

Here are a few comments and observations on behalf of HCA's 48 affiliated Florida hospitals:

- The LIP needs to be an inclusive program such that all hospitals that provide charity care are allocated an equitable payment. Meaning that the threshold for the last tier should not be an unreasonably high percentage to qualify.
- Every hospital that qualifies in each tier should be included in that tier for payment. #71 b. ii. seems to indicate that not all hospitals would have to be included. However, #71 b. iii. states that all providers in the tier must receive "some amount of payment". All hospitals that qualify in a tier should receive the same percentage of payment, for example it would be inappropriate to only include hospitals that provide IGTs, etc.
- It is appropriate to require the non-hospital providers to meet the same standards for documentation of uncompensated care cost as the hospital providers. That provision should be maintained.
- #67. Can the uncompensated care definition be expanded to include the underinsured population that meet the charity care definitions for annual family income and family size and have adequate documentation? Patients with high deductible/co-payment insurance plans can have patient responsibility exceeding a charity care patient's ability to pay.
- #68.b.i. & #71.b. Can the charity care program be revised so that the program meets the requirements of the Florida Hospital Uniform Reporting System (FHURS) – a long standing charity care policy adopted by all Florida hospitals in reporting to the State (see attached excerpts from the manual) – rather than the requirements of the Healthcare Financial Management Association (HFMA)? The FHURS classification of charity care does not include bad debt or Medicaid shortfall so it meets the goal of CMS to only include charity care.
- Special Medicaid payments, rates of return, allocation factors, and any other payment mechanism that uniquely favors one set of providers over another should be completely eliminated on a going forward basis.

- 3) Charity Care.
- 4) Administrative, Courtesy, and Policy Discounts

5900	<p><u>PROVISION FOR BAD DEBTS</u> - This account shall contain the hospital's periodic estimates of the amounts in accounts and notes receivable that are likely to be credit losses. The estimated amount of bad debts may be based on an experience percentage applied to the balance of accounts receivable or the amount of charges to patients' accounts during the period, or it may be based on a detailed aging and analysis of patients' accounts.</p> <p>These losses will occur despite collection efforts of the hospital. <u>This account should not be used to report amounts for charity care.</u></p>
5910	<u>CONTRACTUAL ADJUSTMENTS – MEDICARE</u>
5911	<u>CONTRACTUAL ADJUSTMENTS – MEDICARE/HMO</u>
5920	<u>CONTRACTUAL ADJUSTMENTS – MEDICAID</u>
5921	<u>CONTRACTUAL ADJUSTMENTS – MEDICAID/HMO</u>
5940	<p><u>CONTRACTUAL ADJUSTMENTS – OTHER</u> (PPO's and HMO's other than Medicare/Medicaid)</p> <p>These contractual accounts must be used to report the differential (more or less) between the amount, based on the hospital's full established rates, of contractual patients' charges for hospital services which are rendered during the reporting period and are covered by the contract, and the amount received and due from third-party agencies in payment of such charges, including adjustments made at year end, based upon cost reports submitted.</p> <p>When reporting the contractual adjustments for Medicare and Medicaid programs, these adjustments will be separated into two categories: (1) Conventional Medicare and Medicaid, (2) Medicare and Medicaid HMOs. These adjustments will also be entered on the appropriate lines on worksheet C-2.</p> <p>Prior period contractual revenue adjustments, as appropriate will also be reported in these accounts rather than in the Fund Balance or Retained Earnings accounts.</p> <p>When the difference between the amount of a patient's bill and the payment received by the hospital from a third-party agency is recoverable from the patient, any resulting uncollected amount should be reported in the appropriate bad debt or uncompensated care category and should not be reported in contractual adjustments.</p>
5950	<p><u>CHARITY CARE – HILL BURTON</u> - Account 5950 shall be used to report the charges applicable to any charity services that are being used to comply with the requirements of the Hill-Burton Hospital and Medical Facilities Construction Plan.</p>
5960	<p><u>CHARITY CARE – OTHER</u> - Account 5960 shall be used to report "Charity care" or "uncompensated charity care" which means that portion of hospital charges reported to the Agency for Health Care Administration for which there is no compensation, other than restricted or unrestricted revenues provided to a hospital by local governments or tax districts regardless of the method of payment, for care provided to a patient whose family income for the twelve months preceding the determination is less than or equal to 200 percent of the federal poverty level, unless the amount of hospital charges due from the patient exceeds 25 percent of the annual family income. However, in no case shall the hospital charges for a patient whose family income exceeds four (4) times the federal poverty level for a family of four be considered charity.</p> <p>Each hospital will determine which patients are charity care patients by a verifiable process subject to the following provisions:</p>

