DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

JUL - 2 2007

TO: Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: Daniel R. Levinson
Inspector General

SUBJECT: Review of New Hampshire's Medicaid Disproportionate Share Hospital Payments During Federal Fiscal Year 2004 (A-01-05-00001)

Attached is an advance copy of our final report on New Hampshire's Medicaid disproportionate share hospital (DSH) payments during Federal fiscal year (FY) 2004. We will issue this report to the State agency within 5 business days.

Section 1923 of the Social Security Act, as amended, requires that States make DSH payments to hospitals that serve disproportionately large numbers of low-income patients. The Omnibus Budget Reconciliation Act of 1993 limits these payments to a hospital's uncompensated care costs, which are the annual costs incurred to provide services to Medicaid and uninsured patients less payments received for those patients. A 1994 Centers for Medicare & Medicaid Services (CMS) letter to State Medicaid Directors (1994 CMS letter) stated that the cost of services included in a hospital's DSH limit cannot exceed the amount that would be allowable under the Medicare principles of cost reimbursement.

In New Hampshire, the Department of Health and Human Services, Office of Medicaid Business and Policy (the State agency), administers the DSH program. According to the State plan, hospitals receive DSH payments for the lesser of their calculated DSH limit or 6 percent of "gross patient services [revenue]." The New Hampshire Department of Revenue Administration imposes a 6 percent Medicaid Enhancement Tax on the gross patient services revenue of each DSH.

The objective of our review was to determine whether the DSH payments that the State agency claimed for FY 2004 complied with the hospital-specific DSH limits imposed by Federal requirements and the State plan.

The State agency claimed DSH payments for FY 2004 that did not comply with the hospital-specific DSH limits imposed by Federal requirements and the State plan. Of the $194,145,507 that the State agency claimed, $123,494,571 was allowable. However, the remaining $70,650,936 ($35,325,468 Federal share) was unallowable. The State agency did not comply

with the hospital-specific DSH limits for 24 of the 28 DSHs because it did not properly determine the hospitals' allowable costs in accordance with the Medicare principles of cost reimbursement, as CMS guidance requires. Specifically, the cost-to-charge ratios that the State agency used in determining allowable costs were inflated because they (1) overstated costs by including unallowable costs and (2) understated charges by using net, rather than gross, patient services revenue. We attribute the excess DSH payments to the State agency's lack of policies and procedures to ensure that its methodology for developing the cost-to-charge ratios used to calculate hospital-specific DSH limits complied with Federal requirements and the State plan.

We recommend that the State agency:

- refund $35,325,468 to the Federal Government,

- work with CMS to review DSH payments claimed after our audit period and refund any overpayments, and

- establish policies and procedures to ensure that it complies with Federal requirements and the State plan in calculating future hospital-specific DSH limits.

In its written comments on our draft report, the State agency disagreed with our finding and recommendations. The State agency maintained that the incorporation of Medicare principles of cost reimbursement is out of place in the determination of hospital-specific DSH limits because the 1994 CMS letter does not have the force of law. The State agency further asserted that, even if the application of the Medicare principles of cost reimbursement was required for determining a cap on Medicaid DSH payments, the draft report misapplied these principles.

We maintain that the State agency claimed DSH payments that did not comply with the hospital-specific DSH limits imposed by Federal requirements and the State plan. The requirements set forth in the 1994 CMS letter are still in effect because new regulations have not been finalized. However, in response to the State agency's comments, we modified our finding to allow the inclusion of the Medicaid Enhancement Tax in the calculation of the cost-to-charge ratio and adjusted our monetary recommendation accordingly.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through e-mail at George.Reeb@oig.hhs.gov, or Michael J. Armstrong, Regional Inspector General for Audit Services, Region I, at (617) 565-2684 or through e-mail at Michael.Armstrong@oig.hhs.gov. Please refer to report number A-01-05-00001 in all correspondence.

Attachment

Office of Audit Services
Region I
John F. Kennedy Federal Building
Boston, MA 02203
(617) 565-2684

JUL - 9 2007

Report Number: A-01-05-00001

Mr. John A. Stephen
Commissioner
New Hampshire Department of Health and Human Services
129 Pleasant Street
Concord, New Hampshire 03301

Dear Mr. Stephen:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of New Hampshire's Medicaid Disproportionate Share Hospital Payments During Federal Fiscal Year 2004." A copy of this report will be forwarded to the action official noted on the next page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act (5 U.S.C. § 552, as amended by Public Law 104-231), OIG reports issued to the Department's grantees and contractors are made available to the public to the extent the information is not subject to exemptions in the Act that the Department chooses to exercise (see 45 CFR part 5).

Please refer to report number A-01-05-00001 in all correspondence.

Sincerely,

Michael J. Armstrong

Michael J. Armstrong
Regional Inspector General
for Audit Services

Enclosures

Direct Reply to HHS Action Official:

Charlotte Yeh, M.D.
Regional Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
John F. Kennedy Federal Building, Room 2325
Boston, Massachusetts 02203-0003

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF NEW HAMPSHIRE'S MEDICAID DISPROPORTIONATE SHARE HOSPITAL PAYMENTS DURING FEDERAL FISCAL YEAR 2004

Daniel R. Levinson
Inspector General

July 2007
A-01-05-00001

Office of Inspector General

http://oig.hhs.gov

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OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed, as well as other conclusions and recommendations in this report, represent the findings and opinions of the HHS/OIG/OAS. Authorized officials of the HHS divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

Section 1923 of the Social Security Act, as amended, requires that States make Medicaid disproportionate share hospital (DSH) payments to hospitals that serve disproportionately large numbers of low-income patients. The Omnibus Budget Reconciliation Act of 1993 limits these payments to a hospital's uncompensated care costs, which are the annual costs incurred to provide services to Medicaid and uninsured patients less payments received for those patients. This limit is known as the hospital-specific DSH limit. Further, a Centers for Medicare & Medicaid Services (CMS) letter to State Medicaid Directors (1994 CMS letter) stated that the cost of services included in a hospital's DSH limit cannot exceed the amount that would be allowable under the Medicare principles of cost reimbursement.

States have considerable flexibility in defining their DSH programs under sections 1923(a) and (b) of the Social Security Act. Each State prepares a State plan that defines how it will operate its Medicaid program, including the DSH program, and submits the plan to CMS for approval.

In New Hampshire, the Department of Health and Human Services, Office of Medicaid Business and Policy (the State agency), administers the DSH program. According to the State plan, hospitals receive DSH payments for the lesser of their calculated DSH limit or 6 percent of "gross patient services [revenue]." The New Hampshire Department of Revenue Administration imposes a 6-percent Medicaid Enhancement Tax on the gross patient services revenue of each DSH (New Hampshire State Statute, Title V, Chapter 84-A).

OBJECTIVE

Our objective was to determine whether the DSH payments that the State agency claimed for Federal fiscal year 2004 complied with the hospital-specific DSH limits imposed by Federal requirements and the State plan.

SUMMARY OF FINDINGS

The State agency claimed DSH payments for Federal fiscal year 2004 that did not comply with the hospital-specific DSH limits imposed by Federal requirements and the State plan. Of the $194,145,507 that the State agency claimed, $123,494,571 was allowable. However, the remaining $70,650,936 ($35,325,468 Federal share) was unallowable. The State agency did not comply with the hospital-specific DSH limits for 24 of the 28 DSHs because it did not properly determine the hospitals' allowable costs in accordance with the Medicare principles of cost reimbursement, as CMS guidance requires. Specifically, the cost-to-charge ratios that the State agency used in determining allowable costs were inflated because they (1) overstated costs by including unallowable costs and (2) understated charges by using net, rather than gross, patient services revenue.

