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MS. VIVIAN E. JONES
DISTRICT ADMINISTRATOR

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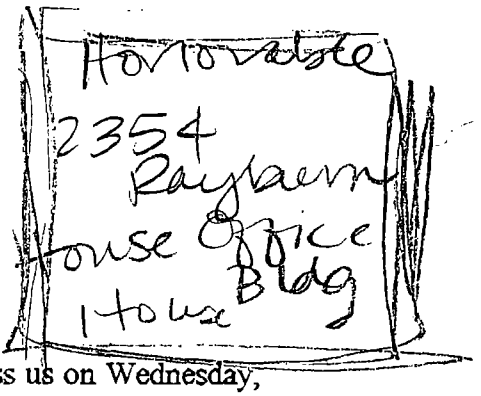
September 24, 1999



Mr. Christopher Jennings
Deputy Assistant to the President
Domestic Policy Council
Old Executive Office
Washington, DC 20500

Dear Mr. Jennings:

The New York Congressional Delegation invites you to address us on Wednesday, September 29, 1999, at 3:00 P.M. in Room B-318 of the Rayburn House Office Building.

We would appreciate your discussing the recent developments concerning the calculation of the Disproportionate Share Add-on for Medicare reimbursements to hospitals. It has come to our attention that the Health Care Financing Administration (HCFA) has informed hospitals in New York that their Disproportionate Share Add-ons will be reduced and previous "over payments" recovered. Because this decision affects primarily hospitals in the poorest communities with the most tenuous financial condition and the most acute obligations to their community the delegation is extraordinarily concerned.

We are also concerned about the what the Administration plans with regard to the reimbursements to hospitals for outpatient services. The cuts that have been imposed by HCFA are significant and seriously affect the fiscal integrity of many of our states hospitals, especially when combined with the other cuts in reimbursement directed by the Balance Budget Act of 1997

We have also invited Michael Hash, Acting Director of HCFA.

We hope to have a frank and fruitful conversation.

Sincerely,

CHARLES B.RANGEL
Member of Congress

CBR:jrs

cc: Charles Brain

Dear
Delaware Chairman
NY Cong Delegation
State

The
Honorable
Charles B Rangel

Dear Rep.

Prepared by HHS.

Talking Points on Medicare DSH

- I am calling to let you know that the Administration is clarifying its position regarding Medicare Disproportionate Share Hospital (DSH).

- As you know, Medicare DSH is paid by HCFA to hospitals based on a complicated statutory formula.

- We have recently determined that our guidance on how to claim Medicare DSH funds was neither sufficiently clear nor well understood.

- And, as a consequence of guidance provided to hospitals before 1998, many hospitals have claimed, and were reimbursed for, services that did not meet the criteria of the formula.

- We have been actively gathering facts about this, and we now have the information we need to resolve the situation.

- We will take two actions. First, due to the confusion that resulted from HCFA's guidance, we will hold harmless the hospitals that have been receiving these payments. This is the fairest way to resolve this situation for the hospitals that provide care to the most vulnerable Americans.

- Second, we will clarify our Medicare DSH policy in guidance both to our fiscal intermediaries and to hospitals.

- We will also provide clarification of our policy to state Medicaid agencies to assist them in submitting data for use in making DSH calculation. The Medicaid data is critical to the Medicare DSH calculation, and the use of this data is the primary source of the payments in question.

- After January 1, 2000, we will begin to apply the policy, and we will hold hospitals responsible for their Medicare DSH claims.

For Calls to New Jersey Members:

- We understand that at least some New Jersey hospitals had claimed funds using criteria that did not meet the formula. These claims were denied and the hospital's then appealed the decision. We have decided to allow the hospitals to receive the additional funds.

For Calls to Pennsylvania Members:

- We understand that some funds have already been recouped from at least some hospitals in Pennsylvania. These funds will be reimbursed.

OCT 4 REC'D

MEDICARE
Part A Intermediary
Telephone: (315) 448-7575

xc Larry
We're not aware Dan

September 28, 1999

Mr. David Polge
President
Delaware Valley Hospital
1 Titus Place
Walton, New York 13856

Provider Number: 33-0121

**** NOTICE OF REOPENING ****

Dear Mr. Polge:

I would like to inform you that we are reopening your final settlements, for the years listed below, to consider new information that we have received from New York State concerning MEDICAID days utilized in the Disproportionate Share Adjustment calculation.

Fiscal Year	12/31/1993
Fiscal Year	12/31/1994
Fiscal Year	12/31/1995
Fiscal Year	12/31/1996

If you have any questions, please contact me at (315) 442-4959.

Sincerely,

Steve Hartmann MAS
Steve Hartmann, Director
Audit & Reimbursement

prepared by HHS

Q. What is the policy that HCFA is announcing today?

A. HCFA is announcing today that they will hold harmless hospitals that have received additional Medicare disproportionate share hospital (DSH) payments because guidance on how to claim these funds was not sufficiently clear. The DSH formula provides additional funds to hospitals that serve low income Americans. HCFA will quickly issue guidance and apply the policy on January 1, 2000.

Q. When this was only a problem for Pennsylvania, HCFA said it would recoup the funds. When it was found that hospitals in New York owed funds, HCFA changed its interpretation? Is your action today simply designed to help the First Lady in her election bid?

A. Of course not. Let's be clear on the what has happened. When a problem was first identified in Pennsylvania, we believed that the fiscal intermediary and the hospitals in that state had simply misunderstood our guidance. After a similar problem was found in another state, HCFA launched a national, comprehensive effort to identify all the states where Medicare DSH issues may exist. This survey shows that as many as 20 states have a potential problem. We believe that holding the hospitals in these states harmless is the fairest thing to do to resolve this situation for the hospitals that care for the most vulnerable Americans.

ROBERT G. TORRICELLI
NEW JERSEY

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(609) 933–2245
http://torricelli.senate.gov/
Senator_Torricelli@Torricelli.Senate.Gov

October 7, 1999

Christopher C. Jennings
Deputy Assistant to the President
The White House
Washington DC, 20500

Dear Chris:

I want to thank you again for meeting with the New Jersey Congressional Delegation in August to discuss the issue of Disproportionate Share Hospital Payments to New Jersey hospitals. As you suggested, the Delegation has contacted the Provider Reimbursement Review Board to inquire as to the progress of their ruling in the Jersey Shore Medical Center Case. We remain hopeful that this decision will be expedited so that HCFA can issue a final ruling in regard to all New Jersey Hospitals.

In the meantime, it has been brought to my attention that hospitals in the State of New York have recently found themselves in a similar situation as New Jersey. I'm sure you share my concern that HCFA's decision to recoup DSH payments from New York hospitals, many of which serve extremely poor patients, could be potentially devastating. I understand that the New York Congressional Delegation is currently working with HCFA to develop an administrative solution to this matter and it is my hope that New Jersey hospitals will be included in any final resolution.

Again, thank you for your responsiveness to this important issue and I look forward to continuing our work together on behalf of New Jersey hospitals.

Sincerely,

ROBERT G. TORRICELLI
United States Senator

RGT:km

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Hospital Reimbursement Bid Dropped After First Lady Intervenes

By Lynne Duke
Washington Post Staff Writer
Saturday, October 16, 1999; Page A14

NEW YORK, Oct. 15—After weeks of intervention by first lady Hillary Rodham Clinton, the federal Health Care Finance Administration has decided not to pursue the reimbursement of roughly $1 billion in overpayments it made for the care of the indigent at New York hospitals, a source close to Clinton confirmed tonight.

Clinton had spoken to administration officials on the subject in recent weeks, in response to concerns raised by hospitals that returning the funds for Medicare patients would affect health care delivery. Clinton is running an exploratory campaign for the U.S. Senate seat from New York that will become vacant next year, and health care issues have emerged as the centerpiece of her burgeoning effort.

Whether the move by HCFA came solely in response to Clinton's intervention or also in response to lobbying by New York hospitals is unclear. But the move occurred just after Clinton criticized the payment recovery dispute during a speech she delivered Thursday to the HealthCare Association of New York.

Speaking to the organization's conference in the resort town of Bolton Landing on Lake George in the Adirondack region, Clinton called for the dispute between hospitals and HCFA to be "resolved as soon as it can be in a way that does not penalize hospitals for providing health care to the indigent."

HCFA has made nearly $1 billion in what it characterized as overpayments to 130 hospitals across New York state because of a discrepancy between the way HCFA calculates Medicare payments and the way the hospitals do, said Jeanne H. Cross, the hospital association's vice president for communications.

During campaign appearances at Lake George and also before a nurses group in Lake Placid the same day, Clinton took another stand in opposition to her husband's administration when she criticized the Balanced Budget Amendment of 1997. Both she and hospital executives have called for the restoration of cuts in Medicare payments to hospitals.

"Those cuts went too far," Clinton said in Lake George. "They have caused too much pain and are cutting into too much muscle and bone."

Peter Sullivan, executive vice president of the Nassau/Suffolk Hospital Council, said after Clinton's speech that he wants her "to persuade her husband to back off on those cuts. . . . I want him to put more restorations on the table." The hospital association said New York health care providers have lost $5 billion as a result of the balanced budget amendment cuts.

Clinton's speeches on health care reform this week were her most comprehensive on the subject since she announced her possible Senate campaign in July. She has recommitted herself to the health care reform agenda she pursued with abysmal results in the early 1990s, when she pushed for a wholesale overhaul of the health care industry, with universal health insurance coverage a primary goal. She maintains that universal coverage remains her goal but acknowledges that the broad and immediate change she once sought must give way to a more incremental approach.

