



TEXAS HOSPITAL ASSOCIATION

February 26, 2009

Tom Suehs  
Deputy Executive Commissioner, Financial Services  
Texas Health and Human Services Commission  
Brown-Heatly Building  
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Austin, TX 78751-2316

*Sent via e-mail*

Dear Mr. Suehs:

Texas hospitals appreciate the time THHSC staff devoted to meet with hospital representatives to review the Medicaid disproportionate share hospital (DSH) audit rule published in the Dec. 19 *Federal Register*. As you know, the Center for Medicare & Medicaid Services developed the rule to comply with provisions found in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).

For more than two decades, Texas hospitals have worked with THHSC to apply rational approaches in reporting, computing and distributing payments made under the state's Medicaid disproportionate share program. As a result, payments currently made under the Texas DSH program are in compliance with nearly all of the key initiatives required by the MMA, and included in the DSH audit rule.

As discussed during our meeting, it is important that stakeholders not lose sight of the overriding goal of the federal DSH audit rule which is to ensure that hospitals are not paid more than their hospital-specific DSH limit. Texas hospitals are committed to work with the commission to develop *realistic* and *consistent* accounting and reporting standards to achieve the audit goal. The following is a summary of a number of the significant policy considerations discussed in our meeting along with comments provided by hospital representatives.

### **Reconciling DSH Payments and Costs/Redistributing Interim DSH Payments**

#### **Background:**

Under the program now in place, current year Medicaid DSH payments are made using historical Medicaid and other data inflated forward. Under existing rules, fiscal year 2011 payments will be based on the latest available fiscal year 2009 patient utilization and cost data. Fiscal year 2011 costs are projected using inflated fiscal year 2009 data, with no reconciliation made to actual costs or patient utilization.

Starting in state fiscal year 2011, the agency will begin reconciling *interim* DSH payments with **actual** costs and payments. *Interim* fiscal year 2011 DSH payments will be distributed using

fiscal year 2009 utilization and cost estimates; however, *final* fiscal year 2011 DSH payments, when audited in calendar year 2014, will be *reconciled* to agree with actual fiscal year 2011 patient utilization and cost report amounts.

**Policy Considerations:**

The hospital industry supports strongly THHSC’s position that any interim DSH payment paid above the hospital-specific cap be redistributed back to remaining eligible DSH hospitals using the existing formulas and methods. Given the level of uninsured in the state, it is critical that available federal dollars are not recouped, especially while there is an opportunity to redistribute those federal DSH dollars to qualifying DSH hospitals.

As noted below, the option allowing redistribution of funds as part of the audit process is supported with language contained on page 77906 of the Dec. 19 *Federal Register*:

*“Beginning in Medicaid State plan rate year 2011, to the extent that audit findings demonstrate that DSH payments exceed the documented hospital-specific cost limits, CMS will regard them as representing discovery of overpayments to providers that, pursuant to 42 CFR Part 433, Subpart F, triggers the return of the Federal share to the Federal government (unless the DSH payments are redistributed by the State to other qualifying hospitals as an integral part of the audit process).”*

In addition, Texas hospitals suggest identifying and establishing predetermined cut-off dates that will be used to finalize and close out Medicaid disproportionate share payments for each state plan year. Establishing final transaction dates will help the agency and the industry avoid administrative problems that will arise since cost report and utilization data are appealed and amended indefinitely.

Given that Medicaid DSH audits likely will occur approximately three years after the interim payments are received by hospitals, defined cut-off dates should correspond with the audit timelines. As audit work plans are formalized, hospital representatives will assist THHSC to with identifying final reconciliation dates for each state plan year.

Another issue that has to be addressed relates to identifying which claims will be included in the reconciliation process. In the current rule, THHSC uses claims that are adjudicated during the state plan year to calculate Medicaid DSH payments. As THHSC moves forward with the audit, the situation will arise where there will be claims adjudicated in the audited state plan year that are several years old. For example, claims adjudicated in state plan year 2011 may have dates of service and related costs from previous state fiscal years. One option would be to use the prior year’s costs to calculate limits for prior year claims. Another option would be to use admissions or discharges from the state plan year to calculate payments and costs.