We attribute the excess DSH payments to the State agency's lack of policies and procedures to ensure that its methodology for developing the cost-to-charge ratios used to calculate hospital-specific DSH limits complied with Federal requirements and the State plan.

RECOMMENDATIONS

We recommend that the State agency:

- refund $35,325,468 to the Federal Government,
- work with CMS to review DSH payments claimed after our audit period and refund any overpayments, and
- establish policies and procedures to ensure that it complies with Federal requirements and the State plan in calculating future hospital-specific DSH limits.

STATE AGENCY'S COMMENTS AND OFFICE OF INSPECTOR GENERAL'S RESPONSE

In its written comments on our draft report, the State agency disagreed with our finding and recommendations. The State agency maintained that the incorporation of the Medicare principles of cost reimbursement is out of place in the determination of hospital-specific DSH limits because the 1994 CMS letter does not have the force of law. The State agency further asserted that, even if the application of the Medicare principles of cost reimbursement was required for determining a cap on Medicaid DSH payments, the draft report misapplied these principles.

We maintain that the State agency claimed DSH payments that did not comply with the hospital-specific DSH limits imposed by Federal requirements and the State plan. The requirements set forth in the 1994 CMS letter are still in effect because new regulations have not been finalized. However, in response to the State agency's comments, we modified our finding to allow the inclusion of the Medicaid Enhancement Tax in the calculation of the cost-to-charge ratio and adjusted our monetary recommendation accordingly.

The State agency's comments are included in their entirety as Appendix C.

TABLE OF CONTENTS

APPENDIXES

INTRODUCTION

BACKGROUND

Medicaid Program

Title XIX of the Social Security Act (the Act) established Medicaid as a jointly funded Federal and State program to provide medical assistance to qualified low-income people. The Centers for Medicare & Medicaid Services (CMS) administers the program at the Federal level. Within a broad legal framework, each State designs and administers its own Medicaid program. Each State prepares a State plan that defines how it will operate its Medicaid program and submits the plan to CMS for approval.

Medicaid Disproportionate Share Hospital Program

The Omnibus Budget Reconciliation Act of 1981 established the disproportionate share hospital (DSH) program, which is codified in section 1923 of the Act. This section requires State Medicaid agencies to make additional payments to hospitals that serve disproportionately large numbers of low-income patients. Sections 1923(a) and (b) of the Act give States considerable flexibility in defining their DSH programs. The Federal Government pays its share of Medicaid expenditures, including DSH expenditures, according to a formula established in section 1905(b) of the Act.

The Omnibus Budget Reconciliation Act of 1993 requires States to limit DSH payments made to individual hospitals to each hospital's uncompensated care costs, which are the annual allowable costs that the hospital incurs for providing services to Medicaid and uninsured patients less any payments that the hospital receives for these patients. This limit is known as the hospital-specific DSH limit.

A CMS letter to State Medicaid Directors dated August 17, 1994, (1994 CMS letter) clarified the DSH provisions of the Omnibus Budget Reconciliation Act of 1993. The letter states that the cost of services included in a hospital-specific DSH limit cannot exceed the amount that would be allowable under Medicare principles of cost reimbursement. These principles provide guidelines and policies for determining the reasonable costs of provider services furnished under the Medicare program. The CMS "Provider Reimbursement Manual" provides hospitals with guidelines for implementing Medicare cost principles and instructions for preparing their annual Medicare cost reports in accordance with these principles.

The financial data used to determine hospital-specific DSH limits can come from various sources, including the hospital's annual audited financial statements and Medicare cost report. A hospital's audited financial statements and cost report are both based on the hospital's accounting records, but they serve different purposes. The audited financial statements show the hospital's total costs and financial position, whereas the audited Medicare cost report presents a hospital's allowable costs for providing Medicare-covered services in accordance with Medicare cost principles.

To comply with Medicare principles when calculating a hospital's DSH limit, the State Medicaid agency must first determine a hospital's allowable costs under the Medicare program by removing the hospital's unallowable costs, i.e., those costs that Medicare does not allow for reimbursement, from its total costs. Because hospitals generally accumulate and report costs by category (e.g., salaries and rent) rather than by payer, the State agency must use an allocation process to determine a hospital's actual costs of providing services specifically to Medicaid and uninsured patients. For example, the State Medicaid agency may determine these costs by developing a cost-to-charge ratio of the hospital's total allowable costs to its total gross charges, in compliance with Medicare principles. It may then determine the hospital's allowable costs of providing services to Medicaid and uninsured patients by multiplying the charges for these services by the hospital's cost-to-charge ratio. Subtracting any payments that the hospital has received for services provided to these patients from its related allowable costs produces the hospital's uncompensated care costs. This amount is the hospital-specific DSH limit.

New Hampshire Disproportionate Share Hospital Program

In New Hampshire, the Department of Health and Human Services, Office of Medicaid Business and Policy (the State agency), administers the DSH program. The Federal Government and the State agency each contribute 50 percent of the costs of the DSH program. The State agency identified all 28 of its general and rehabilitative hospitals as DSHs. Pursuant to the State plan, these hospitals receive DSH payments for the lesser of their calculated hospital-specific DSH limit or 6 percent of "gross patient services [revenue]." The New Hampshire Department of Revenue Administration imposes a 6 percent Medicaid Enhancement Tax on the gross patient services revenue of each DSH.[1]

To develop its claim for DSH payments for Federal fiscal year (FY) 2004 (October 1, 2003, through September 30, 2004), the State agency sent an electronic form to the 28 disproportionate share hospitals and requested that each hospital provide information from its most recently completed audited financial statements for its FY ending in 2002. The State agency used data from this form to develop a cost-to-charge ratio for each hospital. It then used the ratio to calculate the hospital-specific DSH limit.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the DSH payments that the State agency claimed for FY 2004 complied with the hospital-specific DSH limits imposed by Federal requirements and the State plan.

Scope

We reviewed DSH payments totaling $194,145,507 ($97,072,753 Federal share) that the State agency claimed for FY 2004.

[1]New Hampshire State Statute, Title V, Chapter 84-A.

We limited consideration of the State agency's internal control structure to those controls related to the State agency's methodology for determining hospital-specific DSH limits, processing claims, and determining subsequent reimbursements. The objective of our review did not require an understanding or assessment of the State agency's complete internal control structure.

We performed our fieldwork at the State agency in Concord, New Hampshire, from April 2005 to January 2006.

Methodology

To accomplish our audit objective, we:

- reviewed applicable Federal laws, regulations, and guidance and the CMS-approved State plan;

- interviewed officials from CMS, the State agency, the New Hampshire Department of Revenue Administration, the New Hampshire Department of Administrative Services, the State Treasurer's Office, and the New Hampshire Hospital Association;

- reconciled the DSH payments that the State agency claimed during FY 2004 on Form CMS-64, "Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program," to the State agency's detailed accounting records;

- reviewed the State agency's methodology for calculating hospital-specific DSH limits, which was based on data from the 28 hospitals' FY 2002 financial statements;

- reviewed prior audit work performed by the New Hampshire Office of Legislative Budget Assistant; and

- requested assistance from New Hampshire's fiscal intermediary, Anthem Health Plans of New Hampshire, Inc., to recalculate the 28 hospitals' cost-to-charge ratios using data from the hospitals' audited FY 2002 Medicare cost reports.

