

**"Implementation of Section 3133 of the Affordable Care Act: Improvement to Medicare  
Disproportionate Share Hospital Payments"  
National Provider Call  
Moderator: Hazeline Roulac  
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**Operator:** At this time I would like to welcome everyone to today's "Implementation of Section 3133 of the Affordable Care Act: Improvement to Medicare Disproportionate Share Hospital Payments" National Provider Call. All lines will remain in a listen-only mode until the question and answer session. This call is being recorded and transcribed. If anyone has any objections you may disconnect at this time. I will now turn the call over to Hazeline Roulac. Thank you, you may begin.

Hazeline Roulac: Thank you, Brooke. Hello, this is Hazeline Roulac from the Provider Communications Group at here at CMS. I will serve as your moderator today. I would like to welcome you to today's National Provider Call focused on implementation of Section 3133 of the Affordable Care Act – improvement to Medicare disproportionate share hospital payments. This National Provider Call is part of the Medicare Learning Network, your source for official CMS information for Medicare Fee-for-Service providers.

Before we get started, there are a few items that I'd like to cover. A slide presentation has been prepared for this call. A link to the presentation was included in your registration reminder e-mails and was also e-mailed to all registrants today after the close of registration. If you did not receive these e-mails, please check your spam or junk mail folder.

The presentation can be found at the following Web site, [www.cms.gov/npc](http://www.cms.gov/npc). And that's [www.cms.gov/npc](http://www.cms.gov/npc). From the left side of the Web page select National Provider Calls and Events. Once on the Web page, the link to the presentation can be found under the Call Materials heading. This call is being recorded and transcribed. An audio recording and written transcript will be posted to the National Provider Calls and Events Web page in approximately two weeks.

At this time, I would like to introduce Marc Hartstein, the Director of the Hospital and Ambulatory Policy Group in the Center for Medicare here at CMS, Marc.

Marc Hartstein: Thank you, Hazeline. This is Marc Hartstein. I am the Director of the Hospital and Ambulatory Policy Group in the Centers for Medicare & Medicaid Services in the Center for Medicare Management. I want to thank everybody for participating today and look forward to a very productive call on Implementation of Section 3133 of the Affordable Care Act. Before we get started, I do want to take a slight detour from the agenda to make an announcement about the Hospital Value-based Purchasing Program since we have a large audience on this call and information about the Hospital Value-based Purchasing Program may be of interest to participants on this call.

So I'm going to turn it over briefly to Craig Caplan, who'll make a quick announcement about Hospital VBP.

## **Announcements**

Craig Caplan: Thank you, Marc. A couple of things. First, CMS posted the actual value-based incentive payment adjustment factors for the Fiscal Year 2013, Hospital Value-based Purchasing

Program on December 21st. The factors can be found in table 16 of the Fiscal Year 2013 Final Rule home page and on the Hospital VBP page on cms.gov. For hospitals eligible for the Hospital VBP Program, these adjustment factors will be applied to base operating DRG payment amount for discharges occurring in Fiscal Year 2013 and they do not affect CMS' calculation of any IME, DSH, or outlier payment amount.

Second announcement is that CMS updated the Medicare Spending for Beneficiary Measure data on Hospital Compare on December 13<sup>th</sup>, 2012 for the data collection period of May 1<sup>st</sup> through December 31<sup>st</sup> of 2011. The median Medicare Spending per Beneficiary, or MSPB, amount across the nation was \$18,307.30. I'll repeat that. It was \$18,307.30. That is the denominator for the MSPB measure rates currently displayed on Hospital Compare.

Marc Hartstein: Thank you, Craig. So now I'm going into the regular agenda, and I'm very happy to hear that we have so many participants on today's call. Obviously, there's a lot of interest in Section 3133 of the Affordable Care Act. This presentation will cover a review of the Medicare disproportionate share payment requirements of Section 3133 of the Affordable Care Act, to be effective beginning in Federal Fiscal Year 2014.

CMS commissioned Dobson DaVanzo & Associates, LLC and KNG Health Consulting, LLC to provide technical assistance. During today's call they will discuss the statutory requirements and present findings of their analysis, identifying possible data sources and definitions for measuring the change and uninsured and uncompensated care.

Dr. Al Dobson is a Ph.D. economist and co-founder and president of Dobson DaVanzo & Associates. He has over 30 years of experience in health care services research, including designing and evaluating CMS payment systems. Dr. Dobson was the Director of Research for the former HCFA – for the former HCFA when IPPS was designed, implemented, and evaluated. Prior to starting Dobson DaVanzo, Dr. Dobson was the Director of Healthcare Finance Practice at The Lewin Group. He has testified before the U.S. Congress, presidential commissions, and numerous state legislative bodies.

Dr. Dobson has widely published and peer review journals. I've worked with Al for a very long time and we're very grateful to have him on this project. Dr. Lane Koenig is president, founder of KNG Health Consulting. He has led a variety of data-driven analysis covering a broad range of health care issues from payment policies studies, to cost-effective analysis, to legislative and regulatory studies.

Prior to founding KNG Health, Dr. Koenig worked as a senior economist for the Office of Policy in CMS. Dr. Koenig has a Ph.D. in Economics from the University of Maryland, and I've also worked with Lane for a number of years, and I'm also grateful to have him on that project. And with that, I will turn it over to our experts.

## Presentation

Al Dobson: Thank you. Well, I'll give you the page numbers as we move through. On page 2, the presentation overview, we'll start with the goal of a National Provider Call. We'll look at the scope of the work at Dobson DaVanzo and KNG had. We'll review Section 3133 as it pertains to DSH. We'll look at the analytic methods we employed in the study. Lane will then provide the uninsured definitions and data sources and then I'll provide the uncompensated care definitions and data sources. We'll conclude with conclusions, next step and discussion, and entertain public comment.

We will not answer your questions today except for clarifying questions, no policy questions will be answered today. They can only be raised. On page 3, the goal of the provider call, today we're going to solicit our comments to inform the implementation of Section 3133 of the Affordable Care Act as it relates to definitions and measures of the uninsured and uncompensated care.

The call today will review Medicare DSH requirements under the ACA, which is effective in 2014 fiscal year. We'll present our findings and identify possible data sources and definitions for measuring the change in the uninsured and uncompensated care. Page 4, our scope work, Dobson DaVanzo and our partner KNG were commissioned to provide CMS with technical assistance as it implements the revised Inpatient Perspective Payment System DSH program as called for by, again, Section 3133.

The scope of work includes analysis of potential definition and data sources for measuring the change in the uninsured and the levels of uncompensated care. Our scope of work does not include interpretation of Section 3331 policy – 3133 policy divisions. Yes, we review on page 5 Section 3133. Beginning in FY 2014, 25 percent of estimated Medicare DSH payments will continue to be paid to each hospital. That is to say that the now current system will continue at least 25 percent in 2014.

The remaining 75 percent of the estimated Medicare DSH payments will be adjusted by two additional factors and distributed as an additional payment. Factor two, reduce remaining 75 percent of estimated Medicare DSH payments as a result of the estimated decrease in the uninsured.

Dr. Koenig will speak to that today. Factor three, target remainder of the 75 percent of estimated Medicare DSH payments the individual hospitals based on their proportion of the amount of uncompensated care provided by DSH hospitals. On page 4 we have schematic. On the left side, the very far left side, we talk about the estimated Medicare DSH payments in 2014 based on DSH payment percentage. The first thing that happens on the very left side is, as we said, 25 percent of estimated hospitals receiving Medicare DSH payments will flow through. The remaining 25 percent will be adjusted in two ways.

The first way is to reduce the 75 percent by any amount or decrease that would happen to the uninsured rate. Or formerly, it will be adjusted by one minus percent change in a national uninsured rate for the under 65 years from 2013. Then, finally, that amount that remaining

amount will be allocated based on the proportion of hospitals uncompensated care relative to the total national uncompensated care pool. Those together –the 25 percent and the adjusted 75 percent – will then provide the estimated individual hospital Medicare DSH payments plus the new additional payment.

On the right side of six we just take those things that you need to know. You need to know the total estimated Medicare DSH payments, what they would have been. Then, you need to know the change of the uninsured rates and then you need to know each hospital share of uncompensated care using a Section 3133 definition of uncompensated care, for each hospital and the national pool.

We'll speak today primarily to how we estimate the change in the uninsured rates and how we will estimate each hospital share. Our analytic methods on page 7 – we have focus literature review where we identified possible definitions of both the uninsured and uncompensated care and we also looked extensively at data sources for measuring the uninsured and uncompensated care. We had structured interviews where we sought expertise both from survey experts and stakeholders in the field on the definition of uncompensated care.

We also analyzed and practiced data definitions and sources from a wide variety of sources where we try to come up with some notion of how people exist in redefining on uncompensated care. So, for the next section of our presentation Lane Koenig will walk us through uninsured definitions and data sources. Lane.

Lane Koenig: Thank you Al. As Al mentioned, we're going to be reviewing the analysis of potential definitions and data sources for the uninsured. That's factor two and it relates to an adjustment that's being applied to the 75 percent pool of total DSH payments. On slide 9 you will review the legislative context for factor two. For Fiscal Year 2014 through Fiscal Year 2017, Section 3133 prescribes the needs of uninsured estimates from the Congressional Budget Office.

