness of the payment adjustments made."[13] Thus, most of the reporting requirements are based on the Secretary's discretion. The audit requirements also in several cases go beyond the minimal verification requirements in the statute.

A. Reporting Requirements

The Final Rule specifies that each state must report annually to CMS the following information about each hospital that receives DSH payments:

1. Hospital name
2. Estimate of hospital-specific DSH limit
3. Medicaid inpatient utilization rate (MIUR), if the state does not use an alternate methodology
4. Low income utilization rate (LIUR), if the state does not use an alternate methodology
5. State-defined DSH qualification criteria, if applicable
6. Total inpatient and outpatient Medicaid fee-for-service (FFS) basic rate payments
7. Total inpatient and outpatient Medicaid managed care organization payments
8. Supplemental/enhanced Medicaid inpatient and outpatient payments
9. Total Medicaid inpatient and outpatient payments (which is the sum of items 6 through 8)
10. Total Cost of Care for Medicaid inpatient and outpatient hospital services.
11. Total Medicaid uncompensated care (item 10 minus item 9)
12. Uninsured inpatient and outpatient revenue
13. Total applicable Section 1011 payments

[12] 63 Fed. Reg. 54142 (Oct. 8, 1998); 69 Fed. Reg. 15850 (Mar. 26, 2004). Neither notice changed existing federal regulations.
[13] 42 U.S.C. § 1396r-4(j)(1)(2).

14. Total cost of inpatient and outpatient hospital care for the uninsured
15. Total uninsured inpatient and outpatient hospital uncompensated care costs (item 14 minus items 12 and 13)
16. Total annual uncompensated care costs (the sum of items 11 and 15 *minus the sum of items 9, 12 and 13*)[14]
17. Disproportionate share hospital payments (made to both in-state and out-of-state hospitals.)

In comparison to the proposed rule, CMS removed a few reporting requirements, including two that NAPH had flagged as being of concern to NAPH members. First, CMS removed a requirement that a state report intergovernmental transfers, acknowledging that "we agree that it is not appropriate in the context of this reporting and auditing obligation, but instead relates to concerns that are better addressed through other oversight procedures."[15] In addition, CMS removed requirements that states classify each DSH hospital's type of hospital (e.g., acute, long-term care, psychiatric, teaching, etc.) and ownership status—a requirement that could have triggered additional inquiry into a hospital's status as governmental or non-governmental and thus its ability to make an intergovernmental transfer or certify public expenditures. Finally, CMS removed the requirement to report unduplicated counts of both Medicaid and uninsured patients.[16]

B. Audit Requirement

With regard to the audit requirements, the Final Rule specifies that beginning with state plan rate year 2005, a certified independent auditor must verify the following information:

> *Verification 1*: Each hospital that qualifies for a DSH payment in the State is allowed to retain that payment so that the payment is available to offset its uncompensated care costs for furnishing inpatient hospital and outpatient hospital services during the Medicaid State plan rate year to Medicaid eligible individuals and individuals with no source of third party coverage for the services in order to reflect the total amount of claimed DSH expenditures.
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> *Verification 2*: DSH payments made to each qualifying hospital comply with the hospital-specific DSH payment limit. For each audited Medicaid State plan rate year, the DSH payments made in that audited Medicaid State plan rate year must be measured against the actual uncompensated care cost in that same audited Medicaid State plan rate year.
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> *Verification 3*: Only uncompensated care costs of furnishing inpatient and outpatient hospital services to Medicaid eligible individuals and individuals with no third party coverage for the inpatient and outpatient hospital services they received as described in

[14] It is worth noting that although this description tracks the language in the new 42 C.F.R. § 447.299(c)(16) (total annual uncompensated care costs "should equal the sum of paragraphs (c)(11) and (c)(15) subtracted from the sum of paragraphs (c)(9), (c)(12) and (c)(13) of this Section") the italicized language should not have been included. As written, total annual uncompensated care costs would account twice for Medicaid payments, uninsured revenue, and Section 1011 payments. Ropes & Gray has informed CMS of this error.
[15] 73 Fed. Reg. 77904, 77920.
[16] 73 Fed. Reg. at 77918.

