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Pennsylvania DSH [Disproportionate Share Hospital] [Folder 2]

2012-0463-S
rc813

**RESTRICTION CODES**

**Presidential Records Act - [44 U.S.C. 2204(a)]**

**P1** National Security Classified Information [(a)(1) of the PRA]
**P2** Relating to the appointment to Federal office [(a)(2) of the PRA]
**P3** Release would violate a Federal statute [(a)(3) of the PRA]
**P4** Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
**P5** Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
**P6** Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

**C.** Closed in accordance with restrictions contained in donor's deed of gift.
**PRM.** Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
**RR.** Document will be reviewed upon request.

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**b(1)** National security classified information [(b)(1) of the FOIA]
**b(2)** Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
**b(3)** Release would violate a Federal statute [(b)(3) of the FOIA]
**b(4)** Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
**b(6)** Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
**b(7)** Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
**b(8)** Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
**b(9)** Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

# HEALTH CARE FINANCING ADMINISTRATION

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REMARKS:

Final DSH Notice

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**Health Care Financing Administration**

**42 CFR Part 412**

**[HCFA-1124-IFC]**

**RIN 0938-AJ92**

**Medicare Program; Medicare Inpatient Disproportionate Share Hospital (DSH) Adjustment Calculation: Change in the Treatment of Certain Medicaid Patient Days in States with 1115 Expansion Waivers**

**AGENCY:** Health Care Financing Administration (HCFA), HHS.

**ACTION:** Interim final rule with comment period.

**SUMMARY:** This interim final rule with comment period implements a change to the Medicare DSH adjustment calculation policy in reference to section 1115 expansion waiver days. This rule sets forth the criteria to use in calculating the Medicare DSH adjustment for hospitals for purposes of payment under the prospective payment system.

**DATES:** Effective date: **[OFR--insert date of publication]** These regulations are applicable to discharges occurring on or after **[OFR--insert date of publication]**.

Comment date: Comments will be considered if we receive them at the appropriate address, as provided below, no later than 5 p.m. on **[OFR--insert 60 days after the date of publication in the Federal Register]**.

**ADDRESSES:** Mail an original and 3 copies of written comments to the following address:

Health Care Financing Administration,

Department of Health and Human Services,

Attention: HCFA-1124-IFC,

P.O. Box 8010,

Baltimore, MD 21244-8010.

If you prefer, you may deliver an original and 3 copies of your written comments to one of the following addresses:

Room 443-G, Hubert H. Humphrey Building,

200 Independence Avenue, SW,

Washington, D.C. 20201, or

Room C5-16-03,

7500 Security Boulevard,

Baltimore, Maryland 21244-1850.

**FOR FURTHER INFORMATION CONTACT:**

Kathleen Buto, Deputy Director, Center for Health Plans and Providers, (202) 205-2505.

**SUPPLEMENTARY INFORMATION:**

## I. Background

### A. Summary

The Medicare disproportionate share hospital (DSH) adjustment provision under section 1886(d)(5)(F) of the Social Security Act (the Act) was enacted by section 9105 of

the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 and became effective for discharges occurring on or after May 1, 1986, as set forth in the May 6, 1986 final rule with comment period (51 FR 16772).

The size of a hospital's Medicare DSH adjustment, which is applied to the hospital inpatient prospective payment system (PPS) payment, is based on the sum of the percentage of patient days attributable to patients eligible for both Medicare Part A and Supplemental Security Income (SSI), and the percentage of patient days attributable to patients eligible for Medicaid but not Medicare Part A. The first computation includes days for patients who, during a given month, were entitled to both Medicare Part A and SSI (excluding State supplementation). This number is divided by the number of covered patient days utilized by patients under Medicare Part A for that same period. The second computation includes patient days associated with beneficiaries who were eligible for medical assistance (Medicaid) under a State plan approved under Title XIX but who were not entitled to Medicare Part A. (See 42 CFR 412.106(b)(4).) This number is divided by the total number of patient days for that same period.

Currently, hospitals whose disproportionate patient percentage exceeds a certain threshold (which varies for

urban and rural areas) receive either a fixed adjustment or, in the case of large urban hospitals (100 or more beds) or large rural hospitals (500 or more beds), a variable adjustment based on a statutory formula. As of April 1, 1990, variable adjustments were made for large urban hospitals and rural referral centers. Facilities that qualify as rural referral centers as well as sole community hospitals receive the greater of a fixed adjustment or a variable adjustment based on a statutory formula. Qualifying large rural hospitals and sole community hospitals receive a fixed adjustment. Urban hospitals with 100 or more beds that receive funds from State and local governments for indigent care in excess of 30 percent of net inpatient revenues are treated separately (42 CFR 412.106(c)).

B. Section 1115 Expansion Waivers

Some States provide medical assistance under a demonstration project (also referred to as a section 1115 waiver). In some section 1115 waivers, a given population that otherwise could have been made eligible for Medicaid under section 1902(r)(2) or 1931(b) in a State plan amendment is made eligible under the waiver. These populations are referred to as hypothetical eligibles, and are specific, finite populations identifiable in the budget

neutrality agreements found in the Special Terms and Conditions for the demonstrations; the patient days utilized by that population are to be recognized for purposes of calculating the Medicare DSH adjustment. In addition, the section 1115 waiver may provide for medical assistance to expanded eligibility populations that could not otherwise be made eligible for Medicaid.

Under current policy, hospitals were to include in the Medicare DSH calculation only those days for populations under the section 1115 waiver who were or could have been made eligible under a State plan. Patient days of the expanded eligibility groups, however, were not to be included in the Medicare DSH calculation.

## II. Provisions of the Interim Final Rule with Comment Period

In this interim final rule with comment period, we are revising the policy, effective with discharges occurring on or after **[OFR--insert date of publication]**, to allow hospitals to include the patient days of all populations eligible for Title XIX matching payments in a State's section 1115 waiver in calculating the hospital's Medicare DSH adjustment.

One purpose of a section 1115 expansion waiver is to extend Title XIX matching payments to services furnished to

populations that otherwise could not have been made eligible for Medicaid. The costs associated with these populations are matched based on section 1115 authority. In fact, section 1115(a)(2)(A) of the Act states that the "costs of such project which would not otherwise be included as expenditures under section . . . 1903 . . . shall, to the extent and for the period prescribed by the Secretary, be regarded as expenditures . . . approved under (Title XIX)." Thus, the statute allows for the expansion populations to be treated as Medicaid beneficiaries.

In addition, at the time that the Congress enacted the Medicare DSH adjustment, there were no approved section 1115 expansion waivers. Nonetheless, we believe allowing hospitals to include the section 1115 expanded waiver population in the Medicare DSH calculation is fully consistent with the Congressional goals of the Medicare DSH adjustment to recognize the higher costs to hospitals of treating low income individuals covered under Medicaid. Therefore, inpatient hospital days for these individuals eligible for Title XIX matching payments under a section 1115 waiver are to be included as Medicaid days for purposes of the Medicare DSH adjustment calculation.

In order to provide consistency in both components of the calculation, any days that are added to the Medicaid day

count must also be added to the total day count, to the extent that they have not been previously so added.

Regardless of the type of allowable Medicaid day, the hospital bears the burden of proof and must verify with the State that the patient was eligible under one of the allowable categories during each day of the patient's stay. The hospital is responsible for and must provide adequate documentation to substantiate the number of Medicaid days claimed. Days for patients that cannot be verified by State records to have fallen within a period wherein the patient was eligible for Medicaid as described in this rule cannot be counted.

**III. Response to Comments**

Because of the large number of items of correspondence we normally receive on **Federal Register** documents published for comment, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the "DATES" section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

## IV. Waiver of Proposed Rulemaking and 30-Day Delay in the Effective Date

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** and invite public comment on the proposed rule. The notice of proposed rulemaking includes a reference to the legal authority under which the rule is proposed, and the terms and substances of the proposed rule or a description of the subjects and issues involved. This procedure can be waived, however, if an agency finds good cause that a notice-and-comment procedure is impracticable, unnecessary, or contrary to the public interest and incorporates a statement of the finding and its reasons in the rule issued.

We find that it would be contrary to the public interest to undertake prior notice and comment procedures before implementing this interim final rule with comment period. States that have approved section 1115 waivers are continually involved in critical efforts to implement, refine, and operate their Medicaid programs. For example, the States, managed care organizations, and hospitals are always considering their financial positions and the adequacy of rates paid between these critical partners. We believe this policy change impacts their financial positions. Therefore, we believe the extended period of

uncertainty for hospitals and others that would result if this policy change were to go through proposed and final rulemaking could adversely affect the course of these critical efforts and thereby disrupt services to Medicaid beneficiaries and other low-income patients who are served by hospitals, especially safety net hospitals.

Moreover, because our prior guidance on certain aspects of our Medicare DSH policy was insufficiently clear, many hospitals in States with approved section 1115 expansion waivers have been receiving Medicare DSH payments reflecting the inclusion of expansion population patient days. But for an immediate effective date of this rule, these Medicare DSH payments will cease until completion of the notice and comment rulemaking process, and, as a result, many of these hospitals may experience financial difficulties that may adversely affect access to services by the low-income patients served by these safety net hospitals.

Therefore, we find good cause to waive the notice of proposed rulemaking and to issue this final rule on an interim basis. We are providing a 60-day comment period for public comment.

Also, we normally provide a delay of 30 days in the effective date of a regulation. However, if adherence to this procedure would be impracticable, unnecessary, or

contrary to the public interest, we may waive the delay in the effective date. For the reasons discussed above, it is important that the provisions of this final rule with comment period have immediate effect in order to avoid a potential hardship for hospitals and a potential disruption of services for their patients.

## V. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA), we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.

- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are soliciting public comment on each of these issues for the following sections of this document that contain information collection requirements:

Section 412.106(b)(4)(ii) and (iii) contain information collection requirements that are subject to the PRA. The requirements are as follows:

In paragraph (b)(4) (ii), effective with discharges occurring on or after **[OFR--insert date of publication]**, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act.

In paragraph (b)(4)(iii), the hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under paragraph (b)(4) and of verifying with the State that a patient was eligible for Medicaid during each claimed Medicaid day. We solicit comments on the burden associated with these requirements. Based upon the burden estimates received from the public, HCFA will add these new requirements and associated burden

to the existing information collections entitled; "Medicaid Disproportionate Share Adjustment Procedure and Criteria" (OMB #0938-0691, HCFA-R-194, current expiration date 9/30/2002; and/or "Medicaid Disproportionate Share Hospital Payments - Institutions for Mental Disease" (OMB #0938-0746, HCFA-R-0266, current expiration date 6/30/2002.

If you comment on these information collection and recordkeeping requirements, please mail copies directly to the following:

Health Care Financing Administration,
Office of Information Services,
Information Technology Investment Management Group
Attn: Julie Brown
Room N2-14-26, 7500 Security Boulevard,
Baltimore, MD 21244-1850.

Office of Information and Regulatory Affairs,
Office of Management and Budget,
Room 10235, New Executive Office Building,
Washington, DC 20503,
Attn: Allison Herron Eydt, HCFA Desk Officer.

## VI. Regulatory Impact Analysis

### A. Introduction

Section 804(2) of title 5, United States Code (as added by section 251 of Public Law 104-121), specifies that a

"major rule" is any rule that the Office of Management and Budget finds is likely to result in -

- An annual effect on the economy of $100 million or more.
- A major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions; or
- Significant adverse effects on competition, employment, investment productivity, innovation, or on the ability of United States based enterprises to compete with foreign based enterprises in domestic and export markets.

We estimate that the impact of this interim final rule with comment period will exceed $100 million. Therefore, this rule is a major rule as defined in Title 5, United States Code, section 804(2).

We have examined the impacts of this interim final rule with comment period as required by Executive Order 12866, the Regulatory Flexibility Act (RFA) (Public Law 96-354), and the Unfunded Mandates Reform Act of 1995 (Public Law 104-4). Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects,

distributive impacts, and equity). The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, non-profit organizations and government agencies. Most hospitals and most other providers and suppliers are small entities, either by non-profit status or by having revenues of $5 million or less annually. Individuals and States are not included in the definition of a small entity.

We generally prepare a regulatory flexibility analysis that is consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 through 612), unless we certify that a final rule will not have a significant economic impact on a substantial number of small entities. For purposes of the RFA, we consider all hospitals to be small entities.

Also, section 1102(b) of the Act requires us to prepare a regulatory impact analysis for any rule that may have a significant impact on the operations of a substantial number of small rural hospitals. Such an analysis must conform to the provisions of section 604 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital with fewer than 100 beds that is located outside of a Metropolitan

Statistical Area (MSA) or New England County Metropolitan Area (NECMA). Section 601(g) of the Social Security Amendments of 1983 (Public Law 98-21) designated hospitals in certain New England counties as belonging to the adjacent NECMA. Thus, for purposes of the hospital inpatient prospective payment system, we classify these hospitals as urban hospitals.

It is clear that the changes being made in this rule would affect a number of hospitals, and the effects on some may be significant. Therefore, the discussion below constitutes a combined regulatory impact analysis and regulatory flexibility analysis.

Section 202 of the Unfunded Mandates Reform Act of 1995 requires that agencies prepare an assessment of anticipated costs and benefits before issuing any rule that may result in an expenditure in any one year by State, local and tribal governments, in the aggregate, or by the private sector, of $100 million or more (adjusted annually for inflation). We have concluded that this rule does not impose any mandates on State, local, or tribal governments, or the private sector that will result in an annual expenditure of $100 million or more.

B. Impact of this Interim Final Rule with Comment Period

There are currently eight States with section 1115 expansion waivers (Delaware, Hawaii, Massachusetts, Missouri, New York, Oregon, Tennessee, and Vermont). Under this interim final rule with comment period, hospitals in these eight States would be allowed to include in the Medicaid percentage portion of their Medicare DSH calculation the inpatient hospital days attributable to patients who are eligible under the State's section 1115 expansion waiver. Because our policy was that these days were not allowable prior to the effective date of this interim final rule with comment period, by allowing hospitals to begin to include these days in their Medicare DSH calculation the impact will be to increase the DSH payments these hospitals will receive compared to what they would receive absent this change.

Based on data available for the numbers of individuals covered by the expansion waiver in each of the eight States compared to the total number of individuals covered by Medicaid in each State (adjusted for utilization), we have estimated the impact of this change to be $270 million in higher FY 2000 PPS payments, (total FY 2000 DSH payments are projected to be $4.6 billion), and $350 million in FY 2001 payments. Thus the total impact of this change for the

period from FY 2001 through FY 2005 is estimated to be $2.14 billion.

In accordance with the provisions of Executive Order 12866, this interim final rule with comment period was reviewed by the Office of Management and Budget.

**VII. Federalism**

We have reviewed this interim final rule with comment period under the threshold criteria of Executive Order 13132, Federalism. In considering this policy change, we have evaluated any potential Federalism impacts. States are already responsible as needed for providing information to hospitals and fiscal agents under current regulations. In addition, there are existing requirements for maintaining and reporting these data under the Terms and Conditions of their section 1115 demonstration agreement. Therefore, States already possess the information necessary to implement this change, and no new standards or requirements are established as a result of this change. Indeed there may be a reduction in State responsibilities since section 1115 demonstration populations will no longer have to be treated differently from other Medicaid eligibles.

In order to assist the States in making this information available to the Medicare fiscal intermediaries so they can accurately count days related to patients

eligible under an 1115 waiver, we are issuing clarifying instructions to the States specifying exactly what data are to be included in the Medicare DSH calculation, and the States' role in providing this information. In addition, we are in ongoing contact with States that have waivers in order to assist and monitor the development and implementation of their waivers.

We believe this regulation meets Federalism requirements as it does not increase the burden on States and is responsive to requests from hospitals who partner with States in providing health services to needy populations.

**List of Subjects Affected in 42 CFR Part 412**

Administrative practice and procedure, Health facilities, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

For reasons set forth in the preamble, 42 CFR chapter IV, part 412 is amended as follows:

**PART 412--PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES**

1. The authority citation for part 412 continues to read as follows:

**Authority:** Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

2. In §412.106, republish the headings of paragraphs (b) and (b)(4), redesignate paragraph (b)(4)(ii) as paragraph (b)(4)(iii), and add a new paragraph (b)(4)(ii) to read as follows:

**§412.106 Special treatment: Hospitals that serve a disproportionate share of low-income patients.**

* * * * *

(b) Determination of a hospital's disproportionate patient percentage.* * *

(4) Second computation. * * *

(ii) Effective with discharges occurring on or after **[OFR--insert date of publication]**, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act.