So when we talk today in terms of alternative data sources for measuring changes in the uninsured it relates to the period Fiscal Year 2018 and onwards. Now, Section 3133 permits the use of data sources other than CBO for that period and as legislation indicates and are reviewed for Fiscal Year 2018 and each subsequent fiscal year a factor equals the one minus of the percent change in the percent of individual who are uninsured is calculated determined by comparing the percent of individuals who are uninsured in 2013 to individuals who were uninsured in the most recent period for which data is available.

And then for 2018 and 2019 there is a point two percentage point adjustment to that rate. So for years 2018 and beyond, the basis of which 2013 and then we are comparing the changes in the uninsured from that phase. Slide number 10, to conduct our work we review national survey, five national surveys. The five are the Current Population Survey, and that Current Population Survey has an annual social and economic supplement which includes and collects information about insurance status.

Second one is the American Community Survey; third one is the Survey of Income and Program Participation. These three are all produced by the U.S. Census Bureau. And then two additional

surveys we examined one is the Medical Expenditure Panel Survey also referred to as (MEPS) and then fifth one is the National Health Interview Survey, or the NHIS.

The Medical Expenditure Panel Survey is produced by the agency for Health Care Research and Quality and the National Health Interview Survey is produced by the National Center for Health Statistics. We reviewed the methods and results of these surveys respective of the uninsured. We also interviewed survey experts and CBO analysts to gain a better understanding of the methods and approaches used to develop the estimates for the uninsured.

And then we conducted a comparative analysis. We compared data sources along several dimensions and identified the strength and limitations of each. Under slide 11, the next two slides present the dimensions or the primary dimensions, three slides, the primary dimensions on which we compared the five different surveys. The first one was conceptual definition and coverage, and what I mean by that is, how is an uninsured defined and what population is being measured in each in the surveys?

Now, any measure of the uninsured should correlate with the uncompensated care burden. However, how the surveys define and measure uninsured some may be better correlated or more strongly correlated with uncompensated care than others. Second dimension that we compare to surveys on was length of the uninsured period. So is the survey asking respondents about their insured status as time of the survey, or for some time period whether it's partial year or full year before the survey. We referred to surveys that asked questions about whether an individual is uninsured or insured at the time of the survey. Those are referred to as point and time estimates and the other ones are partial year or full year estimates.

Next slide, slide 12 and we examined the recall period. This refers how far back in time does a respondent have to remember in order to answer the survey question correctly. If we're thinking about a point-in-time estimates, then there is no recall period. The question is simply, are you currently insured when you're looking at year – full year estimates or partial year estimates – then there's some recall period that's required. Respondents have to think back to a certain period of time and answer whether they were insured either at any point during that period or uninsured or insured for that entire period.

Timeliness, what is the time period between the reference period, the time period for which data are being collected and the release of the uninsured estimates? The surveys that we reviewed varied in the timeliness. Some come out rather quickly after the day it's been collected and some take a little bit longer to make the information publicly available. Now one other dimension point, the dimension in which we compare that I'll mention. This here is a sampling frame data collection of methods. So methods more generally and we don't list it here because all the surveys are of high quality. All of them do very well in terms of sampling frame, their data collection method. There's some variation which I'll talk about but that was a dimension that we offered to compare.

Slide 13, the last three dimensions on which we compare each of the surveys, one was continuity of the data series, have the survey definitions changed over time or they expected to change. This is an important question because as I reviewed the language of legislation, starting in 2018

we're comparing baseline uninsured rates that is uninsured in 2013 to 2018. So, if there's a change in how the survey measures or defines the uninsured between 2013 or 2018, that's referred to as a break in series and some changes are more significant than others.

But that's one dimension that we reviewed the databases on. Medicaid coverage and undocumented immigrants, how accurately is the survey capturing those responses and respondents were covered by Medicaid and undocumented immigrants – does the survey design inhibit participation by undocumented immigrants. Those were last two dimensions which we evaluated the surveys.

Slide 14, so the next few slides provide a little more detail on each of the surveys. I'm going to describe some key elements of each one before we do a side-by-side comparison of each of the surveys. So the first one, the Current Population Survey, and the Annual Social and Economic Supplement to that, as I mentioned it's produced or sponsored by the Census Bureau.

The CPS is a computerized monthly survey. Respondents participate for four consecutive months, leave the sample for eight months and return for another four months. By computerized survey, what I mean is it's a "Computer-Aided Personal Interview," or CAPI. In fact, all the surveys with the exception of the American Community Survey, all the surveys we reviewed were CAPI, which means that the data collector actually visits the household and conducts the personal interview with a computerized survey instrument allowing for targeted probing to ensure the respondents understand the question.

CPS contains questions on labor force participation and earnings. So it's not specific to healthcare or the uninsured. That comment applies also for the American Community Survey and the Survey of Income Participation. Those three surveys are not specific to health or health-related issues or insurance coverage, but they are more general and ask about labor force participation and other information.

The last two surveys, the MEPS and the National Health Interview Survey, are actually health-specific. A couple of other key points I'll make about on slide 14 and the Current Population Survey and the American Community Survey. The Current Population Survey is a sample size of about 60,000 households. The American Community Survey is a sample size of 2 million households. This is by far the biggest survey.

One of the differences, though, in the American Community Survey versus the other four is that it's a paper survey. So the other ones use Computer-Aided Personal Interview surveys. The ACS is a paper survey with – surveys are mailed to respondents and then there's a rigorous follow-up that is done to ensure a high response rate.

On slide 15 reviewing the Survey of Income Program and Participation – again that's sponsored by the U.S. Census Bureau. It's CAPI as I mentioned. Respondents are interviewed three times a year for 3 to 4 years and the sample ranges from 14,000 to almost 40,000 households per panel. The Medical Expenditure Panel Survey which is sponsored by the Agency for Healthcare Research and Quality.

Again it's a CAPI survey. It is focused specifically on healthcare utilization and insurance coverage, sample size of 14,000 households and 35,000 individuals. The National Health Interview Survey is sponsored by the National Center for Health Statistics. The MEPS, the Medical Expenditure Panel Survey, is actually a sub-sample of the National Health Interview Survey. So a lot of methods are the same. The National Health Interview Survey has questions on Health Care Statistics and Health Services, the MEPS has additional information that's collected but the MEPS is a sub-sample. So The National Health Interview Survey has a larger sample size of 35,000 households included and which covers about almost 88,000 individuals.

OK. So with that overview of each of the surveys, on slide 16 there were certainly a number of factors that were comment across all surveys. One, they all had very similar definitions of the uninsured. The sampling frame and the methodology used by all are very similar. The sampling frame is the civilian non-institutional population and it does not include populations living in group quarters, active duty military staff or residents of Puerto Rico.

The one exception is the American Community Survey. So this is the paper survey. It's different in a couple of respects from the other one and the American Community Survey does include active duty military, residents of Puerto Rico and residents of group quarters in its sampling frame. The surveys are very similar and they're Medicaid coverage and they're treatment of undocumented immigrants. All the surveys, in talking to the experts, all the surveys they say that they probably undercount Medicaid coverage, although they take significant steps and efforts not to do that. The challenge is the Medicaid recipient often do not know that they are covered by Medicaid in part because Medicaid programs have different names in different states or because they believe they're uninsured.

In undocumented immigrants all sample designs are based on household addresses. There's not any demographic information about the household members. So there's no special treatment. However, all the experts that we spoke to said that they would expect that undocumented immigrants might be more reluctant to answer the survey. But along those dimensions the five surveys and perhaps with the exception of the American Community Survey they're all very similar.

Slide 17, we talked about some differences between the survey. They're forming differences that we can compare. One is the length of the uninsured period being measured. Second one is the recall period. The fourth is the timeliness and the fifth is the continuity. The length of the uninsured period have to do with the – it is linked to the recall period actually and it has to do with the period in which the survey is asking whether a person is uninsured. So CPS has currently it asks whether folks are uninsured for the previous calendar year.

Now, the CPS is going to make a change starting in 2014. In 2014 they're going to add in a point-in-time estimate. So starting in 2014 for the CPS there will be previous calendar year and insured estimates as well as point-in-time estimates. The recall period can vary and it varies depending on when individuals are actually asked the question and of course it's going to vary depending on their ask – whether the question is related to the previous calendar year uninsured or starting 2014, whether they're currently uninsured – their point-in-time estimates.

Estimates for CPS are released at least 9 months after the reference period. Effort continuity for the point-in-time estimates from CPS there's going to be a break in the series. There's not going to be a point-in-time estimate available for 2013 since that's going to start in 2014 which would be a limitation in using the CPS and the point-in-time for the CPS going back to 2013 since we didn't exist.

There actually was also a change in the full year estimates but those changes were or we're going to be implemented this year so that the break would be between 2012 and 2013 but they would be continuous in the full year estimates between 2013 and subsequent years. The ACS is the point-in-time estimate. So at the time of the survey they ask people whether they're – what insurance they might have. It's a paper survey. So it's just one question and that's what it's based on. The estimated release date is 10 months after the reference period. So that's comparable to the CPS, where CPS is 9 months after the reference period and ACS is 10 months after. The health insurance questions will be revised. There's a break in series that's expected sometime after 2013, but they don't know for sure when they're going to implement the revision, which is all indications or from the experts that they will be making some revision.

The fifth, a multiple period can be measured from the micro-data. There's not necessarily a public release of information on the uninsured from the CPS but you have to go to the micro-data and from the micro-data you can actually construct many different definitions of the uninsured or length of the uninsured period. Because of that depending on what measure the uninsured review the recall vary depending on which measure up to four months.