Referring to that reform debacle of 1993 and 1994, she said, "Given the results of that effort, there are probably many who might not understand why I would keep talking about health care. But the answer is simple. This is something I've been talking about and working on my entire life. . . . I am proud that we did try to help millions of people that don't have insurance in this country. We were right to be concerned, but we clearly need a different approach."

Sarah E. Gegenheimer 10/16/99 09:24:31 AM

Record Type: Record

To: Christopher C. Jennings/OPD/EOP@EOP, Devorah R. Adler/OPD/EOP@EOP

cc:

Subject: Newsday: Agency Gives NY Hospitals $1B Break

Agency Gives NY Hospitals $1B Break

U.S. office ends efforts to recover disputed funds

By Ellen Yan
Washington Bureau

Washington -- The federal Health Care Financing Administration abruptly abandoned two weeks of work seeking recovery of as much as $1 billion given to New York hospitals that treat a high proportion of poor people.

"It's a billion-dollar sigh of relief," Daniel Sisto, head of the Healthcare Association of New York State, told hospital administrators at their upstate conference Friday. First lady Hillary Rodham Clinton, a likely Senate candidate, addressed the group's annual convention Thursday.

The reversal, which lawmakers were informed about late Thursday night, came only hours after Clinton promised the group's top officials that she would speak to federal health officials about the matter. Some conference members credited Clinton Friday with having resolved the dispute, which involved the reimbursement formula, but it remained unclear precisely what role Clinton played.

The association, which represents about 200 hospitals, estimated its members could have been forced to repay up to $168 million for each of the six years the federal agency had threatened to go back.

The suddenness of the federal agency's turnaround surprised hospital administrators and the New York congressional delegation, which, in pressing for a quick solution, had almost daily inundated President Bill Clinton and federal policy-makers with predictions of massive layoffs, hospital closings and financial meltdowns.

Last October, Pennsylvania hospitals had lost the first round of a similar battle with HCFA, which questioned the formula they used to seek federal reimbursement for serving poor patients. But Friday the agency said it will return money Pennsylvania hospitals had been required to repay.

"This is the fairest thing to do to resolve the situation," said HCFA spokesman Chris Peacock. "It became obvious the confusion regarding

the issue was pervasive."

In an initial report this year, HCFA found that about 20 states, including New York and Pennsylvania, had been calculating the number of poor served in area hospitals by including not just the people eligible for the federal share of the Medicaid program but also those who qualify for the state's share of Medicaid, a health care program for the poor. The method raised reimbursements to state hospitals for serving the poor.

Although New York and Pennsylvania were the only two states to have their reimbursements questioned, the widespread nature of this dispute helped persuade White House and health policy-makers to drop plans to require states to repay any excess payments, officials said.

HCFA also announced that hospitals will no longer be allowed to factor in people who satisfy only the state Medicaid eligibility rules with those who satisfy federal. This will require New York hospitals to shoulder a larger share of the cost of serving eligible adults who have no children. Several lawmakers and hospital administrators said they would fight that decision, as well.

Sen. Charles Schumer (D-N.Y.), a leader in the effort to reverse HCFA's action, suggested that the Clinton administration had zeroed in on the hospital reimbursement rates in a search for budget savings to offset a package of proposals it wanted to offer to lower prescription drug costs for seniors.

"I think the pressure was getting rather intense," Schumer said. "They knew they had done us wrong."

Rep. Charles Rangel (D-Manhattan), who along with Rep. Eliot Engel (D-Bronx), Sen. Daniel Patrick Moynihan (D-N.Y.) and other New York lawmakers pressed the White House for relief, said the threatened hospitals perform "a tremendous public service ... If they were not there, then the costs to society would be far greater because the nation's uninsured and lower-income families would have no place to go."

NATIONAL
New York Region

The New York Times ON THE WEB

October 16, 1999

U.S. to Let Hospitals Keep $1 Billion

Related Article
- Issue in Depth: **Health Care**

By ROBERT PEAR

WASHINGTON -- The Clinton Administration reversed itself and agreed on Friday to let New York hospitals keep $1 billion in Medicare money that the Federal Government had been trying to get back.

The Administration's decision came one day after Hillary Rodham Clinton, a likely candidate for the United States Senate from New York, said the Federal Government should give more money to New York hospitals. White House officials said Mrs. Clinton had repeatedly expressed her view that those hospitals, and other hospitals serving poor people around the country, should receive more Federal money. But they said she had not ordered the change.

The reversal also follows months of intense lobbying by the Senators from New York, Daniel Patrick Moynihan and Charles E. Schumer, and Representative Charles B. Rangel, dean of the state's Congressional delegation. All are Democrats.

Federal officials said they were abandoning their effort to recoup the $1 billion, which was paid over the last 10 years to New York hospitals serving large numbers of poor people. In recent months, the Federal Government asserted that the hospitals had been overpaid because they had overstated the number of poor people they served.

Using a similar argument, Federal officials had made such claims against hospitals in seven other states. All those claims will now be dropped. The Government had already compelled hospitals in Pennsylvania to repay $50 million to the Federal Treasury, and they were trying to collect $200 million more.

The decision will allow 38 hospitals in New Jersey to keep $288 million that they would otherwise have been required to pay back to the Federal Government. An aide to Senator Frank R. Lautenberg, Democrat of New Jersey, said Medicare officials had been "pretty intransigent" until this week.

Jane Horvath, a deputy assistant secretary at the Federal Department of **Health** and Human Services, acknowledged today that it was

unreasonable to make states repay such money because the Federal regulations on the subject were unclear. The $1 billion represents more than 10 percent of what New York hospitals receive from Medicare for in-patient **care** each year, Government data show.

Marsha Berry, a spokeswoman for Mrs. Clinton, said the First Lady had "expressed her deep concerns about the impact" of the repayment demanded by the Medicare agency, the **Health Care** Financing Administration. And Mrs. Clinton is "very glad that the problem has been addressed," Ms. Berry said.

Chris Jennings, the **health** policy coordinator at the White House, said Mrs. Clinton had regularly conveyed her concern about the financial problems of New York hospitals in general and hospitals serving large numbers of poor people in particular.

But, Jennings said, Mrs. Clinton did not directly order or instruct anyone to make the decision announced on Friday.

Sunny Mindel, the press secretary for Mayor Rudolph W. Giuliani, said, "We are very satisfied that the Federal Government has come to the same conclusion that the city has maintained for quite some time." Ms. Mindel declined to comment on the timing of the decision or to speculate on whether Mrs. Clinton's expected Senate candidacy had played a role.

Representative Phil English and Senator Rick Santorum, both Pennsylvania Republicans, have been urging the Administration for months to drop its claims against hospitals in their state.

Jennifer Hall, the press secretary for English, said he wrote to the Medicare agency in October 1998 and met with agency officials several times since then.

But Ms. Hall said: "We didn't get much of a response until on Friday. The reason it took so long is that bureaucrats at the **Health Care** Financing Administration buried their head in the sand and refused to change their policy."

Senator Moynihan said he raised the issue twice with the President in the last 10 days. Schumer said he had raised it with Donna E. Shalala, the Secretary of **Health** and Human Services, and with Clinton.

Federal **health** officials said they first became aware of the problem in Pennsylvania and initially believed that no other states were affected. But, they said, further investigation revealed similar problems in New York and at least six other states: Hawaii, Kansas, Massachusetts, Minnesota, New Jersey and Tennessee.

Preliminary estimates by the Greater New York Hospital Association suggest that Friday's decision will be worth $13.6 million to Beth Israel Medical Center in Manhattan, $6.6 million to Mount Sinai Medical Center in Manhattan, $6.3 million to Montefiore Medical Center in the Bronx, and $4.3 million to St. Vincents Hospital in Manhattan.

Medicare finances **health care** for 39 million people who are elderly or disabled, including 2.7 million in New York State and 1.2 million in New Jersey. Medicare routinely covers hospital **care** for beneficiaries, and the Federal Medicare law guarantees extra payments to hospitals that serve "a disproportionate number of low-income patients with special needs." The law refers to these institutions as "disproportionate share hospitals."

Appearing on Friday before the House Ways and Means Committee, Ms. Horvath said: "Our policy guidance on how to calculate Medicare disproportionate share payments was not clear. We have decided that the guidance needs clarification."

Ms. Horvath said the Federal Government would drop all its claims to money paid before Jan. 1, 2000. But after that, she said, the Administration will insist on its interpretation of the law. which could cost New York hospitals $160 million a year.

The technical issue at the heart of the dispute is whether people in welfare programs financed entirely by the states -- Home Relief and general assistance programs -- should be counted as indigent when the Government computes Medicare payments to "disproportionate share hospitals."

Hospitals in New York and New Jersey have counted such welfare recipients, many of whom are childless adults. But the Federal Government says they should not be counted.

Rangel said: "We are very grateful that the Administration has decided not to go back and seek recoupment for claims made honestly, based on real need. To extract a billion dollars from New York hospitals would have been a disaster."

Senator Schumer welcomed today's announcement as "a first step in preventing the devastation of teaching hospitals and inner city hospitals." But, he said, more needs to be done by the Federal Government, to repair damage done by the 1997 law and to forestall the Administration's policy on "disproportionate share hospitals" after Jan. 1.

October 16, 1999

Viral Outbreak Highlights City-State Tensions

By JENNIFER STEINHAUER

The first time New York City **Health** Department officials learned that their state counterparts were investigating the city's strange viral outbreak, the state was announcing that it had solved the mystery.

It seemed state **health** officials were not so convinced that New Yorkers were falling ill from St. Louis encephalitis -- the original diagnosis by the Federal Centers for Disease Control and Prevention -- so they turned to a scientist with a cutting-edge lab in California for help. But they never told city **health** officials or the C.D.C. in Atlanta of their suspicions, or that they had enlisted the California lab to take a peek.