> Section 1923(g)(1)(A) of the Act are eligible for inclusion in the calculation of the hospital-specific disproportionate share limit payment limit, as described in Section 1923(g)(1)(A) of the Act.
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> *Verification 4*: For purposes of this hospital-specific limit calculation, any Medicaid payments (including regular Medicaid fee-for-service 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.
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> *Verification 5*: Any information and records of all of its inpatient and outpatient hospital service costs under the Medicaid program; claimed expenditures under the Medicaid program; uninsured inpatient and outpatient hospital service costs in determining payment adjustments under this Section; and any payments made on behalf of the uninsured from payment adjustments under this Section has been separately documented and retained by the State.
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> *Verification 6*: The information specified in paragraph (d)(5) of this Section includes a description of the methodology for calculating each hospital's payment limit under Section 1923(g)(1) of the Act. Included in the description of the methodology, the audit report must specify how the State defines incurred inpatient hospital and outpatient hospital costs for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals and individuals with no source of third party coverage for the inpatient hospital and outpatient hospital services they received.

With the exception of the first verification requirement, these verification requirements are the same as those contained in the proposed rule and, in several cases, go beyond the verifications required by statute.

The proposed rule's first verification required that each hospital receiving DSH payments "has reduced its uncompensated care costs for furnishing inpatient hospital and outpatient hospital services during the SFY to Medicaid eligible individuals and individuals with no source of third party coverage for the services in order to reflect the total amount of claimed DSH expenditures."[17] Responding to comments, CMS replaced this provision with a requirement that state audits verify that "[e]ach hospital that qualifies for a DSH payment in the State is allowed to retain that payment so that the payment is available to offset its uncompensated care costs..."[18] In explaining the intent behind this change, CMS states:

[17] 70 Fed. Reg. 50262, 50268 (Aug. 26, 2005)(proposed 42 C.F.R. § 455.204(c)(1)).
[18] 73 Fed. Reg. at 77951 (adding 42 C.F.R. § 455.301(d)(1)(Verification 1)).

> Since there is no statutory requirement that hospitals actually use DSH payments for uncompensated care, we are reading this verification to require examination of whether the DSH payments made to each hospital are retained by the hospital and are actually available to offset uncompensated care costs. We have encountered numerous instances in which Medicaid hospital providers are not permitted to retain Medicaid payments for normal hospital purposes. Instead the hospital is required to divert the funding either by returning it to the payor (either directly or indirectly) or is required to use the funding for another purpose. We have revised the wording of this verification to better reflect our reading of its meaning.[19]

In even stronger language elsewhere in the preamble, CMS states:

> Payments to hospitals for which Federal matching is claimed are made for specified purposes; either to pay for covered services furnished by the hospital or to account for the costs of serving a disproportionate share of low income patients. To the extent that a hospital is required to pass a Medicaid payment on to another entity, that payment is no longer within those statutory purposes and would be unallowable. In other words, hospitals must retain 100 percent of the total computable DSH payments claimed by States. Any redirection of Medicaid payments (including DSH payments) is inconsistent with the Medicaid statute governing expenditures.[20]

This new verification requirement is similar to the retention provision contained in the proposed Medicaid public provider cost limit regulation that is subject to moratorium.[21]

CMS finalized its proposal in Verification 2 requiring that DSH payments be measured against actual audited uncompensated care costs in that same Medicaid State plan rate year.[22] This verification requirement goes well beyond the underlying statutory language, which simply says that the audit should verify that DSH payments comply with the statutory provision establishing the hospital specific DSH cap. CMS has not previously announced or enforced such a requirement. Many states currently use prospective estimates of uncompensated costs to determine compliance with the hospital-specific DSH cap, and do not perform any subsequent reconciliations against actual final costs. Such reconciliations appear to be required under the Final Rule. Moreover, CMS has approved several State Plan Amendments (SPAs) that provide for final DSH payments to be disbursed during or shortly after the current fiscal year. NAPH members may well now see DSH payment take-backs through subsequent reconciliations. Furthermore, CMS made clear in the preamble that unless the state plan specifically allows for subsequent upwards adjustment to DSH payments, these reconciliations will only be able to result in reductions, not increases, in DSH payments.

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[19] 73 Fed. Reg. at 77923.
[20] 73 Fed. Reg. at 77927.
[21] 72 Fed. Reg. 2236, 2247 (Jan. 18, 2007) (proposed 42 C.F.R. § 447.207).
[22] 73 Fed. Reg. at 77951 (adding 42 C.F.R. § 455.304(d)(2)).