So, the longest they ask people to go back is looking over the quarter and asking them whether they had insurance for that quarter. As I mentioned there's no regular release schedule. So it's just part of you accessing the micro-data and developing estimates of the uninsured from that. The health insurance questions will be revised. It's going to be a break in the series expected sometime after 2014. Again we don't know for sure when those changes will be implemented.

But the experts indicated that there will be a change that's coming for that survey. Slide 18, reviews the MEPS and the NHIS. As I mentioned earlier, the MEPS is based on a sub-sample of the NHIS. There's some similarities. There's some differences also in both lengths of uninsured, recall period, timeliness, and continuity although actually there is similar in the continuity.

For MEPS, MEPS can support multiple definitions of the uninsured for first half a year, uninsured for an entire year, uninsured at any time during the survey year. So all three of those are produced by the MEPS depending on the definition or the length of the uninsured period, the recall period can vary and maximum is up to 6 months. Estimates are released about 11 to 20 months after the reference period. There's no anticipated break in series; that is, the questions are expected to be the same for MEPS from 2013 onwards.

For NHIS there's a point-in-time estimates that's available, which ask question about whether you're insured at time of the interview, whether you're insured at least part of the year prior to the interview and then uninsured more than 12 months at time of interview. Again the recall period varies depending on the uninsured period, so it can be up to 12 months recall period.

NHIS is probably the quickest in terms of the release of the data, estimates are released approximately 6 months after the reference period. Again there's no break in series that's expected for the NHIS data. So a couple of quick summaries on our main points, on slide 19 point-in-time estimates versus other estimates. Point-in-time estimates have several advantages over other types of estimates. It's expected that full year and partial year estimates may not capture movement in that of the uninsured pool as well as point-in-time estimates.

There's also sort of recall period that's required for point-in-time estimates and in fact if the point-in-time estimates whether on that day that you're going to survey, whether you're insured then there's no recall period and as a result of that it is expected that point-in-time estimates will produce more accurate estimates as compared to other estimates that are based on longer recall period.

And for those reasons in my affected cases they've got both point-in-time estimates and more likely to be more correlated with any measure of uncompensated care at least compared with full and partial year estimates. So, on slide 20 we lay out our assessment of the data sources because of the commonalities and the number of dimensions we don't repeat those dimensions here instead we look at timeliness, continuity, data collection which is the method whether the topic covered that simplifies, and those types of things.

I'm sorry, data collections what topics are covered and then accuracy which relates to sample size, standard errors and response rates and the result of that are shown on slide 21. I should say that these assessments are not meant to provide some way of comparing the quality of these surveys to each other. They're all very good surveys. They've all been done very well. They all have very low non-response rates.

There is complex survey design. There's effort to ensure that the responses are representing the view and there is adjustments that are made to do that. But along the dimensions that might be important for the DSH policy point-in-time estimates as we said it has some advantages. Timeliness is important, continuity, accuracy in data collection. So we look along those dimensions. Like I said all of them are pretty good. The CPS if you look just the point-in-time estimates the CPS, as I mentioned, will have a point-in-time estimates but that's starting in 2014.

All the other surveys, including CBO, provide point-in-time estimates of the uninsured and so that's the good aspect of these – of the surveys. Timeliness, the time between reference period and release date, they all do pretty good. The NHIS, I would say, in our assessment, is probably better than all the other ones. They're actually for the NHIS this is – this is – well, for the NHIS they do a release every quarter and each quarter sort of builds on each prior release. So in December they would release, for NHIS the January to June estimates, in March they update that through September. So January through September, and then in June, that would provide estimates for periods covering from January to December as a prior year. So that's why NHIS is assessed as excellent on that. Continuity, there's no break from series. I anticipated for MEPS or NHIS and as I discussed earlier they have anticipating some changes in the survey and so some break in series from the CPS, ACS and the SIPP.

Data collection, they all are really solid in terms of their method. The ACS on the downside is the paper survey and so there's no non-opportunity for probing on the part of an interviewee. On the other hand it has the largest sample size and so the estimates are at the smaller standard errors which is a measure of precision than the other ones. So they're all again, I reiterate, they're all sort of good surveys.

And they're all – accuracy is very strong. CPS and ACS are excellent as well and NHIS they have the smallest standard errors or that the lowest margin of error. That's driven in large part by their sample sizes. The SIPP and MEPS we say are good MEPS test or small sample size or they have a relatively small sample size certainly relative to the NHIS. As I mentioned it's a sub-sample that we gave that a good.

We included CBO on here. CBO estimates a projection based on models that uses a SIPP data but the CBO does a number of adjustments to that and the SIPP is a point-in-time estimate. So you can think of CBO as a point-in-time estimate. The continuity obviously for the CBO is going to be excellent. They have their methodology. They upgrade the methodology over time but this continuity in the series there. The other aspects of CBO are not really applicable. So that's it I'll turn it back over to Al Dobson to finish up.

Al Dobson: Thank you Lane. Before I start I'll, kind of, re-phrase what we're doing here. Section 3133 provides a framework for changing how the DSH payments are made from Medicare. It provides a framework. The framework has three parts. The first part is to calculate the DSH pool the way it's currently calculated, call that the sort of current DSH pool or the pool that currently exists. Then that DSH pool is divided into two components, 25 percent, which is roll forward as it currently is, the remaining 75 percent has two things done to it.

First it's reduced by the change in the uninsured rate that was the purpose of Lane's presentation and finally there's a re-distribution of dollars across hospitals. So that's 75 percent of the residual pool after it's reduced for the change in the uninsured rate and that pool is what percent of the nations uncompensated care pool does each hospital have?

Each hospital gets fractionally the proportion of uncompensated care that they represent in the entire pool. So what we're going to talk about now on page 23 is we're going to talk about how we're going to measure in the future uncompensated care such that we get to the point where we need to know what each hospital share is. We'll know how it's measured majored and we'll talk about the gives and takes to how that might be done.

As with Lane's and our entire methodology, we started with literature review and we had our stakeholder interviews. We found some variation in how existing programs and entities that find uncompensated care. We looked at Federal programs, Medicare, Indian Health Service, Health Information Technology for Economic and Clinical Health. We saw that the states have a fair amount of difference in how they define uncompensated care.

And we looked at ratings organizations or research organizations and we looked at provider organizations as they attempt to wrestle with how uncompensated care is defined. We looked

across programs and entities and we found that charity care and bad debt are always included in the definitions of uncompensated care. So the bed rock of the definition is that some form of charity care, some form of bad debt is always in the definition of uncompensated care. Although with that said some entities also include payment shortfalls from government funded plans with third party payers.

Now it's important to know as we go off this page, that as we change the definition of uncompensated care it doesn't change the size of the pools we have talked about. It doesn't change the 25 percent. It doesn't change the 75 percent. What it changes is each hospital share of the definition of uncompensated care.

Page 24 we show some number of programs and entities on the left side and then we see as I had promised that essentially all definitions have bad debt and charity as the heart as the cornerstone, as the art stone. Some definitions however particularly in Medicaid programs will add a government payment shortfall. See Arizona and Florida for instance, Standard and Poor has a bad debt charity care and includes commercial and/or discounts because anything that weakens a hospital from Standard and Poor less payments are less payments.

Price Coopers and Waterhouse again, bad debt charity care and includes commercial and/or discounts, and then we have provider organizations trend watch for American Hospitals Association tends to have bad debt charity care, although other AHA definitions would have shortfalls included. Also the Catholic Health Association suggested in some instances they would feel that the definition should include government payment shortfalls.

On page 25, so again uncompensated care is most often defined as charity care plus bad debt but may include government and or commercial payment shortfalls. Charity care is a care provider to the uninsured who meet financial eligibility requirements and for whom hospital does not expect to receive payment. Somewhat differentially defined by each hospital, hospitals have their own charity care policies which they are then asked to follow, bad debt, unreimbursed care, provided the persons for whom the hospital expected but did not receive payment.

And payment shortfall is a difference between payments and cost by payer. Now, there are some cross cutting themes continued, uncompensated care is reported as cost rather than charges. So the cost to charge ratio is used to take the charges and move them to down, their charges times the cost to charge times ratio are equal the cost.

Charity patients must meet guidelines. Their quality are qualified for uncompensated care such as the uninsured disqualified for a Federal program, under a certain Federal poverty level, etc., each hospital again, define a charity care patient and different cost according to these definitions. Definitions of charity care – vary significantly by state, by counties, and by hospitals in order to accommodate the population served and the financial mission or the ability or the care giving ability of the institution.

Data sources, we looked at data sources and from what we need to do there very few data sources that are actually available and current and publicly available. We looked at the AHA Trend Watch, which isn't publicly available. We looked at publicly available hospital financial

data from state agencies but they're not uniformly available across all states. We looked at the Medicaid DSH audit data, again not uniformly reported across all states.

We looked at the Form 990 but it's only for not profit hospitals. We looked at the old Medicare Cost Reports CMS 2592 which was widely believed not to answer the questions we haven't had and that left us with the new with quotes "Medicare cost reports CMS 2552-10," which I'll spend most of the rest of my time talking about.

Now, on page 28 moving straight to the S102552, I'll look at the lines because the line when you look at the form is really how the thing works. Line 23, cost of charity care, plus the cost of non-Medicare bad debts line 29 provide line 30. Line 30 would be the basic definition cost of non-Medicare uncompensated care but our stakeholder interviews suggested that we ought to look more broadly.