* * * * *

HCFA-1124-IFC ejb December 22, 1999 (11:21am)

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare--Hospital Insurance; and Program No. 93.774, Medicare--Supplementary Medical Insurance Program)

Dated: DEC 22 1999

Nancy-Ann Min DeParle,

Administrator, Health Care Financing Administration.

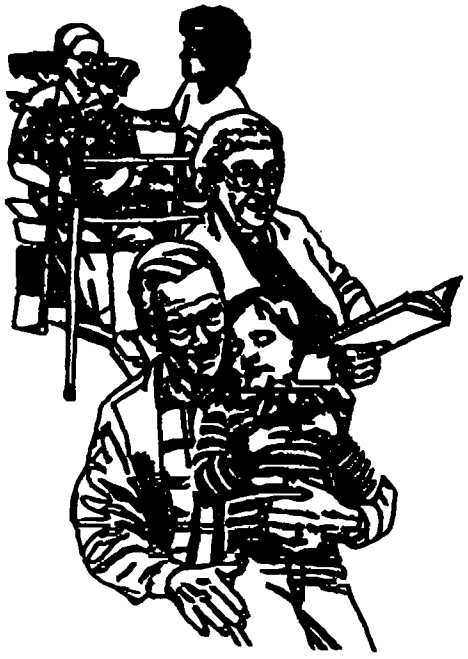
Approved: DEC 22 1999

Donna E. Shalala,

Secretary.

**BILLING CODE 4120-01-P**

# HEALTH CARE FINANCING ADMINISTRATION



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REMARKS:

Final -

Still waiting for OMB/OIR +

# *Medicare DSH Policy – Regulation*
# *Questions and Answers*
# *Internal – Not for Distribution*
# *January 13, 2000*

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

A. HCFA has a regulation on display at the federal register to allow hospitals to include in the Medicare DSH payment formula Medicaid inpatient hospital days for individuals who are covered under Medicaid through a section 1115 waiver effective with discharges occurring on or after January 1, 2000. During our review of the Medicare DSH policy, we realized that Medicaid days related to low-income persons covered under Medicaid through a section 1115 waiver should be included under the DSH calculation. We believe a person covered under Medicaid should count towards Medicare DSH through a section 1115 waiver. So, the new regulation simply provides that the inpatient hospital days related to those covered by a section 1115 waiver can be included in the Medicare DSH calculation.

Background

In mid-October 1999, HCFA released a letter announcing that it would hold harmless hospitals that have received certain Medicare disproportionate share hospital (DSH) payments because HCFA guidance on how to claim these funds was not sufficiently clear.

In December, HCFA issued a formal clarification of its policy (through a Program Memorandum) to our fiscal intermediaries that process Medicare claims for these hospitals explaining the policy effective for cost reporting periods beginning on or after January 1, 2000. The Program Memorandum simply followed-up on the October letter. The DSH formula provides additional funds to hospitals that serve low-income patients.

**Q. Why did HCFA issue the regulation?**

A. We issued the regulation because, the Medicare DSH program is designed to help hospitals pay for the care provided to low income persons enrolled in Medicare and Medicaid and this helps to reach that goal. When the DSH issues arose, we had the opportunity to review all of our policies and procedures regarding Medicaid days in the DSH calculation. During this review, we realized that the Medicaid days related to low-income persons covered under Medicaid through an 1115 waiver should be included

under the DSH calculation. We believe a person covered under Medicaid should count towards Medicare DSH through an 1115 waiver. So, the new regulation simply provides that the inpatient hospital days related to those covered by an 1115 waiver can be included in the Medicare DSH calculation.

**Q. Isn't this policy change unfair to hospitals located in states without 1115 waivers?**

A. No, rather it is fair to the states with Medicaid waivers. We believe the 1115 waiver is an expansion of the Medicaid program and should be included in the calculation of Medicare DSH. At the time Congress enacted the Medicare DSH calculation, there were no approved waiver states. We believe making this policy change to include 1115 expanded waiver population is fully consistent with the Congressional goals of the Medicare DSH calculation to recognize the higher costs to hospitals of treating low income individuals under Medicaid.

**Q. New York and Tennessee will be the most significant winners under the regulations, so isn't this politically motivated?**

A. Of course not. Let's be clear. The Medicare DSH program is designed to help hospitals pay for the care provided to low income persons enrolled in Medicare and Medicaid. The low-income persons covered under an 1115 waiver are –in fact—covered under Medicaid and are eligible or federally-matching funds. The regulation simply gives providers permission to include persons covered under Medicaid through an 1115 waiver in the Medicare DSH calculation. We believe a person covered should count towards Medicare DSH provided through an 1115 waiver.

The Federal Register will publish this regulation that states the 1115 waiver days will be included in the DSH calculation prospectively. Also, the regulation applies to every hospital in a state that has a waiver that expanded coverage and so this change is not specific to hospitals in one State or sub group of states.

[Background: This policy will affect hospitals in any State that implements an 1115 waiver for an expansion population. There are currently 8 such States: Delaware, Hawaii, Massachusetts, Missouri, New York, Oregon, Tennessee, and Vermont. Providers in some of these States had already been claiming the 1115 waiver days for Medicare DSH.]

**Q. People in New York have raised questions regarding the inclusion of 1115 waiver days prospectively. How does the hold harmless policy and the regulation affect New York?**

A. Retrospectively, we will not recoup the funds from these hospitals just as we will not recoup funds from any other hospitals for the various types of days specified (ie, under the parameters set forth in the Program Memorandum issued in December). The regulation we've announced today addresses inpatient hospital days for individuals eligible for Medicaid under a section 1115 waiver. Prospectively, these 1115 days can be counted in the Medicare DSH calculation by providers in all eight waiver States and any future States, including New York.

**Q. How much money is at stake?**

A. HCFA did not initiate a comprehensive audit of the funds that may or may not be owed by hospitals in various states. However, the guidance in the HCFA Program Memorandum will ensure that hospitals are clear about their responsibilities under the DSH formula so that payments can be made to institutions providing care to some of the most vulnerable Americans.

The actuaries have scored the cost of the regulation as $1.9 billion over five years. This assumes that providers in all eight waiver states will begin to include the 1115 waiver days in the DSH calculation. We believe this policy is an appropriate step, both to clarify our policy, and to fairly reimburse hospitals that treat low-income individuals.

[Background: Of the eight States that will be affected by this policy, HCFA believes that providers in two of these states are currently claiming these days –New York and Hawaii-- and that providers in two other states may have claimed these days in the past – Deleware and Massachusetts.]

**Q. Why was there such a long gap between releasing the Program Memorandum and the Regulation?**

A. We were developing our new policy on inclusion of 1115 days in the calculation of Medicare DSH and did so as quickly as we could. I would like to note however, that because this regulation is an interim final rule, this policy will go into effect immediately.

**Q. What is Medicare DSH? How are funds allocated?**

A. Medicare provides additional funds to hospitals where a large proportion of the patients served are low-income through funding known as disproportionate share adjustment, or DSH. Funds from DSH are allocated to hospitals based on a statutory formula.

# *Medicare DSH Policy – Program Memorandum*
# *Questions and Answers*
## *January 13, 2000*

***The following are Q&As that should be used for background on the history of the Medicare DSH problem and what was said regarding the program memorandum if any questions arise.***

**Q. You said that the earlier guidance was unclear. How did HCFA correct the problem?**

A. HCFA has taken several steps to resolve this complicated situation. First, we surveyed states in an effort to determine how the different types of days were being reported. HCFA learned that there were varied applications of the Medicare DSH calculation among hospitals, fiscal intermediaries, and state Medicaid agencies. We then concluded that our guidance was neither sufficiently clear nor well understood.

Second, in late December, HCFA issued a Program Memorandum to the fiscal intermediaries (effective for cost reporting periods beginning on or after January 1, 2000) clearly explaining how to calculate Medicare DSH.

Third, we will widely disseminate this guidance to all relevant parties. HCFA is requesting the intermediaries to send this guidance directly to the hospitals whose claims they pay. HCFA will also send this guidance to the State Medicaid agencies and request that the States transmit this information to all Medicaid managed care organizations. This communication strategy is critical because the hospitals are the ones who are directly responsible for reporting data used to calculate the DSH adjustment. In addition, for many hospitals, the State Medicaid Agency generates the critical Medicaid data that the hospitals use in the Medicare calculations.

**Finally, HCFA, with this regulation is issuing additional guidance to hospitals and state Medicaid agencies regarding the treatment of Medicaid inpatient hospital days for those who are covered under Medicaid through a section 1115 waiver in the DSH payment formula.**

**Q. What exactly is the confusion for the States, the fiscal intermediaries, and the hospitals regarding Medicare DSH?**

A. Medicare DSH is calculated based on a very complicated statutory formula. The confusion centered on the type of "Medicaid days" counted in the Medicare DSH formula as of the effective date of the regulation. About 35 states have programs to provide state-only assistance known sometimes as "General Assistance," to low income individuals not eligible for Medicaid. These types of hospital days cannot be counted in the Medicare DSH calculations. Due to insufficiently clear guidance, hospitals in a significant number of states included "General Assistance" days and other state-only funded days in the Medicare DSH formula.

## In technical terms, what did HCFA's Program Memorandum do?

**Q. In detail, what does this hold harmless policy mean exactly for the hospitals?**

A. In technical terms, HCFA will do the following:

- For hospital Medicare cost reporting periods beginning on or before December 31, 1999, our intermediaries will not disallow the portion of DSH payments claimed that reflect this misunderstanding of the DSH formula where a hospital had previously claimed and received Medicare DSH payments under the incorrect formula. This will apply to both open and closed cost reports.
- Where fiscal intermediaries have disallowed the portion of DSH payment claimed under our insufficiently clear DSH policy, and the hospitals timely pursued jurisdictionally proper appeals, the disallowances will be reversed, and where necessary, the hospitals will be repaid the amounts that had been recouped.

**Q. What do you mean that "certain days" count towards DSH?**

A. The hold harmless policy only applies to a limited set of certain days. These days include hose related to state only-funded programs collectively known as "general assistance days," charity care days, Medicaid DSH, and/or ineligible waiver or demonstration population days, and other state-only funded days. The Federal Register interim final rule permits hospitals to include people covered under a state's 1115 waiver in the calculation of the Medicare DSH formula.

**Q. Under your hold harmless policy, will hospitals be able to claim these additional funds if they have not claimed them previously?**

A. No. Hospitals cannot claim or receive additional funds if they had not already done so in the past.

**Q. Is your policy fair to hospitals that could have claimed these days previously, but interpreted our policy to not allow them to count these days?**

A. We understand that many hospitals did not claim these days on their cost reports because they understood that to be our policy. Our purpose in allowing hospitals that did claim these costs to be held harmless is to recognize that they have been operating under the understanding that these days were allowable and were anticipating DSH revenues based on those days. Hospitals that never claimed these days did not anticipate any revenues associated with them, and therefore we do not believe they are in any way affected by our hold harmless policy.

**Q. How will the policy be applied to hospitals with open cost reporting periods beginning on or before December 31, 1999?**

A. The fiscal intermediaries will continue to calculate the Medicare DSH calculation for all open cost reports only in accordance with the practice followed for the hospital at issue before October 15, 1999. That is, these hospitals will continue to be paid for these otherwise "ineligible days" throughout the balance of the cost reporting period extending into the year 2000. The policy clarification contained in the Program Memorandum will be applied to the hospital's next cost reporting period that follows.

**Q. Why is the October 15, 1999 date significant?**

A. This is the date of the letter from HCFA to members of Congress announcing the hold harmless policy that would be applied to hospitals. The letter also announced that HCFA would issue additional policy guidance on this matter that would apply to cost reporting periods beginning on or after January 1, 2000.

## What is the impact of the hold harmless policy from the program memorandum?

**Q. What does this mean for hospitals?**

A. If hospitals were claiming certain days that were inconsistent with our understanding of the previous guidance on DSH policy, then we will hold those hospitals harmless. Also, for hospital reporting periods beginning on or after January 1, 2000, hospitals will be provided DSH funds for services provided to low-income patients based on the clarification just issued by HCFA.

**Q. What States are affected by the hold harmless policy?**

A. This is not a state-specific issue since it involves individual hospitals and Medicare, which is a federal program. However, because Medicare DSH includes a Medicaid component, hospitals in some states may be more affected than those in other states. Due to concerns raised by hospitals in a few states, HCFA launched a national survey effort to assess the Medicare DSH program. It became obvious at the beginning of our survey effort that the confusion regarding this issue was pervasive and included hospitals, Medicare contractors, and states. Given the extent of the confusion, we felt that it was proper to immediately clarify our policy, and therefore, we do not know for sure the exact number of hospitals affected or all the states in which those hospitals are located.

**BACKGROUND: According to the preliminary results of our survey, we have confirming information that hospitals in approximately 13 States indicated problems or potential problems.**

**Q. Will the hold harmless policy be difficult for contractors to implement?**

A. No. There are no significant contractor system changes required as a result of this policy clarification. We believe the Program Memorandum clearly explains to the contractors, states, and the hospitals how to apply the policy for cost reporting periods beginning on or after January 1, 2000.

## Why were there differences in interpreting the DSH calculation policy?

**Q. You said that your guidance was unclear. What was exactly was unclear?**

A. Through a national survey, it became obvious that hospitals in most of the 35 States with general assistance and other state-only funded programs or waiver programs (these are the only types of hospital days that could be affected) were potentially collecting funds using criteria not allowed by the formula. Given the depth and the extent of the confusion, the Department of Health and Human Services, after consulting with both the Department's Office of General Counsel and Office of the Inspector General, concluded that our guidance on this topic was insufficiently clear and not well understood.

**Q. Earlier this year, HCFA stated that its guidance on this issue was clear. How could the agency now consider the same guidance to be unclear?**

A. HCFA initiated a comprehensive national survey this year regarding DSH policy. This survey showed that hospitals in a significant number of states were claiming funds for a variety of inpatient days that were not attributable to individuals eligible for Medicaid under a state plan. Given the extensive confusion, the Department of Health and Human Services, after consulting with both the Department's Office of General Counsel and Office of the Inspector General, concluded that our guidance was insufficiently clear and not well understood. Therefore, we made our announcement today because we have just come to fully appreciate the confusion surrounding this policy.

**Q. Why did this happen? Did HCFA fail to oversee its contractors?**

A. There are many reasons why the system did not work well. However, as we have repeatedly said, our guidance on this matter was insufficiently clear and not well understood by hospitals, fiscal intermediaries, or state Medicaid agencies. The resulting confusion caused by this guidance led to hospitals in a significant number of States to claim days for individuals who were not eligible under our understanding of our policy.

**Q. Is HCFA fulfilling its fiduciary responsibility?**

A. Absolutely. HCFA takes all program integrity issues very seriously. We have a long and well-established record of aggressively pursuing fraud and abuse issues in the past. We will continue to do so in the future. In this case, HCFA's guidance was not sufficiently clear, and this resulted in hospitals claiming additional funds.

**Q. In Pennsylvania, your contractors have begun to recoup funds, based on your guidance. Now, you are overruling them and ordering them to give the money back. Is this politically motivated?**

A. No. HCFA only recently received the results of a comprehensive, national survey regarding DSH policy. This survey showed that hospitals in a significant number of states were claiming funds not allowed under our DSH policy. Given the extensive confusion, it is now obvious that our guidance was insufficiently clear and not well understood. The money recouped from Pennsylvania hospitals has already been refunded.

## STATE-SPECIFIC ISSUES

**Q. How does this decision affect New Jersey?**

A. 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 some hospital's then appealed the decision. We will hold harmless only those hospitals that filed a timely and jursidictionally proper appeal.

**Q. How does this decision affect Pennsylvania?**

A. As with providers in all States, the providers in Pennsylvania will be held harmless under the parameters set forth in the Program Memorandum issued today. Consistent with this guidance, some funds that were recouped have already been reimbursed.

**Q. Will Pennsylvania hospitals receive interest on the funds that had been recouped?**

A. No interest will be paid on the funds that had been recouped from the hospitals as a result of this disallowance.

# Medicare DSH – 1115 Interim Final Rule
# Talking Points for the Secretary

- I'm calling to let you know that we are revising our policy on Medicare disproportionate share hospitals (DSH) that help hospitals in your state.

- We've sent a regulation up to the federal register that will allow hospitals to count inpatient hospital days of people covered under Medicaid 1115 waiver days in the calculation of Medicare DSH.

- As an 1115 waiver state, DSH hospitals in your state could benefit from this regulation.