We conducted our audit in accordance with generally accepted government auditing standards.

FINDING AND RECOMMENDATIONS

The State agency claimed DSH payments for FY 2004 that did not comply with the hospital-specific DSH limits imposed by Federal requirements and the State plan. Of the $194,145,507 that the State agency claimed, $123,494,571 was allowable. However, the remaining $70,650,936 ($35,325,468 Federal share) was unallowable. The State agency did not comply with the hospital-specific DSH limits for 24 of the 28 disproportionate share hospitals because it did not properly determine the hospitals' allowable costs in accordance with Medicare principles of cost reimbursement, as CMS guidance requires. Specifically, the cost-to-charge ratios that the State agency used in determining allowable costs were inflated because they (1) overstated costs

by including unallowable costs and (2) understated charges by using net, rather than gross, patient services revenue.

We attribute the excess DSH payments to the State agency's lack of policies and procedures to ensure that its methodology for developing the cost-to-charge ratios that it used to calculate hospital-specific DSH limits complied with Federal requirements and the State plan.

PROGRAM REQUIREMENTS

Hospital-Specific Disproportionate Share Hospital Limits

Section 1923(g)(1)(A) of the Act states that DSH payments to a hospital may not exceed:

> . . . the costs incurred during the year of furnishing hospital services (as determined by the Secretary and net of payments under this title [Title XIX], other than under this section, and by uninsured patients) by the hospital to individuals who either are eligible for medical assistance under the State plan or have no health insurance (or other source of third party coverage) for services provided during the year.

The New Hampshire State plan, Attachment 4.19-A, page 5b, effective July 1, 2003, incorporates these same requirements and further limits DSH payments to the lesser of the hospital-specific DSH limit or 6 percent of gross patient services revenue.

CMS clarified the DSH provisions of the Omnibus Budget Reconciliation Act of 1993 in the 1994 CMS letter, in which it states:

> . . . in defining "costs of services" under this provision [the hospital-specific DSH limit], HCFA[2] would permit the State to use the definition of allowable costs in its State plan, or any other definition, as long as the costs determined under such a definition do not exceed the amounts that would be allowable under the Medicare principles of cost reimbursement . . . . HCFA believes this interpretation of the term "costs incurred" is reasonable because it provides States with a great deal of flexibility up to a maximum standard that is widely known and used in the determination of hospital costs.

Allowable Costs

CMS's "Provider Reimbursement Manual," part 1, Chapter 21, section 2100, provides that costs must be subject to Medicare principles of cost reimbursement and directly related to providing patient care by stating:

> All payments to providers of services must be based on the reasonable cost of services covered under title XVIII of the Act [Medicare] and related to the care of beneficiaries or, in the case of acute care hospitals, the prospective payment

[2]The Health Care Financing Administration, which is now CMS.

> system . . . . Reasonable cost includes all necessary and proper costs incurred in rendering the services, subject to principles relating to specific items of revenue and cost.

The CMS "Provider Reimbursement Manual," provides examples of unallowable costs in part 1, Chapter 21, section 2102.3, which prohibits the inclusion of costs not related to patient care, such as meals sold to visitors, gift shops, and entertainment. In addition, 42 CFR § 413.80(c) prohibits the inclusion of bad debts. It states that bad debts are reductions in revenue and are not to be included in the provider's allowable costs.[3]

Appropriate Charges

Medicare principles of cost reimbursement contained in the CMS "Provider Reimbursement Manual," part 1, Chapter 22, section 2202.4, define charges used in developing cost-to-charge ratios as:

> . . . the regular rates established by the provider for services rendered to both beneficiaries and to other paying patients. Charges should be related consistently to the cost of the services and uniformly applied to all patients whether inpatient or outpatient. All patients' charges used in the development of apportionment ratios should be recorded at the gross value; i.e., charges before the application of allowances and discounts deductions.

CALCULATIONS OF HOSPITAL-SPECIFIC DISPROPORTIONATE SHARE HOSPITAL LIMITS

State Agency's Calculation

The State agency claimed DSH payments for FY 2004 that did not comply with the hospital-specific DSH limits imposed by Federal requirements and the State plan because it did not determine allowable costs for 24 of the 28 disproportionate share hospitals in accordance with the Medicare principles of cost reimbursement. Specifically, the cost-to-charge ratios that the State agency used in determining allowable costs were inflated because they (1) overstated costs (numerator) by including unallowable costs and (2) understated charges (denominator) by using net, rather than gross, patient services revenue.

- **Unallowable Costs.** The State agency used the operating expenses that hospitals reported on their FY 2002 audited financial statements to calculate cost-to-charge ratios. Contrary to the requirements of 42 CFR § 413.80(c) and the CMS "Provider Reimbursement Manual," these operating expenses included costs, such as bad debts, meals sold to visitors, gift shops, and entertainment, that are not recognized under the Medicare principles of cost reimbursement because they are not related to patient care. These additional costs overstated the numerators in the cost-to-charge ratios.

[3]Bad debts attributable to deductibles and coinsurance amounts are separately reimbursable up to a set limit under the Medicare program if the provider can show evidence of due diligence.

- **Charges Based on Net Patient Services Revenue.** The State agency based the charges that it used to calculate cost-to-charge ratios on the hospitals' net patient services revenue. Net patient services revenue includes deductions for contractual allowances and other discounts. As a result, the State agency understated the denominators in its cost-to-charge ratios. To adhere to the Medicare principles of cost reimbursement, the State agency should have used gross patient services revenue in calculating cost-to-charge ratios.

Because the numerators were larger and the denominators were smaller than they would have been if the State agency had applied Medicare principles of cost reimbursement, the resulting ratios were inflated. When the State agency multiplied these ratios by the hospitals' total gross charges for services provided to Medicaid and uninsured patients, the resulting costs were also inflated.

Recalculation in Accordance With the Medicare Principles of Cost Reimbursement

We used data from the 28 hospitals' FY 2002 audited Medicare cost reports to identify the costs and charges needed to recalculate the hospitals' cost-to-charge ratios in accordance with the requirements set forth in the CMS "Provider Reimbursement Manual." For our recalculation, we used the audited Medicare cost reports because that was the most direct method of determining costs based on Medicare principles of cost reimbursement. The following table compares the State agency's calculation with our recalculation of the cost-to-charge ratio for one hospital (identified as Hospital 4 in the appendixes).

Comparison of Cost-to-Charge Ratio Calculations for Hospital 4

	State Agency Calculation Using Financial Statement Data	Recalculation Using Medicare Cost Report Data
Components	Costs not based on Medicare principles	Costs based on Medicare principles[4]
	Net patient services revenue	Gross patient services revenue[5]
Dollar amounts	$99,163,239	$84,669,789
	$94,585,189	$184,961,012
Resulting ratio	**1.05**	**0.46**

[4]These costs consisted of total expenses from worksheet C, part I, line 103, column 5; graduate medical education costs from worksheet B, part I, column 26, sum of lines 25 though 62; and hospital-based physician costs from worksheet D-3, column 1 total, as shown on the hospital's FY 2002 audited Medicare cost report. In addition, we included the hospital's prior year Medicaid Enhancement Tax.