On the left hand side, we see that we have cost-to-charge ratio on page 29 times the initial obligation of charity care patients, so we have the cost-to-charge ratio times the charges gives us a cost the total obligation for charity care patients line 21, subtract out their other payments that are made on behalf of charity care patients and we get the cost of charity care, line 23.

In the middle, total facility bad debt line 26, subtract out 1886(d) hospital/CAH of Medicare bad debts. In other words Medicare wouldn't pay its own bad debts back take those out, non-Medicare and non-Medicare reimbursable bad debt in charges, you multiply the charges times the cost charger ratio, and we get line 29, cost of Medicare bad debt.

Again, 23 plus 29 line 30 cost of non-Medicare uncompensated care, now other stakeholder considerations on page 30, we identify areas for further consideration, one would be inclusion of all uncompensated care and unreimbursed costs contained in line 19. Line 19 is total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs. Under this definition total unreimbursed cost would be equal to line 19 plus line 30 equals the line 31.

We could also have the inclusion of charity write-offs as services provided outside of the reporting period. This is a technical issue to make sure that as you move across time, if somebody hadn't reported and it was missed in the cost report, you could go back and pick it up or move it up through time. It's a matter mostly of accounting to make sure that all the bad debt that's out there and charity care would be included in the final estimate of the hospitals uncompensated care.

And then there was an argument made that there should be the inclusion of GME costs in the calculation of the cost-to-charge ratios, by using costs from worksheet B column 24, line 118. The idea there is that the current line 1 of the S10 CCR does not account for GME including GME costs on the S10 could more accurately match cost to gross revenues and that hence charges. This would affect the cost of the charge ratio reported in line 1 and the stakeholders were arguing at least in part that would mean they step down from charges using the cost-to-charge ratio to get costs more accurate.

Page 31, essentially you have to really build a flow chart to go over this very carefully but we spent some amount of time understanding the flow of the S10 when it will become available. The long and short of page 31 is we believe there will be sufficient S10 data on hand that it could support to development of a 2014 IPPS NPRM that would build the definitions that I've outlined and alluded to above.

Conclusions, again not to hammer away too much but 25 percent of the old way stays this way forward, 75 percent of that pool will be reduced in part by changing the uninsured rate than those dollars to be allocated based on the hospital share of uncompensated care, defined however CMS makes their final policy calls. That said then, for the measurement of changes for the uninsured from FY 2018 and forward that's factor two.

Point-in-time estimates of insurance status have several advantages, as Lane said, over other estimates. Other considerations for selecting an uninsured data source are timeliness, continuity, survey focus, and accuracy. And finally with respect to bad debt and charity current compensated care, the common definition is bad debt plus charity but the stakeholders did suggest other inclusions that could be added.

It looks as if we could use the—the Form S10 could be used to broaden the definition if that should be the final policy call. So no Section 3133 DSH policy, I'm on page 33, will be released by CMS until the FY 2014 NPRM is available, hence we will not be answering policy questions today. CMS will – address data source definitions procedures and timing in the end NPRM, moderator.

## Polling

Hazeline Roulac: Thank you Allen. In just a moment will open the call to receive your questions and comment. But before we do, we will pause briefly to conduct keypad polling. Keypad polling allows CMS to obtain an estimate of the number of participants in attendance today. Please note that there may be a few moments of silence while we tabulate the results, Brooke we're ready to start polling.

**Operator:** CMS greatly appreciates that many of you minimize the governments teleconference expense by listening to these calls together in your office using only one line. At this time please use your telephone keypad and enter the number of participants that are currently listening in. If you're the only person in the room enter one, if there are between two and eight of you listening in, enter the corresponding number between two and eight.

If there are nine or more of you in the room enter nine. Again if you're the only person in the room, enter one. If there are between two and eight of you listening in enter the corresponding number between two and eight. If there are nine of you in the room enter nine. Please hold while we complete the polling. Please continue to hold while we complete the polling. Please hold while we complete the polling.

Thank you for your participation. We will now move in to the Q&A session for this call. To ask a question please press star followed by the number one on your touch tone phone, to remove yourself from the queue, please press the pound key. Remember to pick up your handset before asking your question to ensure clarity. Please note your line will remain open during the time you are asking your question so anything you say or any background noise will be heard in the conference.

Please hold while we compile the Q&A roster.

## **Question-and-Answer Session**

Hazeline Roulac: Thank you, Brooke, please note that only clarification questions will be answered during this call. Please remember that this call is being recorded and transcribed. When your phone line is open, please first state your name and the name of your organization. In an effort to get to as many participant questions and comments as possible, we ask that you limit your questions and comments to one.

If you have a follow-up question or comment we ask that you get back in queue. Brooke, we're ready to take the first question or comment.

(Bob Homensky): Yes. Good afternoon. This is actually (Bob Homensky) in Jim Coleman's office. Question on slide 16, a comment was made about undocumented immigrants that the experts expect there's a reluctance to participate, OK. And so we're saying that the commonalities or it's similar – you know, similar across all the surveys and they're using household addresses. So if you sort of keep that in mind and then you sort of go to slide 21 and we talk about the comment was made that pull the surveys or the sources have a low non-response rate.

So I'm having a hard time sort of reconciling the comments that it appears that undocumented immigrants are not being captured in the uninsured would not be captured in the surveys but then again we're saying there's a good response rate, you know, to the survey. So I was hoping to get a little bit of clarification about the undocumented immigrants and how they would be captured in the various sources- surveys? Thank you.

Lane Koenig: Hi. This is Lane Koenig. So, none of the surveys exclude undocumented immigrants. In fact you know all the surveys sort of take efforts to maximize the response rate as much as possible. What's being – sampled in all of the survey are helpful and then they're collecting information at all the residence of that houseful. So I don't think it's correct to say that undocumented immigrants are excluded. I think in discussions with all the experts they all noted that although the response rate is high there is some non-response and then I say high, very high for most of these surveys we're talking about response rate in the 90 percent range but they just sort of acknowledge that, you know, it's – they can't quantify it but they would suspect that some of the non-response might be undocumented immigrants or others who are just a reluctant to answer government surveys.

(Bob Homensky): Yes. The concern would be, again if you look at the data sources is that the baseline is sort of understanding the level of uninsured that the, you know, that being the denominator where you're going to compare to you know really sort of key is to understand sort of that dynamic, you know, the undocumented immigrants, you know, if that's not captured properly if people are thinking they can't quantify but you know again or just making a comment. It seems like, you know, potentially there could be an issue there because it could result in more money be coming out of the 75 percent that's coming off of the Section 31 reduction.

So anyway that's my comment and thank you for the clarification.

Hazeline Roulac: Thank you, Bob. Next caller?

**Operator:** Your next question comes from the Molly Cullen.

Caroline Steinberg: Hi. This is actually Caroline Steinberg from the American Hospital Association. I just wanted to make a couple of comments. Last year we worked with our State Association executives and AHA members to develop a set of principles to guide the development of our policy positions. We've shared these principles with CMS at past meetings but would like to just highlight a couple of points that relate to today's discussion. We also submitted a letter to CMS on October 10<sup>th</sup> highlighting a number of member concerns with the reporting around uncompensated care on Form S10 some of which were mentioned on this call. We just wanted to highlight on those. First of all AHAs position is that the definition of uninsured you should be based on the best available national survey data that's reflective of current coverage letters levels and specifically Section B-I/2 should be interpreted to require the estimates be made using the most up-to-date data possible, data that is reflective of coverage – of how coverage expansions are actually planned out.

Second we agree with others that the definition of uninsured should capture all populations regardless of citizen status and we share concerns that there may be survey improvements needed to ensure that this happens. Third, the components of uncompensated care should encompass charity care, bad debt, and payment shortfalls for Medicaid and other state and local indigent care programs. So we agree that line with some of the other stakeholders that line 31 of the S10 should really be used. And you also raised a couple of issues about Form S10 that we agree with, including the issue around the cost-to-charge ratio, making it more appropriate for non-Medicare populations by including medical education costs and that some revisions need to be made in terms of how charity care is captured to ensure that all of that is reflected that happens in a particular cost report in the year.. Thank you.

Hazeline Roulac: Caroline, thank you for your comments. We appreciate it. Next participant.

**Operator:** Your next question comes from (Rich Reifenberg).

(Rich Reifenberg): How you doing? (Rich Reifenberg) from Deborah Heart and Lung Center. From what I understand you don't qualify for payments under the secondary pool unless you need the initial 15 percent percentage to qualify for the traditional pool. Am I correct?

Hazeline Roulac: Just a moment please. Thank you.

Marc Hartstein: Yes. I mean I think on a 25 percent it's very clear that you have to qualify for (DSH) to get – you qualify in the same way for the 25 percent as you do for (DSH). Now it would just be – you get 25 percent of the current formula. I think on the remaining 75 percent I think that's an issue that we're going to have to address in rule-making and appreciate you raising it on this call.

(Rich Reifenberg): Thank you.

Hazeline Roulac: Thank you Rich. Next caller.

**Operator:** Your next question comes from Edward Coyle.

Edward Coyle: Hi. Yes I, just, do want to throw at a couple of items for consideration in rule-making. First of all the inclusion of presumptive charity care in addition to the regular charity care is something that the IRS also considered in their charitable hospital 501(r) comments that they were requesting. Also related to IRS, 501(r) for the charitable hospitals they are requiring now self-pay discounts for people there financial assistant eligible. So that's something I think needs to be taken into account how to handle those self-pay discounts and when there is a bad debt, you know, after the discount is done as well as because there is no administrative or judicial review because of this as mentioned in the statute CMS really ensure that the calculation and all the figures that user transparent verifiable in rule-making. Thanks.