- After reviewing our policies on the Medicare DSH calculation, we realized that the Medicaid days related to low-income persons under an 1115 expansion waiver should be included in the DSH calculation.

- At the time that Congress enacted the Medicare DSH adjustment, there were no approved waiver states. We believe making this policy change to include the 1115 expanded waiver population is fully consistent with the Congressional goals of the Medicare DSH calculation to recognize the higher costs to hospitals of treating low income individuals under Medicaid.

- This regulation, an interim final rule, will become effective on the date of publication. We'll be sending a copy of the regulation to your staff as soon as it goes on display at the Federal Register.

# FACSIMILE TRANSMISSION

**Greater New York Hospital Association**
555 West 57th Street / New York, N.Y. 10019 / (212) 246-7100 / FAX (212) 262-6350
Kenneth E. Raske, President

**Date:** 11-24-99

**Time:** _____

**TO:** Chris Jennings
Name
202 456 5557
Location

**FROM:** Karen Heller
Name

Location

We are transmitting 9 pages including this cover sheet. If you have not recieved all of the pages, PLEASE CALL OUR OFFICE AS SOON AS POSSIBLE.

Message: _____

Main Number 212/246-7100
Fax Number 212/262-6350

Hard Copy [ ] will [ ] will not be sent by mail.

**Total Fiscal Impact of the BBA Relief Bill**

| | | | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 6-Year Total |
|---|---|---|---|---|---|---|---|---|---|
| 330361 | Bayley Seton Hospital | New York City | 372,787 | 768,831 | 581,075 | 324,783 | 135,868 | 135,868 | 2,319,212 |
| 330204 | Bellevue Hospital Center | New York City | 408,426 | 716,635 | 112,412 | - | - | - | 1,237,474 |
| 330169 | Beth Israel Medical Center | New York City | 3,096,206 | 3,491,975 | (837,485) | (1,858,026) | (2,596,616) | (3,364,102) | (2,068,048) |
| 330009 | Bronx Lebanon Hospital Center | New York City | 543,567 | 959,785 | 155,725 | - | - | - | 1,659,077 |
| 330233 | Brookdale University Hospital and Medica | New York City | 781,765 | 1,303,473 | 145,911 | - | - | - | 2,231,149 |
| 330056 | Brooklyn Hospital Center (The) | New York City | 1,282,147 | 2,259,708 | 818,908 | 388,579 | 168,145 | 168,145 | 5,085,632 |
| 330133 | Cabrini Medical Center | New York City | 975,461 | 1,788,057 | 1,003,057 | 618,058 | 273,039 | 273,039 | 4,930,711 |
| 330357 | Catholic Medical Center (Excl. St. Mary's | New York City | 2,510,394 | 4,410,507 | 1,746,521 | 263,449 | (840,294) | (1,151,720) | 6,938,857 |
| 330196 | Coney Island Hospital | New York City | 321,163 | 562,450 | 87,307 | - | - | - | 970,920 |
| 330212 | Doctors' Hospital of Staten Island, Inc. | New York City | 76,554 | 153,108 | 140,932 | 123,436 | 56,768 | 56,768 | 607,566 |
| 330128 | Elmhurst Hospital Center | New York City | 330,268 | 566,350 | 77,555 | - | - | - | 974,173 |
| 330240 | Harlem Hospital Center | New York City | 229,468 | 121,805 | (533,668) | (847,066) | (1,079,312) | (1,320,593) | (3,429,367) |
| 330389 | Hospital for Joint Diseases Orthopaedic I | New York City | 282,954 | 374,778 | (10,418) | (90,615) | (193,451) | (262,277) | 100,971 |
| 330270 | Hospital for Special Surgery | New York City | 859,320 | 1,282,575 | 230,191 | (26,787) | (326,568) | (434,589) | 1,584,141 |
| 330397 | Interfaith Medical Center | New York City | 560,567 | 1,106,393 | 579,973 | 287,205 | 112,907 | 112,907 | 2,759,951 |
| 330127 | Jacobi Medical Center | New York City | 411,090 | 711,430 | 103,118 | - | - | - | 1,225,637 |
| 330014 | Jamaica Hospital Medical Center | New York City | 857,787 | 1,417,038 | 664,858 | 440,824 | 281,951 | 287,141 | 3,949,598 |
| 330202 | Kings County Hospital Center | New York City | 248,964 | 451,505 | 83,409 | - | - | - | 783,878 |
| 330201 | Kingsbrook Jewish Medical Center | New York City | 332,348 | 547,115 | 54,900 | - | - | - | 934,363 |
| 330119 | Lenox Hill Hospital | New York City | 2,862,080 | 4,344,615 | 2,334,013 | 1,751,128 | 1,288,692 | 1,319,765 | 13,900,293 |
| 330080 | Lincoln Medical & Mental Health Center | New York City | 398,754 | 704,881 | 115,045 | - | - | - | 1,218,679 |
| 330308 | Little Neck Community Hospital, Inc. | New York City | 9,256 | 18,511 | 17,642 | 16,774 | 11,561 | 11,561 | 85,304 |
| 330152 | Long Island College Hospital (The) | New York City | 1,885,372 | 2,752,352 | 1,657,677 | 1,476,317 | 1,158,118 | 1,187,580 | 10,117,415 |
| 330195 | Long Island Jewish Medical Center | New York City | 3,492,771 | 4,156,292 | (419,794) | (924,936) | (1,407,000) | (1,907,978) | 2,989,356 |
| 330306 | Lutheran Medical Center | New York City | 1,093,858 | 2,014,216 | 928,712 | 494,925 | 202,038 | 202,038 | 4,935,785 |
| 330194 | Maimonides Medical Center | New York City | 3,637,540 | 6,044,678 | 1,713,714 | 952,369 | 450,993 | 456,143 | 13,255,437 |
| 330247 | Manhattan Eye Ear and Throat Hospital | New York City | 19,504 | 29,620 | 697 | - | - | - | 49,821 |
| 330154 | Memorial Hospital for Cancer and Allied D | New York City | 1,080,682 | 2,161,364 | 1,990,036 | 1,748,954 | 804,693 | 804,693 | 8,590,422 |
| 330199 | Metropolitan Hospital Center | New York City | 292,474 | 511,870 | 79,166 | - | - | - | 883,510 |
| 330059 | Montefiore Medical Center | New York City | 4,482,168 | 5,646,369 | (1,769,515) | (3,074,400) | (4,179,694) | (5,327,997) | (4,223,069) |
| 330024 | Mount Sinai Hospital | New York City | 8,935,231 | 12,417,736 | 3,825,412 | 2,008,269 | 677,525 | 123,190 | 27,987,383 |
| 330100 | New York Eye & Ear Infirmary | New York City | 359,923 | 704,237 | 639,560 | 632,509 | 632,509 | 632,509 | 3,601,247 |
| 330193 | New York Flushing Hospital Medical Cent | New York City | 708,181 | 1,206,495 | 429,361 | 338,809 | 156,229 | 156,229 | 2,995,304 |
| 330101 | New York Hospital (The) | New York City | 6,899,746 | 8,761,238 | 5,208,173 | 5,177,231 | 5,330,324 | 5,488,623 | 36,865,336 |
| 330055 | New York Hospital Medical Center of Que | New York City | 2,081,641 | 3,694,435 | 1,933,687 | 1,130,537 | 487,218 | 487,218 | 9,814,735 |
| 330236 | New York Methodist Hospital | New York City | 1,761,322 | 3,149,878 | 1,284,894 | 896,170 | 282,332 | 282,332 | 7,456,928 |
| 330064 | New York University Downtown Hospital | New York City | 515,925 | 920,659 | 337,513 | 165,581 | 68,115 | 68,115 | 2,075,909 |
| 332012 | New York University Medical Center - Ru | New York City | 256,686 | 340,221 | 286,610 | 259,453 | 228,760 | 235,740 | 1,617,471 |
| 330214 | New York University Medical Center - Tis | New York City | 2,620,806 | 3,958,872 | 1,116,472 | 1,066,160 | 706,112 | 718,636 | 10,187,058 |
| 330385 | North Central Bronx Hospital | New York City | 85,184 | 159,089 | 33,212 | - | - | - | 277,485 |
| 330390 | North General Hospital | New York City | 338,022 | 674,086 | 356,234 | 170,628 | 68,147 | 68,281 | 1,675,408 |
| 330353 | North Shore University Hospital at Forest | New York City | 329,788 | 546,000 | 158,188 | 93,595 | 38,229 | 38,229 | 1,204,028 |
| 330072 | Our Lady of Mercy Medical Center | New York City | 676,359 | 1,152,911 | 303,080 | 204,450 | 199,103 | 199,103 | 2,735,008 |
| 330041 | Parkway Hospital | New York City | 440,116 | 860,232 | 587,656 | 331,651 | 112,218 | 112,218 | 2,464,092 |

**Total Fiscal Impact of the BBA Relief Bill**

| | | | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 6-Year Total |
|---|---|---|---|---|---|---|---|---|---|
| 330002 | Peninsula Hospital Center | New York City | 288,582 | 542,101 | 245,141 | 199,200 | 199,928 | 200,677 | 1,675,629 |
| 330012 | Presbyterian Hospital - Main Campus | New York City | 4,922,628 | 8,041,334 | 3,121,996 | 2,600,020 | 1,486,783 | 1,504,454 | 21,677,216 |
| 330231 | Queens Hospital Center | New York City | 85,795 | 168,613 | 41,980 | - | - | - | 296,388 |
| 330399 | St. Barnabas Hospital | New York City | 1,025,934 | 1,867,553 | 731,827 | 369,978 | 134,679 | 134,690 | 4,254,662 |
| 330230 | St. Clare's Hospital and Health Center | New York City | 117,383 | 262,793 | 208,966 | 125,153 | 56,323 | 56,323 | 826,942 |
| 330046 | St. Luke's-Roosevelt Hospital Center | New York City | 3,417,127 | 5,573,544 | 2,559,360 | 1,686,319 | 1,104,164 | 1,127,164 | 15,447,679 |
| 330290 | St. Vincents Hospital & Medical Center | New York City | 1,678,684 | 2,838,044 | 908,752 | 712,641 | 335,182 | 335,182 | 6,808,485 |
| 330026 | St. Vincent's Medical Center of Richmon | New York City | 671,982 | 1,168,607 | 545,244 | 376,765 | 168,621 | 168,621 | 3,099,820 |
| 330160 | Staten Island University Hospital | New York City | 1,787,049 | 3,103,160 | 1,214,986 | 691,898 | 408,142 | 408,142 | 7,813,377 |
| 330034 | Union Hospital | New York City | 12,274 | 29,880 | 27,524 | 17,437 | 7,914 | 7,914 | 102,943 |
| 330350 | University Hospital of Brooklyn | New York City | 1,144,420 | 1,916,810 | 862,050 | 545,061 | 342,214 | 349,361 | 5,159,915 |
| 330242 | Victory Memorial Hospital | New York City | 57,505 | 115,011 | 115,011 | 115,011 | 115,011 | 115,011 | 632,560 |
| 330316 | Westchester Square Medical Center | New York City | 237,554 | 475,108 | 433,990 | 343,771 | 155,986 | 155,986 | 1,802,396 |
| 330258 | Western Queens Community Hospital | New York City | 137,266 | 274,533 | 249,832 | 187,562 | 84,442 | 84,442 | 1,018,077 |
| 330396 | Woodhull Medical & Mental Health Cente | New York City | 190,866 | 369,867 | 88,025 | - | - | - | 648,758 |
| 330221 | Wyckoff Heights Medical Center | New York City | 544,667 | 983,519 | 381,958 | 261,010 | 120,726 | 120,726 | 2,412,605 |
| 330141 | Brookhaven Memorial Hospital Medical C | NYC Suburbs | 109,513 | 219,027 | 219,027 | 219,027 | 219,027 | 219,027 | 1,204,647 |
| 330314 | Brunswick Hospital Center | NYC Suburbs | 156,280 | 312,399 | 262,850 | 182,004 | 81,315 | 81,315 | 1,076,161 |
| 333026 | Burke Rehabilitation Hospital (The) | NYC Suburbs | 729 | 1,458 | 1,458 | 1,458 | 1,458 | 1,458 | 8,019 |
| 330107 | Central Suffolk Hospital | NYC Suburbs | 70,584 | 141,167 | 141,167 | 141,167 | 141,167 | 141,167 | 776,420 |
| 330038 | Community Hospital at Dobbs Ferry | NYC Suburbs | 75,223 | 150,445 | 126,127 | 75,559 | 32,216 | 32,216 | 491,786 |
| 330088 | Eastern Long Island Hospital | NYC Suburbs | 87,335 | 170,191 | 153,552 | 95,508 | 44,559 | 44,739 | 595,883 |
| 330395 | Episcopal Health Services, Inc. | NYC Suburbs | 1,289,198 | 1,958,797 | 502,347 | (372,081) | (1,111,911) | (1,437,477) | 828,874 |
| 330372 | Franklin Hospital Medical Center | NYC Suburbs | 105,470 | 189,037 | 126,133 | 126,133 | 126,133 | 126,133 | 799,039 |
| 330286 | Good Samaritan Hospital Medical Center | NYC Suburbs | 343,448 | 575,513 | 255,627 | 255,627 | 255,627 | 255,627 | 1,941,469 |
| 330333 | Hempstead General Hospital Medical Ce | NYC Suburbs | 83,582 | 167,164 | 154,648 | 142,133 | 67,039 | 67,039 | 681,606 |
| 330267 | Hudson Valley Hospital Center | NYC Suburbs | 64,650 | 129,300 | 129,300 | 129,300 | 129,300 | 129,300 | 711,148 |
| 330045 | Huntington Hospital | NYC Suburbs | 165,096 | 351,032 | 304,248 | 305,407 | 306,601 | 307,831 | 1,740,215 |
| 330185 | John T. Mather Memorial Hospital | NYC Suburbs | 485,041 | 970,082 | 739,915 | 439,970 | 182,874 | 182,874 | 3,000,755 |
| 330061 | Lawrence Hospital | NYC Suburbs | 85,912 | 171,825 | 171,825 | 171,825 | 171,825 | 171,825 | 945,036 |
| 330225 | Long Beach Medical Center | NYC Suburbs | 516,264 | 697,122 | 389,320 | 392,166 | 401,174 | 410,488 | 2,806,534 |
| 330336 | Massapequa General Hospital | NYC Suburbs | 272,001 | 483,353 | 246,575 | 147,150 | 61,928 | 61,928 | 1,272,935 |
| 330259 | Mercy Medical Center | NYC Suburbs | 414,044 | 822,039 | 758,280 | 711,892 | 433,563 | 433,563 | 3,573,380 |
| 330332 | Mid-Island Hospital, Inc. | NYC Suburbs | 46,808 | 94,404 | 85,181 | 85,181 | 85,181 | 85,181 | 483,935 |
| 330086 | Mount Vernon Hospital | NYC Suburbs | 320,910 | 603,696 | 363,561 | 328,731 | 245,474 | 250,574 | 2,112,946 |
| 330027 | Nassau County Medical Center | NYC Suburbs | 795,152 | 1,104,764 | 5,804 | (559,828) | (1,029,023) | (1,294,395) | (977,527) |
| 330106 | North Shore University Hospital | NYC Suburbs | 3,500,858 | 5,392,483 | 1,145,844 | (208,365) | (1,445,224) | (1,896,633) | 6,488,963 |
| 330181 | North Shore University Hospital at Glen C | NYC Suburbs | 272,063 | 440,175 | 265,820 | 260,476 | 219,962 | 221,781 | 1,680,278 |
| 330331 | North Shore University Hospital at Plainv | NYC Suburbs | 64,483 | 128,967 | 128,967 | 128,967 | 128,967 | 128,967 | 709,318 |
| 330398 | North Shore University Hospital at Syoss | NYC Suburbs | 117,004 | 213,066 | 133,304 | 80,088 | 34,474 | 34,474 | 612,411 |
| 330182 | Northern Westchester Hospital | NYC Suburbs | 91,130 | 182,259 | 182,259 | 182,259 | 182,259 | 182,259 | 1,002,425 |
| 330261 | Phelps Memorial Hospital Center | NYC Suburbs | 162,715 | 262,968 | 265,245 | 267,601 | 270,036 | 272,554 | 1,501,119 |
| 330184 | Sound Shore Medical Center of Westches | NYC Suburbs | 516,256 | 902,414 | 408,075 | 347,095 | 178,690 | 178,690 | 2,531,221 |
| 330198 | South Nassau Communities Hospital | NYC Suburbs | 281,438 | 494,645 | 299,467 | 299,467 | 299,467 | 299,467 | 1,974,152 |