The oversight did not have any practical effect on how the city

WEST NILE VIRUS

responded to the outbreak, which began in August, killing six people and sickening dozens. Scientists now believe it resulted from a version of the West Nile virus, which is transmitted by mosquitoes. But the state's actions were more than an aberration.

The episode underscored ages-old tensions between the two agencies, which sometimes resemble squabbling siblings rather than coadjutant partners. Stephen C. Joseph, who was the city's **Health** Commissioner from 1986 to 1990, summarized the relationship in a phrase: "porcupines making love."

"The city guys feel like, 'We are doing the work and taking the hits, and the state sits up there and makes pronouncements without getting their hands dirty,' " Joseph said. "And the state feels like, 'Hey, we are sitting up here trying to run the world, and the cowboys are down there in the city just running around.' "

Joseph, who now runs a biotechnology and computing research company in Santa Fe, N.M., lived through one of the most public battles, which centered on a controversial proposal for intravenous needle users during the height of the AIDS crisis. But over the years, the tensions have varied from the petty (which agency will hold a news conference and who will be invited) to the complex (how to administer immunization programs).

Of course, the two agencies have worked successfully in tandem on some important public **health** emergencies, like a 1990's outbreak of the AIDS virus that centered on one man who traveled the state spreading sickness. But several factors, like the city's unusual relationship with the Federal Government, its storied history in the annals of public

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history in the annals of public **health**, and the awkward divisions of responsibilities between the two agencies, have contributed to the tension.

Holiday Plans (Sept. 6, 1999)
Elderly Queens Resident Is 2d to Die of Encephalitis (Sept. 5, 1999)
Encephalitis Strikes 3 People, 1 Fatally, in Queens, City Says (Sept. 4, 1999)

In a way, the source of it goes back to 1866: the year the city agency was founded but 35 years before its state counterpart was even conceived.

In part because of its early formation -- it is the oldest city agency in the country -- the department has played a huge national role in identifying illnesses, starting vital record keeping and containing threats like a Russian cholera epidemic in 1892, according to "A History of Public **Health** in New York City," by John Duffy.

And unlike any other city **health** agencies in the nation, New York's has its own set of vital records and its own **health** code, and reports vital statistics directly to the C.D.C. It also receives large grants from that Federal agency, independently of the state.

In some ways, its mandate is strikingly similar 100 years later: it still pushes doctors to improve illness reporting, it still worries about the local water supply, it still tries to keep disease outbreaks at bay. (It no longer, however, browbeats local merchants and farmers to clean up accumulated piles of manure.)

But when the State **Health** Department greatly expanded in the 1970's, certain functions slowly were turned over to that agency. Sometimes, there was duplication of services.

Simple geography and vast population differences also divide the two. They are three hours apart by car, but a world away demographically. And each often reflect the wishes and agendas of the presiding mayor and governor, who do not always see eye to eye.

"Public **health** issues often evidence themselves in the city and large urban areas first," said Maria K. Mitchell, the former chief **health** policy adviser to Mayor Rudolph W. Giuliani. "Therefore, the city is in the position of having to react first on the ground."

Yet the state is often perturbed that the city does not readily cooperate with or credit them for their role in city issues, former officials said. And unlike anywhere in the country, both the city and the state have world-class laboratories and disease experts under their respective roofs, a boon for public **health** that can create professional rivalries.

"There have always been some difficulties," said Mark Chassin, who was the State **Health** Commissioner during the early 1990's and now heads the department of **health** policy at the Mount Sinai School of Medicine in New York. "There are inherent issues of responsibility and turf, credit and coverage and blame and glory that will always be there."

One of the most difficult points in recent history occurred during the tenures of Joseph and his state counterpart, David Axelrod, during the administrations of Mayor Edward I. Koch and Gov. Mario M. Cuomo. Both commissioners were very strong-willed, outspoken and fierce proponents for their programs. Joseph said that he always had great respect for Axelrod, who died in 1994. But Joseph conceded that the AIDS crisis, including his battle with the state, was one of the most trying moments in his career.

The struggle between the two centered on Joseph's proposal to distribute free needles to drug addicts, whose sharing of contaminated needles had contributed to the spread of the disease. Prosecutors and law enforcement officials hated the idea, as did Axelrod, who made it very difficult for the city to start a pilot project, which was ultimately scratched. "The state was much more cautious and much more political about getting out on the limb," Joseph said. "They made us jump through hoop after hoop."

Later, in the early 1990's, there was a tuberculosis outbreak in the city. Directly observed therapy -- getting sick people to take their medication in front of **health care** workers to insure that they finished it -- was chosen. Who deserved the credit for carrying out the plan still remains an issue for debate.

"The TB epidemic was case in point," Chassin said. "The state folks did not feel their role was credited properly by city. All the connections with the hospitals were all done by state," which also paid for a large part of it, he said.

Former city officials countered that the critical role was played by the C.D.C., not by the state.

But it is the city's relationship with the C.D.C. that has often put it at odds with Albany.

For instance, New York City frequently sends data to the C.D.C., bypassing the state, officials there complained.

"It has been a longstanding battle for every administration," said a former state official, who spoke on the condition of anonymity. The ramifications, the official said, were delayed reports and even research that got stymied because the city had failed to report statistics.

Former officials from both departments say that when the system works, it really works, as was the case in tracking Nushawn J. Williams, the man who infected at least 13 women around the state with the virus that causes AIDS, and was sentenced to prison in April for reckless endangerment and rape.

But when the system fails, it can have serious consequences. A study released last month by IPRO Inc., a nonprofit group that studies the quality of **health care**, found that only 23.5 percent of New York State residents 65 and older received a pneumococcal vaccine in 1997; in the city, that rate averaged 14.7 percent, the lowest rate in the state.

Many **health care** experts concur that vaccine delivery is an area in which the state and the city need to better coordinate their respective areas of authority.

"In the early 1990's, there was a measles epidemic, and it was obvious that kids were not immunized," Chassin said. The state started an initiative to increase immunization rates, he said, but "the city was not able to take the regulatory action that would make it happen."

No great calamity befell any New Yorker because the state decided not to tell the city what it was up to with the West Nile investigation and its subsequent announcement that it was now taking over, a month into the outbreak. But public confusion over who is running the investigation and containment of a **health care** crisis can create its own sort of hazards, **health** experts said.

The appearance is that "you have no straight line of command," said Charles Calisher, a professor of microbiology at Colorado State University and a former C.D.C. scientist. "That doesn't change mosquito control, but it gives the perception that officials don't know what they are doing.

And if people don't have confidence in the people who are responsible for their well-being, that makes for rumors and people saying ridiculous things about ticks and thinking they should take their children to the doctor for penicillin shots."

Since then, **health** workers for the city and the state have been on the phone daily, said

Perry Smith, the epidemiologist in charge of the investigation for the State Department of **Health**. "It is critical that we keep each other informed," Smith said, adding later, "It is remarkable how well everyone has worked together on this one."

LAW OFFICES

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ONE PENN CENTER - 19TH FLOOR

1617 JOHN F. KENNEDY BOULEVARD

PHILADELPHIA, PA 19103-1895

(215) 665-3000

FAX (215) 665-3165

THOMAS A. LEONARD

DIRECT DIAL (215) 665 3220

August 23, 1999

CC: Chris Jennings

VIA FACSIMILE & REGULAR MAIL

Mr. John Podesta
Chief of Staff
White House
Washington, DC 20502

Dear John:

Please accept this letter as a follow up to discussions with your office concerning the Health Care Financing Administration's (HCFA) policy of recouping Medical Disproportionate Share (DSH) payments already made to Pennsylvania hospitals for General Assistance (GA) days. This new interpretation threatens our health care delivery system as well as the financial viability of many Pennsylvania hospitals.

Both House Ways and Means Health Subcommittee Chairman Bill Thomas and Ranking Member Pete Stark agree that Pennsylvania's hospitals and health systems should not be punished for HCFA's past mistakes. While legislation to fix this Pennsylvania specific problem has been introduced and co-sponsored by every member of Pennsylvania's Congressional delegation, HCFA does have the ability to solve this problem administratively.

This is a very important issue for me and Pennsylvania. It would be a great service to the hospitals and health systems in Pennsylvania and the patients they serve if you would work with HCFA to resolve this issue in favor of our hospitals.

Thank you for your consideration.

Very truly yours,

Tom

Thomas A. Leonard

TAL:bjp

208103

THE WHITE HOUSE

FACSIMILE TRANSMISSION

OFFICE OF LEGISLATIVE AFFAIRS,
WEST WING

office phone: 456-2230
office Fax: 456-6220

DATE: _____

TO: Devorah / Jeanne

FAX NUMBER: 65557 TOTAL PAGES: ____

FROM:
___ LARRY STEIN
___ JANET MURGUIA
✓ MINDY MYERS
___ ERICA MORRIS

SUBJECT: _____

COMMENTS: _____

312 175

ROBERT G. TORRICELLI
NEW JERSEY

COMMITTEES
GOVERNMENT AFFAIRS
JUDICIARY
[redacted] ADMINISTRATION
FOREIGN RELATIONS

ONE RIVERFRONT PLAZA
NEWARK, NEW JERSEY 07102
[redacted]

[redacted] BOULEVARD
KRAMER INTERSTATE BUSINESS PARK
SUITE A-1
BELLMAWR, NEW JERSEY 08031
[redacted]

United States Senate

717 DIRKSEN SENATE OFFICE BUILDING
WASHINGTON, DC 20510-3003
(202) 224-3224

July 29, 1999

The Honorable William J. Clinton
The White House
1600 Pennsylvania Avenue
Washington, DC 20500

Dear President Clinton:

On behalf of the citizens of New Jersey, I am writing to bring your attention to an issue of critical importance: the collection of millions of dollars for New Jersey hospitals that serve the highest percentage of low-income patients.