The Final Rule also requires that states use the Medicare 2552-96 hospital cost report, hospital financial statements and accounting records, along with the Medicaid state plan and information from the state's Medicaid Management Information System (MMIS), in completing the audit. CMS has extended the period for completion of the audit from one year to three years. The audit reports for state plan rates years 2005 and 2006 are due by the end of calendar year 2009. As discussed later, the regulatory language indicates that there would be no retroactive enforcement based on the new auditing and reporting requirements, although the preamble language creates some uncertainty.

IV. Analysis

A. Definition of Uncompensated Care Costs

As noted above, the greatest area of concern in the Final Rule results from CMS's narrow definition of what can and cannot be included in the hospital-specific DSH limit. The Final Rule's definition of the hospital-specific DSH limit explicitly excludes from uncompensated care costs:

- All costs related to services furnished to underinsured patients, i.e. individuals who have health insurance or another third party source of payment that does not cover, or covers only a minimal amount of, the hospital services provided.

- Costs related to physicians and pharmaceuticals, even if those costs are incurred by a hospital and are a necessary component of providing inpatient or outpatient hospital services.

CMS further outlines a prescriptive cost calculation methodology in a "General DSH Audit and Reporting Protocol" issued at the same time as the Final Rule. The methodology in this protocol is very specific and is likely substantially different from most existing state hospital-specific DSH limit calculation methodologies.

All of these changes represent a significant retrenchment from CMS's 1994 guidance. In a section entitled "Cost of Services" and describing "considerations that must be made in determining the cost of services under the DSH limit," CMS indicated:

> In defining "costs of services" under this provision, [CMS] would permit the State to use the definition of allowable costs in its State plan, or any other definition, as long as the costs determined under such a definition do not exceed the amounts that would be allowable under the Medicare principles of cost reimbursement.[23]

In the preamble to the Final Rule, CMS states that this language was intended only to explain states' "flexibility to define Medicaid costs for purposes of setting Medicaid payment rates"[24] and not for the purpose of the hospital-specific DSH limit. However, since the 1994 letter was only guidance, there is little legal basis to hold CMS to its prior interpretation (at least for future time periods).

[23] Letter to State Medicaid Directors, Aug. 17, 1994, at page 3.
[24] 73 Fed. Reg. at 77907.

Exclusion of Costs Related to the Underinsured

In its 1994 State Medicaid Director's Letter, CMS clarified that "it would be permissible for States to include in this definition [of uncompensated care costs] individuals who do not possess health insurance which would apply to the service for which the individual sought treatment."[25] In a 1995 letter from CMS to the State Medicaid Directors' Association, CMS reiterated, "[a]s we explained in our August 17, 1994, State Medicaid Director's letter concerning the OBRA 93 DSH provisions, for the purpose of determining uninsured patients, it would be permissible for States to include in their determination of uninsured patients those individuals who do not possess health insurance which would apply to the service which the individual sought."[26] Many states and hospitals interpreted this guidance to allow inclusion of costs related to services for which a patient had no insurance, even if the patient did have some insurance. For example, if a patient had insurance coverage but did not have coverage for outpatient psychiatric services, the costs associated with the outpatient psychiatric services could be included in the hospital-specific DSH limit calculation. Many hospitals included among their uninsured costs, costs of services for which their accounting records showed no third party payment received, without further inquiring whether the patient in question nevertheless has insurance.

In the Final Rule, CMS rejects this interpretation and states that the agency "never read this language to be service-specific"[27]:

> We do not agree with this reading of the 1994 CMS State Medicaid Director letter, which did not refer to underinsured individuals. Moreover, the statute appears to be clear on this issue. While we regret any misconceptions about that letter, we take this opportunity to clarify that the only costs relevant to the calculation of the hospital-specific limit are costs of furnishing hospital services to individuals who are Medicaid eligible or who have no health insurance (or other source of third party coverage).[28]

In the preamble language, CMS further interprets the phrase "who have health insurance (or other third party coverage)" to broadly include individuals who have "creditable coverage" consistent with federal regulatory definitions[29] as well as "individuals who have coverage based

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[25] Letter to State Medicaid Directors, Aug. 17, 1994, at page 4.
[26] Letter to State Medicaid Director's Association from Sally Richardson, Director, Center for Medicaid and State Operations, Health Care Financing Administration, Jan. 10, 1995.
[27] 73 Fed. Reg. at 77911.
[28] 73 Fed. Reg. at 77916.
[29] 73 Fed. Reg. at 77911. The preamble specifically references the definition of creditable coverage used for purposes of the Health Insurance Portability and Accountability Act under 45 C.F.R. Parts 144 and 146. Section 146.113 defines creditable coverage to include: a group health plan; group, individual or short-term coverage as broadly defined in 45 C.F.R. § 144.103 ("benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer"); Medicare; Medicaid; SCHIP; an FEHBP plan; medical and dental care for members of the uniformed services and their dependents; an Indian Health Service program; a State health benefits risk pool; a health benefit plan under the Peace Corps Act; or, a "public health plan" established or maintained by a State, the federal government, or a foreign country (or any subdivision of these) that provides health coverage to individuals who are enrolled in the plan.