**Total Fiscal Impact of the BBA Relief Bill**

| | | | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 6-Year Tota |
|---|---|---|---|---|---|---|---|---|---|
| 330340 | Southampton Hospital | NYC Suburbs | 213,933 | 427,866 | 403,854 | 379,842 | 235,772 | 235,772 | 1,897,037 |
| 330043 | Southside Hospital | NYC Suburbs | 142,912 | 267,273 | 147,574 | 122,139 | 105,055 | 105,055 | 890,008 |
| 330338 | St. Agnes Hospital | NYC Suburbs | 67,255 | 134,510 | 126,933 | 119,355 | 73,892 | 73,892 | 595,837 |
| 330246 | St. Charles Hospital & Rehabilitation Cen | NYC Suburbs | 138,765 | 355,364 | 303,140 | 282,561 | 203,705 | 206,419 | 1,489,954 |
| 330182 | St. Francis Hospital | NYC Suburbs | 375,882 | 670,088 | 435,521 | 435,521 | 435,521 | 435,521 | 2,788,053 |
| 330208 | St. John's Riverside Hospital | NYC Suburbs | 104,797 | 209,594 | 209,594 | 209,594 | 209,594 | 209,594 | 1,152,767 |
| 330006 | St. Joseph's Medical Center | NYC Suburbs | 203,292 | 351,737 | 138,183 | 118,247 | 118,247 | 118,247 | 1,047,934 |
| 330171 | United Hospital Medical Center | NYC Suburbs | 73,813 | 147,626 | 147,626 | 147,626 | 147,626 | 147,626 | 811,941 |
| 330393 | University Hospital at Stony Brook | NYC Suburbs | 1,978,561 | 3,180,553 | 768,316 | 670,356 | 380,414 | 360,414 | 7,318,615 |
| 330234 | Westchester Medical Center | NYC Suburbs | 1,399,083 | 2,207,313 | 133,804 | - | - | - | 3,740,200 |
| 330304 | White Plains Hospital Center | NYC Suburbs | 154,230 | 308,459 | 308,459 | 308,459 | 308,459 | 308,459 | 1,696,527 |
| 330167 | Winthrop-University Hospital | NYC Suburbs | 1,561,457 | 2,403,568 | 334,639 | 331,619 | 313,502 | 313,502 | 5,258,286 |
| 330122 | Yonkers General Hospital | NYC Suburbs | 48,728 | 97,457 | 95,451 | 93,444 | 81,406 | 81,406 | 497,892 |
| 330085 | A.O. Fox Memorial Hospital | Upstate | 65,230 | 130,461 | 130,461 | 130,461 | 130,461 | 130,461 | 717,534 |
| 330079 | Adirondack Medical Center | Upstate | 126,763 | 253,525 | 234,568 | 215,610 | 101,865 | 101,865 | 1,034,195 |
| 330013 | Albany Medical Center Hospital | Upstate | 1,447,735 | 2,273,250 | 292,811 | 224,077 | 224,077 | 224,077 | 4,686,028 |
| 330003 | Albany Memorial Hospital | Upstate | 316,652 | 633,304 | 582,590 | 506,427 | 232,683 | 232,683 | 2,504,340 |
| 330075 | Albert Lindley Lee Memorial Hospital | Upstate | 32,547 | 65,094 | 63,142 | 61,191 | 49,483 | 49,483 | 320,940 |
| 330084 | Alice Hyde Hospital | Upstate | 30,270 | 60,540 | 60,540 | 60,540 | 60,540 | 60,540 | 332,971 |
| 330010 | Amsterdam Memorial Hospital | Upstate | 79,907 | 159,814 | 148,500 | 137,186 | 69,301 | 69,301 | 664,009 |
| 330126 | Arden Hill Hospital | Upstate | 60,215 | 120,430 | 120,430 | 120,430 | 120,430 | 120,430 | 662,367 |
| 330090 | Arnot Ogden Medical Center | Upstate | 131,503 | 263,007 | 263,007 | 263,007 | 263,007 | 263,007 | 1,446,538 |
| 330235 | Auburn Memorial Hospital | Upstate | 65,214 | 130,429 | 130,429 | 130,429 | 130,429 | 130,429 | 717,359 |
| 330268 | Bassett Hospital of Schoharie County | Upstate | 22,686 | 45,371 | 45,371 | 45,371 | 45,371 | 45,371 | 249,543 |
| 330339 | Bellevue Maternity Hospital, Inc. | Upstate | 9,363 | 18,725 | 17,373 | 16,022 | 7,912 | 7,912 | 77,306 |
| 330224 | Benedictine Hospital | Upstate | 94,375 | 155,953 | 98,188 | 83,799 | 68,647 | 53,313 | 554,476 |
| 330111 | Bertrand Chaffee Hospital | Upstate | 29,042 | 58,084 | 54,780 | 51,476 | 31,650 | 31,650 | 256,683 |
| 330229 | Brooks Memorial Hospital | Upstate | 53,684 | 107,368 | 107,368 | 107,368 | 107,368 | 107,368 | 590,523 |
| 330005 | Buffalo General Health System | Upstate | 1,311,329 | 2,276,031 | 1,065,211 | 943,503 | 522,814 | 522,814 | 6,641,701 |
| 330161 | Buffalo General Health System | Upstate | 11,871 | 23,741 | 16,116 | 9,443 | 3,724 | 3,724 | 68,619 |
| 330197 | Canton-Potsdam Hospital | Upstate | 35,388 | 70,777 | 70,777 | 70,777 | 70,777 | 70,777 | 389,273 |
| 330263 | Carthage Area Hospital, Inc. | Upstate | 18,476 | 36,951 | 36,951 | 36,951 | 36,951 | 36,951 | 203,233 |
| 330307 | Cayuga Medical Center at Ithaca | Upstate | 73,759 | 147,517 | 147,517 | 147,517 | 147,517 | 147,517 | 811,345 |
| 330250 | Champlain Valley Physicians Hospital | Upstate | 330,696 | 655,262 | 598,667 | 559,677 | 325,736 | 325,736 | 2,795,772 |
| 330033 | Chenango Memorial Hospital | Upstate | 70,593 | 141,186 | 141,186 | 141,186 | 141,186 | 141,186 | 776,523 |
| 333300 | Children's Hospital of Buffalo (The) | Upstate | 3,107 | 6,213 | 6,213 | 6,213 | 6,213 | 6,213 | 34,174 |
| 330189 | Child's Hospital | Upstate | 68,895 | 137,595 | 137,031 | 137,031 | 137,031 | 137,031 | 754,614 |
| 330265 | Clifton Springs Hospital And Clinic | Upstate | 84,959 | 189,919 | 178,693 | 167,467 | 100,113 | 100,113 | 831,264 |
| 330179 | Clifton-Fine Hospital | Upstate | 6,856 | 13,711 | 12,327 | 7,592 | 3,305 | 3,305 | 47,097 |
| 330094 | Columbia Memorial Hospital | Upstate | 214,652 | 429,304 | 391,746 | 305,880 | 138,508 | 138,508 | 1,618,599 |
| 330359 | Community General Hospital of Sullivan C | Upstate | 1,167 | 2,334 | 2,334 | 2,334 | 2,334 | 2,334 | 12,837 |
| 330386 | Community General Hospital of Sullivan C | Upstate | 154,082 | 308,164 | 280,772 | 214,482 | 96,812 | 96,812 | 1,151,123 |
| 330249 | Community Memorial Hospital, Inc. | Upstate | 27,163 | 54,326 | 54,326 | 54,326 | 54,326 | 54,326 | 298,796 |
| 330159 | Community-General Hospital of Greater S | Upstate | 176,012 | 332,944 | 273,094 | 268,037 | 237,695 | 237,695 | 1,525,477 |

**Total Fiscal Impact of the BBA Relief Bill**

| | | | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 6-Year Total |
|---|---|---|---|---|---|---|---|---|---|
| 330277 | Corning Hospital | Upstate | 101,912 | 203,823 | 189,067 | 174,311 | 85,775 | 85,775 | 840,663 |
| 330264 | Cornwall Hospital | Upstate | 96,862 | 193,725 | 180,044 | 166,364 | 84,282 | 84,282 | 805,558 |
| 330175 | Cortland Memorial Hospital | Upstate | 124,264 | 248,528 | 227,080 | 180,532 | 81,959 | 81,959 | 944,321 |
| 330203 | Crouse Hospital | Upstate | 417,839 | 890,719 | 578,523 | 545,785 | 549,894 | 554,126 | 3,536,887 |
| 330039 | Cuba Memorial Hospital, Inc. | Upstate | 1,082 | 2,163 | 1,470 | 863 | 344 | 344 | 6,265 |
| 330007 | Degraff Memorial Hospital | Upstate | 66,472 | 132,943 | 132,943 | 132,943 | 132,943 | 132,943 | 731,188 |
| 330121 | Delaware Valley Hospital | Upstate | 19,650 | 39,300 | 37,504 | 35,707 | 24,928 | 24,928 | 182,018 |
| 330114 | Edward John Noble - Samaritan Hospital | Upstate | 22,234 | 44,468 | 30,017 | 17,373 | 6,535 | 6,535 | 127,162 |
| 330177 | Edward John Noble Hospital | Upstate | 14,174 | 28,349 | 28,349 | 28,349 | 28,349 | 28,349 | 155,919 |
| 330252 | Elizabethtown Community Hospital | Upstate | 36,599 | 73,199 | 57,921 | 34,544 | 14,507 | 14,507 | 231,277 |
| 330327 | Ellenville Community Hospital | Upstate | 8,542 | 17,084 | 17,084 | 17,084 | 17,084 | 17,084 | 93,962 |
| 330153 | Ellis Hospital | Upstate | 205,024 | 395,470 | 353,603 | 353,603 | 353,603 | 353,603 | 2,014,903 |
| 330219 | Erie County Medical Center | Upstate | 966,564 | 1,771,629 | 867,253 | 479,414 | 198,104 | 198,104 | 4,481,069 |
| 330048 | Faxton Hospital | Upstate | 104,979 | 209,958 | 209,958 | 209,958 | 209,958 | 209,958 | 1,154,768 |
| 330074 | FF Thompson Hospital | Upstate | 86,766 | 173,532 | 173,532 | 173,532 | 173,532 | 173,532 | 954,429 |
| 330183 | Genesee Hospital (The) | Upstate | 391,173 | 671,084 | 325,002 | 315,571 | 315,571 | 315,571 | 2,333,973 |
| 330073 | Genesee Memorial Hospital | Upstate | 42,875 | 85,749 | 85,749 | 85,749 | 85,749 | 85,749 | 471,622 |
| 330058 | Geneva General Hospital | Upstate | 326,905 | 653,809 | 548,558 | 328,646 | 140,150 | 140,150 | 2,138,219 |
| 330191 | Glens Falls Hospital | Upstate | 384,168 | 768,337 | 722,517 | 676,697 | 401,776 | 401,776 | 3,355,272 |
| 330158 | Good Samaritan Hospital | Upstate | 113,989 | 227,978 | 227,978 | 227,978 | 227,978 | 227,978 | 1,253,879 |
| 333027 | Helen Hayes Hospital | Upstate | 207,374 | 255,803 | 250,715 | 226,992 | 207,719 | 214,127 | 1,362,730 |
| 330211 | Hepburn Medical Center | Upstate | 51,087 | 100,940 | 95,684 | 93,970 | 83,691 | 83,691 | 509,062 |
| 330164 | Highland Hospital of Rochester | Upstate | 297,434 | 497,905 | 194,574 | 185,741 | 185,741 | 185,741 | 1,547,137 |
| 330001 | Horton Medical Center | Upstate | 132,621 | 265,242 | 265,242 | 265,242 | 265,242 | 265,242 | 1,458,832 |
| 330016 | Hospital (The) | Upstate | 11,776 | 23,553 | 23,553 | 23,553 | 23,553 | 23,553 | 129,539 |
| 330025 | Inter-Community Memorial Hospital at Ne | Upstate | 19,837 | 39,674 | 39,674 | 39,674 | 39,674 | 39,674 | 218,206 |
| 330144 | Ira Davenport Memorial Hospital | Upstate | 49,556 | 99,112 | 90,189 | 67,647 | 30,451 | 30,451 | 367,405 |
| 330086 | Jones Memorial Hospital | Upstate | 35,607 | 71,213 | 71,213 | 71,213 | 71,213 | 71,213 | 391,674 |
| 330102 | Kenmore Mercy Hospital | Upstate | 144,221 | 288,442 | 288,442 | 288,442 | 288,442 | 288,442 | 1,586,430 |
| 330004 | Kingston Hospital (The) | Upstate | 99,086 | 155,436 | 68,112 | 54,125 | 39,590 | 24,489 | 440,837 |
| 330293 | Lake Shore Hospital, Inc. | Upstate | 26,194 | 52,388 | 50,471 | 48,553 | 37,048 | 37,048 | 251,702 |
| 330037 | Lakeside Memorial Hospital | Upstate | 26,271 | 52,542 | 52,542 | 52,542 | 52,542 | 52,542 | 288,979 |
| 330213 | Lewis County General Hospital | Upstate | 17,028 | 34,056 | 34,056 | 34,056 | 34,056 | 34,056 | 187,308 |
| 330148 | Little Falls Hospital | Upstate | 28,933 | 57,866 | 57,866 | 57,866 | 57,866 | 57,866 | 318,262 |
| 330163 | Lockport Memorial Hospital | Upstate | 61,097 | 122,195 | 122,195 | 122,195 | 122,195 | 122,195 | 672,071 |
| 330092 | Margaretville Memorial Hospital | Upstate | 68,132 | 136,264 | 102,433 | 60,835 | 25,179 | 25,179 | 418,022 |
| 330136 | Mary Imogene Bassett Hospital | Upstate | 439,410 | 756,594 | 405,569 | 405,569 | 405,569 | 405,569 | 2,818,279 |
| 330223 | Massena Memorial Hospital | Upstate | 95,674 | 191,347 | 174,748 | 137,990 | 62,586 | 62,586 | 724,930 |
| 330053 | Medina Memorial Hospital | Upstate | 33,803 | 67,606 | 67,606 | 67,606 | 67,606 | 67,606 | 371,833 |
| 330135 | Mercy Community Hospital | Upstate | 60,296 | 120,592 | 120,592 | 120,592 | 120,592 | 120,592 | 663,257 |
| 330279 | Mercy Hospital of Buffalo | Upstate | 330,745 | 613,823 | 414,529 | 393,179 | 393,147 | 393,114 | 2,538,539 |
| 330118 | Millard Fillmore Hospital | Upstate | 1,021,679 | 1,723,571 | 715,362 | 664,558 | 488,669 | 488,669 | 5,102,508 |
| 330116 | Moses-Ludington Hospital | Upstate | 55,385 | 110,769 | 75,228 | 44,130 | 17,474 | 17,474 | 320,460 |
| 330188 | Mount St. Mary's Hospital | Upstate | 90,287 | 180,573 | 180,573 | 180,573 | 180,573 | 180,573 | 993,153 |

