NATIONAL ASSOCIATION of PUBLIC HOSPITALS and HEALTH SYSTEMS
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October 25, 2005

Via Courier

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

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

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

Dear Dr. McClellan:

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

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

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

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

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

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

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

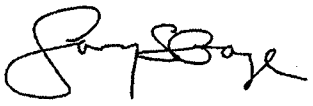
Finally, NAPH requests that CMS revise ambiguous language and correct technical errors in the preamble and Proposed Rule as detailed in the attached comments.

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

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

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

Sincerely,



Larry S. Gage
President

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

Attachment

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

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

I. THE PROPOSED RULE IMPOSES NEW SUBSTANTIVE REQUIREMENTS ON HOSPITALS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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[6] *Id.* at 50265.

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

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

[9] 42 C.F.R. §440.10(a)(2).

[10] 42 C.F.R. §440.20(a)(2).

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

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

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

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

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

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

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

II. THE PROPOSED RULE WILL SUBJECT HOSPITALS TO BURDENSOME REQUIREMENTS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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[18] 70 Fed. Reg. at 50267.

III. THE PROPOSED RULE INCLUDES AMBIGUOUS LANGUAGE AND TECHNICAL ERRORS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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