On October 30, 1998, the Provider Reimbursement Review Board (PRRB) issued a unanimous decision recognizing that New Jersey hospitals have been underpaid millions of dollars due to a incorrect interpretation of the law governing the calculation of New Jersey's Disproportionate Share Hospital Payments (DSH). A hospital's Medicare DSH percentage is the sum of Medicare and Medicaid calculations, and it is the Medicaid calculation that is at issue here.

New Jersey's Charity Care Program is part of the State Medicaid plan, receives federal matching Medicaid dollars, and reimburses hospitals for charity care based on Medicaid rates. The New Jersey intermediary, Blue Cross and Blue Shield of New Jersey, has traditionally excluded charity care days from the calculation. This error has resulted in significantly reduced rates DSH payments to New Jersey.

I understand that the Health Care Financing Administration (HCFA) is currently reviewing the merits of the PRRB's ruling. On December 14, 1998, I signed a letter, along with the members of the New Jersey Congressional Delegation to Administrator DeParle requesting that the ruling be affirmed as soon as possible. Still, there has been no decision made in this case.

Since this is an issue of such importance to New Jersey's most vulnerable population, I wanted to make you personally aware of the matter and request the opportunity for the New Jersey Congressional Delegation to meet with a high-level official from your Administration to discuss a potential resolution.

Thank you in advance for your consideration.

Sincerely,

ROBERT G. TORRICELLI
United States Senator

RGT:km

OFFICE OF THE MAYOR

FAX TRANSMITTAL

cc: Mickey Ibarra

DATE: 7.30.99

TO: John Podesta

COMPANY/DEPT.:

FROM: Ed Rendell / Donna

NO. OF PAGES (INCLUDING THIS SHEET): 3

Notes

If all pages have not been received please call at the number below.

215 City Hall
Philadelphia, PA 19107

Phone: (215) 686-2181
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(215) 686-2180

cc: Mickey Ibarra

CITY OF PHILADELPHIA

OFFICE OF THE MAYOR
ROOM 215 CITY HALL
PHILADELPHIA, PENNSYLVANIA 19107-3295
(215) 686-2181
FAX (215) 686-2170

EDWARD G. RENDELL
MAYOR

July 30, 1999

The Honorable Albert Gore, Jr.
Vice President
United States of America
Office of the Vice President
The White House
1600 Pennsylvania Avenue
Washington, D.C. 20500

Dear Vice President Gore:

I remain grateful for all that you and the President have done on behalf of cities, especially Philadelphia. My letter today is a follow-up on an issue I raised with you in a February 28 letter -- the Health Care Financing Administration's (HCFA) policy of recouping Medicare Disproportionate Share (DSH) payments already made to Pennsylvania hospitals for General Assistance (GA) days. This new interpretation is having a significant effect on health care delivery in Philadelphia and Pennsylvania, and threatens to impact our local economy as well. Moreover, HCFA appears to have singled out Pennsylvania for enforcement of this policy.

Since I last wrote to you, many hospitals are being forced to pay back millions of dollars to HCFA. The impact for Pennsylvania is $256 million; for the Philadelphia region, it's $144 million. I am writing again to ask you to contact Health and Human Services Secretary Donna Shalala and HCFA Administrator Nancy Ann Min DeParle on behalf of the hospitals and health systems in this region, and the patients they serve.

I understand that HCFA has taken the position that appropriate notice of policy changes must be given to providers. Additionally, I have been told that HCFA also has declined to recoup money from providers in cases where the Fiscal Intermediary (FI) did not make the rules clear. As I see it, the situation in Pennsylvania meets both standards. The hospitals and health systems are asking HCFA to order the FIs in Pennsylvania to allow GA days to be counted for purposes of Medicare DSH payments for discharges occurring before October 1, 1998.

Both House Ways and Means Health Subcommittee Chairman Bill Thomas and Ranking Member Pete Stark agree that Pennsylvania's hospitals and health systems should not be punished for HCFA's mistake. While legislation to fix this Pennsylvania-specific problem has been introduced and co-sponsored by every member of Pennsylvania's congressional delegation -- both Republicans and Democrats -- HCFA does have the ability to solve this problem administratively.

From my vantage point here in Philadelphia, it is becoming more evident that hospitals and health systems across the nation and, most notably in the Philadelphia region, are facing extreme financial pressures on several fronts. The impact of Medicare payment reductions imposed by the Balanced Budget Act of 1997 (BBA), discounted payments from managed care plans, denied and delayed payments from insurers, declining revenues from Medicaid patients and increasing numbers of uninsured and under-insured patients are placing patients in jeopardy of not receiving quality health care, and threatening to further reduce our regional workforce and the very existence of some of our neighborhood hospitals.

Nearly three-quarters of the hospitals in Southeastern Pennsylvania lost money on patient care services during 1998. Hospitals and health systems in our state are going to experience an estimated $4.1 billion in reductions in Medicare payments under the BBA and, in this region, more than $1.5 billion.

In addition to government cutbacks, an apparent policy of delaying or denying payments to hospitals by managed care plans is adversely affecting the institution's ability to deliver services to patients. A study of insurer payment trends by the Delaware Valley Healthcare Council of The Hospital and Healthsystem Association of Pennsylvania (DVHC), a regional trade association representing hospitals and health systems, found that, as of March 31, 1999, more than 50 percent of medical claims filed with insurers are more than 60 days old, even though a new law in Pennsylvania requires medical bills to be paid within 45 days. According to DVHC's data, on any given day more than $825 million is owed hospitals for more than 60 days, and almost $640 million is owed more than 90 days.

Another study done by DVHC shows hospitals have reduced their payrolls by more than 10,000 jobs over the past five years, with more cuts to come.

The growth of uncompensated care is very real, and is contributing to significant stress on our hospitals and health systems. In 1997, the last year for which official state figures for this region are available, local hospitals spent more than $361 million treating patients who couldn't pay, a $15 million increase over the comparable 1996 level. According to more recent DVHC data, the level of uncompensated care grew to approximately $400 million in 1998.

While several of these issues are out of your control, I share them with you to illustrate the tenuous environment in which our health care system now finds itself and to give you the context that makes the HCFA repayment issue so crucial to us. In fact, if it were not for the healthy performance of our national economy, hospitals and health systems would be in worse shape, as the record performance of stock market investments masks the fact that most hospitals in this region are in a sense "eating their seed corn."

As we grapple with ways to ensure that the safety net is there for people most in need of health care, this is one issue where we can reap tangible and quick beneficial results.

Mr. Vice President, this is a very important issue to me and to Philadelphia. It would be a great service to the hospitals and health systems in Pennsylvania and the patients they serve if you would work with HCFA to resolve this issue in favor of our hospitals.

Thank you very much for all that you done on our behalf.

Sincerely yours,

Ed

EDWARD G. RENDELL

EGR/dmc
cc: John Podesta, Esquire

OPM NEWS

R|E|L|E|A|S|E

FOR IMMEDIATE RELEASE
September 20, 1999

CONTACT: Michael Orenstein
202-606-2402 or mworenst@opm.gov

Plan to Control Health Premiums for Federal Employees and Retirees Announced with Release of Premium Increase for 2000

Washington, D.C. -- The U.S. Office of Personnel Management today announced new initiatives to hold the line on premium increases in the Federal Employees Health Benefits Program, which covers approximately nine million employees, retirees and their families. At the same time, OPM released FEHBP premium rates for 2000. Consistent with increases being experienced by other large employers, the FEHBP includes an average 9.3 percent increase.

"It is clear that competition in the marketplace has not effectively slowed the growth in FEHBP premiums," said Janice R. Lachance, Director of the U.S. Office of Personnel Management, which administers the health insurance program for federal employees and retirees. "We must consider new and bold approaches so we can continue providing affordable, high-quality health care to our employees, retirees and their families.

"The increases of the last several years are unacceptable," said Lachance. This year's rate increase follows a 9.5 percent increase in 1999 and a 7.2 percent increase in 1998.

On average, an FEHBP member with self-only coverage will pay $33.04 every two weeks - $2.94 more than in 1999. A member with family coverage will pay $71.76, or $7.09 more than last year.

Therefore, to control future increases and improve the program, Lachance announced her intention to:

- o raise the quality and cost effectiveness of health plans by raising the standards for participation in FEHBP, and
- o achieve efficiencies and economies of scale by contracting directly for selected benefits

OPM will consult with stakeholders this fall and expects to submit legislative proposals early in the new year.

- more -

Healthcare costs continue to increase, especially for prescription drugs. Absent aggressive steps by OPM, the overall increases would have been even higher. To counteract the high cost of prescription drugs, members will find that many plans have changed their prescription benefit to encourage the use of mail-order drug purchases and the purchase of generic drugs. In addition, most participants will pay a minimum $10 copayment for all visits to a primary care doctor.

Lachance strongly encourages FEHBP members to look beyond a plan's premium. Members should review a plan's benefits, paying particular attention to prescription drugs, copayments and coinsurance.

"Each FEHBP member should review their health care needs and select the plan that offers the very best value," said Lachance. OPM makes information about health plans available in both print and electronic formats. This year, the FEHBP open season guides have even greater comparison information about benefits and out-of-pocket costs. Information can be viewed on OPM's web site at www.opm.gov/insure. This year, members can compare health plans by zip code using an interactive web tool. This feature was available last year for users in five states.