**Total Fiscal Impact of the BBA Relief Bill**

| | | | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 6-Year Tota |
|---|---|---|---|---|---|---|---|---|---|
| 330254 | Myers Community Hospital | Upstate | 33,345 | 66,691 | 62,680 | 58,669 | 34,605 | 34,605 | 290,595 |
| 330276 | Nathan Littauer Hospital & Nursing Home | Upstate | 56,266 | 112,531 | 112,531 | 112,531 | 112,531 | 112,531 | 618,922 |
| 330030 | Newark-Wayne Community Hospital, Inc. | Upstate | 67,704 | 135,407 | 127,245 | 119,084 | 70,113 | 70,113 | 589,667 |
| 330065 | Niagara Falls Memorial Medical Center | Upstate | 165,065 | 328,480 | 282,070 | 267,265 | 267,265 | 267,265 | 1,577,409 |
| 330238 | Nicholas H. Noyes Memorial Hospital | Upstate | 38,699 | 77,397 | 77,397 | 77,397 | 77,397 | 77,397 | 425,684 |
| 330049 | Northern Dutchess Hospital | Upstate | 34,150 | 68,300 | 68,300 | 68,300 | 68,300 | 68,300 | 375,648 |
| 330104 | Nyack Hospital | Upstate | 371,833 | 762,497 | 658,611 | 390,736 | 170,464 | 170,464 | 2,524,605 |
| 330103 | Ofean General Hospital | Upstate | 86,852 | 173,705 | 173,705 | 173,705 | 173,705 | 173,705 | 955,375 |
| 330115 | Oneida Healthcare Center | Upstate | 57,152 | 114,305 | 114,305 | 114,305 | 114,305 | 114,305 | 628,676 |
| 330218 | Oswego Hospital | Upstate | 54,570 | 109,140 | 105,258 | 101,376 | 78,085 | 78,085 | 526,514 |
| 330011 | Our Lady of Lourdes Memorial | Upstate | 708,334 | 1,416,669 | 1,307,620 | 1,184,577 | 547,074 | 547,074 | 5,711,348 |
| 330095 | Our Lady of Victory Hospital | Upstate | 6,924 | 86,088 | 83,435 | 80,711 | 77,896 | 74,984 | 410,018 |
| 330226 | Park Ridge Hospital | Upstate | 264,254 | 528,507 | 485,260 | 411,739 | 188,587 | 188,587 | 2,066,934 |
| 330273 | Putnam Hospital Center | Upstate | 72,134 | 120,297 | 121,171 | 122,075 | 123,009 | 123,976 | 682,662 |
| 330125 | Rochester General Hospital | Upstate | 1,550,120 | 2,754,659 | 1,532,909 | 918,910 | 399,009 | 399,009 | 7,554,618 |
| 330215 | Rome Memorial Hospital, Inc. | Upstate | 64,079 | 128,158 | 128,158 | 128,158 | 128,158 | 128,158 | 704,869 |
| 330354 | Roswell Park Cancer Institute | Upstate | 457,168 | 914,337 | 823,986 | 529,526 | 232,349 | 232,349 | 3,189,716 |
| 330180 | Samaritan Hospital | Upstate | 413,950 | 827,900 | 750,100 | 526,658 | 234,628 | 234,628 | 2,987,865 |
| 330157 | Samaritan Medical Center | Upstate | 119,846 | 239,692 | 239,692 | 239,692 | 239,692 | 239,692 | 1,318,304 |
| 330222 | Saratoga Hospital (The) | Upstate | 188,490 | 376,980 | 345,025 | 280,657 | 127,822 | 127,822 | 1,446,795 |
| 330062 | Schuyler Hospital, Inc. | Upstate | 13,418 | 26,836 | 26,836 | 26,836 | 26,836 | 26,836 | 147,598 |
| 330232 | Seton Health System, Inc. | Upstate | 473,680 | 947,760 | 851,197 | 514,648 | 223,254 | 223,254 | 3,233,994 |
| 330029 | Sheehan Memorial Hospital | Upstate | 41,247 | 107,042 | 97,567 | 74,355 | 52,504 | 52,743 | 425,458 |
| 330078 | Sisters of Charity Hospital | Upstate | 244,305 | 462,284 | 313,361 | 287,313 | 287,313 | 287,313 | 1,881,888 |
| 330097 | Soldiers & Sailors Memorial Hospital | Upstate | 22,158 | 44,316 | 44,316 | 44,316 | 44,316 | 44,316 | 243,737 |
| 330205 | St. Anthony Community Hospital | Upstate | 22,461 | 44,923 | 44,923 | 44,923 | 44,923 | 44,923 | 247,076 |
| 330066 | St. Clare's Hospital | Upstate | 390,696 | 721,834 | 491,711 | 376,574 | 170,256 | 170,256 | 2,321,327 |
| 330245 | St. Elizabeth Medical Center | Upstate | 760,429 | 1,474,011 | 898,953 | 519,629 | 198,084 | 198,084 | 4,049,189 |
| 330067 | St. Francis Hospital, Poughkeepsie | Upstate | 141,235 | 311,890 | 265,876 | 218,045 | 204,403 | 204,403 | 1,345,852 |
| 330151 | St. James Mercy Hospital | Upstate | 87,878 | 175,756 | 165,612 | 155,468 | 94,602 | 94,602 | 773,919 |
| 330038 | St. Jerome Hospital | Upstate | 141,537 | 283,073 | 256,802 | 183,960 | 82,220 | 82,220 | 1,029,813 |
| 330091 | St. Joseph Hospital | Upstate | 102,047 | 204,093 | 204,093 | 204,093 | 204,093 | 204,093 | 1,122,512 |
| 330108 | St. Joseph's Hospital | Upstate | 90,088 | 180,175 | 178,131 | 176,088 | 163,824 | 163,824 | 952,131 |
| 330140 | St. Joseph's Hospital Health Center | Upstate | 608,409 | 1,012,625 | 378,263 | 361,234 | 361,234 | 361,234 | 3,082,999 |
| 330209 | St. Luke's Hospital of Newburgh | Upstate | 53,895 | 107,790 | 107,790 | 107,790 | 107,790 | 107,790 | 592,845 |
| 330044 | St. Luke's Memorial Hospital Center | Upstate | 233,772 | 467,544 | 429,274 | 364,112 | 166,765 | 166,765 | 1,828,232 |
| 330275 | St. Mary's Hospital | Upstate | 331,560 | 646,162 | 392,230 | 349,603 | 183,251 | 181,309 | 2,084,114 |
| 330047 | St. Mary's Hospital at Amsterdam | Upstate | 305,763 | 611,526 | 563,026 | 494,549 | 227,526 | 227,526 | 2,429,917 |
| 330057 | St. Peter's Hospital, Albany | Upstate | 343,242 | 599,226 | 348,626 | 348,626 | 348,626 | 348,626 | 2,336,974 |
| 330285 | Strong Memorial Hospital | Upstate | 3,156,665 | 5,502,116 | 1,808,025 | 971,224 | 316,833 | 312,836 | 12,067,697 |
| 333025 | Sunnyview Hospital and Rehabilitation Ce | Upstate | 18,426 | 42,257 | 30,569 | 20,367 | 11,651 | 11,828 | 135,097 |
| 330132 | Tri-County Memorial Hospital | Upstate | 33,018 | 66,037 | 63,498 | 60,959 | 45,728 | 45,728 | 314,968 |
| 330394 | United Health Services Hospitals | Upstate | 575,768 | 876,915 | 271,376 | 160,749 | 66,131 | (32,167) | 1,920,771 |
| 330241 | University Hospital Suny Health Science | Upstate | 1,648,126 | 2,802,531 | 975,143 | 544,517 | 227,996 | 227,927 | 6,426,238 |

**Total Fiscal Impact of the BBA Relief Bill**

| | | | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 6-Year Tota |
|---|---|---|---|---|---|---|---|---|---|
| 330023 | Vassar Brothers Hospital | Upstate | 186,698 | 373,396 | 361,856 | 350,315 | 281,069 | 281,069 | 1,834,403 |
| 330166 | Westfield Memorial Hospital | Upstate | 60,302 | 120,605 | 108,416 | 66,651 | 29,006 | 29,006 | 413,985 |
| 330239 | Woman's Christian Association | Upstate | 128,596 | 257,192 | 257,192 | 257,192 | 257,192 | 257,192 | 1,414,558 |
| 330008 | Wyoming County Community Hospital | Upstate | 53,105 | 106,210 | 106,210 | 106,210 | 106,210 | 106,210 | 584,154 |
| | | | | | | | | | |
| | Total New York State | | 120,201,670 | 195,836,778 | 83,975,513 | 56,750,616 | 29,436,660 | 24,888,072 | 511,089,309 |
| | New York State Teaching | | 108,576,608 | 172,782,496 | 62,681,927 | 38,287,553 | 15,487,228 | 11,930,906 | 410,748,718 |
| | New York State Net Losers | | 8,602,993 | 10,364,912 | (3,134,864) | (6,339,320) | (8,684,645) | (11,307,087) | (10,698,011) |
| | Total New York City | | 77,353,522 | 119,633,649 | 40,600,692 | 22,369,779 | 6,916,862 | 3,186,043 | 270,062,548 |
| | New York City Teaching | | 76,138,584 | 117,376,925 | 38,759,019 | 20,992,121 | 6,152,116 | 2,416,316 | 261,835,081 |

HANYS
HEALTHCARE ASSOCIATION OF NEW YORK STATE
74 N. Pearl Street, Albany, NY 12207
(518) 431-7600 Fax: (518) 431-7915

# FAX COVER SHEET

***PLEASE DELIVER THE FOLLOWING PAGES AS SOON AS POSSIBLE***

TO: Chris Jennings

FROM: Dan Sisto

DATE: 11-30-99

TOTAL # OF PAGES 6

***COMMENTS:***

Urgent. - Please see following letters.

If you do not receive all of the pages
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***PLEASE CALL AS SOON AS POSSIBLE***
Cheryl at (518) 431-7725

HANYS
HEALTHCARE ASSOCIATION OF NEW YORK STATE

Daniel Sisto, President



November 30, 1999

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

Dear President Clinton:

On behalf of more than 500 hospitals, health systems, and continuing care providers that comprise the Healthcare Association of New York State (HANYS), and the communities they serve, I write to thank you for helping repair some of the unintended consequences of the Balanced Budget Act of 1997 (BBA). The Balanced Budget Refinement Act of 1999, which you signed into law this week, will return approximately $630 million in Medicare payments to New York State's hospitals and hospital-based continuing care providers over the next five years.

New York State's urban, suburban, and rural hospitals and health care systems – as well as hundreds of thousands of hospital employees, trustees, physicians, and auxiliary volunteers – are grateful for your support and leadership. While this BBA relief represents only a modest percentage of the $5 billion in total BBA cuts to New York State's hospitals, every hospital will receive some short-term relief. It is important to note that the largest restoration for New York's hospitals is the result of the successful efforts to address the across-the-board cut to all hospitals under the proposed outpatient prospective payment system.

We are appreciative of your efforts on our behalf, as well as the hard work of your staff. We are especially appreciative of the efforts of Chris Jennings and Barbara Woolley, who have both worked closely with us over the years. Mr. Jennings and Ms. Woolley have always been accessible to HANYS and have facilitated our involvement in many legislative and administrative issues. They are a credit to your Administration and I hope you will share HANYS' appreciation with them.

74 N. Pearl Street
Albany, NY 12207

*phone* (518) 431-7600
*fax* (518) 431-7915
http://www.hanys.org

The HANYS membership looks forward to working with your Administration to continue refining the BBA and minimizing the adverse consequences of the additional cuts to be implemented over the next two and one-half years.

Finally, I enjoyed talking with you at Monday's bill signing ceremony and appreciate your interest in the current discussion of New York's future Medicare Disproportionate Share Hospital (DSH) program payments. With your support, I know we can resolve this issue in a manner that protects the access to health care for New York's poor and uninsured.

My best wishes to you and Mrs. Clinton for the holiday season.

Sincerely,

Daniel Sisto
President

DS/clb

cc: John Podesta
Chris Jennings
Barbara Woolley
Mary Beth Cahill

HANYS
HEALTHCARE ASSOCIATION OF NEW YORK STATE

Daniel Sisto, President



November 30, 1999

Honorable Al Gore
Vice President of the United States
The White House
1600 Pennsylvania Avenue, NW
Washington, DC 20500

Dear Vice President Gore:

On behalf of more than 500 hospitals, health systems, and continuing care providers that comprise the Healthcare Association of New York State (HANYS), and the communities they serve, I write to thank you for helping repair some of the unintended consequences of the Balanced Budget Act of 1997 (BBA). The Balanced Budget Refinement Act of 1999, which President Clinton signed into law this week, will return approximately $630 million in Medicare payments to New York State's hospitals and hospital-based continuing care providers over the next five years.

New York State's urban, suburban, and rural hospitals and health care systems – as well as hundreds of thousands of hospital employees, trustees, physicians, and auxiliary volunteers – are grateful for your support and leadership. While this BBA relief represents only a modest percentage of the $5 billion in total BBA cuts to New York State's hospitals, every hospital will receive some short-term relief. It is important to note that the largest restoration for New York's hospitals is the result of the successful efforts to address the across-the-board cut to all hospitals under the proposed outpatient prospective payment system.

We are appreciative of your efforts on our behalf, as well as the hard work of your health policy staff. David Beyer and Sarah Bianchi have been helpful on many issues and I hope you will share HANYS' appreciation with them.

74 N. Pearl Street
Albany, NY 12207

*phone* (518) 431-7600
*fax* (518) 431-7915
http://www.hanys.org

The HANYS membership looks forward to working with the Administration to continue refining the BBA and minimizing the adverse consequences of the additional cuts to be implemented over the next two and one-half years. We also appreciate your interest in the resolution of the current discussion of New York's future Medicare Disproportionate Share Hospital (DSH) program payments in a manner that protects the access to health care for New York's poor and uninsured.

My best wishes to you for the holiday season.

Sincerely,

Daniel Sisto
President

DS/clb

cc: David Beyer
Sarah Bianchi
Chris Jennings
Barbara Woolley

– Chris Jennings 6-5560

cc: Mickey Ibarra DPC

# 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

# FAX TRANSMISSION

HEALTH CARE FINANCING ADMINISTRATION
Office of Legislation
Washington, D.C. 20201
202-690-5510
Fax: 202-690-8168

**To:** Devorah Adler

**Fax #:** 456-5557

**From:** Julie Salz

**Subject:** New Jersey DSH Background info

**Date:** August 4, 1999

**Pages:** , including this cover sheet.

COMMENTS:

Devorah - Attached is background info for tomorrow's meeting on NJ DSH - Let me know if you have any questions.

Nancy Edwards
Ted Tony Lim

## Talking Points on New Jersey PRRB Case

- While the PRRB did rule in favor of the provider in this case, the HCFA Administrator reviewed the PRRB decision and remanded the case to the PRRB. In other words, the Administrator has sent back the case to the PRRB.

- The case was sent back to the PRRB because the Administrator found the PRRB record lacked certain evidence to support their decision. Specifically, the Administrator remanded the case for further development of the record with respect to:

  + (1) whether matching Medicaid Federal Financial Participation (FFP) funds (as opposed to other federal program funds) were paid for individual charity care patients, or (2) whether matching Medicaid FFP funds were paid as part of the Medicaid DSH payment and

  + the legal effect, if any, of the payment, or lack of payment, on the determination of the Medicare DSH calculation.

- The PRRB will now be required to obtain the necessary data and review the case again (Note: There is no timeframe for the PRRB; they may take as long as they need to render a new decision).

**Background**

- This case, Jersey Shore Medical Center v. Blue Cross and Blue Shield Association/Blue Cross of New Jersey, concerns inclusion of charity care days in the calculation of Medicare DSH.

- Under the Medicare prospective payment system, the disproportionate share hospital (DSH) adjustment provides additional payments to hospitals that treat a large number of low-income patients.

- The Medicare statute prescribes specific criteria for calculating DSH payments.

- Under the statute, Medicare DSH payments depend in part on the number of patient days associated with individuals who were "eligible for Medical Assistance [Medicaid]" but not entitled to Medicare Part A.

- The dispute is over whether charity care days should be included in the Medicare DSH calculation.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

FEB 12 1999

The Honorable Robert Menendez
House of Representatives
Washington, D.C. 20515

FEB 16 1999

Dear Mr. Menendez:

Thank you for your letter requesting that I affirm a decision issued by the Provider Reimbursement Review Board (PRRB) concerning charity care days provided by Jersey Shore Medical Center and their inclusion in the calculation of the Medicare disproportionate share adjustment. I reviewed this case carefully, and determined that it should be remanded to the PRRB for further development of some of the facts at issue. I have enclosed a copy of my decision for your information. As you can see, it notes that you and other members of the New Jersey delegation contacted me to urge affirmance of the PRRB.

I want to assure you that this issue has received careful consideration. A similar letter is also being sent to the co-signors of your letter.

Sincerely,

Nancy-Ann Min DeParle
Administrator

Enclosure

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

Washington, D.C. 20201

VIA OVERNIGHT

JAN 4 1999

Joseph D. Glazer, Esq.
Reed Smith Shaw McClay, LLP
Princeton Forrestal Village
136 Main Street, Suite 250
Princeton, NJ 08543-7839

Dear Mr. Glazer:

Re: Jersey Shore Medical Center, PRRB Decision No. 99-D4

Enclosed is a copy of the Administrator's order in the above-captioned case. This order remands this case to the Provider Reimbursement Review Board for further action. The Board's chairman will write you further.