upon a legally liable third party payer."[30] The phrase would not include individuals with insurance that provides only excepted benefits, such as those referenced in federal regulations[31] (including accident insurance, disability income, liability insurance, limited-scope dental or vision plans, and certain health flexible savings accounts), "unless that insurance actually provides coverage for the hospital services at issue (such as when an automobile liability insurance policy pays for a hospital stay)."[32]

In addition, CMS clarifies that states cannot including the following costs in the calculation of the hospital-specific DSH limit:

- Claims denied by a third party insurer due to prior authorization or late billing;
- Unpaid co-payments related to patients with insurance;
- Unpaid deductibles related to a patient with insurance, even if a high deductible means that the patient effectively has no third-party coverage for the services provided;
- The portion of hospital charity care costs that consists of costs associated with individuals with third party coverage; and
- Bad debt, except for bad debt associated with uninsured individuals.[33]

Inability to track uninsured patients is not an excuse for inclusion of any of these costs. CMS expects hospitals to modify their accounting systems as necessary to separately identify uncompensated care related to services provided to uninsured individuals.[34]

Exclusion of Physician Costs from the Calculation of Uncompensated Care

The Final Rule states explicitly in the language of the regulation that the uncompensated care costs of providing physician services to Medicaid and uninsured patients cannot be included in the calculation of the hospital-specific DSH limit.[35] The preamble discussion clarifies that this exclusion applies to "physician costs that are billed as physician professional services and reimbursed as such."[36] To the extent that physician services are currently reimbursed as hospital services under the Medicaid state plan, the preamble suggests that related unreimbursed costs may be included in the hospital-specific DSH limit. The preamble language interprets the term "hospital services" under the DSH statute "to mean the same as it means under the approved Medicaid State

[30] *Id.*
[31] 45 C.F.R § 146.145.
[32] 73 Fed. Reg. at 77911.
[33] CMS distinguishes between bad debt that "arises when there is non-payment on behalf of an individual who has third party coverage" and therefore cannot be included in the hospital-specific DSH calculation and amounts recorded by a hospital as bad debt "if an uninsured patient does not pay the amount he or she was expected to pay," which a hospital may include. 73 Fed. Reg. at 77909-10.
[34] 73 Fed. Reg. at 77910.
[35] *See* 73 Fed. Reg. at 77950 (adding 42 C.F.R. § 447.329(c)(11), (15)).
[36] 73 Fed. Reg. at 77924.

plan description of inpatient hospital services and outpatient hospital services."[37] CMS also explicitly acknowledges that "[t]o the extent that there are States that have consistent practices of including physician services as an integral part of hospital services for coverage and payment purposes, and does not provide for separate payment (either directly or through an add-on methodology), we would agree that this practice would be applicable in calculating the hospital-specific DSH limit."[38] CMS caveats, however, that they "do not believe this is a customary practice."[39] And the unqualified exclusion of physician costs from allowable DSH costs in the regulatory text itself confirms that any such exception would indeed be limited and very strictly scrutinized.

In NAPH's comments to the proposed regulation, NAPH objected to CMS' use of preamble language to announce what we viewed as a major policy change unendorsed by Congress. A number of other commenters echoed those views, noting, as NAPH did, that many safety net hospitals would be unable to provide inpatient or outpatient hospital services to low-income populations without incurring costs for physicians.