Hazeline Roulac: Thank you for your comments. Next participants.

**Operator:** Your next question comes from David Benassi.

David Benassi: Yes. Good afternoon. My question relates, I'm calling from (inaudible) Medical Center in New York City. My question relates to slide 31. I wanted to give a clarification from you if I could. You mentioned in there that you know that the you believe that there is the worksheet S10 data is available right now for CMS to implement this new policy starting in Federal Fiscal Year 2014. My concern is that, you know, and you have brought up certain issues that the stakeholders have talked to you about which Caroline also mentioned regarding the RCC and which you know some other issues with S10 which you know were not incorporated in the S10s that we just filed and completed.

So I wanted to sort of ask you to clarify when you say that you believe the data is available what would happen if you felt that you know the data we submitted recently wasn't good enough that needed to be changed. How is that data available to you if you were to have – had to make such changes to it?

Marc Hartstein: Yes. Thank you for raising that question. I think we're going to have to consider that further as part of implementation.

David Benassi: OK. Thank you.

Marc Hartstein: And certainly feel free to raise a public comment if it's not addressed in the proposed rule.

David Benassi: OK. Thanks.

Hazeline Roulac: Thank you, David. Next question.

**Operator:** Your next question comes from Joanne Allen.

Joanne Allen: Hi. Yes. I would just like to get some clarification regarding the uncompensated care. In our state we do submit the shortfalls from Medicaid and that is done for the state (DSH). It seems reasonable to me that that should be included in the Federal as well. We did have a question regarding the states who opted out of the Medicaid expansion and I'm assuming that using the national rate of uninsured will include all states whether they expanded Medicaid or not, is that correct?

Marc Hartstein I mean the remaining 75 percent is the national pool of DSH adjustment up – adjustment downward for the change in the percent of uninsured as Al and Lane explained.

Joanne Allen: Irrespective of whether – and so all states whether they expanded Medicaid or not will be included in that calculation?

Marc Hartstein: The national, it's a national pool; so it's calculated at the national level, correct. So it would take into account the change in the percent of the uninsured for whatever reasons.

Hazeline Roulac: Thank you. Next question.

**Operator:** Your next question comes from Steve Speil.

Steve Speil: Good afternoon, and thank you and thank you Al and Lane for really excellent exhaustive presentation. A couple of points, one is that first is a point of clarification. I think I know the answer but I just want to make sure because the wording is unclear to me. On slide nine, where you indicate that for FY 14 to FY 17 Section 3133 prescribes the use of insured estimates from CBO. My read of the language is that's only for 2013. Is that yours as well?

Hazeline Roulac: One moment please.

Marc Hartstein: Yes. Al, sorry Steve. Yes Steve, our read of this statutory provision that it was CBO estimates through 2014 through 2017. Obviously the issue is going to be subject to rule-making. So if you disagree with how we propose it you certainly can raise that.

Steve Speil: Right. But just – so I'm reading these words correctly. These words on page nine suggesting that the difference in the uninsured rate between 2013 and each of the year's 14 through 17 is based on the same CBO estimate that the statute prescribes to use to establish what the 2013 baseline is? I mean if that's the case we kind of (inaudible) the need for survey. So that's the kind of the paradox I'm trying to get out.

Hazeline Roulac: One moment, Steve.

Marc Hartstein: Yes. Steve, these are excellent questions and again I think probably the best source of information on how we're going to implement the provision is the proposed rule. I think we described it in this presentation today to the best of our knowledge. Obviously the rule-making process is where our official agency is positioned on implementation and these provisions can be found and that will be subjected in notice with comment rulemaking.

Steve Speil: OK. Very good sir. Two other comments if I may, one having to do with the definition of uncompensated care and we believe that limiting that definition to what most other definitions include as the elements of bad debt and charity care. It makes a lot of sense particularly with respect to Medicaid, you know, their programs vary the significantly from state to state and is notoriously difficult to figure out exactly what the payment is and what the costs are attributable to all services.

So in the interest of uniformity and clarity and also to the extent that these DSH payments are Medicare payment from the Medicare Trust Fund and we do have a separate Medicaid DSH payment. It seems logical to us to confine the definition to bad debt and charity care.

Finally, with respect to the data sources for uncompensated care, clearly the S10 is the best vehicle to collect the data. We would ask you to consider, though, that you would change the instructions with respect to how you would define charity care make it consistent with bad debt and the interest of simplifying, clarifying, and consistency, at least give hospitals the option, if not the instruction, to use the charity care number that hospitals report in the general ledger that is also reported on the hospital financial statement. To the extent that there are differences between when the services rendered and when it's written off, that would clearly self-correct over time and it would create greater consistency across all hospitals. Thank you very much.

Hazeline Roulac: We appreciate your comment Steve. Thank you. Next call.

**Operator:** Your next question comes from Rainbow Jung.

Rainbow Jung: Hi. Hello? This is Rainbow.

Hazeline Roulac: Yes. We can hear you.

Rainbow Jung: Yes. My question is when will be the first call (suite thought) to be used for the calculation?

Male: It will be the most...

Ing-Jye Cheug: This is Ing-Jye Cheug. . These payment changes will be effective for Federal Fiscal Year 2014.

Rainbow Jung: Yes. So does that mean the cost report for 2013 will be used or will the previous years such 2011, 2012 will be used as well?

Marc Hartstein: Yes. This is Marc Hartstein. I think some of these details, I appreciate you asking the question, those are issues that we're going to consider for the proposed rule when we describe in the proposed rule for determining the fiscal 2014 payment, how we would all of the parameters of the calculation and how hospitals will be compensated for both the 25 percent and 75 percent (inaudible) their share (inaudible).

Hazeline Roulac: Thank you for your question. Next question.

**Operator:** Your next question comes from Tanni Thai.

Tanni Thai: Hi there. My question has been answered. So thank you. Your next question comes from Jim Johnston.

Jim Johnston: Thanks. I'm calling from ACA Healthcare. My question is related to the implementation of the uncompensated care formula. When all is said and done is this going to be designed as an additional data element that is used in the Pricer to impact a hospital's base rate. And the main reason I ask that question is CMS now has about a third of its eligible beneficiaries enrolled in Medicare Advantage programs that in large part used the CMS Pricer to a price and pay claims based on Medicare methodology.

Hazeline Roulac: One moment please.

Marc Hartstein: Yes. We're having a little consultation amongst ourselves and then we always decide what will address that through the rule-making process. These are – we really appreciate getting these kinds of questions because I think we're taking good notes on these when these are things that will to the best of our ability try to address in the proposed rule and of course you can certainly comment on the proposed rule. So this is very – please continue to provide these questions or make these comments because these I think are going – are very, very useful to us for implementation even though we can't answer them on the call today.

Hazeline Roulac: Thank you for your question. Next question.

**Operator:** Our next question comes from Robert Gricius.

Robert Gricius: Hi. It's Bob Gricius from NAVEOS. I have a couple of questions. Related to the S10, you know, we review the first 1100 filing and that's widely, there are widely despaired results reported by hospitals basically the same demographics and so given that the S10 is an auditable form, as my question will be what will happen it as the result of audits through our adjustments made to the S10 and funds that we're distributed based on that filing turnout to be incorrect when it will be a subsequent settlement to account for those differences between the S filed and the settled numbers.

And secondly, you know, there was recently a court decision that could have an impact on the 75 percent piece for all the DSH hospitals for Fiscal Year 2012 and is that something that you were considering or you will consider as part of the rule-making process?

Marc Hartstein: I can tell you right now they were considering all of these issues in questions as part of the rule-making process. So I appreciate that question. I mean I guess that is also a very important factor as and I think we're going to probably have to balance between timeliness and (inaudible) and I also note that there is no judicial or administrative review and obviously the S10 is going to be very important for the distribution of the payments to hospitals. So to the extent that hospitals can accurately report that obviously will be a benefit to not just a Medicare program but to the hospital community as a whole overall, but yes, we'll consider all of these questions as were developing the (inaudible) proposed rule.

Robert Gricius: Thank you.

Hazeline Roulac: Thank you Robert. Next question.

**Operator:** Your next question comes from Denise Lukes.

Dennis Lukes: Hi, it's Dennis Lukes. The question really touches back to the end compensated care and both the question it was just raised related to audit but also the earlier one. It doesn't appear that there needs to be a consistent – consistency in uncompensated care. On slide 26 you mentioned you know individual being disqualified for a Federal program or under a Federal poverty level – that whole presumptive charity topic raises incidence because frequently that's not known. If hospitals are including presumptive charity, what will be the audit requirements to demonstrate that they have fulfilled the requirements for charity?

Hazeline Roulac: One moment while we confer amongst ourselves. Thank you.

Deanna Rhodes: It's Deanna Rhodes with the Division of Cost Reporting. As far as recognizing the charity care, as long as the amounts are written off following the individual hospitals charity care policy and they meet the criteria of your individual charity care policy, they're recognized this charity care and that's also instructionalized in the S10 instructions for reporting charity care.

Dennis Lukes: But if there is no application that's been completed and you're relying on presumptive charity from the standpoint that the patient did not cooperate with the charity care process, how will you be able to demonstrate that to an auditor? And in theory there will be documentation as to how you will arrive at presumptive charity but that may vary significantly from hospital to hospital.

Marc Hartstein: Yes. This is Marc Hartstein. We can consider that issue further.

Hazeline Roulac: Thank you Dennis. Next question.