[5]These costs consisted of total charges (both inpatient and outpatient) from worksheet C, part I, line 103, column 8, and charges for hospital-based physician costs from worksheet D-3, column 2 total, as shown on the hospital's 2002 audited Medicare cost report.

The State agency's calculation resulted in a higher cost-to-charge ratio than did our recalculation based on Medicare principles of cost reimbursement. A higher cost-to-charge ratio produced higher hospital costs and thus higher hospital-specific DSH limits. Appendix A details how the revised cost-to-charge ratio affected the hospital-specific DSH limit for Hospital 4. Appendix B contains summary information on the DSH calculation and recalculation for each of the 28 hospitals.

LACK OF POLICIES AND PROCEDURES

The State agency did not have policies and procedures to ensure that its methodology for developing the cost-to-charge ratios that it used to calculate hospital-specific DSH limits complied with Federal requirements and the State plan. As a result, the State agency's calculations based on hospitals' financial statements included unallowable costs and inappropriate charges. Although the State agency could have used financial statements as a data source if its procedures had included appropriate adjustments, it had no policies and procedures to ensure that all costs and charges used in its calculations were based on Medicare principles of cost reimbursement.

PAYMENTS CLAIMED IN EXCESS OF HOSPITAL-SPECIFIC DISPROPORTIONATE SHARE HOSPITAL LIMITS

Because the State agency's calculations of cost-to-charge ratios were not based on Medicare principles of cost reimbursement, the hospital-specific DSH limits calculated using these ratios were too high for 24 of the 28 hospitals. As a result, the State agency claimed a total of $70,650,936 ($35,325,468 Federal share) for unallowable DSH payments.

RECOMMENDATIONS

We recommend that the State agency:

- refund $35,325,468 to the Federal Government,
- work with CMS to review DSH payments claimed after our audit period and refund any overpayments, and
- establish policies and procedures to ensure that it complies with Federal requirements and the State plan in calculating future hospital-specific DSH limits.

STATE AGENCY'S COMMENTS AND OFFICE OF INSPECTOR GENERAL'S RESPONSE

The State agency disagreed with our finding and recommendations. In response to the State agency's comments, we modified our finding and adjusted our results and monetary recommendation accordingly. We maintain that the State agency claimed DSH payments that did not comply with the hospital-specific DSH limits imposed by Federal requirements and the State plan, and we stand by our recommendations as modified.

The State agency's comments regarding specific issues in the report and our responses follow.

Relevance of the Medicare Principles of Cost Reimbursement

State Agency's Comments

The State agency stated that: "The incorporation of the Medicare Reimbursement Manual is out of place in calculating the Medicaid DSH cap." Specifically, the State agency maintained that section 1923(g)(1)(A) of the Act does not "define the costs that may count toward uncompensated care costs and does not provide a specific method for determining these costs." In addition, the State agency commented that the 1994 CMS letter stated that CMS was "planning regulations to codify" the requirements of the Omnibus Budget Reconciliation Act of 1993; the State agency noted that the planned regulations have never materialized. The State agency also claimed that the 1994 CMS letter was not a product of the agency's rulemaking authority and therefore did not have the force of law and was not entitled to deference. It concluded that the letter simply "describes what HCFA 'would permit' in its anticipated—but not actually forthcoming—regulations."

Office of Inspector General's Response

We disagree with the State agency's claim that the incorporation of the Medicare principles of cost reimbursement is out of place in the determination of hospital-specific DSH limits. Section 1923(g)(1)(A) of the Act states that a DSH payment shall not exceed " . . . the costs incurred during the year of furnishing hospital services . . . by the hospital . . . ." In the 1994 CMS letter from the Director of the Medicaid Bureau, CMS issued guidance to all State Medicaid Directors that limited the costs of services to those allowable under the Medicare principles of cost reimbursement. The CMS "Provider Reimbursement Manual" provides hospitals with guidelines for implementing these principles.

The State agency correctly noted that the 1994 CMS letter stated that CMS was planning to codify the requirements of the Omnibus Budget Reconciliation Act of 1993. However, this same letter also stated that "until these regulations are published, this summary represents HCFA's interpretation of the new DSH requirements." As the State agency remarked in its response, the proposed rules on DSH payments have not been finalized, and therefore the requirements set forth in the letter are still in effect.

In addition, Departmental Appeals Board decision No. 2037, issued in July 2006, found that "[t]he Board has repeatedly held that a federal agency's interpretation of the statute which it is responsible for implementing and of the regulations which that agency issues under that statute is 'entitled to deference as long as the interpretation is reasonable and the grantee had adequate notice of that interpretation.' " The "Provider Reimbursement Manual" and the 1994 CMS letter represent CMS's interpretation of the statutes that it is responsible for implementing. Therefore, we disagree with the State agency's assertion that the "Provider Reimbursement Manual" was not relevant to the determination of uncompensated care costs and that the 1994 CMS letter did not have the force of law and was not entitled to deference.

Application of the Medicare Principles of Cost Reimbursement

The State agency asserted that, even if it was required to use Medicare principles of cost reimbursement for determining a cap on Medicaid DSH payments, the draft report misapplied these principles. The State agency maintained that we did not correctly interpret the meaning of these principles and that we applied them too strictly.

We disagree. The 1994 CMS letter gave States flexibility in determining their allowable costs "so long as the costs determined . . . do not exceed the amounts that would be allowable under the Medicare principles of cost reimbursement." As stated on page 6 of our draft report, we used the Medicare cost report filed by each hospital to apply the Medicare principles of cost reimbursement because it is the most direct method of determining each hospital's cost-to-charge ratio in accordance with these principles. The hospital community recognizes the Medicare cost report as the basis for establishing costs allowable under the Medicare principles of cost reimbursement. Moreover, we used the hospitals' settled cost reports, which represent the hospitals' allowable Medicare costs as agreed to by the hospitals and their fiscal intermediaries.

Medicaid Enhancement Tax

State Agency's Comments

The State agency disagreed with our disallowance of the Medicaid Enhancement Tax. It stated that the Medicaid Enhancement Tax was covered by the general rule in the "Provider Reimbursement Manual" that taxes assessed on providers are allowable costs because this tax does not fit into any of the categories that the "Provider Reimbursement Manual" lists as unallowable in section 2122.2. The State agency also asserted that the Medicaid Enhancement Tax is a provider tax because it is based on gross patient services revenue rather than on net income. The State agency cited several decisions from the Provider Reimbursement Review Board to support its definition of the Medicaid Enhancement Tax as a provider tax.

Office of Inspector General's Response

Based on the State agency's comments, we modified our report to allow the inclusion of the Medicaid Enhancement Tax in the calculation of the cost-to-charge ratio. When we included the Medicaid Enhancement Tax in our recalculation for each hospital, four hospitals' DSH payments no longer exceeded the DSH limit. We adjusted our results to reflect this change as well.

Bad Debt

State Agency's Comments

The State agency asserted that bad debts were not necessarily excluded by section 1923(g) of the Act or by the 1994 CMS letter. Although it acknowledged that, under the Medicare regulations, bad debts are deductions from revenues and should not be included in allowable costs, it maintained that bad debts may be reimbursed through DSH payments because Medicare itself reimburses bad debts. The State agency also acknowledged CMS's proposed rule, 70 Federal

Register 50268, and noted that it would eliminate bad debt from its calculations if the rule is promulgated.

The State agency questioned whether our reference to 42 CFR § 413.80(c) in the draft report was a typographical error and whether the intended citation was 42 CFR § 413.89(c).