During the FEHBP open season, which runs from November 8 to December 13, eligible federal employees and retirees can stay with their current health plan or select a new plan.

About 300 health plans participate in FEHBP. There are seven, open fee-for-service plans available worldwide. Most members also can select from HMOs and point-of-service plans that are available locally. In the Washington, DC, area, there are 15 plans from which to choose.

Forty-three health plans have notified OPM that they are leaving the program in 2000. About 43,000 individuals (less than 1 percent of FEHBP members) must select a new health plan because of the withdrawals. Health plans that leave the program must tell each of their members that they need to select a new plan during the open season.

In 2000, the average biweekly premium for self-only coverage is $33.04 for the member and $76.35 for the agency. For family coverage, the average premium for the member and agency is $71.76 and $172.44, respectively.

By comparison, the 1999 biweekly rate for self-only coverage is $30.10 for the member and $69.92 for the agency; for family coverage the rate is $64.67 for the member and $157.71 for the agency. A detailed list of individual plan premiums accompanies this release and is available from OPM's Office of Communications at 202-606-2402 and the agency's web site at www.opm.gov.

- end -

PENNSYLVANIA DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

CALCULATING DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

Hospitals that treat a large number of low income patients receive additional payments under the Medicare PPS system called disproportionate share hospital payments. The formula used to calculate DSH payments is established in statute. It states clearly that DSH payments depend in part on the number of patient days associated with individuals enrolled in Medicaid but not entitled to Medicare part A.

SITUATION IN PENNSLYVANIA

HCFA believes that Pennsylvania has incorrectly included general assistance days, which are days of care provided to individuals enrolled in a separate state health insurance program, in the formula when calculating their DSH adjustments. This mistake was not detected by the fiscal intermediary and was allowed to continue for over 10 years (since 1986). In addition, some of the hospitals claim that they calculated the adjustments correctly, but were instructed by the fiscal intermediaries to include the general assistance days in their DSH calculations. HCFA discovered this problem during an audit of the Pennsylvania contractors and estimate that the total amount subject to recoupment is approximately $95 million for those account years which are currently unsettled and those for the three years preceding, which are subject to reopening (1994 to the present). These DSH payments represent between 1 and 6 percent of the total Medicare payments to the 79 hospitals in Pennsylvania. Pennsylvania is the only state that has included general assistance days in their DSH calculations.

PROCESS FOR RECOVERING OVERPAYMENTS

When an overpayment is discovered, the fiscal intermediary sends a "demand" letter to the hospital informing them of HCFA's intention to collect the overpayments. The provider has 15 days from the issuance of the demand letter to develop a plan to collect the money. The fiscal intermediary will begin to recover the overpayment within 30 days. If the provider takes longer than 30 days to repay the overpayment, they will be required to pay interest (13.75 percent). Once the account is settled and the fiscal intermediary has sent a Notice of Program Reimbursement to the hospital, the provider can appeal the fiscal intermediary's decision to the Provider Payment Review Board within 180 days. While the appeal is pending, the provider must continue to repay the overpayment. The HCFA Administrator can reverse, modify, or affirm the board's decision, or remand the matter back to the PPRB for further proceedings. If the decision is unfavorable to the provider, they can appeal in Federal district court.

CURRENT STATUS OF PENNSYLVANIA APPEALS

The fiscal intermediary has sent approximately 60 demand letters and six Notice of Program Reimbursements to Pennsylvania hospitals. The hospitals are expected to begin filing their appeals shortly. In addition on April 22, 1999, Representative English and the rest of the Pennsylvania delegation introduced legislation that would forgive the hospitals' overpayments before October 1, 1998.

SITUATION IN NEW JERSEY

CURRENT STATUS OF NEW JERSEY APPEAL

Update on Pennsylvania DSH. John sent you a note asking for an update on this issue. Supreme court case – delegated authority to intermediaries. HCFA does not have the authority to solve administratively. Statute says that it has to be title XIX days – can't be GA days. Charity care is anything for which we're not being paid general assistance is program under state law (in addition for Medicaid, we will have separate state program) 1886 (d)(5)(F)(vi)(II) # hosp patient days eligible for XIX; surveyed the entire country – PA is the only one that has this problem – at end of last year.

THE WHITE HOUSE

OFFICE OF LEGISLATIVE AFFAIRS
HOUSE LIAISON
--FAX COVER SHEET--

DATE: 12/2

TO: Chris Jennings
DPC

FAX: 65557

FROM:
- [x] CHUCK BRAIN
- [ ] AL MALDON
- [x] DARIO GOMEZ
- [ ] LISA KOUNTOUPES
- [ ] BRODERICK JOHNSON
- [ ] ELISA MILLSAP
- [ ] JADE RILEY

(202)456-6620 (TELEPHONE)
(202)456-2604 (FAX)

SUBJECT: Chris, Chuck wanted to make sure you had a copy of this

1 OF 16

COMMITTEE ON
WAYS AND MEANS

HUMAN RESOURCES
RANKING MEMBER
OVERSIGHT

COLEMAN J. CONROY
ADMINISTRATIVE ASSISTANT

Congress of the United States
House of Representatives
Washington, DC 20515–3814

FAX COVER SHEET

TO: Chuck Brain

FROM: Mona Miller

DATE: 11/24

This is just FYI. We're hoping this might more HCFA's lawyers. Anything you could do to move it along would be much appreciated.

TOTAL NUMBER OF PAGES (INCLUDING COVER): 17

OFFICE FAX NUMBER: (202) 225-1844

OFFICE TELEPHONE NUMBER: (202) 225-2301

PENNSYLVANIA
14TH DISTRICT

COMMITTEE ON
WAYS AND MEANS

SUBCOMMITTEES

HUMAN RESOURCES
RANKING MEMBER
OVERSIGHT

COLEMAN J. CONROY
ADMINISTRATIVE ASSISTANT

WASHINGTON, DC 20515
(202) 225-2301

DISTRICT OFFICE

2003 FEDERAL BUILDING
1000 LIBERTY AVENUE
PITTSBURGH, PA 15222
(412) 644-2870

Congress of the United States
House of Representatives
Washington, DC 20515–3814

November 23, 1998

The Honorable Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Administrator DeParle:

I am writing to again ask that you reconsider your decision to seek repayment of Medicare Disproportionate Share (DSH) payments made to Pennsylvania hospitals based on General Assistance (GA) days. As you know, this decision is causing considerable hardship for Pennsylvania's safety-net hospitals, which rely heavily on this funding to subsidize care for vulnerable populations and do not have the resources to return past payments.

I understand that your attorneys believe that the law clearly forbids inclusion of these days, notwithstanding the fact that the fiscal intermediary has for the past 12 years required hospitals to include them. However, I have recently learned of a similar case in which HCFA's own provider review board determined that it was appropriate to include charity care days which were part of the Title XIX state plan, whether or not they were federally reimbursable. I am enclosing the case for your review.

As you will see, the situation in Jersey Shore Medical Center vs. Blue Cross of New Jersey closely parallels the one in Pennsylvania. If anything, finding in the provider's favor in this case required a broader interpretation of the law than Pennsylvania is requesting, since the days in this case were part of a separate program, and Pennsylvania's are actually part of its Medical Assistance program.

At the very least, this ruling shows that the law does not clearly bar hospitals from including Title XIX days which are not federally funded in their DSH calculations. In fact, I believe that Congress intended for the days to be covered. I have discussed this matter with Congressman Pete Stark, who chaired the Health Subcommittee at the time this law was drafted, and he agrees with my recollection on this point.

I hope you will review the case I am sending you and reconsider your decision. I look forward to working with you and your staff to resolve this matter in a way that protects hospitals that provide health care to vulnerable populations.

With all best wishes, I am

Sincerely,

William J. Coyne
Member of Congress

WJC:mm

PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON-THE-RECORD

99-D4

PROVIDER - Jersey Shore Medical Center
Neptune, New Jersey

DATE OF HEARING -
August 26, 1998

Provider No. 31-0073

Cost Reporting Period Ended -
December 31, 1992

VS.

INTERMEDIARY -
Blue Cross and Blue Shield Association/
Blue Cross and Blue Shield of New Jersey

CASE NO. 95-0907

INDEX

ISSUE:

Was the Intermediary's calculation of the Provider's disproportionate share hospital adjustment proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Jersey Shore Medical Center ("Provider") is a 527 bed acute care hospital located in Neptune, New Jersey. As such, the Provider is reimbursed under Medicare's prospective payment system ("PPS") for inpatient hospital services furnished Medicare beneficiaries.[1]

For its cost reporting period ended December 31, 1992, the Provider qualified for a disproportionate share hospital ("DSH") adjustment to its PPS payments pursuant to 42 C.F.R. § 412.106. Blue Cross and Blue Shield of New Jersey ("Intermediary") determined the amount of the Provider's DSH adjustment using only Medicaid paid days in the numerator of the Medicaid proxy portion of the payment formula.[2]

On August 16, 1994, the Intermediary issued a Notice of Program Reimbursement for the subject cost reporting period, which reflected its DSH determination. On February 9, 1995, the Provider appealed the Intermediary's determination to the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. § 405.1835-.1841, and met the jurisdictional requirements of those regulations.

The Provider, in its appeal to the Board and in its Position Paper, argued in a broad sense that the Medicaid proxy should not be limited to Medicaid paid days but should include all Medicaid eligible days. However, in a letter dated November 13, 1997, the Provider supplemented its Position Paper and identified six specific categories of patient days that should be included in the numerator of the Medicaid proxy.[3] The Intermediary reviewed this information and disagreed with the Provider's assertion that: "[s]ll "charity care" days, as that term is used in the New Jersey State plan" should be included in the payment formula. The five categories of patient days that were not disputed are as follows:[4]

- All days for which a patient was both Medicaid eligible and Medicare Part B eligible.