**Medicaid DSH and UPL Payments/Application of All Medicaid Payments to Hospital-Specific Limits**

**Background:**

Currently Medicaid DSH payments are compared to and, if necessary, capped by hospital-specific Medicaid DSH limits. DSH hospitals' Medicaid supplemental upper payment limit (UPL) payments are capped by the Medicaid DSH hospital-specific limits.

Under the method now in use to distribute DSH and UPL payments, the commission calculates a hospital-specific limit and does not reimburse any hospital more than its limit. The state's approach of simultaneous calculation and disbursement of DSH and UPL payments ensures that no hospital receives more than its hospital-specific limit.

### **Policy Considerations:**

After assessing CMS' final rules, Texas hospitals maintain that the current DSH and UPL payment methodologies are consistent with the regulations published in the Dec. 19 *Federal Register*. Sections (d)(2) and (d)(4) of Part 455, Subpart D, Section 455.304 found on page 77951 of the *Register*, address the question of limiting DSH payments to a hospital-specific limit, and to the inclusion of all payments under the Medicaid program:

*“(d) Specific requirements. The independent certified audit report must verify the following:*

*(2) 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.*

*(4) 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.***”

As mentioned previously, under the DSH and UPL methodology now in place:

- DSH payments made to each DSH hospital comply with that hospital's specific DSH payment limit; and
- THHSC considers all Medicaid payments, including UPL payments, when comparing total Medicaid payments to the DSH limit.

In addition, related to the reporting of Medicaid revenues, the following comment and response is found on page 77920:

*“Comment: A few commenters recognized the importance of the sum of Regular Medicaid Payments, Medicaid Managed Care Organization Payments and Enhanced/Supplemental Medicaid Payments in determining hospital eligibility for Medicaid DSH payments and in calculating the hospital-specific limits for such payments. However, the commenters 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 and is not mandated by the MMA.*

*Response: The statute called for reporting of specific payments and data necessary to ensure the appropriateness of those payments, and provides for States to obtain independent certified audits of such payments. The data elements we are requiring are those that we believe are necessary to determine the appropriateness of DSH payments, and to verify audit findings. In an effort to provide States with uniform instructions, CMS provided detailed identification of the data elements necessary to comply with Congressional instruction on such reporting and auditing. To determine the eligible uncompensated care hospital-specific DSH limit and to ensure that all eligible costs under such limit are offset by total Medicaid payments made, the regulation requires a separate accounting of types of Medicaid payments. The separate reporting of each type of Medicaid payment creates a verification mechanism to ensure that all Medicaid payments are properly offset against the hospital-specific DSH limit. Regular Medicaid payment and supplemental Medicaid payment information is readily available to the State via the Medicaid Management Information System. Information regarding Medicaid managed care payments made to hospitals is available from hospital accounting systems.”*

Again, under the DSH and UPL programs currently in place, THHSC tracks all Medicaid payments: regular Medicaid payments, supplemental Medicaid payments and Medicaid managed care payments. These payments all are reported separately and offset against the hospital-specific DSH limit.

## **Calculating the Cost of Caring for Medicaid and the Uninsured**

### **Background:**

Designed to calculate the cost of caring for Medicaid and the uninsured for use in determining each hospital's specific DSH limit, THHSC currently uses an overall “ratio of cost-to-charges” in the DSH payment formula. Developed using Medicare principles of cost-based reimbursement, the aggregate or global RCC is applied against total charges for each Medicaid and uninsured patient to determine the Medicare allowable cost for these populations.

It is important to note that using Medicare reimbursement principles, THHSC is not including a number of costs incurred by the hospital in the normal operation of the facility, including significant expenses related to physicians and bad debt.