Office of Inspector General's Response

We did not exclude bad debts from the DSH calculation (see Appendix A, Lines 5 and 11), nor did we state that hospitals could not be reimbursed for bad debts through DSH payments. However, we excluded bad debts from the cost-to-charge ratio that the State agency used to determine allowable costs in the DSH calculation. As the State agency acknowledged in its response, 42 CFR § 413.80(c) states that bad debts "are deductions from revenue and are not to be included in allowable costs." Although the proposed CMS rule regarding DSH payments has not yet been codified, it has been a longstanding CMS policy that bad debts are not to be included in determining allowable costs under Medicare pursuant to 42 CFR § 413.80(c). By including bad debts in the cost-to-charge ratio that the State agency used to determine allowable costs, the State agency ignored these longstanding requirements. As a result, its cost-to-charge ratios were overstated.

Appendix A illustrates how the State agency included bad debts twice in its DSH calculations. On line 3, the State agency included bad debts in its operating expenses, which were part of the costs in the numerator of the cost-to-charge ratio. On line 5, the State agency again included bad debts as charges that were multiplied by the cost-to-charge ratio (see line 11). By removing bad debts from the cost-to-charge ratio in our recalculation, we eliminated the State agency's duplicate reimbursement for bad debts.

The reference to 42 CFR § 413.80(c) in the draft report was not a typographical error. During our audit period, 42 CFR § 413.80(c) was in effect. Effective October 1, 2004, it was recodified as 42 CFR § 413.89(c).

Other Costs

State Agency's Comments

The State agency maintained that the "other costs" (the costs of meals sold to visitors, gift shops, and entertainment) are legitimate costs that a hospital incurs in running its business even though these other costs may not be directly related to patient care. The State agency also asserted that the inclusion of these costs did not materially affect the calculation of uncompensated care costs.

Office of Inspector General's Response

The three examples of "other costs" that we cited (the costs of meals sold to visitors, gift shops, and entertainment) were not an inclusive list of all unallowable costs in this category. These "other costs" came from each hospital's financial statements, which included all costs, not just those related to patient care. To comply with Medicare principles of cost reimbursement when

calculating a hospital's DSH limit, the State agency must first determine a hospital's allowable costs by removing from its total costs those costs that Medicare does not allow for reimbursement. As we stated in our draft report, we used the hospitals' Medicare cost reports to determine allowable costs to be used in the cost-to-charge ratios because the cost reports excluded the costs that were not allowable under the Medicare principles of cost reimbursement.

We disagree with the State agency's assertion that including these unallowable costs is immaterial to the calculation of uncompensated care costs. Because the category of "other costs" included more than the three examples that the State agency cited, their inclusion significantly affected the calculations of the cost-to-charge ratios used to determine uncompensated care costs. For example, removing "other costs" from the State agency's DSH calculation for Hospital 4 (page 6) reduced the costs included in the cost-to-charge ratio by $14 million.

The Use of Net Charges in the Cost-to-Charge Ratio

State Agency's Comments

The State agency asserted that the draft report incorrectly implied that Medicare required gross charges to be used in allocating costs to Medicaid and the uninsured. It stated that the 1994 CMS letter did not say how costs should be apportioned and that the report pointed to no authority requiring States to allocate costs based on a cost-to-gross charges basis because none existed. The State agency noted that it had long used the cost-to-net revenue ratio for determining the cost associated with Medicaid and the uninsured and that this approach had never been questioned. The State agency acknowledged that its method produced higher calculated costs but stated that the higher costs were justified because Medicaid and uninsured patients were more expensive to treat. It said that our calculated costs were artificially low because they did not account for the greater expense of treating low-income patients.

The State agency acknowledged CMS's proposed rule in 70 Federal Register 50262 and noted that it would not use the cost-to-net-charge ratio if this rule is promulgated unless an independent audit determines that this ratio is an appropriate measure of uncompensated costs.

Office of Inspector General's Response

We disagree with the State agency's assertion that Medicare does not require the use of gross charges in the cost-to-charge ratios. As we noted in our draft report, the Medicare principles of cost reimbursement contained in the CMS "Provider Reimbursement Manual," part 1, chapter 22, section 2202.4, establish that charges used in the apportionment ratios should be recorded at the gross value to ensure that costs are equally allocated to all payers.

The State correctly noted that the 1994 CMS letter does not tell States how to apportion costs in determining the cost of services. States are free to choose their own methodology. However, the 1994 CMS letter also states that the resulting costs must not exceed the costs that would be allowable under the Medicare principles of cost reimbursement. The State agency chose to use a cost-to-charge ratio to apportion costs in its DSH limit calculation. Accordingly, we developed cost-to-charge ratios based on the Medicare principles of cost reimbursement for each of the 28

hospitals and compared our recalculations to the State agency's calculations. Our cost-to-charge ratios differed from the State agency's ratios because, unlike the State agency, we excluded costs not allowable under the Medicare principles of cost reimbursement in the numerator and used gross rather net charges in the denominator.

The State agency did not cite any CMS regulations or guidance to support its claim that the higher costs that resulted from using net charges in the cost-to-charge ratio were justified. If low-income patients require more services and more expensive services (e.g., frequent emergency room visits), then these additional expenses will be reflected in the hospital's charges for these services.

We have included the State agency's comments in their entirety as Appendix C.

APPENDIXES

STATE AGENCY'S DISPROPORTIONATE SHARE HOSPITAL PAYMENT CALCULATION AND OFFICE OF INSPECTOR GENERAL'S RECALCULATION FOR HOSPITAL 4

		State Agency Calculation	Recalculation Based on Medicare Principles
Elements of Disproportionate Share Hospital (DSH) Calculation			
Gross patient services revenue Includes all charges to patients during fiscal year (FY) 2002	**1**	$183,120,911	$184,961,012 [1]
Net patient services revenue Includes all charges to patients during FY 2002, excluding charity care and all contractual allowances	**2**	94,585,189	—
Operating expenses	**3**	89,557,636 [2]	75,064,186 [1,3]
Medicaid Enhancement Tax paid Amount paid in October 2002	**4**	9,605,603	9,605,603
Bad debt Expressed as charges, net of recoveries	**5**	6,493,987	6,493,987
Charity care Expressed as charges	**6**	2,094,673	2,094,673
Medicaid charges Includes inpatient and outpatient, laboratory and radiology, New Hampshire and all other states, fee for service and health maintenance organization, swing and extended care (if part of the hospital), and capital during FY 2002	**7**	4,915,106	4,915,106
Medicaid payments Includes total amounts received for all above Medicaid-related charges during FY 2002	**8**	1,699,102	1,699,102
DSH Payment Calculation			
Cost-to-charge ratio (CCR)	**9**	**1.05** [4]	**0.46** [5]
DSH limit:			
Medicaid shortfall ((line 7 × CCR) - line 8)	**10**	3,453,902	550,891
Cost of uninsured patients ((line 5 + line 6) × CCR)	**11**	9,004,362	3,931,640
Total DSH limit (Medicaid shortfall + cost of uninsured patients)		**$12,458,264**	**$4,482,531**
DSH payment according to New Hampshire State plan is the lesser of:			
Total DSH limit		12,458,264	4,482,531
6 percent of gross patient services revenue		10,987,255	11,097,661
Hospital 4's DSH payment in FY 2004		**$10,987,255**	**$4,482,531**
Overpayment for Hospital 4			**$6,504,724** [6]
Federal share of overpayment			**$3,252,362**

[1]Per the Hospital's 2002 audited Medicare cost report.