	<p>Documentation shall include one of the following forms:</p> <ol style="list-style-type: none"> 1) W-2 withholding forms 2) Paycheck stubs 3) Income tax returns 4) Forms approving or denying unemployment compensation or worker’s compensation. 5) Written verification of wages from employer 6) Written verification from public welfare agencies or any governmental agency which can attest to the patient’s income status for the past twelve (12) months 7) A witnessed statement signed by the patient or responsible party, as provided for in public law 770-725, as amended, known as the Hill-Burton Act, except that such statement need not be obtained within the 48 hours of the patients’ admission to the hospital as required by the Hill-Burton Act. The statement shall include an acknowledgement that, in accordance with Section 817.50 F.S., providing false information to defraud a hospital for the purpose of obtaining goods or services is a misdemeanor in the second (2nd) degree. 8) A Medicaid remittance voucher which reflects that the patient’s Medicaid benefits for that Medicaid fiscal year have been exhausted. <p>Charges applicable to account 5950 should not be reported in this account. Contractual adjustments should not be reported in this account. When the hospital receives lump-sum grants or subsidies (rather than specific payments for an individual patient’s bill) from governmental or voluntary agencies for the care of medically indigent patients, the amount of the lump-sum grant or subsidy must be reported under “Restricted Donations and Grants for Indigent Care” (Account 5970).</p>
5980	<u>ADMINISTRATIVE, COURTESY AND POLICY DISCOUNTS</u> - This account shall be used to report write-offs of debit or credit balances in patient’s accounts in which the cost of billings or refunding exceeds the amount of the account balance. In addition, reductions in the nature of courtesy allowances must be reported in this account.
5981	<u>EMPLOYEE DISCOUNTS</u> - This account shall be used to report employee discounts from the hospital’s full established rates for services rendered.
5990	<u>OTHER DEDUCTIONS FROM REVENUE</u> - Other deductions from revenue which are not included elsewhere must be reported in this account.
5995	<u>RESTRICTED DONATIONS AND GRANTS FOR INDIGENT CARE</u> - This account is used to report voluntary and governmental agency grants or subsidies for the care of nonspecified medically indigent patients during the current reporting period.

OTHER OPERATING REVENUE - 5010-5890

This group of accounts is used to report all operating revenues other than those that are directly associated with patient care.

5020	<u>TRANSFERS FROM RESTRICTED FUNDS FOR RESEARCH EXPENSES</u> - This account reflects the amount of transfers from restricted funds to the Operating Fund to match expenses incurred in the current period by the Operating Fund for restricted fund research activities.
5220	<u>NURSING EDUCATION</u>
5240	<u>POSTGRADUATE MEDICAL EDUCATION – APPROVED TEACHING PROGRAMS</u>
5250	<u>POSTGRADUATE MEDICAL EDUCATION – NON APPROVED TEACHING PROGRAMS</u>
5260	<u>OTHER HEALTH PROFESSION EDUCATION</u> - These accounts (5220-5260) are used to report the revenue from the schools of nursing, postgraduate medical education, paramedical education, and other professional education activities.