### **Policy Considerations:**

The General DSH Audit and Reporting Protocol document published by CMS outlines a proposed process for calculating ancillary departments' costs and per diem amounts for routine care cost centers to use in calculating hospital-specific limits. While the audit protocol document suggests that the cost-to-charge ratio be based on departmental costs and charges, no mention is made in the MMA, the final regulations or in the preamble to the final rule that requires states to make departmental cost determinations. As mentioned on page 77921 of the rule:

*“Comment: One commenter noted a reference to the cost determination method via the Medicare cost report would be beneficial.*

*Response: CMS agrees that the same methods used in preparing the Medicare 2552-96 cost report should be applied in determining costs to be used in calculating the DSH hospital-specific limits. We believe that hospitals’ Medicare cost report and audited financial statements and accounting records should contain the information necessary for reporting and auditing responsibilities, in combination with information provided by the States’ Medicaid Management Information Systems (MMIS) and the approved Medicaid State plan governing the Medicaid payments made during the audit period.”*

As previously noted, Texas currently uses a Medicare 2552-96 cost report reimbursement methodology to compute the cost of care for Medicaid and uninsured patients. While CMS assumes that much of the information reported to THHSC and included in the MMIS reporting system has been audited, it is questionable whether this has occurred for Medicaid patients served by Texas Medicaid managed care organizations. Since the rollout of Medicaid managed care began in the mid-1990s, the state’s MCOs have been challenged to report correctly the number of admissions, days and charges on an aggregate basis for use in the state’s Medicaid DSH program. Texas hospitals question if all of the Medicaid MCOs will be able to accurately report charges and days of care on a departmental basis for the correct time periods required.

In addition, most Texas hospitals do not have the ability to report days and charges for the uninsured using departmental data. Hospitals may be able to capture and retain charges on a departmental basis. However, reporting and retrieving patient days by department on a case-by-case basis is not easily accomplished. While appreciative of CMS’ confidence in their abilities to record and retain information, hospitals disagree strongly with the phrase, on page 77921:

*“We believe that hospitals’ Medicare cost report and audited financial statements and accounting records should contain the information necessary for reporting and auditing responsibilities.”*

Any requirement to report departmental data for the uninsured will result in the less accurate measurement of actual hospital costs. And, reporting at the departmental cost level significantly increases the volume of the information.

Given the reasons cited above, Texas hospitals recommend that the current method of calculating Medicaid and uninsured costs using hospital-specific Medicare cost report data with a global or aggregate ratio of cost-to-charges satisfies any requirements implied in the MMA legislation.

## **Charges Included in Calculating the Cost of Caring for Medicaid Patients**

### **Background:**

Currently all charges and costs related to providing care for Medicaid patients are included in the calculation of Medicaid allowable costs, which are used to compute the hospital-specific limit.

**Policy Considerations:**

If an individual is eligible for Medicaid on the day hospital inpatient or outpatient services are rendered, and they are within the definition of hospital inpatient or outpatient services, then their entire cost should be included in the calculation of Medicaid costs.

This position is supported by the following comments offered on page 77912 of the *Federal Register*:

*“Comment: One commenter questioned how a hospital would classify individuals who had Medicaid coverage for some discharges and no insurance for others.*

*Response: The hospital-specific DSH limit comprises uncompensated care costs of furnishing inpatient and outpatient hospital services to Medicaid eligible individuals and individuals with no source of third party coverage for the inpatient and outpatient hospital services they receive. If an individual is Medicaid eligible on the day they received inpatient or outpatient hospital services, then those services would be included in calculating the hospital specific limit. To the extent the Medicaid payment does not fully cover the cost of the inpatient or outpatient hospital services provided, the unreimbursed costs of those services would be counted in calculating that limit. Services that are not within the State’s definition of inpatient or outpatient hospital services, and any revenue associated with such services, however, would not be included in that calculation. The same is true for hospital services furnished to individuals whose insurance status fluctuates; hospital services furnished while individuals are uninsured would be included in the calculation, and those furnished while individuals are insured would not be included.”*

Based on the information provided above, Texas hospitals maintain that this requires that the state include costs associated with the following as part of allowable Medicaid costs:

- Medicaid-eligible patients over 21 years of age receiving inpatient hospital services more than 30 days in duration;
- Medicaid-eligible patients whose claims for payment for inpatient and outpatient hospital services were submitted more than 95 days after discharge; and
- All other costs for Medicaid-eligible clients receiving inpatient and outpatient hospital services.