In the context of payments by Medicaid managed care organizations (MCOs) to hospitals that might cover both hospital and physician service costs, CMS requires that "to the extent that the MCO payment combines payment for inpatient and outpatient hospital services with payment for other services, the hospital may need to allocate the revenues based on the ratio of charges for hospital services to total charges, or another reasonable allocation method."[40]

Exclusion of Pharmacy Service Costs

The Final Rule generally excludes from the hospital-specific limit any pharmacy service costs that are not billed as part of the inpatient hospital or outpatient hospital rates. CMS explains that "pharmacy service costs are separately identified on the Medicare 2552–96 cost report and are not recognized as an inpatient or outpatient hospital service. Pharmacy service costs that are not part of an inpatient or outpatient rate and are billed as pharmacy service and reimbursed as such are not considered eligible for inclusion in the hospital-specific uncompensated cost limit."[41]

B. Burden on Hospitals

A second major concern is the administrative burden that this regulation will impose on states and on NAPH members. For some audit requirements, the state MMIS will be the best source of audit information (for example, data on Medicaid payments in state fee-for-service inpatient hospital, outpatient hospital and DSH payments).[42] However, the Final Rule recognizes that states will have to rely on hospitals for at least three types of revenue data required for the audit:

[37] *Id.*
[38] 73 Fed. Reg. at 77925.
[39] *Id.*
[40] *Id.*
[41] 73 Fed. Reg. at 77915.
[42] 73 Fed. Reg. at 77917.

(1) Medicaid and DSH payments received from states other than the state in which the hospital is located,

(2) Medicaid MCO payments, and

(3) payments by or on behalf of uninsured individuals (other than state and local government indigent care payments).[43]

As a result, hospitals will be required to produce audited financial statements and accounting records. However, it is not altogether clear that existing financial statements for all members will contain this information or that financial systems will be able to generate this information. In addition, states and CMS will require data from hospital Medicare 2552–96 cost reports.[44]

To the extent that the Medicaid state plan rate year does not align with the hospital fiscal year, the annual reporting burden will be doubled. Hospitals will need to produce data from two different Medicare cost reports and from two different sets of financial statements.

The Final Rule also requires states to report post-audit adjustments based on claims for the Medicaid state plan rate year paid subsequent to the audit date.[45] Payments made subsequent to the audit date but related to a prior period may thus continue to impact the hospital-specific DSH limit in prior years. However, with regard to payments related to the uninsured, CMS elsewhere indicates that "audits should take into account these self-pay revenues (including liens and collections) during the year in which they are received, irrespective of whether such revenues are applicable to a prior period."[46] For Medicaid payments, the Final Rule is ambiguous. Despite the regulatory language, the preamble elsewhere indicates that Medicaid (and even DSH payments) should be treated as revenues applicable to the Medicaid state plan rate year in which they are received.[47] In any event, to the extent the post-audit adjustments impact a prior year, the regulation requires the prospective estimates based on those prior years reflect the adjustment, at least beginning with Medicaid state plan rate year 2011.[48]

C. Offset for Section 1011 Payments

We are disappointed that contrary to comments by NAPH and others, CMS retained language requiring states to offset a hospital's uncompensated care costs by a portion of the payments for emergency services for undocumented immigrants received pursuant to Section 1011 of the MMA.[49] Specifically, states must consider "the portion of Section 1011 payments attributable to eligible aliens with no source of third party coverage for the inpatient and outpatient

[43] 73 Fed. Reg. at 77917.
[44] *Id.*
[45] 73 Fed. Reg. at 77951 (adding 42 C.F.R. § 455.304(b)).
[46] 73 Fed. Reg. at 77927.
[47] *See* 72 Fed. Reg. at 77942.
[48] 73 Fed. Reg. at 77909.
[49] 73 Fed. Reg. at 77950 (adding 42 C.F.R. § 447.299(c)(15)-(16)).

hospital services they receive as revenue for purposes of calculating the hospital-specific DSH limit."[50]

In its comment letter, NAPH noted that CMS had no statutory authority to require a reduction for Section 1011 payments, since the statute requires a reduction only for Medicaid payments and payments "by uninsured patients."[51] CMS has essentially interpreted this language to mean payments made "*by or on behalf of* uninsured individuals."[52] CMS thus concludes that "to the extent that Section 1011 payments are paid to a hospital to offset uncompensated care costs eligible under the hospital-specific DSH limit, this Section 1011 payment must be recognized as a payment *on behalf of* Section 1011 eligible individuals when determining a hospital's eligible uncompensated cost under the hospital-specific DSH limit."[53] CMS notes that there is no statutory exception for payments made under Section 1011 (unlike payments made to a hospital through local or state indigent care programs).

D. Retroactive Application

Although CMS made some modifications in the Final Rule to lessen the impact of retroactively applying the new reporting and audit requirements, the Final Rule requires states to submit audit reports beginning with state plan rate year 2005.

CMS modified the audit period to apply to state plan rate years in order to recognize the "varying fiscal periods between hospitals and States" and create a uniform time period for state estimates.[54] However, as stated above, this will only increase the burden on hospitals by forcing them to draw data from multiple time periods.