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1 Intermediary's Position Paper at 1.

2 The term "Medicaid proxy" is used to refer to the portion of the DSH payment formula found at 42 C.F.R. § 412.106(b)(4). Intermediary's Position Paper at 3.

3 Provider Letter Dated November 13, 1997 at 16.

4 Intermediary's Supplemental Position Paper at 2.

- Other Primary Insurance with Medicaid TPL.

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5 Note: A variation of these days are actually in dispute. See next paragraph.

6 Intermediary's Supplemental Position Paper at 3.

Accordingly, the Medicaid patient days in controversy in this case are: (1) those days pertaining to patients that have exhausted their Medicare Part A benefits, and (2) those days pertaining to charity care under the New Jersey State plan. The estimated amount of Medicare reimbursement in controversy exceeds $10,000.

The Provider was represented by Joseph D. Glazer, Esquire, of Reed Smith Shaw & McClay LLP. The Intermediary was represented by Bernard M. Talbert, Esquire, Associate Counsel, Blue Cross and Blue Shield Association.

Patients Who Have Exhausted Medicare Part A Benefits

PROVIDER'S CONTENTIONS:

The Provider contends that patient days related to Medicaid payments for dual-eligible individuals should be included in the numerator of the Medicaid proxy. Specifically, the Provider asserts that in those instances where, during a patient stay, a patient eligible for both Medicare Part A and Medicaid exhausts his or her benefits, Medicare stops paying for the patient's outlier days and Medicaid begins to reimburse the hospital for those costs. The Provider asserts that in these instances the patient is no longer entitled to Medicare benefits and the days related to these costs should therefore be included in the Medicaid proxy.[7]

The Provider asserts that this contention is based upon the articulated principles of the DSH adjustment. The Provider cites 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II) as expressly requiring the inclusion of all days in the Medicaid proxy for which patients were eligible for medical assistance under a State Medicaid plan, which would include the dual-eligible days paid by Medicaid, as follows:

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX of this chapter [the Medicaid program], but who were not entitled to benefits under part A of this subchapter, and the denominator of which is the total number of the hospital's patient days for such period.

42 U.S.C. § 1395ww(d)(5)(F)(vi)(II).

The Provider also cites, in part, HCFA Ruling 97-2, which changed the Secretary's interpretation of what days should be included in the Medicaid proxy, as follows:

> [u]nder the new interpretation, the Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to

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[7] Provider's Supplemental Position Paper at 7.

include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a State Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for those inpatient hospital services.

HCFA Ruling 97-2.[8]

The Provider notes that according to HCFA Ruling 97-2, the Secretary of Health and Human Services' ("Secretary") agrees that all days for patients eligible for medical assistance under a State Medicaid plan should be included in a hospital's DSH calculation. Moreover, the ruling is applied prospectively to cost reports that are settled after the date it was issued (February 27, 1997) and to cost reports that have been settled prior to the effective date, but for which a hospital has a proper appeal pending on the issue, as does the Provider.

Also regarding the articulated principles of the DSH adjustment, the Provider cites an instructional memorandum issued by the Health Care Financing Administration ("HCFA") on June 12, 1997, which explains how HCFA Ruling 97-2 should be implemented.[9] The Provider asserts that this memorandum further clarifies the Secretary's interpretation of the days to be included in the Medicaid proxy, as follows:

> [c]onsistent with the Courts of Appeals decisions on the issue of Medicaid days, the HCFA Ruling 97-2 was meant to be inclusive, rather than exclusive. This means that, in calculating the number of Medicaid days, fiscal intermediaries should ask themselves, "Was this person a Medicaid (Title XIX) beneficiary on that day of service?" If the answer is "yes," the day counts in the Medicare disproportionate share adjustment calculation. This does not mean that Title XIX had to be responsible for payment for any particular services. It means that the person had to have been determined by a State agency to be eligible for Federally-funded medical assistance for any one of the services covered under the State Medicaid Title XIX plan (even if no Medicaid payment is made for inpatient hospital services or any other covered service). Any examples of days to be counted given in the HCFA Ruling or in HCFA instructions should not be construed as an all-inclusive list.

HCFA Memorandum, FKA-31, June 12, 1997.

Finally, the Provider contends that a letter issued by HCFA on February 29, 1996, also supports the fact that days paid by Medicaid after Medicare Part A benefits are exhausted should be included in the DSH calculation. In that letter, HCFA instructs the Intermediary that in situations where Medicare is the primary payor and Medicaid is the secondary payor, the days related to a

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8 Provider's Supplemental Position Paper at Exhibit A.

9 Provider's Supplemental Position Paper at Exhibit B.

patient's stay should be prorated between the two agencies. As an example, HCFA states that "if a stay of 10 days costs $10,000 and Medicare paid $3,000 and Medicaid paid $7,000, then Medicare would be credited with 3 days and Medicaid would be credited with 7 days." HCFA Letter, FKA-31, February 29, 1996.[10]

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Provider's fundamental argument that Medicaid pays for patient days after Medicare Part A benefits are exhausted is wrong.[11] The Intermediary asserts that these days are, in fact, paid by Medicare and must be excluded from the DSH calculation in accordance with 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), which states, in part,

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX of this chapter [the Medicaid program], but who were not entitled to benefits under part A of this subchapter, and the denominator of which is the total number of the hospital's patient days for such period.

42 U.S.C. § 1395ww(d)(5)(F)(vi)(II).

The Intermediary asserts that there is a maximum number of days under Medicare Part A which are covered for a Medicare beneficiary. When Part A eligibility is exhausted in the course of a hospital admission, Medicare Part B provides coverage for certain ancillary services. Also, under PPS the Medicare program pays the full diagnostic related group ("DRG") payment for an admission even if technically, the day maximum is reached during the course of the stay. Therefore, Medicare Part A makes payment on behalf of a beneficiary's days because the DRG/operating cost payment is not factored down even if covered days are exhausted before discharge.

The Intermediary concludes that in order to be included in the Medicaid proxy, days in which a patient is entitled to Medicaid can not be paid by Medicare Part A, and that condition is not met in this instance.

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10 Provider's Supplemental Position Paper at Exhibit D.

11 Intermediary's Supplemental Position Paper at 4.

Charity Care Program Days Under the New Jersey State Plan

PROVIDER'S CONTENTIONS:

The Provider contends that days related to patients who are eligible for New Jersey's Charity Care program should be included in the DSH calculation since they meet the relevant statutory requirements.[12] Pursuant to 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), patient days included in the numerator of the Medicaid proxy are defined in terms of whether the patient was "eligible for medical assistance under a State plan approved under subchapter XIX of this chapter."[13] Respectively, the Provider asserts that the Charity Care program at issue generally provides "medical assistance," or payment for inpatient hospital services, under the New Jersey State Medicaid plan for certain indigent individuals who are not eligible for Medicaid. If a patient meets certain specific guidelines and does not get charged by a hospital for its services, or the patient pays a reduced amount of the hospital's charges, the Charity Care program pays the hospital for its unreimbursed costs.[14] Patient eligibility criteria and standards for hospital reimbursement are both detailed in the State plan.[15] The Provider emphasizes that the statutory language includes days in the DSH calculation that pertain to patients eligible under a State plan for Medicaid, as quoted above, and not specifically eligible for Medicaid.

The Provider asserts that New Jersey's Charity Care program is also an essential part of the State satisfying its statutory obligation regarding payments to DSH hospitals.[16] Federal law requires that every State have a federally approved Medicaid plan that details, among other things, the State's methodology for paying for inpatient hospital services. 42 U.S.C. § 1396a. Although such Medicaid plans are formulated by each State, the plans must comply with the federal Medicaid statute and be approved in order to receive federal funds. 42 U.S.C. § 1396a(a).[17] Among the statutory requirements, State plans must satisfy certain standards related to disproportionate share hospitals. Specifically, each State's Medicaid plan must provide payment rates to hospitals that take into account the situation of hospitals that serve a disproportionate number of low income patients with special needs. 42 U.S.C. § 1396a(a)(13). The Provider submits that the purpose of the DSH adjustment (to provide additional reimbursement to those hospitals that serve a disproportionately large percentage of low income patients), is fully served only if Charity Care

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12 Provider's Supplemental Position Paper at 9.

13 Provider's Supplemental Position Paper at 14.

14 Provider's Supplemental Position Paper at 11.

15 See Provider's Supplemental Position Paper at Exhibit F at 69-73, § 3.31.

16 Provider's Supplemental Position Paper at 14.

17 Provider's Supplemental Position Paper at 9.

patients are included in the DSH calculation.[11] The Provider adds that many patients who receive Charity Care are patients who would be eligible for Medicaid except for the fact that their income or resources are too high, based on Medicaid limits. Accordingly, the Provider argues that the Charity Care program is essentially an extension of the Medicaid program: an extension fully sanctioned by the federal government, subject to extensive federal review through the State plan approval process, and paid for with both State Medicaid dollars and federal matching funds.

Finally, the Provider contends that even if all days related to Charity Care patients are not included in the DSH calculation, there are some Charity Care patients that were actually eligible for the standard Medicaid program. Whether through inadvertence or inability to determine eligibility at the relevant time, these patients' expenses were reimbursed by the Charity Care program rather than the standard Medicaid program. At the very least, all patient days related to such patients should be included in the Provider's DSH calculation.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Charity Care days at issue may not be included in the Provider's DSH calculation based upon a straight forward reading of the pertinent regulation. At 42 C.F.R. § 412.106(b)(4), the regulations specifically include patient days in the Medicaid proxy that are attributable to patients "entitled to Medicaid." The Provider's own description of Charity Care patients clearly recognizes that they are not eligible for Medicaid coverage. See e.g. Provider Letter Dated November 13, 1997 at 2.