In addition, the position taken by the hospital industry is bolstered by an important ruling involving the courts and applying to payments and coverage determinations made in the *Medicare* disproportionate share program.

In the late 1980s, CMS (then known as the Health Care Financing Administration) issued a regulation implementing the Medicare DSH law. Under the regulation, the only Medicaid patient days that could be included in the Medicare DSH formula were Medicaid patient days for Medicaid-eligible individuals and for which the hospital actually was paid by the state Medicaid agency.

A number of hospitals challenged this interpretation, and contended that as long as a patient was eligible for Medicaid, the patient day should be included in the Medicare payment formula regardless of whether the state Medicaid program actually paid the hospital for that day. Ultimately, four different U.S. Circuit Courts of Appeal ruled that the interpretation issued by HCFA was incorrect, and that the Medicare DSH formula must include all days for which a patient was eligible for Medicaid, whether or not the state Medicaid program actually paid the hospital for the days in question. The courts held that HCFA improperly had restricted Medicare DSH eligibility by limiting Medicaid days and, as a consequence, improperly reduced payments to eligible hospitals.

In response to these circuit court decisions, HCFA Ruling 97-2 was issued on Feb. 27, 1997, announcing that the agency had changed its interpretation of the calculation of the Medicare DSH formula to follow the rulings of the courts. Ruling 97-2 directed that in calculating the Medicaid days for purposes of Medicare DSH, all Medicaid inpatient days for eligible Medicaid patients must be counted, regardless of whether the hospital received payment.

While HCFA Ruling 97-2 applies directly to the *Medicare* program, the courts and CMS have clearly indicated that all days of care and their costs for Medicaid-eligible patients should be counted.

## **Identifying and Reporting Patients without Insurance**

### **Background:**

Currently, in developing hospital-specific DSH limits, hospitals report charges and are able to include costs for patients who are not covered for the hospital services provided, but who may otherwise have other health insurance coverage. In meeting with THHSC, the agency indicated that hospitals will no longer be able to report charges and related costs for patients that have exhausted lifetime benefits, are not covered due to pre-existing conditions, or are not otherwise covered for the services provided.

### **Policy Considerations:**

In this section of the rule, CMS has made a broad departure from existing policy, and has promoted rules that are not consistent with the intent of provisions found in the MMA. The MMA gave clear direction to CMS to compare DSH payments to hospital-specific DSH limits. MMA did not give CMS the latitude to redefine the hospital-specific limit by re-defining which patients may be included in the hospital-specific cap.

Texas hospitals agree with a portion of the agency's arguments that patients without creditable health insurance coverage should be included as uninsured for calculation of the hospital-specific limit. As recorded on pages 77910 and 77911 of the *Federal Register* the following language includes:

*“Comment: One commenter questioned whether claims denied by insurers for lack of prior authorization or claims submitted too late would be considered uninsured since the service is not reimbursed by the insurer and the amount is not*

*a contractual allowance. The commenter asserted that, in that instance, the cost of that portion of the stay is uninsured.*

*Response: Section 1923(g)(1) refers to the costs of hospital services furnished by the hospital “in individuals who \* \* \* have no health insurance (or other source of third party coverage).” We have always read this language to distinguish between care furnished to individuals who have health insurance or other coverage, and care furnished to those who do not. We have never read this language to be service-specific and we believe that such an interpretation would be inconsistent with the broad statutory references to insurance or other coverage. Furthermore, such a reading would result in cost shifting from private sector coverage to the Medicaid program. We interpret the phrase “who have health insurance (or other third party coverage)” to broadly refer to individuals who have creditable coverage consistent with the definitions under 45 CFR Parts 144 and 146, as well as individuals who have coverage based upon a legally liable third party payer. The phrase would not include individuals with insurance that provides only excepted benefits, such as those described in 45 CFR 146.145, 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).”*

The industry supports the concept that hospitals should be able to include, as uninsured, patients who do not have creditable insurance coverage such as:

- Coverage only for accidents (including accidental death and dismemberment);
- Disability income coverage;
- Liability insurance, including general liability insurance and automobile liability insurance;
- Coverage issued as a supplement to liability insurance;
- Workers’ compensation or similar coverage;
- Automobile medical payment insurance;
- Credit-only insurance (for example, mortgage insurance);
- Coverage for on-site medical clinics;
- Limited-scope dental benefits;
- Limited-scope vision benefits;
- Long-term care benefits that are not an integral part of a group health plan;
- Non-coordinated benefits such as coverage for only a specified disease, (for example cancer-only policies); and
- Supplemental benefits, such as Medicare supplemental health insurance or similar plans.