[2]Includes all bad debt and taxes except the Medicaid Enhancement Tax.

[3]Excludes costs unallowable under Medicare principles of cost reimbursement, such as bad debts and meals sold to visitors.

[4]The State agency's methodology determined the CCR as (lines 3 + 4) / line 2, based on data in the Hospital's 2002 financial statements. Rounded to 8 decimals, the CCR is 1.04840134.

[5]Our recalculation based on Medicare principles determined the CCR as (lines 3 + 4) / line 1. Rounded to 8 decimals, the CCR is 0.45777101.

[6]The State agency's DSH payment ($10,987,255) minus our recalculated DSH payment ($4,482,531).

APPENDIX B

STATE AGENCY'S DISPROPORTIONATE SHARE HOSPITAL PAYMENT CALCULATIONS AND OFFICE OF INSPECTOR GENERAL'S RECALCULATIONS

	A	B	C	D	E	F
Hospital	State Agency DSH Payment	State Agency CCR	OIG[1] Recalculated DSH Payment	OIG Recalculated CCR	Total Overpayment (A - C)	Federal Share of Overpayment (E × 50% FMAP[2])
1	$15,689,440	1.08	$6,682,728	0.49	$9,006,713	$4,503,356
2	13,117,453	0.91	5,423,491	0.45	7,693,962	3,846,981
3	33,385,440	1.09	26,423,075	0.64	6,962,365	3,481,182
4	10,987,255	1.05	4,482,531	0.46	6,504,724	3,252,362
5	17,019,876	1.10	11,076,775	0.54	5,943,101	2,971,551
6	10,486,755	1.05	4,911,664	0.51	5,575,091	2,787,546
7	9,755,997	0.99	5,346,840	0.50	4,409,157	2,204,578
8	16,904,460	1.09	12,773,830	0.55	4,130,630	2,065,315
9	8,807,211	1.14	4,945,656	0.51	3,861,555	1,930,777
10	6,551,123	1.07	3,407,751	0.50	3,143,371	1,571,686
11	10,613,181	1.05	7,784,289	0.54	2,828,892	1,414,446
12	5,021,627	1.15	3,025,390	0.57	1,996,237	998,119
13	1,792,081	1.04	252,572	0.54	1,539,509	769,755
14	2,934,169	1.08	1,679,344	0.54	1,254,825	627,413
15	2,042,108	1.10	931,816	0.64	1,110,292	555,146
16	2,088,426	1.10	1,109,198	0.53	979,228	489,614
17	3,223,524	1.16	2,324,547	0.63	898,977	449,488
18	3,157,943	1.08	2,419,124	0.60	738,819	369,409
19	2,310,899	1.07	1,755,480	0.54	555,419	277,710
20	2,022,285	1.48	1,479,730	0.79	542,555	271,277
21	1,837,777	1.04	1,467,848	0.62	369,930	184,965
22	346,570	0.81	0	0.48	346,570	173,285
23	1,777,394	1.13	1,541,735	0.70	235,658	117,829
24	2,530,013	1.17	2,506,657	0.64	23,356	11,678
25	5,931,629	1.04	5,931,629	0.54	0	0
26	1,665,563	1.25	1,665,563	0.62	0	0
27	709,377	1.19	709,377	0.64	0	0
28	1,435,931	1.09	1,435,931	0.67	0	0
Total	**$194,145,507**		**$123,494,571**		**$70,650,936**	**$35,325,468**

[1]OIG = Office of Inspector General.

[2]FMAP = Federal medical assistance percentage.

State of New Hampshire
DEPARTMENT OF HEALTH AND HUMAN SERVICES
129 PLEASANT STREET, CONCORD, NH 03301-3857
603-271-4688 FAX: 603-271-4912 TDD ACCESS: 1-800-735-2964

JOHN A. STEPHEN
COMMISSIONER

April 2, 2007

Michael J. Armstrong
Regional Inspector General for Audit Services
Department of Health and Human Services, Office of Inspector General
Office of Audit Services, Region I
John F. Kennedy Federal Building
Boston, MA 02203
Michael.Armstrong@oig.hhs.gov

Certified Mail No.7099 3400 0003 6187 0427

RE: Review of New Hampshire's Medicaid Disproportionate Share Hospital Payments During Federal Fiscal Year 2004, Report No. A-01-05-00001

Dear Mr. Armstrong:

The New Hampshire Department of Health and Human Services hereby responds to the draft report of the above-referenced audit, which you forwarded to the Department on February 1, 2007. The time for reply was extended to April 2, 2007.

The draft report finds that the Department claimed disproportionate share hospital (DSH) payments that did not comply with the hospital-specific DSH limits imposed by Federal requirements and the State plan. For the reasons explained below, we disagree with this finding and with the recommendations that accompany it.

New Hampshire's methodology for calculating the costs of uncompensated care was designed to take account of the real costs of treating the low-income individuals whom the DSH program is designed to assist. The State's current methodology has been in place for over ten years. In all these years, the State has been completely forthright about the method it employs to calculate DSH payments, and CMS has never challenged the State's approach. CMS and the State have worked together to make certain changes to the DSH methodology and other components of State law, and the State is always willing to cooperate with CMS concerning possible future changes, but it is improper to propose a retroactive disallowance as to an approach that we have always understood to be an appropriate means of determining the costs of serving Medicaid and the uninsured.

Michael J. Armstrong
Page Two.
April 2, 2007

I. The Findings of Noncompliance with Federal Requirements are Erroneous

A. The Incorporation of the Medicare Reimbursement Manual is Out of Place In Calculating The Medicaid DSH Cap

Section 1923(g)(1)(A) does not define the costs that may count toward uncompensated care costs and does not provide a specific method for determining these costs. In a State Medicaid Director Letter circulated on August 17, 1994 ("Letter"), HCFA[1] took the position that

> in defining "costs of services" under this provision, HCFA would permit the State to use the definition of allowable costs in its State plan, or any other definition, as long as the costs determined under such a definition do not exceed the amounts that would be allowable under the Medicare principles of cost reimbursement. The Medicare principles are the general upper payment limit under institutional payment under the Medicaid program. HCFA believes this interpretation of the term "costs incurred" is reasonable because it provides States with a great deal of flexibility up to a maximum standard that is widely known and used in the determination of hospital costs.

Letter Attachment at 3.

HCFA also stated that it was "planning regulations to codify" the requirements of OBRA 1993. Letter at 1. The planned regulations have never materialized. To date, "CMS has not promulgated any regulations specifically addressing the hospital-specific DSH limit." *La. Dept. of Health & Hosps. v. Ctr. for Medicare & Medicaid Servs.*, 346 F.3d 571, 573 (5th Cir. 2003). The federal regulation setting upper payment limits for inpatient hospital services simply states that "[d]isproportionate share hospital (DSH) payments are subject to the following limits: . . . The hospital-specific DSH limit in section 1923(g) of the Act." 42 C.F.R. § 447.272(c)(2)(ii). The regulations on DSH payments simply address aggregate payments within a State and reporting requirements. *Id.* §§ 447.296-447.299.