Sincerely,

Jacqueline R. Vaughn
Attorney Advisor

Enclosure

cc: Bernard M. Talbert, Esq., Intermediary's Representative

# HEALTH CARE FINANCING ADMINISTRATION

*Order of the Administrator*

| In the case of: | Claim for: |
|---|---|
| **JERSEY SHORE MEDICAL CENTER**<br>**Provider**<br><br>**vs.**<br><br>**BLUE CROSS AND BLUE SHIELD ASSOCIATION/BLUE CROSS OF NEW JERSEY**<br>**Intermediary** | **Provider Cost Reimbursement Determination of Payment For Cost Reporting Period Ending: 12/31/92**<br><br>**Review of:**<br>**PRRB Decision No. 99-D4**<br>**Dated: 10/30/98** |

This case is before the Administrator, Health Care Financing Administration (HCFA), for review of the decision entered by the Provider Reimbursement Review Board (Board). The review is during the 60-day period in §1878(f)(1) of the Social Security Act (Act), as amended [42 USC 1395oo(f)]. The parties were notified of the Administrator's intention to review the Board's decision. Subsequently, the parties and HCFA's Center for Health Plans and Providers (the Center) commented. Accordingly, the case is now before the Administrator for final administrative decision.

The issue before the Board was whether the Intermediary's calculation of the Provider's disproportionate share hospital (DSH) adjustment was proper. The categories of patient days excluded by the Intermediary from the DSH calculation were: a) days in which the Provider claims a patient had exhausted Medicare Part A benefits, and was then eligible for benefits under the State Medicaid Plan,[1] and b) days for which the patient was eligible for benefits under the State's "Charity Care" plan.

[1] The Administrator notes the ambiguity presented in the Board's statement in the decision that at least some of the disputed days in this category had been administratively settled. See Board's Decision at 3, note 5.

With respect to the first category, the Board found that, where a State's approved Medicaid program assumes responsibility for payment of a provider's inpatient charges, the days associated with those charges are, in fact, "Medicaid days," and that all Medicaid days not paid by Medicare must be included in the "Medicaid proxy" of the DSH formula consistent with the Medicare statute and regulations.

With respect to the second category, the Board found that, while the regulation at 42 CFR 412.106(b)(4) states that the DSH calculation includes days on which the patient is "entitled to Medicaid," §1886(d)(5)(F)(vi)(II) of the Act defines these days as pertaining to patients "eligible for medical assistance under a State plan approved under [title] XIX." The Board determined that the State's Charity Care program was included in the Medicaid State Plan approved under Title XIX of the Social Security Act, and that the State received matching Federal Financial Participation (FFP) funds for this program. Thus, the Board concluded that the Charity Care program is a part of the State's Medicaid plan and that the days for which a patient was eligible for Charity Care benefits are to be included in the numerator of the DSH Medicaid proxy.

The Intermediary requested reversal of the Board's decision with respect to both categories of days. The Center also requested reversal of the Board's decision with respect to both categories of days. The Provider requested affirmance of the Board's decision with respect to both categories of days.[2]

The entire record furnished by the Board has been examined, including all correspondence, position papers, exhibits, and subsequent submissions. All comments received timely are included in the record and have been considered.

Relevant to the issue involved in this case, two Federal programs, Medicare and Medicaid, involve the provision of health care services to certain distinct patient populations. The Social Security Amendments of 1965 established Title XVIII of the Social Security Act, which authorized the establishment of the Medicare program to pay part of the costs of the health care services furnished to entitled beneficiaries. The Medicaid program is a

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[2] By letter dated December 16, 1998, which has been made part of the administrative record, Senators Robert Torricelli and Frank R. Lautenberg and Representatives James Saxton, Bill Pascrell, Steven Rothman, Donald Payne, Frank Pallone, Christopher Smith, Robert Menendez, Marge Roukema, Robert E. Andrews, and Rodney Frelinghuysen requested that the Administrator affirm the Board's decision. In addition, Senator Lautenberg, by a telephone conversation on December 22, 1998, with the Administrator, urged affirmation of the Board's decision.

cooperative Federal-State program that provides health care to indigent persons who are aged, blind or disabled or members of families with dependent children. Medicaid, under Title XIX of the Social Security Act, establishes two eligibility groups for medical assistance: categorically needy and medically needy. In addition to the provision of medical services for Title XIX-eligible individuals, a State plan must take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs, for which payments made by the State and local governmental units to these hospitals may qualify as Medicaid DSH payments, eligible for matching FFP funds.

At its inception in 1965, Medicare paid for the reasonable cost of furnishing covered services to beneficiaries. However, concerned with increasing costs, Congress enacted Title VI of the Social Security Amendments of 1983, which added §1886(d) to the Act and established the prospective payment system (PPS) for reimbursement of inpatient hospital operating costs for all items and services provided to Medicare beneficiaries, other than physician's services, associated with each discharge. Under PPS, hospitals and other health care providers are reimbursed their inpatient operating costs on the basis of prospectively determined national and regional rates for each discharge rather than reasonable operating costs.

Concerned with possible payment inequities for PPS hospitals that treat a disproportionate share of low-income patients, pursuant to §1886(d)(5)(F)(I) of the Act, Congress directed the Secretary to provide, for discharges occurring after May 1, 1986, "for an additional payment amount for each subsection (d) [PPS] hospital" serving "a significantly disproportionate number of low-income patients ...."[3] To be eligible for the DSH payment under the proxy method, a PPS hospital must meet certain criteria concerning, inter alia, its disproportionate patient percentage. Relevant to this case, with respect to the proxy method, Section 1886(d)(5)(F)(vi) of the Act states that the term "disproportionate patient percentage" means the sum of two fractions often referred to as the "Medicare low-income proxy" and the "Medicaid low-income proxy." HCFA implemented the provisions of the Act at 42 CFR 412.106.

In this case, the Provider claims that there are two categories of patient days which the Intermediary improperly excluded from the second computation or Medicaid proxy of the DSH calculation pursuant to §1886(d)(5)(F)(vi)(II) and the regulations at 42 CFR 412.106(b)(4). The first category of patients is described by the Provider as days related to

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[3] Section 9105 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. L. No. 99-272). See also 51 Fed. Reg. 16772, 16773-16776 (1986).

dual eligible patients who have partially exhausted their Medicare Part A benefits. The second category is described by the Provider as "Charity Care" days.

After a review of the record the Administrator finds that the Board's decision in this case should be vacated and the case should be remanded for further development of the record with respect to the "Charity Care days." To avoid bifurcation of the case, the Board's decision as to both categories of days is vacated and both issues are remanded to the Board. Consequently, all aspects of this case with respect to both categories of days are preserved for Administrator review upon the Board's rendering of a new decision pursuant to this remand order.

The Administrator finds that, although the Board made a finding that FFP was paid for the Charity Care days at issue, the evidence is limited to a Provider stipulation. Moreover, having made a finding that FFP was paid, the Board did not determine whether the FFP was for the services rendered to the individual Charity Care patient or was a payment made pursuant to the Medicaid DSH provisions for hospitals that serve a disproportionate share of low-income patients.[4]

Consequently, the Administrator remands this case for further development of the record with respect to: 1) whether matching Medicaid FFP funds (as opposed to other Federal program funds)[5] were paid for individual charity care patients, or 2) whether matching Medicaid FFP funds were paid as part of the Medicaid DSH payment and 3) the legal effect, if any, of the payment, or lack of payment, on the determination of the Medicare DSH calculation.

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[4] In stating that matching FFP was paid by the State for Charity Care patients, the Provider referred to that section of the State plan addressing Medicaid DSH payments. Of note, the Superior Court of New Jersey, in County of Camden v. Waldman, 292 N.J. Super.268 (1996), has recognized that FFP for matching DSH payments are not 'Medicaid payments in the sense they cover identifiable costs of individual patients but rather, Medicaid DSH payments are help to cover the extraordinary costs of those hospitals which serve a particular high number of indigent patients whether Medicaid and Medicare eligible or not.

[5] The Administrator notes that the State plan requires reduction of the Charity Care compensation for hospitals that failed to meet their Hill-Burton obligations, a program recognized as a separate and distinct program from both the Medicare and Medicaid program, with separate and distinct goals and obligations.

Accordingly, the Administrator orders:

THAT the Board's decision is hereby vacated and that the case is remanded for further development of the record in accordance with the foregoing opinion; and

THAT the Board will issue a new decision in accordance with the provisions of Section 1878 of the Act and the regulations at 42 CFR 405.1801, et seq.

Date: Jan. 4, 1999

Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration



**Pennsylvania Disproportionate Share Hospital (DSH) Payments**
**Questions and Answers**
**FOR INTERNAL USE ONLY**
**HCFA Legislative Office Final -- March 5, 1999**

**Background:** Under the Medicare prospective-payment system, the disproportionate share hospital (DSH) adjustment provides additional payments to hospitals that treat a large number of low-income patients. The Medicare statue prescribes specific criteria for calculating DSH payments. Under the statute, DSH payments depend in part on the number of patient davs associated with individuals who were "eligible for medical assistance under [Medicaid]" but were not entitled to Medicare part A. HCFA believes that Medicare DSH adjustments dating back to 1986 were incorrectly calculated in Pennsylvania because so-called "general assistance" days were included in the DSH payment calculations. General assistance days are patient days associated with individuals receiving help under non-Medicaid, state-only assistance programs. It appears that the hospitals have received payments that are inconsistent with the applicable laws, regulations and audit instructions to not count general assistance days in DSH calculations. We have also been told that some hospitals calculated the adjustments correctly but were instructed by the fiscal intermediaries to include general assistance days in their DSH calculations, but we have not confirmed this assertion. About 79 Pennsylvania hospitals receive DSH payments. Total overpayments subject to recoupment are estimated at about $95 million. This estimate is for cost reporting years (CRY) unsettled (principally CRY 1997 and 1998) and those cost reporting years subject to reopening (up to three years following Notice of Program reimbursements (NPRs)).

**Hill Talking Points**

We are aware of and concerned about the problem in Pennsylvania. We want to bring you up to date on the following events:

1) 50 to 60 "demand" letters have been issued by the fiscal intermediary. Demand letters are issued any time an overpayment is found to exist. While hospitals can not formally appeal demand letters, they can raise any objections they may have with the fiscal intermediary as well as the Regional Office on an informal basis. After receiving demand letters, hospitals can develop repayment plans.

2) Once hospital cost reports are finally settled, the fiscal intermediary issues Notice of Program Reimbursements (NPRs). To date, six NPRs have been issued to Graduate Hospital, Philadelphia, Hahnemann Hospital, Philadelphia, Elkins park, Philadelphia, Medical College, Philadelphia, City Avenue, Philadelphia, and Allegheny Hospital, Pittsburgh.

3) The hospitals have a right to appeal a NPR within 180 days of the notice of program reimbursement.

4) Hospitals will likely receive notices of adjustments to their interim payments to adjust for exclusion of general assistance days for this fiscal year. The intermediaries should begin making the interim rate adjustments shortly and will average 10-15 adjustments per month. The intermediaries must complete the adjustments by September, 1999.

5) The fiscal intermediary has acknowledged that corrective action needs to be taken. The statute authorizes and requires inclusion of medical assistance days (Medicaid only); to the extent that

general assistance days were improperly included for an individual hospital, the hospital has received excess payments. If the intermediary determines that a hospital has been overpaid, then the intermediary must recoup the overpayment in accordance with the applicable rules.

6) We are obligated to follow the statutory and regulatory process for overpayments.

7) We will do everything we can to ensure that care for Medicare beneficiaries and other patients is not disrupted because of this problem.

**Questions and Answers**

Q. **Wasn't there a similar case in New Jersey where the Provider Reimbursement Review Board (PRRB) ruled in favor of the provider?**

A. The case that you refer to is Jersey Shore Medical Center v. Blue Cross and Blue Shield Association/Blue Cross of New Jersey. This case concerns inclusion of "charity care days" in the calculation of Medicare DSH. While the PRRB did rule in favor of the provider, the HCFA Administrator reviewed the PRRB decision and remanded the case to the PRRB. In other words, the Administrator has sent back the case to the PRRB because the Administrator found the PRRB record lacked certain evidence to support their decision. The PRRB will be required to issue a new decision, however they may take as long as they need to render a new decision.

Q. **What happens once the fiscal intermediaries ask for the money back?**

A. Thirty days after a fiscal intermediary issues a demand letter, the fiscal intermediary begins to recover the overpayment. This can be done by withholding future payments to the provider. The provider has 15 days from the issuance of the demand letter to develop a plan to repay the money, and once the 30-day period ends, the provider must begin paying interest, which by law is currently 13.75 percent. The provider can appeal the fiscal intermediary's decision to the Provider Reimbursement Review Board (PRRB) within 180 days of the notice of program reimbursement. While the appeal is pending before the PRRB, the provider must return the money to the fiscal intermediary. Once the PRRB rules, the HCFA Administrator may reverse, modify or affirm the board's decision or remand the matter back to tne PRRB for further proceedings. If the final decision is unfavorable to the provider, the provider can appeal in federal district court.

Q. **If the fiscal intermediaries gave incorrect instructions to the providers, isn't it unfair of the government to now demand the money back?**

A. The statute requires and authorizes inclusion of Medicaid days. If DSH payments to a hospital improperly reflect general assistance days, then the hospital has received payments that are inconsistent with the statute. We are reviewing what instructions the fiscal intermediaries provided to the hospitals.

Q. **Some hospitals say they may have to declare bankruptcy if HCFA demands that they pay the money back. What will happen to Medicare beneficiaries and other people who depend on these hospitals?**

A. We will do everything we can to ensure that care for Medicare beneficiaries and other patients is not disrupted. At the same time, we have to meet our obligations to safeguard Medicare's resources . We understand what's at stake for the hospitals, and we're trying to find a solution. Also, DSH payments are a small portion of total Medicare payments to hospitals and represent between 1 percent and 6 percent of total Medicare payments of the affected Pennsylvania hospitals.

Q. **Have the fiscal intermediaries asked any hospitals to pay back the money yet?**

A. The fiscal intermediaries have advised us that several hospitals have been asked to repay a portion of the overpayments.

Q. **Does the problem exist in any other state?**

A. We have determined that Pennsylvania is the only state where general assistance days were included in the DSH calculations.

Q. **What will you do to the fiscal intermediaries if you confirm they gave incorrect information to the hospitals?**

A. This situation is a good example of why we need contracting reform legislation. Current law prevents the Government from taking any action of recovery against the contractor unless it is found that the contractor was grossly negligent or intended to defraud the United States. The only options available to the Government are to non-renew a contract at the end of its current term or terminate a contract. Either action is costly and procedurally onerous. The problem is exacerbated by the fact that the pool of contractors available to us to assume the duties of a departing contractor is shrinking. This is because current law restricts the types of entities with which we can contract -- another reason we would like contracting reform. We've asked Congress to give us additional tools to hold Medicare contractors accountable, but so far Congress has not enacted the changes we have requested. The changes include authority to contract with a wider range of entities to administer the program and would allow us to terminate poor-performing contractors and transfer the workload more expeditiously.

Q. **How could this possibly go on for 12 years undetected?**

A. HCFA discovered this problem during an audit of the Pennsylvania contractors. This is another example of how additional funding for contractor oversight would help prevent this kind of situation. Medicare processes more than a billion claims and provides more than $200 billion in benefits each year. But currently, Medicare's administrative costs are about 1 percent -- far smaller than private-sector insurers.

# FAX COVER SHEET

## OFFICE OF LEGISLATION

Number of Pages: C+7 Date: 8/2/99

To: Deborah Adler

Fax: 456-5557 Phone: _____

From: **Jennifer Boulanger**
email: **JBoulanger@HCFA.GOV**

Fax: **202-690-8168**

Phone: **202-690-5705**

REMARKS: Various letters/draft letters, internal talking points, FYI

**HEALTH CARE FINANCING ADMINISTRATION**
200 Independence Ave., SW
Room 341-H, Humphrey Building
Washington, DC 20201

DEPARTMENT OF HEALTH & HUMAN SERVICES

OCT - 1 1998

The Honorable Arlen Specter
United States Senate
Washington, DC 20510

Dear Senator Specter:

Thank you for your letter regarding the calculation of Medicare disproportionate share (DSH) payments for Pennsylvania hospitals. You have specifically asked that HCFA revise its decision to disallow inclusion of General Assistance days when calculating Medicare DSH payments. I want to assure you that I understand your concerns and those of the Pennsylvania delegation, and want you to know how this matter will be addressed.