**Operator:** Your next question comes from (Mike Katz).

(Mike Katz): Hi, this is (Mike Katz) from a Legion Crittenton Health. I have just a comment. It appears to me that there is a disconnect in this process in the fact that DSH has been calculated in the past based on Medicaid and Medicare supplemental security income volumes applied to Medicare DRG payments and now we're going to be taking 75 percent of that and spreading it based on a different population which is the uncompensated care of the charity and bad debt.

Therefore, high Medicaid and Medicare populated hospitals seemed to be losing out so to speak. There might be a shift. So I agree with AHA in the fact that perhaps we should include the government shortfalls so that we can, not take too much away from the high Medicaid and Medicare indigent hospitals under the original DSH methodology. Is that the intent of CMS?

Marc Hartstein: Well, I don't want you to talk about the intent of CMS. I would like to talk about the requirements of the statute. I mean the requirements of the statute are that we use the current DSH formula and pay each hospital 25 percent of what it would get under the current DSH formula and that the remaining 75 percent be distributed based on a national pool adjusted for the change of the percent of insured distributed to each hospital based on (each share) of (uncompensated).

Obviously, there are the pool of dollars that's available to each hospital is fixed in the national pool and each hospital will get each share of it based on uncompensated care and I think what our intent is, is to listen to your comments and your questions consider all of the information that's available to us and propose what we think is the most equitable distribution of that fixed pool of dollar consistent with what we think the goals of the statutory provision are.

(Mike Katz): In that case I prefer that to or at least recommend that you consider the government's shortfalls to keep that of those high Medicaid and Medicare populated DSH hospitals more you know equal to what they were getting as best we can.

Marc Hartstein: Yes. Thank you for that comment. Obviously that comment is now been made by several people. So we'll consider it carefully.

(Mike Katz): Thank you.

Hazeline Roulac: Thanks Mike. Next question.

**Operator:** Your next question comes from Tom Westmoreland.

Tom Westmoreland: Hi. This is Tom Westmoreland from Westmoreland Consulting in New York. I just want to respond to the...

Hazeline Roulac: I'm sorry. Could you speak up? We can't hear you that well. Thank you.

Tom Westmoreland: Yes. So it's Tom Westmoreland from Westmoreland Consulting in New York. Is that better?

Hazeline Roulac: Yes it is. Thank you so much.

Tom Westmoreland: Sure. I just wanted to respond to the comment made much earlier regarding whether or not which hospitals would be eligible to receive the 75 percent portion. It seems to me that since the exist the pool of dollars is going to be driven by the hospitals that qualify for DSH today, then it would seem logical to me that those hospitals would be eligible for that 75 percent and not any others that didn't historically qualify for DSH unless there were some sort of compelling reason to include them based upon some sort of you know measure of uninsured activity. That was my comment.

Hazeline Roulac: Thank you Tom. Next question.

**Operator:** Your next question comes from Brian Sherin.

Brian Sherin: Hi. This is Brian Sherin from Besler Consulting. With regard to the 25 percent component, is it anticipated that the data source for that will be as it is now with hospital documenting their Medicaid days or is there a potential that there will be an alternative data source or proxy used for that?

Marc Hartstein: Yes. I think our understanding of the statutory provision is that the current DSH formula would stay unchanged in the statute and you would just get 25 percent of the amount that you get for DSH. So it really would stay unchanged.

Brian Sherin: OK. Thank you.

Hazeline Roulac: Thank you Brian. Next question.

**Operator:** Your next question comes from Jeff Chrobak.

Jeff Chrobak: Hi. This is Jeff Chrobak from Sharon Regional Health System. Question on the flag on number 30 as it relates to the inclusion of GME cost and the calculation of large RCCs or CCRs – excuse me – I look at that for (inaudible) that would similar to what was stated earlier not including Medicare bad debt and that Medicare already pays for the Medicare bad debt piece. So we're not going to include that in the formula since GME already paid by Medicare I was just curious from a standpoint of a regulatory aspect why it would be included in the CCR and then the other question was related to bad debt.

Some bad debts obviously are the patient responsibility piece that the patient is responsible and is not at gross charges to factor that down by a cost-to-charge ratio. Again, it would in my mind further reduce something that's significantly been reduced because it's just the patient responsibility of bad debt. It's not the full charge of that bad debt. Thank you.

Al Dobson: Now, as of now the (GME) is just a consideration which should be undertaken in the rule-making process

Marc Hartstein: and we appreciate your comment on the bad debt patient care bad debt.

Hazeline Roulac: Thank you, Jeff. Next question please.

**Operator:** Your next question comes from Jim Rose.

Jim Rose: Hi. This is Jim Rose from Reimbursement Services Group. I have a follow-up on that on a previous call or a request regarding the timing of charity care and bad debt write-offs included in the uncompensated care calculation. Related to the point that you have on slide 30 indicates the need for further consideration for inclusion of the charity care write-offs for services outside the reporting period. You anticipate using the same definition of non-Medicare bad debt as on the current Medicare statutes namely that bad debt is not recognized until all collection efforts are exhausted because that would almost certainly mean that bad debt write-offs would be in the different period than when the services were provided.

Deanna Rhodes: That's correct.

Marc Hartstein: Yes. I think you correctly what our current policy is. I think on the application of this particular provision again that gets to something to consider through rule-making and we would expect to address in the proposed rule and certainly would be subject to public comment.

Deanna Rhodes: If I just elaborate just for a second, the bad debt policy remains the bad debt policy as is, the write-offs is recognized in the year in which it's written off in that cost reporting period, the charity care policy needs to continue to be considered because when that was initially defined that was for EHR purposes and now we have an expansion with 3133. So that we need to consider that further.

Jim Rose: OK. Thank you.

Hazeline Roulac: Thank you, Jim. Next question.

**Operator:** Our next question comes from Marsha Ford.

Marsha Ford: Hi. This is Marsha Ford with the UY Hospital. And I understand that the 25 percent is going to get paid like that used to be on the claim. It's in addition to your DRG amount. How is that 75 percent going to get paid to the hospital and how will they be able to reconcile it?

Marc Hartstein: Yes. That's currently under consideration.

Hazeline Roulac: Thank you Marsha. Next question.

**Operator:** Your next question comes from Mike Parr.

Mike Parr: Yes. This is Mike Parr with South Prairie Hospital District in Florida and I just had more of a comment I guess on of using S10 data in this allocation process. You are excluding Medicaid HMOs, which have been pushed into a lot of different states, and how is that going to be addressed? It doesn't seem to be addressed in these rules or is it going to be?

Ing-Jye Cheug: Hi, this is Ing-Jye Cheug. Would you please elaborate a little bit on your concern? I'm not sure I understand.

Mike Parr: You're going to be splitting the dollars among hospitals without considering Medicaid HMOs. So states that have pushed Medicaid HMOs is a process are losing out if you're using S10 by itself.

Ing-Jye Cheug: I'm sorry. I apologize. I'm still not clear as to your concern. When you speak of Medicaid HMOs are you talking about the definition of uncompensated care? Is that your concern?

Mike Parr: Yes.

Marc Hartstein: So does this issue – does this question get to the issue of payment shortfalls and whether that's included in the definition of compensated care?

Mike Parr: Right. If you're going to use S10 alone then you're not including that population in that definition. I'm just making a comment that it should be. OK. Thank you.

Ing-Jye Cheug: OK. Thank you.

Hazeline Roulac: Thank you. Next question.

Your next question comes from Candice Le-Tron.

Candice Le-Tron: Hello. I have a question about the uninsured factor. So I know that the DSH is based on a national level and when we look at the uncompensated care factor it is hospitals specific that this is on S10 but when it comes to the uninsured as based on the national level percentage and it looks like it's unfair because (inaudible) you know we are located in Pomona from Los Angeles county and we are located in the very highly uninsured area and if you would to compare this to somebody in Beverly Hills the rate will be different.

Marc Hartstein: Yes. Of course but if you have a higher proportion of uninsured we're really uncompensated care from your S10 then you would be getting a higher proportion of the uncompensated care pool or uninsured pool.

Candice Le-Tron: Right but the formula started out with the national uncompensated pool, right, and then it'd be multiplied by the inverse or the one minus the uninsured factor from CBO. So wouldn't that factor be regionally adjusted?

Marc Hartstein: Well the national pool will shrink. It will be 75 percent (inaudible) nationally for DSH it will shrink based on the reduction in the uninsured. I mean I guess theoretically or ideally that pool would shrink if the Affordable Care Act were to produce universal insurance everybody would have some kind of insurance that 75 percent would shrink to nothing. And we would only be paying 25 percent in DSH (inaudible) but I think there is essentially a safety net here if the Affordable Care Act does not produce universal insurance then it would adjust that 75 percent based on how successful it is in reducing the pool of insured but recognizing that

hospitals are going to treat different proportions of those uninsured and have uncompensated care and each hospital would get its share of that national pool.

So if your hospital in Pomona California treats a lot of uninsured and another hospital in Beverly Hills, California treats no uninsured you're going to get a share of the uncompensated care pools the hospitals in Beverly Hills will get none.

Ing-Jye Cheug: And certainly if you think that in addressing the presentation that Lane Koenig made about factor two if you if you can think there is an alternative approach to that and you will (inaudible) open to that welcome comments to the e-mail address that was supplied.

Candice Le-Tron: OK. I'll put something together but I just – I thought it would be more appropriate for that factor to be originally adjusted just like with the wage index. You know we have one way to next number and being adjusted locally. So I'll (put) something in an e-mail. Thank you.