The position taken in the draft audit is that the Letter itself, unaccompanied by any formal notice-and-comment rulemaking, binds the State to following all of the intricacies of the Medicare manual on hospital reimbursement. We disagree. Where the HCFA letter is not

[1] At the time of the Letter, CMS was known as the Health Care Financing Administration (HCFA).

a product of the agency's rule-making authority, it does not have the force of law, nor is it entitled to deference. *Christensen v. Harris County,* 529 U.S. 576, 587 (2000). Moreover, the draft audit report itself notes that "States have considerable flexibility in designing their DSH programs under sections 1923(a) and (b)." Draft Audit Rep. at i. The Letter simply describes what HCFA "would permit" in its anticipated -- but not actually forthcoming -- regulations. Letter Attachment at 3.

Notably, the recent proposed rule by CMS on DSH cost accounting (some eleven years after the Letter) omits any mention that the calculation of costs is capped by Medicare principles, defining total uncompensated care costs simply as "the total cost of care for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals and to individuals with no source of third party coverage for the hospital services they receive less the sum of [enumerated payments for these services]." 70 Fed. Reg. 50262, 50268 (Aug. 26, 2005); *see also id.* (stating that "DSH payments . . . must be measured against the actual uncompensated care cost").

It is also worth mentioning that all of the hospitals included in the review were private hospitals, and that the motivating purpose of the hospital-specific DSH limit was to prevent inflated payments to public hospitals:

> The Committee is . . . concerned by reports that some States have made DSH payment adjustments to State psychiatric or university hospitals in amounts that exceed the net costs, and in some instances the total costs, of operating the facilities. According to such reports, once received by the State hospital, these excess Medicaid DSH payments are transferred to the State general fund, where they may be used to fund public health or mental health services, to draw down more Federal Medicaid matching funds, or to finance other functions of State government, such as road construction and maintenance. A parallel transaction can occur at the local level. The Medicaid program is intended to assist States in paying for covered acute and long-term care services for the poor. In the view of the Committee, use of Federal Medicaid funds for unrelated purposes, such as building roads, operating correctional facilities, balancing State budgets, is a clear abuse of the program.

H. R. Rep. No. 103-111, at 211-12 (May 25, 1993).

In light of this concern, the original bill simply "limit[ed] the amount of payment adjustments to *State or locally-owned or operated* DSH hospitals to the [uncompensated] costs (as determine[d] by the Secretary) these facilities incur in furnishing inpatient or outpatient services to Medicaid-eligible patients and uninsured patients." *Id.* at 212 (emphasis added). Although the final version of the hospital-specific DSH limit ultimately did extend to private hospitals as well as public ones, *see* H. Conf. Rep. No. 103-213, at 813 (Aug. 4, 1993), it is important to keep in mind that Congress was not primarily concerned with overpayments to private hospitals, as is claimed to have occurred here.

B. In Any Case, the Draft Report Audit Misapplies Medicare Principles

Even if application of Medicare principles of cost reimbursement is required for purposes of determining a cap on Medicaid DSH payments, the draft audit report misapplies these principles. First, the draft report is simply mistaken in several respects about the meaning of these principles. Second, to the extent that these principles leave room for interpretation, they should not be applied in an unduly strict manner. On the contrary, if they are applied at all, they should be read in the way that most preserves State discretion, for the reasons stated in Part I.A above.

According to CMS's Provider Reimbursement Manual ("Manual"), "[a]ll payments to providers of services must be based on the reasonable cost of services covered under title XVIII of the Act and related to the care of beneficiaries," where "[r]easonable cost includes all necessary and proper costs incurred in rendering the services, subject to principles relating to specific items of revenue and cost." Manual, pt. I, ch. 21, § 2100. "Reasonable cost takes into account both direct and indirect costs of providers of services, including normal standby costs." *Id.* § 2102.1.

The Manual distinguishes between costs related to patient care and costs not so related. Costs related to patient care "include all necessary and proper costs which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities," and they "are usually costs which are common and accepted occurrences in the field of the provider's activity." *Id.* § 2102.2. Costs not related to patient care are those that "are not appropriate or necessary and proper in developing and maintaining the operation of patient care facilities and activities." *Id.* § 2102.3.

1. The Medicaid Enhancement Tax

The draft audit report is incorrect in its position that the Medicaid Enhancement Tax was not a proper expense under Medicare principles of cost reimbursement. The Manual clearly states that "[t]he *general rule* is that taxes assessed against the provider, in accordance with the levying enactments of the several States and lower levels of government and for

which the provider is liable for payment, *are allowable costs*." *Id.* § 2122.1 (emphases added). The Manual goes on to state that "[c]ertain taxes which are levied on providers are not allowable costs." *Id.* § 2122.2. The specific taxes in this unallowable category are then listed. The Medicaid Enhancement Tax fits into none of these categories and therefore remains within the general rule that taxes assessed on providers are allowable costs.

Of the specifically enumerated taxes that are deemed unallowable in § 2122.2, the draft audit report apparently regards the category for "State or local income and excess profit taxes" as barring the inclusion of the Medicaid Enhancement Tax. The Medicaid Enhancement Tax is not, however, an income tax, nor is it an excess profit tax. During the period in question, it was a tax on gross patient services revenue. It was, in short, a provider tax. Provider taxes are a cost of doing business as a hospital -- unlike income taxes, which simply represent the sharing of profits with the government -- and as such they are allowable costs. Thus, in *Regions Hospital v. Blue Cross & Blue Shield Ass'n/Noridian Govt.*, PRRB Dec. No. 2000-D64 (2000), the Provider Reimbursement Review Board (PRRB) held that two Minnesota taxes imposed only on hospitals and based on a percentage of net patient revenues were allowable costs for Medicare purposes. *Id.* at 8. The Board noted, among other things, that each tax was "levied and imposed on all [State] providers," that each was "a liability subjecting the provider to severe sanctions for non-payment," and that each was "a cost incurred for doing business as an ordinary and necessary business expense." *Id.* The Board also stressed that "the tax is not listed in § 2122.2 [of the Manual] as a non-allowable type of tax nor does it fall within the scope of any excluded tax listed in this section." *Id.* at 9.

And more recently, in *Central Maine Medical Center v. BlueCross BlueShield Ass'n/Associated Hospital Service*, PRRB Dec. No. 2007-D4 (2006), the PRRB addressed the costs of the Maine Hospital Tax, which was imposed on all Maine hospitals and which was "equal to 6 percent of a hospital's gross patient service revenue limit." *Id.* at n.2. The PRRB stated that the tax was plainly a reimbursable cost under Medicare principles. Precisely the same reasoning applies to New Hampshire's tax. *See also St. Joseph Hosp. v. Blue Cross & Blue Shield Ass'n/Blue Cross & Blue Shield of Minn.*, PRRB Dec. No. 2000-D47 (2000) (distinguishing tax on health care providers based on "the receipts from health care services" from taxes that "are essentially based on income," and holding that the former was an allowable cost of doing business); *id.* (describing tax in question as "a cost of doing business, i.e., an ordinary and necessary business expense" and noting that it was "not a specifically listed tax" in § 2122.2);[2] *La. Dept. of Health And Hosps.*, DAB No. 1176 (1990) ("FFP is

[2] For two decisions employing the same reasoning as that in *St. Joseph Hospital*, see *Bethesda Lutheran Med. Ctr. v. Blue Cross & Blue Shield Ass'n/Blue Cross & Blue Shield of Minn.*, PRRB Dec. No. 2000-D48 (2000);

available for provider charges that reflect state taxes that, like Social Security, are a cost of doing business.").[3]

We also note that the Manual specifically addresses franchise taxes, which it defines as "a periodic assessment levied by a State . . . on the operation of a business within [its] borders." *Id.* § 2122.4. The Manual provides that "[w]here the amount of the franchise tax is based upon the net income of the provider, with a minimum amount stated, [four] criteria will be used to determine whether and in what amount a franchise tax is an allowable cost." *Id.* While the Medicaid Enhancement Tax, during the period in question, was not "based upon the net income of the provider, with a minimum amount stated," the four criteria of § 2122.4 are instructive in demonstrating why the Medicaid Enhancement Tax should not be treated as an income tax or excess profits tax. The basic principle of these criteria is that to the extent a minimum franchise tax is imposed without regard to net income (or lack thereof), the tax is an allowable cost. *See* § 2122.4(A)-(D). It is plain that the Medicaid Enhancement Tax was imposed without regard to net income: for the period in question, hospitals were required to pay 6% of their gross patient services revenue, even if they had zero net patient services revenue, net income, or profit. Thus, were the principles of § 2122.4 applicable to New Hampshire's situation, they would show that the costs of the tax were allowable.