CMS does lengthen the time period for submission of the audit from one year to three years, with the idea that by that time, hospitals would have received all Medicaid and DSH payments associated with that Medicaid state plan rate year. In addition, States will be required to submit reports for state plan rate years 2005 and 2006 by the last day of calendar year 2009, and to complete audits for subsequent years by the last day of the Federal fiscal year ending three years from the end of the Medicaid state plan rate year.[55] Audit reports are due 90 days from the completion of the audit.[56]

CMS also provides a transition period before the audit findings will automatically trigger repayment requirements. In the transition years, the principal purpose of the audits will be to test and refine auditing techniques, and to help inform prospective estimates of future year DSH caps. CMS states that "findings of State reports and audits for Medicaid State Plan years 2005–2010 will not be given weight except to the extent that the findings draw into question the reasonableness of

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[50] 73 Fed. Reg. at 77917.
[51] 42 U.S.C. 1396r-4(g)(1)(A).
[52] 73 Fed. Reg. at 77918 (emphasis added).
[53] *Id.* (emphasis added).
[54] 73 Fed. Reg. at 77908.
[55] 73 Fed. Reg. at 77951 (adding 42 C.F.R. § 455.304(b)).
[56] *Id.*

State uncompensated care cost estimates used for calculations of prospective DSH payments for Medicaid State plan year 2011 and thereafter."[57] Beginning in state plan rate year 2011 when the transition period expires, CMS will regard audit findings demonstrating that DSH payments exceed the hospital-specific limit as discovery of an overpayment and will recoup the funds "unless the DSH payments are redistributed by the State to other qualifying hospitals as an integral part of the audit process."[58] In order for a state to redistribute such DSH payments, the Medicaid state plan must reflect that payment policy.[59]

Notwithstanding the transition period, however, CMS clarifies in the preamble that its policy does not "preclude review of DSH payments and discovery of overpayments prior to Medicaid State plan rate year 2011 . . . independent of the State audit process."[60] In addition, CMS states that "the information disclosed by the audit and reporting requirements may reveal the need for retroactive adjustments to account for payments that are improper" and that "this is no different from any other audit situation."[61] Thus, while the regulatory language creating the transition period appears to clearly preclude retroactive enforcement based on audit and reporting findings, certain statements in the preamble suggest continued risk of disallowance of DSH payments for these periods.

E. Application to Waiver States

CMS clarifies in the Final Rule that the reporting and auditing requirements apply to states with section 1115 demonstration waivers unless CMS has explicitly waived "the requirements of section 1923 of the Social Security Act [the statutory provision regarding DSH] so that the State does not make Medicaid DSH payments at all."[62]

F. Calculation of MIUR and LIUR

CMS provides some interesting guidance in the preamble to the Final Rule regarding the calculation of the Medicaid Inpatient Utilization Rate (MIUR) and low income utilization rate (LIUR). The preamble clarifies that Medicaid patients also eligible for Medicare should be included in the MIUR calculation.[63] With regard to the LIUR calculation, CMS makes a distinction between the charity care data that may be used in this calculation and the uncompensated charity care costs that may be included in the calculation of the hospital-specific cap. The latter, as noted above, includes only charity care provided to uninsured persons. The definition of charity care used in the LIUR calculation, however, may or may not relate to care for uninsured patients. "For the purposes of defining a hospital's LIUR, States may adopt a reasonable definition of charity care to

[57] 73 Fed. Reg. at 77952 (adding 42 C.F.R. § 455.304(e)).
[58] 73 Fed. Reg. at 77906.
[59] *Id.*
[60] 73 Fed. Reg. at 77908.
[61] *Id.*
[62] 73 Fed. Reg. at 77942.
[63] 73 Fed. Reg. at 77912.

reflect care given free or with reduced charge to indigent individuals."[64] Further, charity care for LIUR purposes may include underinsured persons.[65]

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CONCLUSION

The Final Rule could substantially impact NAPH members, both through lowering hospital-specific DSH limits and decreasing DSH payments to certain hospitals, and through the increased burden of reporting, particularly where information is otherwise not available to states. We encourage NAPH members to assess this impact and report back to NAPH. The Obama Administration could address some areas of concern through additional guidance, or by issuing new or amended regulations. A legislative solution is also possible.

[64] *Id.*
[65] 73 Fed. Reg. at 77919.