First, let me make clear that it was not HCFA's decision to disallow inclusion of General Assistance days when calculating DSH payments. Rather, the calculation of Medicare DSH payments is established by statute. Section 1886(d)(5)(F)(vi)(I) of the Social Security Act establishes a formula that includes "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 title XIX." General Assistance days are not "patient days . . . eligible for medical assistance under a State plan approved under title XIX." That is, they are not Medicaid days under the statute. Therefore, hospitals are not entitled to claim General Assistance days toward the calculation of Medicare DSH payments.

While the law on this subject is clear, I understand that some of the facts surrounding this situation remain to be determined by the fiscal intermediary. Nonetheless, it appears likely that General Assistance days have been erroneously included in the calculation since the Medicare DSH adjustment began with the hospitals' 1986 cost reports. There are three stages of cost report settlement -- (1) closed, not subject to reopening by the fiscal intermediary; (2) closed but subject to reopening by the fiscal intermediary during a 3-year period following the closure; and (3) open and being settled by the fiscal intermediary. The stage of the settlement determines the action of the fiscal intermediary in this case.

For those cost reports that are closed and not subject to reopening, the fiscal intermediary will not take any action to recover the very considerable sums which I understand that the hospitals received in extra payments from Medicare. I expect that a considerable proportion of the payments at issue here will fall in this category.

For cost reports that are closed and within the 3-year reopening period, the fiscal intermediary has discretion whether not to reopen (42 CFR 405.1885(a)). See Your Home Visiting Nurse Services, Inc. v. Shalala 132 F.3d 1135 (6th cir. 1997), cert. granted, 66, U.S.L.W. 3789 (U.S. June 125, 1997 (No. 97-1489). In exercising that discretion, the intermediary must consider whether reopening is appropriate under criteria prescribed in program operating instructions. Also, the intermediary must give the hospitals adequate notice and opportunity to submit comments and evidence as to any reopening. In finally determining whether to reopen, the intermediary must decide whether reopening is appropriate given the prescribed criteria, the hospitals' submissions, and the totality of the relevant circumstances (42 CFR 405.1887). If the intermediary does reopen and the hospitals are dissatisfied with the result, they may exercise their appeal rights. Their appeal would be to the Provider Reimbursement Review Board (42 CFR 405.1889).

Finally, for those cost reports that are still open, the fiscal intermediary is bound to apply the statute that defines what may be included in the Medicare DSH calculation. Under the statute, neither I nor the fiscal intermediary have the authority to forgive this debt.

I regret this response cannot be more favorable. Should you choose to explore a legislative solution, we would be glad to provide you with any assistance you may require. With best regards,

Sincerely,

Nancy-Ann Min DeParle
Administrator

DRAFT

not yet sent out - FYI only.

The Honorable William J. Coyne
House of Representatives
Washington, D.C. 20515

Dear Mr. Coyne:

Thank you for your letters regarding the calculation of Medicare disproportionate share (DSH) payments for Pennsylvania hospitals. In addition, I appreciate you sending the information regarding the Provider Reimbursement Review Board (PRRB) hearing decision on Jersey Shore Medical Center v. Blue Cross of New Jersey. I regret the delay in my response, however I do want to update you on the current status of this issue.

As we stated in our previous letter, general assistance days are not "patient days...under a state plan approved under Title XIX." Days that are utilized by state-only eligibility groups, for which no Federal participation is available, are not considered to be Medicaid days under title XIX, and therefore cannot be included in the calculation of Medicare DSH.

It appears that DSH hospitals in Pennsylvania have received payments that are inconsistent with the laws and regulations to not count general assistance days in DSH calculations. Therefore, in accordance with applicable rules, the fiscal intermediaries have begun 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 can not formally appeal recoupment letters, they can raise their concerns with the fiscal intermediary as well as the HCFA Regional Office on an informal basis.

Once 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 a 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.

In addition, as you stated in your letter, the PRRB did rule in favor of the provider in the Jersey Shore Medical Center v. Blue Cross of New Jersey case concerning inclusion of "charity care days" in the calculation of Medicare DSH. However, after careful consideration, I decided to remand this case to the PRRB because I found the PRRB record lacked certain evidence to support their decision. The PRRB will now be required

to obtain the necessary data and review the case again.

I regret that my answer could not be more favorable at this time. 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,

Nancy-Ann Min DeParle
Administrator

**Pennsylvania Disproportionate Share Hospital (DSH) Payments**
**Questions and Answers**
**FOR INTERNAL USE ONLY**
**HCFA Legislative Office Final – March 5, 1999**

**Background:** Under the Medicare prospective-payment system, the disproportionate share hospital (DSH) adjustment provides additional payments to hospitals that treat a large number of low-income patients. The Medicare statue prescribes specific criteria for calculating DSH payments. Under the statute, DSH payments depend in part on the number of patient days associated with individuals who were "eligible for medical assistance under [Medicaid]" but were not entitled to Medicare part A. HCFA believes that Medicare DSH adjustments dating back to 1986 were incorrectly calculated in Pennsylvania because so-called "general assistance" days were included in the DSH payment calculations. General assistance days are patient days associated with individuals receiving help under non-Medicaid, state-only assistance programs. It appears that the hospitals have received payments that are inconsistent with the applicable laws, regulations and audit instructions to not count general assistance days in DSH calculations. We have also been told that some hospitals calculated the adjustments correctly but were instructed by the fiscal intermediaries to include general assistance days in their DSH calculations, but we have not confirmed this assertion. About 79 Pennsylvania hospitals receive DSH payments. Total overpayments subject to recoupment are estimated at about $95 million. This estimate is for cost reporting years (CRY) unsettled (principally CRY 1997 and 1998) and those cost reporting years subject to reopening (up to three years following Notice of Program reimbursements (NPRs)).

**Hill Talking Points**

We are aware of and concerned about the problem in Pennsylvania. We want to bring you up to date on the following events:

1) 50 to 60 "demand" letters have been issued by the fiscal intermediary. Demand letters are issued any time an overpayment is found to exist. While hospitals can not formally appeal demand letters, they can raise any objections they may have with the fiscal intermediary as well as the Regional Office on an informal basis. After receiving demand letters, hospitals can develop repayment plans.

2) Once hospital cost reports are finally settled, the fiscal intermediary issues Notice of Program Reimbursements (NPRs). To date, six NPRs have been issued to Graduate Hospital, Philadelphia, Hahnemann Hospital, Philadelphia, Elkins park, Philadelphia, Medical College, Philadelphia, City Avenue, Philadelphia, and Allegheny Hospital, Pittsburgh.

3) The hospitals have a right to appeal a NPR within 180 days of the notice of program reimbursement.

4) Hospitals will likely receive notices of adjustments to their interim payments to adjust for exclusion of general assistance days for this fiscal year. The intermediaries should begin making the interim rate adjustments shortly and will average 10-15 adjustments per month. The intermediaries must complete the adjustments by September, 1999.

5) The fiscal intermediary has acknowledged that corrective action needs to be taken. The statute authorizes and requires inclusion of medical assistance days (Medicaid only); to the extent that

general assistance days were improperly included for an individual hospital, the hospital has received excess payments. If the intermediary determines that a hospital has been overpaid, then the intermediary must recoup the overpayment in accordance with the applicable rules.

We are obligated to follow the statutory and regulatory process for overpayments.

7) We will do everything we can to ensure that care for Medicare beneficiaries and other patients is not disrupted because of this problem.

## Questions and Answers

**Q. Wasn't there a similar case in New Jersey where the Provider Reimbursement Review Board (PRRB) ruled in favor of the provider?**

A. The case that you refer to is Jersey Shore Medical Center v. Blue Cross and Blue Shield Association/Blue Cross of New Jersey. This case concerns inclusion of "charity care days" in the calculation of Medicare DSH. While the PRRB did rule in favor of the provider, the HCFA Administrator reviewed the PRRB decision and remanded the case to the PRRB. In other words, the Administrator has sent back the case to the PRRB because the Administrator found the PRRB record lacked certain evidence to support their decision. The PRRB will be required to issue a new decision, however they may take as long as they need to render a new decision.

**Q. What happens once the fiscal intermediaries ask for the money back?**

A. Thirty days after a fiscal intermediary issues a demand letter, the fiscal intermediary begins to recover the overpayment. This can be done by withholding future payments to the provider. The provider has 15 days from the issuance of the demand letter to develop a plan to repay the money, and once the 30-day period ends, the provider must begin paying interest, which by law is currently 13.75 percent. The provider can appeal the fiscal intermediary's decision to the Provider Reimbursement Review Board (PRRB) within 180 days of the notice of program reimbursement. While the appeal is pending before the PRRB, the provider must return the money to the fiscal intermediary. Once the PRRB rules, the HCFA Administrator may reverse, modify or affirm the board's decision or remand the matter back to the PRRB for further proceedings. If the final decision is unfavorable to the provider, the provider can appeal in federal district court.

**Q. If the fiscal intermediaries gave incorrect instructions to the providers, isn't it unfair of the government to now demand the money back?**

A. The statute requires and authorizes inclusion of Medicaid days. If DSH payments to a hospital improperly reflect general assistance days, then the hospital has received payments that are inconsistent with the statute. We are reviewing what instructions the fiscal intermediaries provided to the hospitals.

**Q. Some hospitals say they may have to declare bankruptcy if HCFA demands that they pay the money back. What will happen to Medicare beneficiaries and other people who depend on these hospitals?**

We will do everything we can to ensure that care for Medicare beneficiaries and other patients is not disrupted. At the same time, we have to meet our obligations to safeguard Medicare's resources . We understand what's at stake for the hospitals, and we're trying to find a solution. Also, DSH payments are a small portion of total Medicare payments to hospitals and represent between 1 percent and 6 percent of total Medicare payments of the affected Pennsylvania hospitals.

**Q. Have the fiscal intermediaries asked any hospitals to pay back the money yet?**

A. The fiscal intermediaries have advised us that several hospitals have been asked to repay a portion of the overpayments.

**Q. Does the problem exist in any other state?**

A. We have determined that Pennsylvania is the only state where general assistance days were included in the DSH calculations.

**Q. What will you do to the fiscal intermediaries if you confirm they gave incorrect information to the hospitals?**

A. This situation is a good example of why we need contracting reform legislation. Current law prevents the Government from taking any action of recovery against the contractor unless it is found that the contractor was grossly negligent or intended to defraud the United States. The only options available to the Government are to non-renew a contract at the end of its current term or terminate a contract. Either action is costly and procedurally onerous. The problem is exacerbated by the fact that the pool of contractors available to us to assume the duties of a departing contractor is shrinking. This is because current law restricts the types of entities with which we can contract -- another reason we would like contracting reform. We've asked Congress to give us additional tools to hold Medicare contractors accountable, but so far Congress has not enacted the changes we have requested. The changes include authority to contract with a wider range of entities to administer the program and would allow us to terminate poor-performing contractors and transfer the workload more expeditiously.

**Q. How could this possibly go on for 12 years undetected?**

A. HCFA discovered this problem during an audit of the Pennsylvania contractors. This is another example of how additional funding for contractor oversight would help prevent this kind of situation. Medicare processes more than a billion claims and provides more than $200 billion in benefits each year. But currently, Medicare's administrative costs are about 1 percent -- far smaller than private-sector insurers.

10/19

proposal:
Supreme Court Case?

Anna
Jennifer B.
Jane

Instead of surgical removal blanket instruction to financial intermediaries want to look more closely — instructions to FIs re: reopening cost reports they wouldn't open; time limited instructions

open instruct FIs to not issue notices of reimbursement to those entities; time limited. do whatever audit wk they need to do

reg. authority

HCFA ≠ DOJ?
just HCFA
don't know
whether
DOJ is involved

oney (97-2)
on letter;
says we need
to adjust.

could justice
overrule? or
IG?

PA claims to
have recieved
some notices.

general
asst.
days in DSH
calculations

closed - total
open
closed subj.
reopening

questions
re: consistency
of application
nationally.

Specter conceded
that case is
much harder
after ruling.
this oney applies
to pre ruling.

97-02 (2/97)
ruling
applicable
retrospectively,
but PA only
prospective.

HCFA's position
is that this
has always
been clear.

reopen cost
report allows
for 3 years

Cost reporting
proper need
to reopen 1 full
year of cost
reports

this is likely
to cause
concern—

do we need
to notify?
probably.

$300 M liability?

no scoring off
our baseline—

if we recapture
baseline 4
PA
NY
AZ prob in
1st years
since 1990 ok

| | |
|---|---|
| AZ precedent? no way to disentangle QA from MC RO decided not to go after them. | uncomfortable w/ policy forgive retrosp. allow prosp. & clarify to say meant all the time. |
| conedit letter threaten but provide moratorium. | moratorium buys goodwill & time |
| Cost reporting people want to contain it to FY cycle. | go to RO & find out what we're approved. |
| Dept recommend open & closed? | do we need to collect if we don't do this. Yes. |

both FIs have allowed this to happen — lax on audits then they picked up.

extent to which 5-7 states have this problem.

someone should call the IG → they'll start drafting something.

briefing & letter on Th. conclusion focused on 97 ruling; no statement in this letter re: open & closed.

hospitals not properly claiming it.

Omaha still lax, FYI

Spector & Santorum.

PA DSH — 10·21

HCFA –
theres nothing
in this documentation
that shows
they're right

argument
continues to
be that they were
given the wrong
#s; no clear
direction

submitted ≠
approved →
= direction for
them.

statute doesn't
reference #
days.

MC DSH can
compensate
high volume
MC hospitals
OR high rates
of uninsured.

GA days are
a proxy for
high rates
of uninsures

GA days can
push someone
over the edge
to make them
a DSH hospital

that's not how Medicare works

so everything they've submitted is irrelevant to the Statute

QA med prog out of same office as MC prog. this is inextricable

intent of leg NOT to include addtl days.

call Diane & Bill Vaughn to check.

1 year moratorium letter from HCFA to all FIs.

confusion around QA 97-02

if cost report filed before 97-2, hold unless 3 year period due to expire.

after 97-02, we will collect?

HHS-yes OMB-yes

all post 97 & prospective will be subject to recoupment.

want to deal w/ this legislatively next year → bandaid.

this only fixed ½ of PAs prob.

how can we push this off?

this letter doesn't suggest that their past liability is waived, even.

intermediaries settle after extended time period.

Clarify in letter that this doesn't indemnify them from action

In the meantime hospitals get interim estimated payments.

this is just one aspect of overall payment

Chris wants to soften.

okay in future to be hard; but wants to be soft on moratorium notice

can't go past this week - CHRIS wanted tomorrow.

Dan doesn't want this to be too open.

FIs haven't been reviewing since 97 consistency issues.

Chris wants draft.

out by Friday.

# THE WHITE HOUSE

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

DATE: 10/19

TO: Chris Jennings

FAX: 6-5557

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

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

SUBJECT: FYI - Please forward to appropriate HHS people

1 OF 12

10/20/98 TUE 07:01 FAX
10/19/98 13:38 FAX 001 002

COMMITTEE ON COMMERCE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
RANKING MEMBER
SUBCOMMITTEE ON TELECOMMUNICATIONS, TRADE AND CONSUMER PROTECTION

RON KLINK
Congress of the United States
House of Representatives
19th District, Pennsylvania

FAX: (202) 226-2274

WASHINGTON OFFICE:
125 CANNON BUILDING
WASHINGTON, DC 20515
(202) 225-2565

DISTRICT OFFICES:
NORTH HUNTINGDON TOWNSHIP
(412) 864-8581
(800) 453-5078

BEAVER COUNTY
(412) 728-3005

CRANBERRY TOWNSHIP
(412) 772-6080

NEW CASTLE
(412) 656-8036

LOWER BURRELL
(412) 335-4518

TO: Chuck Brain

FROM:
___ Honorable Ron Klink
___ James Bresner
___ Joe Brimmeier
___ Mary Kiernan
___ Peter Madaus
___ Kevin Kinross
___ ~~Emmett O'Keefe~~, Morna Miller & Debbie Tekavic
(Cayuga) (Munhall)
___ Beth Osborne
___ Charles Territo

DATE: _____

FAX NUMBER: _____

SUBJECT: _____

Number of Pages, including cover: 11

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COMMENTS:

Here is some documentation to support our claim. Call if you have any questions.

Emmett

# Congress of the United States
Washington, DC 20515

October 19, 1998

Mr. Charles Brain
House Liaison
The White House
1600 Pennsylvania Avenue, N.W.
Washington, D.C. 20500

Dear Mr. Brain:

This letter is to follow up on our meeting last Thursday. Enclosed are two sets of documents: one from the Pennsylvania Department of Public Welfare, and one from Bob Lux, the Chief Financial Officer of the Temple University Health System. The documents show that the Health Care Financing Administration (HCFA) approved Pennsylvania's definition of Medical Assistance, which included General Assistance (GA) patients, and that the hospitals included GA days in their Medicare Disproportionate Share (DSH) calculations because they were instructed to do so by the fiscal intermediaries (FI).