The Intermediary also contends that the Provider's arguments for including Charity Care patient days in the Medicaid proxy are based upon a perceived conflict between the pertinent regulations and the pertinent statute. As noted above, 42 C.F.R. § 412.106(b)(4) includes patient days in the DSH calculation attributable to patients "entitled to Medicaid." The pertinent statute, however, references patient days attributable to patients "eligible for medical assistance under a State plan." 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). The Provider argues that in New Jersey the definition "entitled to Medicaid" is broadened by patients who receive some level of care under a State plan, albeit, not specifically the Medicaid program. However, an analysis of the regulation does not support that definition.

Finally, the Intermediary contends that the Board is bound by regulations and, therefore, may affirm its rejection of the Charity Care days from the Provider's DSH calculation based upon 42 C.F.R. § 412.106(b)(4). However, the Intermediary also asserts that the Board may not be the proper forum to address this matter, and may consider expediting it for judicial review. 42 C.F.R. § 405.1842.

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[11] Provider's Supplemental Position Paper at 15.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Law - 42 U.S.C.:

§ 1395ww(d)(5)(F)(vi)(II)	-	PPS Transition Period; DRG Classification System; Exceptions and Adjustments to PPS
§ 1396a et seq.	-	State Plans for Medical Assistance

2. Regulations - 42 C.F.R.:

§ 405.1835-.1841	-	Board Jurisdiction
§ 405.1842	-	Expediting Board Proceedings
§ 406.10(b)(2)	-	Beginning and End of Entitlement
§ 412.106	-	Special Treatment: Hospitals that Serve a Disproportionate Share of Low Income Patients
§ 412.106(b)(4)	-	Determination of a Hospital's Disproportionate Patient Percentage - Second Computation
§ 430.10	-	The State Plan

3. Other:

HCFA Ruling 97-2.

HCFA Letter, FKA-31, February 29, 1996.

HCFA Memorandum, FKA-31, June 12, 1997.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, and evidence presented, finds and concludes as follows:

Patients Who Have Exhausted Medicare Part A Benefits

The Board finds that the Intermediary refused to include patient days attributable to dual eligible patients in the numerator of the Provider's Medicaid proxy. These days pertain to individuals who exhausted their Medicare Part A benefits during an inpatient stay. According to the Provider, Medicare stopped paying for the patients' outlier days in these instances and the New Jersey State Medicaid program began to pay the hospitals. The Provider argues that the outlier days not covered by Medicare but paid by Medicaid should be included in the DSH formula.

The Board agrees with the Provider. The Board finds that where a state's approved Medicaid program assumes responsibility for payment of a provider's inpatient charges that the days associated with these charges are, in fact, "Medicaid days." A fundamental characteristic of health care cost finding, including that employed in the Medicare cost reporting process, requires patient days to be assigned to the program, insurer, or private pay patient responsible for a provider's charges.

The Board also finds that the subject days must be included in the Provider's Medicaid proxy in order for a "correct" DSH adjustment to be determined. That is, in order for the DSH formula to produce results or payment levels anticipated by statute, definitive data must be used. In this regard, the Medicaid proxy must reflect all patient days associated with health care costs and benefits attributable to Medicaid patients that are not paid by Medicare. The Board finds that the days at issue precisely meet these requirements, and their exclusion from the Medicaid proxy results in an understatement of the Provider's DSH adjustment.

The Board rejects the Intermediary's argument that the subject days can not be included in the Medicaid proxy because Medicare Part A paid 100 percent of the applicable DRGs; that is, even though the patients had exhausted Part A benefits during their admissions, DRG reimbursement was not prorated downward. The Board, however, finds the patient days at issue to be outside the DRG payments made by the Intermediary as well as any day outlier payments that may also have been made. As stipulated by the Provider, the days at issue in this case consist of outlier days which, by definition, are outside of DRG reimbursement. Moreover, they are days that were not reimbursed through Medicare's outlier mechanism because Part A benefits had been exhausted.

The Board finds that its position regarding this matter is consistent with the enabling statute and regulations. Controlling authorities at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II) and 42 C.F.R. § 412.106(b)(4) require days furnished to patients eligible for Medicaid but not entitled to Medicare Part A to be included in the Medicaid proxy. The Board concludes that this exact condition exists in this case. Once the patients had exhausted their Part A benefits they were no longer entitled to have Medicare Part A pay for their inpatient hospital health care costs.[19]

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[19] The Board distinguishes the term "entitled to Medicare Part A" as used in 42 C.F.R. § 412.106(b)(4) from the term "entitlement" as that term is used, for example, in 42

Concurrently, these same patients became eligible for Medicaid benefits.

Finally, the Board finds that it is not essential to this case that the New Jersey State Medicaid program had actually reimbursed the Provider for the subject outlier days. Consistent with HCFA Ruling 97-2, it is not necessary for a hospital to have received payment in order to include patient days in the Medicaid proxy; it is only necessary for the patient to have been eligible for medical assistance under the State's Medicaid plan.

Charity Care Program Days Under the New Jersey State Plan

The Board finds that the Intermediary refused to include Charity Care program days in the numerator of the Provider's Medicaid proxy because it concluded that these days do not pertain to patients "entitled to Medicaid" as required by 42 C.F.R. § 412.106(b)(4). In support of its position the Intermediary cites the Provider's general description of the Charity Care program as providing medical assistance under the New Jersey State plan for certain indigent individuals who do not meet the State's Medicaid eligibility requirements.

The Board, however, finds that the subject Charity Care days clearly meet the statutory definition of patient days included in the numerator of the Medicaid proxy and, therefore, should be included in the Provider's DSH calculation. The controlling authority at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II) defines patient days included in the numerator of the Medicaid proxy as those days pertaining to patients "eligible for medical assistance under a State plan approved under subchapter XIX of this chapter." In this regard, the Board finds that the enabling New Jersey State plan was approved under Title XIX of the Social Security Act as required by the statute, and contained the subject Charity Care program which provided medical assistance to eligible persons.

The Board rejects the Intermediary's argument that the Charity Care patients at issue in this case were not entitled to Medicaid. Essentially, the Board finds that any person qualifying for and receiving medical assistance under an approved State plan is, by virtue, entitled to Medicaid. The Board cites 42 C.F.R. § 430.10, which states in part:

> [t]he State plan is a comprehensive written statement submitted by the agency describing the nature and scope of its Medicaid program. . . .

42 C.F.R. § 430.10.

The Board understands that the New Jersey State plan contains different eligibility criteria for Charity Care program patients than it does for its other, more typical, program patients.

C.F.R. § 405.10(b)(2). The Board does not believe the referenced word "entitled" used in 42 C.F.R. § 412.106(b)(4) is intended to reflect the absolute end of an individual's health insurance benefits under Medicare.

Moreover, the Board believes this difference is the basis for the Intermediary's argument regarding Charity Care patient entitlement, and the Provider's statement that Charity Care patients are not eligible for Medicaid. In effect, both the Intermediary and the Provider chose to define Medicaid as a type of subset of medical services within the broader context of the State plan. The Board, however, finds no authoritative basis for this distinction. The Board finds that once a State plan is approved, the Federal Government provides matching funds for all medical services costs provided for in that plan, including costs attributable to the subject Charity Care program. The Board notes the Provider's argument that the State did, in fact, receive Federal matching funds for the costs of the Charity Care program days at issue, and that this argument was not disputed by the Intermediary. Moreover, the Board notes HCFA Memorandum, FKA-31, dated June 12, 1997, which explains that Federal funding is an important factor in determining whether or not a patient day is included in the Medicaid proxy. The memorandum states, in part:

> [c]onsistent with the Courts of Appeals decisions on the issue of Medicaid days, the HCFA Ruling 97-2 was meant to be inclusive, rather than exclusive. This means that, in calculating the number of Medicaid days, fiscal intermediaries should ask themselves, "Was this person a Medicaid (Title XIX) beneficiary on that day of service?" If the answer is "yes," the day counts in the Medicare disproportionate share adjustment calculation. This does not mean that Title XIX had to be responsible for payment for any particular services. It means that the person had to have been determined by a State agency to be eligible for Federally-funded medical assistance for any one of the services covered under the State Medicaid Title XIX plan. . . .

HCFA Memorandum, FKA-31, June 12, 1997 (emphasis added).

Finally, the Board, having concluded that a State plan necessarily defines a State's Medicaid program, finds no basis for the Intermediary's proposition that the Charity Care days issue may best be suited for expedited judicial review. The Board finds that the provision of 42 C.F.R. § 412.106(b)(4), which bases the DSH calculation on patient days attributable to patients "entitled to Medicaid" is essentially synonymous with 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), which references patient days attributable to patients "eligible for medical assistance under a State plan." The Board notes that on February 27, 1997, HCFA issued Ruling 97-2 to clarify a specific aspect of the DSH calculation. The Board believes this Ruling supports its position since the Ruling apparently uses the aforementioned terms interchangeably.

DECISION AND ORDER

Patients Who Have Exhausted Medicare Part A Benefits

The Intermediary should confirm the number of outlier days of service furnished by the Provider to dual eligible patients after their Medicare Part A benefits had exhausted, and which were eligible for reimbursement under the State's Medicaid plan, and include this number of days in the

Provider's DSH calculation. The Intermediary's refusal to include these days in the numerator portion of the Provider's Medicaid proxy is reversed.