2. Bad Debts

The draft report states that the State improperly included bad debts[4] in calculating costs. These costs were not necessarily excluded by Section 1923(g)'s reference to "costs

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and *Divine Redeemer Hosp. v. Blue Cross & Blue Shield Ass'n/Blue Cross & Blue Shield of Minn.*, PRRB Dec. No. 2000-D49 (2000).

[3] Earlier DAB decisions also support the view that taxes of the sort at issue here are costs of doing business as a hospital, and as such are allowable. *See N.M. Human Servs. Dept.*, DAB No. 787 (1986) (where State imposed a tax on the "gross receipts of all for-profit businesses . . . for the privilege of doing business in the State," and where State Medicaid plan stated that "all costs not expressly provided for in the plan would be reimbursed in accordance with the terms of the Provider Reimbursement Manual (HIM-15), applicable to Medicare," holding that "[u]nder these Medicare principles, it is clear that the State would reimburse providers and fiscal agents for gross receipts taxes"); *Haw. Dept. of Soc. Servs. and Hous.*, DAB No. 779 (1986) (where State imposed tax "on the gross receipts of all businesses . . . for the privilege of doing business in the State," and where State Medicaid plan stated that "providers' costs would be reimbursed in accordance with Medicare principles of reimbursement," holding that "[u]nder Medicare principles it is clear that the State could use excise taxes as a provider cost in calculating provider reimbursement rates").

[4] The draft audit report cites 42 C.F.R. § 413.80(c) several times. We believe that this citation is simply a typographical error and that the intended citation is 42 C.F.R. § 413.89 (providing for treatment of bad debts). Section 413.80 pertains to the treatment of foreign medical graduates, a category not actually discussed in the draft audit report. We ask that if § 413.80 is actually relied upon, some explanation of its relevance be provided so that we can have the opportunity to justify our approach.

incurred . . . of furnishing hospital services" or by the Letter giving States maximum flexibility in calculating costs up to the Medicare maximum.

It is true that under the Medicare regulations, bad debts "are deductions from revenue and are not to be included in allowable cost." 42 C.F.R. § 413.89(a); *see also id.* § 413.89(c) ("Bad debts, charity, and courtesy allowances represent reductions in revenue. The failure to collect charges for services furnished does not add to the cost of providing the services. Such costs have already been incurred in the production of the services."). Even so, bad debts may be reimbursed though DSH payments, for the simple reason that Medicare itself reimburses bad debts. Thus, although Medicare principles generally provide that bad debts should not be included in cost, "bad debts attributable to the deductibles and coinsurance amounts *are* reimbursable under the program." *Id.* § 413.89(a) (emphasis added); *see also* Manual, pt. I, ch. 3, § 304 ("Bad debts resulting from deductible and coinsurance amounts which are uncollectible from beneficiaries are not includable as such in the provider's allowable costs; however, unrecovered costs attributable to such bad debts are considered in the Program's calculation of reimbursement to the provider.").

Thus, it is not inconsistent with Medicare principles of cost reimbursement to include these costs in the DSH calculation. The State acknowledges that CMS's proposed rule on DSH costs expressly provides that "[u]ncompensated costs do not include bad debt or payer discounts," 70 Fed. Reg. at 50268, and it is therefore preparing to eliminate these costs in the future, should these rules be promulgated.

3. Other Costs

The draft audit also claims that the State failed to exclude the costs associated with meals sold to visitors, with operating gift shops, and with entertainment, citing Manual, pt. I, ch. 21, § 2102.3; *see also id.* § 2105.2. Neither the statute nor the regulations require the exclusion of these costs. While they may not be directly related to patient care, they are legitimate costs of the hospital in running its business. In any case, the inclusion of these costs does not materially affect the calculation of uncompensated care costs.

4. The Use of Net Charges In the Cost-to-Charge Ratio

Even if the draft audit is correct that the statute and the Letter mean that the State DSH program can only reimburse for those costs that are considered reasonable under Medicare, it is incorrect in its implication that Medicare requires gross charges to be used in allocating those costs to Medicaid and the uninsured. The Letter says nothing as to how costs are to be apportioned. The draft audit report points to no authority requiring States to allocate on the basis of costs-to-gross-charges, because none exists.

Michael J. Armstrong
Page Eight
April 2, 2007

The State has long used the cost-to-net-revenue ratio as a means of determining the costs associated with Medicaid and the uninsured, and this approach has never been questioned until the draft audit. On the contrary, the State's approach has been an open book to CMS, which has never expressed any concerns. While the State's longstanding method produces a higher calculated cost than using the gross charge ratio, it is a fact that Medicaid patients and the uninsured are more expensive to treat, and the actual services received by these patients costs more to provide. *See, e.g.*, John Holahan, "Health Status and the Cost of Expanding Insurance Coverage," *Health Affairs* at 279-86 (Nov./Dec. 2001) (explaining that "[e]xpenditures increase sharply as health status worsens," and that because of differences in health status, both uninsured individuals and Medicaid individuals are significantly more expensive to treat than average -- Medicaid individuals more so than the uninsured); *see also id.* (reviewing data showing that the expense of treating an individual increases as income decreases). For instance, these patients tend to have worse primary care and higher rates of using emergency services. These and other factors make it more expensive for hospitals to provide services to Medicaid patients and the uninsured. The draft audit report's method fails to recognize the disparity in the cost of care for Medicaid and uninsured patients as compared to other patients. Rather, the report assumes that for any given treatment (and any given amount of gross charges), it costs the same to treat Medicaid and uninsured patients as it does to treat other patients. This assumption is incorrect and results in artificially low "costs" of treating Medicaid and uninsured patients. By contrast, the State's method takes account of the greater expense of treating these low-income patients relative to other patients. As such, in addition to operating in good faith under CMS's long standing tacit, if not explicit, approval, the State's approach is supportable.

That said, the State is aware that under CMS's proposed DSH rule, 70 Fed. Reg. 50262, uncompensated costs must be determined by an independent audit. Going forward, therefore, in the event this rule is promulgated, the State will not be using the cost-to-net-charge ratio unless it is also determined by the independent auditors to be the appropriate measure of uncompensated costs.

We look forward to working with your office to correct the inaccuracies reflected in the draft report. Please do not hesitate to contact me if you have any questions about the foregoing responses to the draft report.

Sincerely,

John A. Stephen
Commissioner