Hazeline Roulac: We really appreciate your comments and questions. Thank you. Next question.

**Operator:** Your next question comes from Rick Leinfelder.

Rick Leinfelder: Yes. Hi. So, I just want some clarification. So under current DSH it's a proportion that counts. So if you have 50 or 60 percent of your patients are medically indigent you get more money, doesn't matter where your absolute number of uncompensated care is, it's the proportion of your patients and therefore your revenue. In this new formula it sounds like the proportion doesn't count. So for example Columbia Presbyterian (inaudible) or maybe 20 percent of their patients were uncompensated that number is going to be much bigger than 50 percent of my patients being uncompensated, will they be getting more money than (me) because they're absolute number or uncompensated care is greater as oppose to the proportion of the care I delivered to the medically indigent?

Marc Hartstein: So again it gets back to the statutory provision. I mean one can try to make some presumptions as to exactly what the theory underlines statutory provision. If you go back to the MPAC, Medicare Payment Advisory Commission Report, I think they would articulate that patients that served high proportions of low-income patients that those patients are more difficult to treat and that a portion of the DSH adjustment is to compensate for the higher cost of treating patients who has supplemental security income or Medicaid or at least all Medicare patients in hospitals were a high proportion of those patients are treated. And since the statute used that 25 percent one may link those two and say that that's the connection that the higher cost of treating patients where there is a lot of low-income patients is 25 percent of the current DSH formula.

I think it's very clear that the purpose of the other 75 percent is to pay each hospital in essence to create a share, a pool, a national pool of uncompensated care and pay each hospital based on each share of that uncompensated care of pool of dollars. So yes, if a hospital has a higher

proportion of uncompensated or has more uncompensated care as a share of the pool it will get more of that pool.

Rick Leinfelder: So the intent of the legislature was changed to actually not just the formula but to change the intent, is that correct?

Marc Hartstein: Yes. We can't really speak to what the intent was. We can only tell you what the language said. The language says pay 25 percent of the current DSH adjustment put the other 75 percent in a pool and adjust the other 75 percent downward based on the reduction in the number of uninsured. And again with the idea being that if the Affordable Care Act is successful in reducing the uninsured then the portion of DSH that's intended to compensate hospitals for uncompensated care using (inaudible) or proxy may no longer be necessary. Again that's – one can hypothesize (inaudible) what that – that's what the purpose of the statute is.

I think what we can only tell you is what the statute tells us to do and it tells us to pay 25 percent of DSH to each hospital as they currently get paid and the other 75 percent as a national pool distributed based on each hospital's share that pool for their own individual uncompensated care.

Rick Leinfelder: OK. So this small safety net is getting screwed but I got it. Thank you.

Hazeline Roulac: We appreciate your comment. Next question.

**Operator:** Your next question comes from Barney Osborne.

Barney Osborne: Hi. Excuse me. Good afternoon. Actually a comment more so than a question I would suggest that you review between states and particularly between match the way the definitions and the qualifications for bad debt and charity are applied across the board, particularly in regards to presumptive bad debt and documented bad debt and for that matter even charity whoever will determine the accuracy of what is considered uncompensated needs to be applied consistently among all hospitals in all states. Thanks.

Hazeline Roulac: Thanks for your comment. Next question.

**Operator:** At this time I would like to remind everyone. In order to ask a question please press star then the number one on your telephone keypad. Your next question comes from Rolondo.

Hazeline Roulac: Hi. Your phone line is open. Go ahead.

**Operator:** Rolondo, your line is open.

Rolondo Enabulele: I'm sorry. Yes. My question has been answered already. Thank you.

**Operator:** Your next question comes from Frank Burns.

Frank Burns: Yes. This is Frank Burns calling from the University of Utah Hospitals and Clinics in the State of Utah. I have a comment on the prior comment on the GME costs on slide 30. Yes. CMS does actually pay some of that cost for GME. However, it's a very small

fractions of the cost incurred by the hospital. So we would definitely like that to be considered in the ruling because we train over 700 residents here and we get paid a fraction of the cost from CMS. So to actually have that cost put in there to drive that cost to charge ratio on S10 line 1 would actually accurately match the cost to our gross revenues.

And just like I mentioned before we are also concerned about the consistency of everything that goes into S10 and would hope that there would be some clear definition on what should go in there because we do not include – we do include bad debt in charity but not the other point mentioned about the where is this – the third piece were the – let’s see – I’m trying to find the slide again. (inaudible) if I can find here. Sorry about that. No I can’t find it but the third piece that people are included in their S10 and we are not, the actual difference between what you’re paid and what you’re not from the government payers.

Hazeline Roulac: OK. So was that the end of your comments?

Frank Burns: Yes. Yes it is.

Hazeline Roulac: OK. Thank you so much. We appreciate it. Next question.

**Operator:** Your next question comes from Ellen Kugler.

Ellen Kugler: Hi. This is Ellen Kugler with the National Association of Urban Hospitals. My question again concerns the uncompensated care and the uncompensated care data collection. As we have reviewed the current and the old S10 data we’ve noticed that there is significant inconsistencies between states and types of providers, particularly local indigent care programs, expansion populations and of course presumptive charity care, very tremendously different from state to state and among and between different types of providers.

As you were looking through the survey data and the S10 data did you look for accuracies or inconsistencies or a way given that it appears you’ll use now the file 2012 S10 data to improve the accuracy given that it will involve significant shifting of dollars?

Hazeline Roulac: One moment please. Thank you.

Ing-Jye Cheug: Ellen this is Ing-Jye Cheug. Thanks very much for you comment. I think that’s been an important point that you raised about taking a look at the inconsistencies within the S10 data. I understand that you and your association have done significant research in this areas so to the extent that you have specific concerns that you would like to share with us or like for us to take a look at as we undertake rule-making on this topic. We’d be very interested in taking a look at that material and I believe you’ve got to e-mail address that we’ve included in the materials to send that too.

Ellen Kugler: I do. I will send it to you and it is important that the data be as many has mentioned as consistent across the board as possible because there is as many have noted will be a significant shift in knowledge that will affect safety net hospitals.

Hazeline Roulac: Ellen, thank you very much for your comments. Next question.

**Operator:** Your next question comes from Kevin Field.

Kevin Field: Hi. Thank you for taking my call. This is Kevin Field from Medical Center. I'm just wondering if there is any discussion regarding whether providers across the nation are profit versus not for profit and the reason for that is the cost differences that might exist certainly across the country will there be any adjustments or any adjustment being considered based on geography when you take a cost structure down to the cost- to-charge ratio and apply that to or value the amount of charity care delivered. Thank you.

Ing-Jye Cheug: This is Ing-Jye Cheug again. I guess I'd be curious to understand a little bit more but specifically what you would be interested in having CMS propose certainly within the IPPS payment t there is already adjustment for geography and to the extent that uncompensated care varies across different areas that would be included within this particular new provision. So if you have a little bit more information as far as what you would like us to do we welcome that in the form of an e-mail or other written documents.

Kevin Field: OK. Thank you.

Hazeline Roulac: Thank you Kevin. Next question.

**Operator:** Your nest question comes from Steve Hand.

Steve Hand: Can you hear me?

Hazeline Roulac: Yes we can. Go ahead Steve.

Steve Hand: OK. Where is my question? OK. One of the things that I was concerned about and I don't or listened to everything you said it doesn't sound like the surveys will be instrumental at maybe the department of budget but how do we know that these surveys actually take in consideration, all states, all markets, urban and rural because I mean some of us are in remote areas and we wonder if it's really impacting us at all. That's just a comment but the other thing I want to ask is we have a couple of hospitals that we know of that are impacted by the 12 percent cap if you are an urban hospital under 100 beds. I mean would that still be in place is that your understanding for the new rule and then I have one follow-up question when that's answered.

Ing-Jye Cheug: As far as your question about the current DSH rule where some hospitals are subject to to a 12 percent cap for their Medicare DSH payment Section 3133 does not change the way in which we apply the various formula and statue. What it does is that takes the output of those formula and then multiply that by 25 percent for your future DSH payments before creating this new add-on payment which Al and Lane spent a lot of time talking about.

Steve Hand: So we don't – I mean we're assuming that we're still under 12 percent cap but you're saying between the 25 and the 70 (inaudible) limited to 12?

Ing-Jye Cheug: That's not what I'm saying. What I'm saying is that for the 25 percent to calculate that we would calculate a hospitals DSH payment subject to the 12 percent cap is

applicable and then after that calculation multiply by 25 percent. The 75 percent calculations to be add-on payment as a separate calculation. I think there is a very good graphic in the presentation that shows that.

Steve Hand: OK. And the last thing I wanted to ask is that your understanding of the 75 percent payout will have some type of cap that you would not actually go over what your normal DSH would have been if you received a full allotment or is it completely independent and could actually receive more payments in this new scenario than you would have under the old methodology.

Ing-Jye Cheug: Statute doesn't describe for the add-on payment. Statute doesn't really describe the relationship to the current DSH payment because that's to except to create factor one. So if there is an interpretation where you think there either is a cap or isn't a cap again you know we'd be open to hearing that.

Steve Hand: You know I just wondered it sounds like there is not a caps that's on.

Hazeline Roulac: Thanks Steve. Next question.

**Operator:** Your next question comes from Terry Brennan.

Terry Brennan: Hi. Just a question on the proposed rule, is there an estimated time or date when this is going to be released?