Charity Care Program Days Under the New Jersey State Plan

The Intermediary should confirm the number of patient days of service furnished by the Provider to patients eligible for medical assistance under the State's Charity Care program, and include this number of days in the Provider's DSH calculation. The Intermediary's refusal to include these days in the numerator portion of the Provider's Medicaid proxy is reversed.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esquire
Martin W. Hoover, Jr., Esquire
Charles R. Barker

FOR THE BOARD:
OCT 30 1998

Irvin W. Kues
Chairman

Weekly

- Medicare commission
- stem cell
- carcinogen — who to get more detailed info from
  - right name of prog
    Scientific ~~Advisory~~ Board decision → sec for final decision
  - what's the history of this board.
    process re recomm →
    approved
    purpose
    application

- MC IG →
- VT CHIP approval?
  What's status
  determination of whether to do VP announcement
- MD CHIP approvals?
  that should go in weekly.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Washington D.C. 20201 – 0001

Office of Legislation
Medicare Part A
Analysis Group-fax 202-690-8168

FAX

TO: Deloris

FAX NO. 456-5557

DATE: 8/3/99 **Pages** 5

FROM:		**PHONE:**
JB	**Jennifer Boulanger**	**690-5705**
	Valerie Barton	**690-5520**
	Susan Bielaus	**690-8070**
	Sheila Fenner	**690-8605**
	Dave Gardner	**690-8285**
	John Hammarlund	**690-8062**
	Julie Salz	**690-5510**

COMMENTS:

Problems with transmission, call (202) 690-5444

#3

COMMITTEE ON WAYS AND MEANS

99 JUL 21 AM 8:47

U.S. HOUSE OF REPRESENTATIVES
WASHINGTON, DC 20515

SUBCOMMITTEE ON HEALTH

July 15, 1999

Nancy Ann Min DeParle
Administrator
Health Care Financing Administration
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Dear Administrator DeParle:

I write to urge that you rescind HCFA's policy of recouping Disproportionate Share (DSH) payments already made to Pennsylvania hospitals for General Assistance (GA) days. These unfair and arbitrary recoupments are the direct result of HCFA's failure to instruct and monitor properly its own fiscal intermediaries (FIS). Pennsylvania hospitals, which depend on these funds to meet the health care needs of the poor and elderly, should not suffer because HCFA failed to exercise sufficient oversight of its FIS.

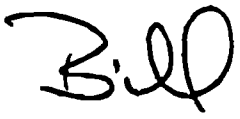
Pennsylvania hospitals have been permitted to count all Medical Assistance days, including those for its General Assistance programs, in calculating Medicare DSH eligibility since the adjustment was added to the prospective payment system. Since 1986, HCFA's FIS certified these days as allowable and authorized DSH payments accordingly. In many cases, the FIS obtained the count of days from the state Medicaid program. The hospitals did not determine the final days count used. However, in 1998, HCFA reversed this longstanding policy and directed the FIS in Pennsylvania not only to disallow GA days, but also to recoup payments for past years that included GA days in the calculation. This sudden and complete turnaround in policy was applied inconsistently: as late as this past winter, one of the FIS was still allowing GA days in the calculation of DSH payments.

I believe that you can correct this inequity administratively. The issue here is one of due process. Pennsylvania hospitals did not receive instructions from the FIS until they were told verbally that general assistance days could no longer be accepted. After the FIS began implementing their latest interpretations on how to count general assistance days, hospitals across the state continued to receive contradictory instructions. It is grossly unfair to penalize Pennsylvania's hospitals for HCFA's management problems by retroactive application of new payment rules.

In the past, HCFA has taken the position that appropriate notice of policy changes must be given to providers. Secondly, I know that HCFA also has declined to recoup money from providers in cases where the FI did not make the rules clear. This situation in Pennsylvania meets both criteria. I request that you order the FIs in Pennsylvania to allow GA days to be counted for purposes of Medicare DSH payments for discharges occurring before October 1, 1998, which is when HCFA addressed this issue with the Pennsylvania congressmen.

I look forward to discussing this with you.

Sincerely,



Bill Thomas
Chairman

DRAFT

The Honorable Bill Thomas
House of Representatives
Washington D.C. 20515

Dear Mr. Thomas:

Thank you for your letter regarding the calculation of Medicare disproportionate share (DSH) payments for Pennsylvania hospitals. I regret the delay in my response, however I do want to update you on the current status of this issue.

The Medicare statute precisely defines the elements used to calculate DSH payments. General assistance days are simply not within the scope of the statutory phrase "patient days...for patients...eligible for medical assistance under a state plan approved under Title XIX." General assistance days are utilized by patients who are not eligible under state plans approved by Title XIX, but who are eligible under state-only eligibility group for which no Federal participation is available. In sum, such days are not Medicaid days, nor are they provided to patients eligible for Medicaid. Thus, such days cannot be included in the calculation of Medicare DSH.

It appears that DSH hospitals in Pennsylvania have received payments that are inconsistent with Federal laws as well as HCFA regulations and instructions to not count general assistance days in DSH calculations. In the Fall of 1998, in accordance with applicable rules, the fiscal intermediaries began issuing recoupment letters to Pennsylvania hospitals that included general assistance in their DSH calculations. Recoupment letters are issued any time an overpayment is found to exist. While hospitals cannot formally appeal recoupment letters, they can raise concerns with the fiscal intermediary as well as the HCFA Regional Office on an informal basis.

Once the hospitals' cost reports are settled, the fiscal intermediaries will issue a final decision in a Notice of Program Reimbursement (NPR). Hospitals have a right to appeal these notices within 180 days of receiving the NPR. Hospitals will likely also receive notices of adjustments to their interim payments to adjust for the inclusion of general assistance days for this fiscal year.

DRAFT

I regret that my answer could not be more favorable. However, neither I nor the fiscal intermediary have the authority to forgive the debts owed in the form of DSH overpayments. Legislation would be needed to forgive the debt in the absence of a decision favorable to the hospitals through an appeal.

Sincerely,

Michael M.Hash
Deputy Administrator

Congress of the United States

Washington, DC 20515

February 1, 1999

The Honorable William Jefferson Clinton
President of the United States
The White House
1600 Pennsylvania Avenue
Washington, DC 20500

Dear Mr. President:

On behalf of the more than 2 million Pennsylvania Medicare recipients and the 225 hospitals and health systems that provide their health care, we urge that you not include any additional Medicare spending reductions in your Fiscal Year 2000 budget.

The Balanced Budget Act of 1997 (BBA) already reduced projected increases in Medicare spending for health care by $115 billion. Pennsylvania's senior citizens and health care providers are feeling the impact of this five-year slow down in spending through reduced access to inpatient and home health services, and the closing of skilled nursing facilities.

In addition, consideration must be given to the following factors:

- 53% of Pennsylvania hospitals are now operating with net margins below 4%, which is considered insufficient for sustaining financial viability.
- The BBA reductions in projected Medicare spending over the next 2 years, estimated in excess of $960 million, will remove more money from the health care system than Pennsylvania hospitals currently earn in net income.
- Nearly 2/3rds of Pennsylvania hospitals are unable to cover operating expenses with patient revenues and are forced to subsidize patient care through non-operating sources of revenue, such as investment earnings from endowments. There is risk in relying on stock market performance to ensure a bottom line. Additionally, hospitals may be forced to fund operations through increased borrowing or reduction on endowment principal. This has a negative impact on overall bond ratings and threatens providers' ability to serve the health care needs of their communities.
- HCFA is attempting to retroactively change the DSH payment formula for Pennsylvania hospitals. While this action is subject to potential litigation, it has the potential to drain over $60 million from already fragile health care providers.

We in the Pennsylvania delegation urge you to resist any proposal which goes beyond the BBA and mandates reductions to Medicare in your upcoming budget. Our seniors and Pennsylvania's health care system should not be subject to unwarranted reductions in this vital program.

Sincerely,

Robert A. Brady

Phil English

John P. Murtha

George Gekas

Bud Shuster

Chaka Fattah

Robert A. Borski

Curt Weldon

Tim Holden

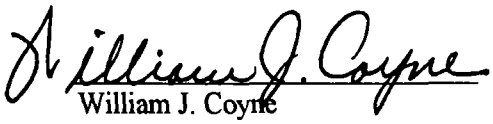
Frank Mascara

Don Sherwood

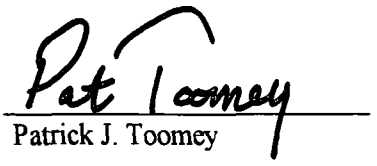
John Peterson

Mike Doyle

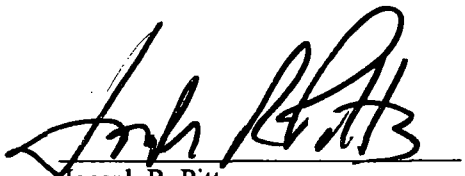
Paul E. Kanjorski



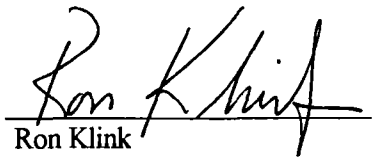
William J. Coyne



Patrick J. Toomey

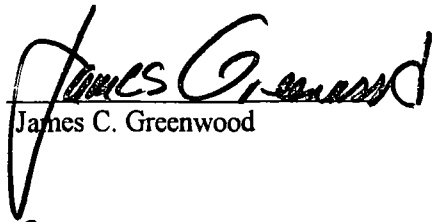


Joesph R. Pitts



Ron Klink

William F. Goodling



James C. Greenwood

Joseph M. Hoeffel