## **Defining Indigent Patients**

### **Background:**

More than 100 hospital districts currently operate in Texas. These locally operated hospital districts are primarily responsible for providing primary and tertiary care for patients without insurance in their county. Individual districts have developed local programs that use income

levels to determine eligibility for care. Generally funded with local property tax revenues, these programs do not provide health insurance coverage, but do provided much-needed care for the indigent population.

### **Policy Considerations:**

As noted on pages 77912 and 77913 of the *Federal Register*, the following comments specifically addresses the policy that local-only government programs do not constitute health insurance coverage:

*“...To the extent that hospitals include such eligible uncompensated inpatient and outpatient hospital care as part of their hospital-specific DSH limit calculation, the included costs must be offset by payments actually made by or on behalf of patients with no source of third party coverage in the Medicaid State plan rate year under audit. **These payments do not include payments made by State-only or local-only government programs for services provided to indigent patients.**”*

As noted on page 77915 of the *Federal Register*, the comments clearly point out that health insurance does not include coverage or payments made by a local government unit on the basis of indigent status:

*“Comment: One commenter requests CMS clarify how the indigent are to be identified. In particular, the commenter asked for clarification on the treatment of other State or local funded services for indigent patients and how that fits into the reporting for the uninsured, and noted that some hospitals have included items in the ‘uninsured’ category that are State or locally funded. Examples include items such as county jail patients, public employee workers’ compensation funded services, and services to juveniles referred from secure State facilities.*

*Response: We interpret the phrase ‘who have health insurance (or other third party coverage)’ to broadly refer to individuals who have creditable coverage consistent with the definitions under 45 CFR Parts 144 and 146, as well as individuals who have coverage based upon a legally liable third party payer. The phrase would not include individuals who have insurance that provides only excepted benefits, such as those described in 42 CFR 146.145, 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). The phrase also does not include coverage or payments made on the basis of indigency by a State or a local unit of government within the State, pursuant to Section 1923(g)(1)(A) of the Act. Inpatient and outpatient hospital costs incurred for individuals for which the State or local government is responsible on a basis other than indigency should not be included in calculating the hospital-specific limit. This would include costs for care for which the State makes payments on the basis of status as State employees, prisoners or other wards of the State. A State Medicaid Director letter dated August 16, 2002, specifically addressed the issue of treatment for Medicaid DSH purposes of hospital costs associated with inmates of correctional facilities. The letter specified that these costs were ineligible as*

*uncompensated costs for purposes of DSH because the inmates are wards of the State and the State is directly responsible for their basic economic and medical needs. Failure to do so would be in violation of the eighth Amendment of the Constitution. Similarly, inmates of a county jail or juvenile facility are wards of the State or local government detaining them and their basic economic and medical needs are the obligation of that governmental entity. In addition, uncompensated inpatient and/or outpatient hospital costs associated with providing services for public employee worker's compensation programs are not eligible for inclusion in a hospital's DSH limit. Workers' compensation programs provide third party coverage for medical services that is not based on indigency."*

Consistent with a Texas Attorney General opinion published in 1993, if a county's hospital district is statutorily responsible for providing care to the county's indigent residents incarcerated in the county jail, then all the district's costs associated with qualifying prisoners' care should be included in the hospital's costs of caring for the uninsured.

Texas hospitals look forward to working with the agency as it addresses these concerns. If you have any questions or need additional information, please call me at 512/465-1056 or John Berta at 512/465-1556.

Sincerely,

A handwritten signature in black ink, appearing to read "Richard Schirmer". The signature is fluid and cursive, with a long horizontal stroke at the end.

Richard Schirmer, FACHE  
Vice President, Healthcare Policy Analysis