As the letter from Robert Zimmerman, the Deputy Secretary for Medical Assistance Programs in Pennsylvania, explains, Pennsylvania discussed its GA program with HCFA officials in some detail when they amended the Title XIX State Plan. Based on that discussion and HCFA's approval of the amended state plan, it is clear that HCFA and its intermediaries were fully aware of the nature and structure of Pennsylvania's GA program.

The materials from Mr. Lux clearly show that hospitals included GA days on FI instructions. The state issues a Medical Assistance Management Information System (MAMIS) report which lists all Medical Assistance patients, whether they are funded by the state or federal government. The GA patients are coded differently than patients that are federally funded. When auditing hospitals, the FI required that the total number of Medical Assistance days reported for Medicare DSH match the total number of days shown on MAMIS. As you can see on the audited reports for Lower Bucks Hospital, if the number of Medical Assistance days reported on the hospital's cost reports did not match the totals in the MAMIS report, the FI changed the number on the cost reports.

As we have discussed, HCFA's decision to recoup these payments will have a devastating impact on Pennsylvania's safety net hospitals. HCFA officials have told us several times that the law clearly states that GA days are not to be included. On the contrary, the enclosed documents show that, for the past 12 years, the FI not only knew but took affirmative steps to ensure that GA days were included by requiring the hospital cost reports to match the MAMIS totals, which included separately coded GA patients. That should at least indicate that the law is not clear.

We trust that this documentation, which addresses two of the key issues raised in our meeting, will allow the Administration to resolve this problem in a way that will protect Pennsylvania's safety net hospitals. We would appreciate your advice about who else should receive copies of these materials. Thank you very much for your assistance in this matter.

Sincerely,

William J. Coyne
Member of Congress

Ron Klink
Member of Congress

John P. Murtha
Member of Congress

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
P.O. BOX 2675
HARRISBURG, PENNSYLVANIA 17105-2675

Robert S. Zimmerman, Jr.
Deputy Secretary for Medical Assistance Programs

Telephone 717/787-1870
Facsimile 717/787-4639

OCT 16 1998

Ms. Becky Halkias
Pennsylvania Governor's Washington Office
444 North Capitol Street #700
Hall of the States
Washington, D.C. 20001

Dear Ms. Holkias:

On March 19, 1993, the Pennsylvania Department of Public Welfare sought approval from the Health Care Financing Administration (HCFA) to amend its state plan to implement an additional disproportionate share payment for hospitals that serve low income patients who do not qualify for benefits under the AFDC or Medicaid Programs. These individuals receive cash assistance benefits under the Commonwealth's General Assistance (GA) Program.

In response, HCFA specifically acknowledged that it was possible to include this GA population as allowable in determining the eligibility of the hospital for a disproportionate share adjustment. Pennsylvania needed to classify GA recipients as "low income" patients in its state plan amendment (see enclosure #1).

The Department specifically included such language in Attachment 4.19A, Page 25 of State Plan Amendment (SPA) Number 93-03 (see paragraph two of enclosure #2). SPA Number 93-03 was approved by HCFA effective February 14, 1993; approval date June 23, 1993.

I believe that this clearly demonstrates HCFA's awareness of the Commonwealth's GA Program.

Sincerely,

Robert S. Zimmerman, Jr.

Enclosures

Title XIX Plan Amendment
Approved June 23, 1993.

Enclosure 2

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT ATTACHMENT 4.19A
STATE: COMMONWEALTH OF PENNSYLVANIA Page 25
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT HOSPITAL CARE

ADDITIONAL DISPROPORTIONATE SHARE PAYMENT

The state's methodology used to take into account the situation of disproportionate share hospitals also includes additional payments to meet the needs of those facilities which serve a large number of medical assistance eligible, low income patients, including those eligible for general assistance, who other providers view as financially undesirable. These payments are available to hospitals on behalf of certain low-income persons who are described below and are made in addition to, and not as a substitute for, disproportionate share payments described in other portions of this state plan.

These additional payment adjustments are made by the Department to disproportionate share hospitals who have provided services to persons determined to be low-income by reasoning of their having met the income and resource standards for the state's General Assistance Program. These persons must have demonstrated to the Department that their household income and resources do not exceed the income and resource standards established by the Department such standards being equal to or more restrictive than those for the Aid to Families with Dependent Children (AFDC) program.

Each hospital will determine that patients qualify as low-income persons eligible for additional payments by a verifiable process subject to the above eligibility conditions. Each hospital must maintain documentation of the patients eligibility for additional payments and must document the amounts claimed for additional payments.

A disproportionate share hospital for purposes of receiving additional disproportionate share payments under this provision is any hospital which furnishes medical care to a qualified low-income person without expectation of payment from the person due to the patients inability to pay as documented by his or her having met the income and resource standards for the General Assistance Program as set forth above. In addition, a disproportionate share hospital (except hospitals serving an inpatient population predominately comprised of persons under 18 years of age and hospitals which did not offer non-emergency obstetrical care on or before December 21, 1987) must have at least two obstetricians with staff privileges who have agreed to provide obstetrical care in services to Medicaid-eligible patients on a non-emergency basis.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: COMMONWEALTH OF PENNSYLVANIA
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT HOSPITAL CARE

ATTACHMENT 4.19A
Page 26

The amount of this disproportionate share adjustment will vary by hospital and reflect the dollar amount of payments from the state to the hospital for services provided to low-income patients. For each hospital such adjustment shall be paid in the normal medical assistance payment process and according to established rates or fees. To receive payment of this adjustment, each hospital must submit a claim in the form and manner specified by the Department.

Disproportionate share payments eligible for federal financial participation under this Plan cannot exceed the state disproportionate share allotment calculated in accordance with the provisions of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (42 U.S.C. 1396(w) et seq.).

TN# 93-03
Supersedes
TN# New

Approval Date JUN 23 1993

Effective Date 02-14-93

Temple University
Health System

Financial Administration

3401 N. Broad Street
Philadelphia, PA 19140-5189

October 16, 1998

Ms. Rebecca Halkias
Federal Affairs Deputy Chief of Staff
Commonwealth of Pennsylvania
444 N. Capitol St., NW, Ste. 700,
Washington, DC 20001

Dear Ms. Halkias:

Your office has request a clarification of the process by which the Medicare Fiscal Intermediary would certify a provider's Medicare Cost Report and how that process has historically resulted in the inclusions of the Commonwealth's General Assistance Medical Assistance recipients in the Medicare Disproportionate Share calculation.

In preparing a Medicare Cost Report, a hospital provider is required to report patient day statistics for both Medicare and Medical Assistance recipients. In the Commonwealth of Pennsylvania the Medicare Fiscal Intermediary would certify the reported Medical Assistance patient day statistic by comparing it with the Medical Assistance payment summaries. These summaries currently known as "MAMIS" reports contain payment statistics for all patient days (Title XIX days as well as General Assistance days) paid to the provider by the Medical Assistance program. As a result of this action, the provider's Medicare cost reports have been routinely certified by the Medicare Fiscal Intermediary to include the General Assistance patient days in the Medicare Disproportionate Share Calculation. It is important to note that the eligibility classification of the recipient was transparent to the hospital provider given that the Medical Assistance program in the Commonwealth of Pennsylvania historically did not incorporate any meaningful differences between the programs in regard to benefits, payments, or process. This has essentially been the practice in the Commonwealth of Pennsylvania since the beginning of the Disproportionate Share Program.

Attached are selected examples that clearly show the Fiscal Intermediary adjusting the provider submitted days to the MAMIS reports.

If you require any additional information please contact me at (215) 707-3802.

Sincerely,

Robert H. Lux, CPA
Vice President and Chief Financial Officer

Cc: Leon S. Malmud, MD
Paul H. Boehringer
Martha Casey

# Withdrawal/Redaction Marker
## Clinton Library

| DOCUMENT NO. AND TYPE | SUBJECT/TITLE | DATE | RESTRICTION |
|---|---|---|---|
| 003. report | re: personal medical (2 pages) | 10/20/1998 | P6/b(6) |

**COLLECTION:**
Clinton Presidential Records
Domestic Policy Council
Devorah Adler
OA/Box Number: 20465

**FOLDER TITLE:**
Pennsylvania DSH [Disproportionate Share Hospital] [Folder 2]

2012-0463-S
rc813

**RESTRICTION CODES**

*Presidential Records Act - [44 U.S.C. 2204(a)]*

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

*Freedom of Information Act - [5 U.S.C. 552(b)]*

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

Independence Blue Cross
Version 1.08

HCFA-2552-89 Desk Review Adjustment Report

Run Date: 03/06/95 Page: 1

Provider Name: LOWER BUCKS HOSPITAL
Provider Number: 39-0079

Fiscal Period: 07/01/93 TO 06/30/94

| ADJ # | W | P | F | T | LINE | COL | A/B LTR | Explanation of Audit Adjustments | AS Reported | Increase/ Decrease | AS Adjusted | W/P Ref | Report Ref |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | S3 | 1 | - | - | 101 | 5 | | ADULTS & PEDIATRICS | 3,837 | 303 | 4,140 | 3A | 1 |
| 1 | S3 | 1 | - | - | 2 | 5 | | ICU | 277 | 22 | 299 | 3A | 2 |
| 1 | S3 | 1 | - | - | 3 | 5 | | CCU | 133 | 10 | 143 | 3A | 3 |
| 1 | S3 | 1 | - | - | 7 | 5 | | NURSERY | 556 | 44 | 598 | 3A | 4 |
| 1 | S3 | 1 | - | - | 8 | 5 | | TOTAL | 4,801 | 379 | 5,180 | 3A | 5 |
| | | | | | | | | To adjust Medicaid Days to reflect the HANIS Report. | | | | | |
| 2 | D | - | - | - | D | 8 | | MEMO ADJUSTMENT | 0 | 0 | 0 | | 6 |
| | | | | | | | | The following amounts should be used when calculating the IME adjustment: | | | | | |
| | | | | | | | | Interns/Residents 2 | | | | | |
| | | | | | | | | Beds 197 | | | | | |
| | | | | | | | | CFR 413.118 | | | | | |
| 3 | A | - | - | - | 98 | 2 | | OTHER CAPITAL COST | 0 | 23,812 | 23,812 | A7-1 | 7 |
| 3 | A | - | - | - | 7 | 2 | | MAINTENANCE & REPAIRS | 1,726,996 | -23,812 | 1,703,184 | A7-1 | 8 |
| | | | | | | | | To properly record Other Capital Costs in accordance with PRM 2807. | | | | | |
| 4 | A | - | - | - | 606 | 2 | | ADMINISTRATIVE & GENERAL | 3,088,856 | -352,767 | 2,736,089 | A7-1 | 9 |
| 4 | A | - | - | - | 88 | 2 | | INTEREST EXPENSE | 0 | 352,767 | 352,767 | A7-1 | 10 |
| | | | | | | | | To properly record interest expense in accordance with CFR 413.56. | | | | | |
| 5 | A | - | - | - | 1 | 2 | | OLD CAPITAL-BUILDINGS & FIXTURES | 829,389 | -111,443 | 717,946 | A7-1 | 11 |
| 5 | A | - | - | - | 2 | 2 | | OLD CAPITAL-MOVEABLE EQUIPMENT | 980,645 | 265,203 | 1,245,848 | A7-1 | 12 |
| 5 | A | - | - | - | 3 | 2 | | NEW CAPITAL-MOVEABLE EQUIPMENT | 222,526 | -62,476 | 160,050 | A7-1 | 13 |
| 5 | A | - | - | - | 4 | 2 | | NEW CAPITAL-MOVEABLE EQUIPMENT | 368,805 | -73,442 | 295,363 | A7-1 | 14 |
| | | | | | | | | To properly record depreciation as based on audit analysis. | | | | | |
| 6 | A | - | - | - | 60 | 1 | | CLINIC | 366,710 | -28,000 | 338,710 | 10B | 15 |
| 6 | A | - | - | - | 6001 | 1 | | WELL BABY CLINIC | 0 | 28,000 | 28,000 | 100 | 16 |
| 6 | A | - | - | - | 60 | 2 | | CLINIC | 187,723 | -49,952 | 137,771 | 10B | 17 |
| 6 | A | - | - | - | 6001 | 2 | | WELL BABY CLINIC | 0 | 49,952 | 49,952 | 10B | 18 |
| | | | | | | | | To replace the Well Baby Clinic to its own cost center line since it is a separate cost center. PRM 2502.6 and 2502.11. | | | | | |
| 7 | A6 | - | - | - | 30 | 7 | | 992 LOWER BUCKS SYSTEM | 0 | -9,368 | -9,368 | 50 | 19 |
| 7 | A6 | - | - | - | 31 | 7 | | 993 LOWER BUCKS FOUNDATION | 0 | -10,017 | -10,017 | 50 | 20 |
| 7 | A6 | - | - | - | 32 | 7 | | 994 LOWER BUCKS SERVICES | 0 | -14,396 | -14,396 | 50 | 21 |
| 7 | A6 | - | - | - | 30 | 6 | | 5 EMPLOYEE BENEFITS | 0 | 702 | 702 | 50 | 22 |
| 7 | A6 | - | - | - | 31 | 6 | | 606 ADMINISTRATIVE & GENERAL | 0 | 60,509 | 60,509 | 50 | 23 |

Provider Name Lower Bucks Hospital

ADJUSTMENT REPORT - MEDICAID DAYS

Provider # 39-0070 Period Ended 6/30/94

| Work-Paper | Report Reference: HCFA Form | Page or Sht | Line | Col. | Adj # | Explanation of Adjustment | AS REPORTED | INCREASE (DECREASE) | AS ADJUSTED |
|---|---|---|---|---|---|---|---|---|---|
| | 2552 | S-3 | 1.01 | 5 | | Hospital Adults & Pediatrics | 3,460 | 1,712 | 5,172 |
| | -92 | | 1.06 | 5 | | Total Adults & Pediatrics | 3,460 | 1,712 | 5,172 |
| | | | 2 | 5 | | Intensive Care Unit | 219 | 108 | 327 |
| | | | 3 | 5 | | Coronary Care Unit | 194 | 96 | 290 |
| | | | 7 | 5 | | Nursery | 410 | 203 | 613 |
| | | | 8 | 5 | | Total Hospital | 4,283 | 2,119 | 6402 |
| | | | 9 | 5 | | Subprovider | 1,770 | 0 | 1770 |
| | | | 10 | 5 | | Total | 6053 | 2,119 | 8172 |

To adjust Title XIX days per the intermediary's analysis.

NOTE: All interrelated schedules and parts of schedules are to be changed due to the foregoing adjustments.

PA-DSH

# THE WHITE HOUSE

## OFFICE OF LEGISLATIVE AFFAIRS

### HOUSE LIAISON

--FAX COVER SHEET--

DATE: 10/21

TO: Chris Jennings

OPD

FAX: 65557

FROM:

- X CHUCK BRAIN
- ___ AL MALDON
- ___ DARIO GOMEZ
- ___ LISA KOUNTOUPES
- ___ BRODERICK JOHNSON
- ___ ELISA MILLSAP
- ___ JADE RILEY

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

SUBJECT: F.Y.I.

1 OF ___

## COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES
WASHINGTON, DC 20515

SUBCOMMITTEE ON HEALTH



COPY

October 19, 1998

The Honorable Nancy Ann DeParle
Administrator
Health Care Financing Administration
Washington, DC 20201

Dear Nancy Ann:

Please reconsider HCFA's proposal to disallow disproportionate share payments to Pennsylvania's hospitals based on their state's Medical Assistance days.

As you know, I was Chairman of the Ways and Means Health Subcommittee when the legislation authorizing Medicare DSH (PL 99-272) was drafted. Our intention was clearly to help hospitals provide access to the low income and uninsured and ensure that hospitals which disproportionately provided that care could survive.

As you know, Pennsylvania has no public hospitals, and state-funded general assistance helps hospitals serve the low-income and uninsured by filling in the gaps where Federal Medicaid falls short. To exclude the State's medical assistance program from the calculation of DSH will create serious harm and runs counter to the spirit and intention of the Federal DSH law. HCFA's decision in Pennsylvania is a severe blow to the intent and purpose of the DSH program, and I urge you to reconsider and reverse HCFA's position in this case.

Thank you very much for your consideration.

Sincerely,

/s/

Pete Stark
Ranking Member