Ing-Jye Cheug: Typically the IPPS proposed rules released sometime in mid-spring. At this time we don't have an update or with the future with the specific dates. So that will be included in the IPPS release. These policies are effective for Federal Fiscal Year 2014. Therefore they would have to be – they would have to undergo notice of proposed rule-making in time to be effective for 10-1, 2013, meaning that that proposed rule would come out this spring, spring of 2013.

Terry Brennan: Thank you.

Hazeline Roulac: Thank you. Next question.

**Operator:** Your next question comes from Daniel McHale.

Daniel McHale: Good afternoon. Thank you for the call. In addition to the other comments that were made in support of using the bottom line on the S10 at line 31 I just like to raise another issue related to state local indigent care program because if you were not to use line 31 these costs would be excluded and that would just know that in a lot of states there are these program and their focus on the uninsured, those who don't qualify for Medicaid and they're not reimbursing at (inaudible) in fact the hospital, mainly public hospitals are paying for themselves. So there is a lot of uncompensated care contained within that section and if you would not to use line 31 that would go missing.

So I would just echo the other comments made in you know in support of using the bottom line. Thank you.

Hazeline Roulac: Thank you, Dan. Next question.

**Operator:** Your next question comes from Rocky Iachini.

Rocky Iachini: I have three comments. One my network has two hospitals that are both teaching. One qualifies for operating DSH, the other does not. I would be interested in the proposed rules discussing how the effect on capital DSH to each hospital would occur. Second, I'd hope that in the proposed rule that CMS will use an actual hospital with numbers to see what the end result would be and third I think it would be helpful if CMS created a template of all the elements that have to be gone into to come up with the calculation. Thank you.

Hazeline Roulac: We appreciate your comment. Thank you. Next question. Your next question comes from Melissa Rose.

Melissa Rose: Melissa Rose from Southcoast Health System. It was my understanding that the original intent of DSH was to keep hospital doors open for those that serve a large proportion of low-income and elderly and it appears from the new formula that only the 25 percent is really recognizing that original intent and as a proposal it appears that maybe in that final step where it's each hospitals uncompensated care to total national that if the Medicare shortfalls were included in both the numerator and denominators that it would at least get back to that original intent of what Medicare DSH was for.

Hazeline Roulac: We appreciate your comment. Thank you. Next question.

**Operator:** Your next question comes from Ronald Knapp.

Ronald Knapp: Good afternoon. This Ronald Knapp from Toyon Associates. I wanted to just talk about the S10 schedule. It seems that this will be used in the future at least in all likelihood. Lines 20 and 21 reporting the charity care are pretty difficult to complete at this point-in-time because we're looking for recording uninsured patients based on date of service. Often times information that we have to use in filing the cost is their total write-offs in the hospitals. So I just want to tack on to their comments or made in the presentation that anything you can do to break that out further or maybe it would have a period time that would be outside of the reporting period but have been written off in given year would be very helpful for us in terms of preparing that. Hopefully that was a clear comment.

Hazeline Roulac: Ron, we appreciate your comment. Thank you. Next question.

**Operator:** Your next question comes from (Lindy Fromkin).

(Lindy Fromkin): Yes. My question is just will there be any preliminary estimates published for each hospital when the proposed rule-making comes out on how much of that pool they're estimated to be receiving. And this is only you know less than a year away and a lot of us

depend on a lot of that DSH money and need to be able to budget how much our percentage is going to be.

Ing-Jye Cheug: As part of notice the comment rule-making typically there impact analogies included in the rule-making and I think that's a really important suggestion that you're making as far as transparencies so the hospitals understand what's the potential impact can be. Thank you.

Hazeline Roulac: Thank you for your comment. Next question.

**Operator:** Your next question comes from (Larry Carlton).

(Larry Carlton): Yes. Thank you for your time today. With regard to uncompensated care and although it's defined most often as bad debt and charity care, my observation is around the proxy for uncompensated care to use a cost-to-charge ratio would seem to reward inefficiency versus efficiency and result in a redistribution of dollars in that fashion and I'm sure that's something that can be addressed in the NPRM but just wanted to bring that to your attention. Thank you.

Hazeline Roulac: Thank you, Larry, very much. Next question.

**Operator:** Our next question comes from Edward Coyle.

Edward Coyle: Hi. Yes. I just had a question. Since this is rule as effective for Federal Fiscal Year of 2014. The rates – the interim rates would really be effective as coming October 1, 2013. So I was wondering, what to expect in the interim payment – just the 25 percent – until you figure out how to allocate, you know, the data together to allocate the other 75 percentage or is there going to be sort of interim payment estimate. I'm not sure how – like for budgeting purposes and financial planning, what to expect come 10-1 in my interim payments.

Ing-Jye Cheug: Thanks for the question. I think there have been a couple of folks to have asked specifically about how CMS intends to distribute hospital share of the 75 percent pool as well as questions that whether or not the 75 percent the add-on payment number would be included in PC Pricer so that Medicare Advantage plans could use that estimates payment I think this is an important consideration that we will need to address through rule-making and if you have specific suggestions about how you would like to see the payment that's something that we would appreciate hearing from you on at the e-mail address included (in this) presentation.

Edward Coyle: OK. Thank you.

Hazeline Roulac: Thank you, Edward. Next question. Your next question comes from Denise Lukes.

Dennis Lukes: Hi. This question relates the factor two and the uninsured rate and it was touched on by an earlier commenter but it seems that the sample size relative to the number of states is relatively small. If we look at the an NHIS we're talking about 35,000 households – that would be in average of 700 per state and 87,500 individuals which would be 1,750 per state , how do we know that we get the geographic dispersion necessary, you know whether you're in

California or Pennsylvania or Montana to identify that you've got the appropriate level of the uninsured identified?

Lane Koenig: Hi. This is Lane Koenig. You know all the surveys do a stratified random sample. They take great effort to try and make sure that there is appropriate geographic coverage and then they develop adjustments, weighting adjustments to insure that the results are national representative when they produce national estimates. There is also – you can look at the margin of errors, or the precision estimates around each one of them. Clearly the larger the sample size the more precise the estimates but all the surveys are relatively precise. They do a good job but...

Dennis Lukes: I understand. I understand what you're saying to a point. Now I won't claim to be a survey expert but I am Pennsylvania when I think about a sample size of 700 for Pittsburgh, Philadelphia area, Harrisburg as well as the rural. I just don't know how you get to a sufficient level of satisfaction in that state alone with 700.

Ing-Jye Cheug: This is Ing-Jye Cheug. I mean I think there was another caller who had a question about, the degree to which the payments for these 75 percent the add-on payment would be adjusted for geographic factors and what I'm hearing you ask is to the extent that these surveys may or may not represent areas that you're concerned in, you're trying to understand other means to which the survey results could be adjusted. Then...

Dennis Lukes: And I'm not focused on the impact to the individual state but because I understand that's not how it works. I'm just geared towards the accuracy of determining the overall uninsured for the nation and understanding that we've got the appropriate geographic dispersion of sampling to achieve that.

Ing-Jye Cheug: Understood and I think you know Dr. Koenig here was trying to explain the sampling methodology that the different data sources we've looked at (use), we would very much be open to any thoughts or ideas you have about adjustments that you think would be appropriate or other data sources you think that would offer a more precise or accurate representation of the areas that you're concerned in. So that's a national number is as right as possible.

Dennis Lukes: I guess the part of the question is the size of the samples sufficient.

Ing-Jye Cheug: Understood.

Hazeline Roulac: Thanks for your comment. Next question.

**Operator:** One moment. Your next question comes from Michael Racioppo.

Michael Racioppo: Yes. Hi. I agree with some of the previous callers at the 75 percent deviates from from the original intent of DSH and the inclusion of payment shortfall may help to get us back to the original intent. We are not a safety net hospital but we do have increased numbers of high deductible plans and the inclusion of payment shortfalls would certainly help.

Hazeline Roulac: Thank you for your comments. (Brooke), we'll take one more questions.

**Operator:** At this time there are no further questions. I'll turn it back to Hazeline Roulac for closing remarks.

## **Additional Information**

Hazeline Roulac: Thank you, Brooke. We appreciate all of the questions and comments that we have received today. A resource e-mail box has been set up to receive any additional questions or comments that you may have. Please e-mail your questions and comments to [section3133dsh@cms.hhs.gov](mailto:section3133dsh@cms.hhs.gov).

You will find this e-mail address on the last slide of the presentation. You may submit questions and comments to this e-mail box until January 15<sup>th</sup>. To ensure that the National Provider Call program continues to be responsive to your needs we are providing an opportunity for you to evaluate your experience with today's call, evaluations are anonymous and strictly voluntary. To complete an evaluation please visit <http://npc.blh> – “boy,” “larry,” “harry” – and then [tech.com](http://tech.com). And again that is <http://npc.blhtech.com>.

And select the title of today's call on the menu. All registrants of today's call will also receive a reminder e-mail from the CMS National Provider Calls resource mailbox within two business days, regarding the opportunity to evaluate this call. Please disregard this e-mail if you have already completed the evaluation. We appreciate your feedback. I'd like to thank everyone who participated in today's call, Marc Hartstein, Al Dobson and Lane Koenig and everyone who participated on the conference line. An audio recording and written transcript will be posted on approximately two week to the national provider calls and events Web page which is located at [www.cms.gov/npc](http://www.cms.gov/npc). This concludes today's National Provider Call. Have a great day.

**Operator:** Thank you. This concludes the conference. You may now disconnect.

**END**