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Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, S.W.
Washington, DC 20201

*Re: CMS-2198-P; Medicaid Program; Disproportionate Share Hospital Payment –
Implementing the Medicare Modernization Act of 2003 Reporting and Auditing Requirements;
Proposed Rule.*

Dear Dr. McClellan:

The American Hospital Association (AHA), on behalf of our 4,800 member hospitals, health care systems, other health care organizations, and 33,000 individual members, appreciates the opportunity to comment on the proposed rule implementing the Medicaid Disproportionate Share Hospital (DSH) Payment reporting and auditing requirements found in the Medicare Modernization Act of 2003 (MMA). The Medicaid DSH program provides essential financial assistance to our nation's safety net hospitals. These hospitals care for our nation's most vulnerable populations – the poor, the disabled and the elderly. And, they shoulder critical community services such as trauma and burn care, high-risk neonatal care, and disaster preparedness resources. The AHA has numerous concerns with the presently drafted rule and believes it would have a significant negative impact on Medicaid DSH hospitals.

The Medicaid DSH program has operated with little written regulatory guidance since the publication of the program's initial regulations in 1992. Two communications sent to State Medicaid Directors in 1994 and 2002 address questions regarding the hospital-specific DSH limits. Much of the current DSH policy has been forged in negotiations between the Centers for Medicare & Medicaid Services (CMS) and individual state governments. The absence of consistent federal policy has been a source of frustration for hospitals. Unfortunately, CMS has chosen to use this proposed rule implementing the MMA reporting and auditing requirements to establish new DSH policy.

The AHA has four overriding concerns regarding the proposed rule:



- CMS' substantive changes to standard DSH policy not required by the MMA;
- CMS' definition of uncompensated care that excludes bad debt;
- CMS' proposed retroactive application of the auditing requirements to fiscal year 2005; and
- the reporting burden imposed on hospitals.

The AHA strongly urges CMS to rethink its approach adopted in this proposed rule.

REPORTING REQUIREMENTS

Uncompensated Care

The proposed rule represents the agency's attempt to substantively change long-standing DSH policy without properly calling for public comment and reaches beyond the statutory requirements of the MMA. The rule purports only to implement section 1001(d) of the MMA that establishes new reporting and auditing requirements for DSH payments. That provision of the MMA did not amend section 1923(g) of the Social Security Act, which establishes hospital-specific DSH limits for the costs of uncompensated care. A review of the legislative history of the MMA DSH reporting and auditing provision does not reveal that Congress raised any concerns about how CMS or state Medicaid programs were determining unreimbursed costs for setting the hospital-specific DSH limit.

The proposed rule would alter the definition of uncompensated care to exclude both bad debt and physician services, despite the fact that the MMA left the underlying law governing DSH limits in place, and that Congress expressed no concern about the calculation of uncompensated care costs. Interestingly, the proposed rule does not even acknowledge that it is proposing to alter the definition of uncompensated care. Rather, the new definition is simply included in the preamble and regulation text as though nothing is being substantively changed. The AHA has procedural and substantive concerns with the proposed rule.

As a procedural matter, CMS fails to acknowledge that it is changing the definition of a key term and inadequate notice has been provided to the public – violations of the Administrative Procedure Act. In addition, the changed definition raises the following substantive concerns.

Bad Debt. The proposed rule, in both the preamble and draft regulatory language, states that uncompensated care does not include bad debt for purposes of setting the hospital-specific DSH limit. This new definition of uncompensated care that excludes bad debt is inconsistent with the statute, legislative history and long-standing agency policy guidance and practice. The underlying statute (section 1923(g)(1)(A)) permits the inclusion of the costs of services provided to individuals with no health insurance or other source of third-party coverage. The legislative history of the Omnibus Budget Reconciliation Act of 1993 (OBRA) provision that originally established the hospital-specific DSH limit reveals Congress' intent regarding determining hospitals' unreimbursed costs. The report language states that the costs of providing services to uninsured patients would be net of any out-of-pocket payments received from uninsured individuals.

In a 1994 letter to state Medicaid programs implementing the OBRA 1993 provision, CMS stated:

One of the key provisions in the [DSH] limit is the determination of which of a hospital's patients "have no health insurance or source of third-party payment for services provided." A number of States have asked about the meaning of this provision, and whether it includes, for example, individuals with indemnity policies, or individuals whose policies contain day limits that are exhausted.

[CMS] believes it would be permissible for States to include in this definition individuals who do not possess health insurance which would apply to the service for which the individual sought treatment.

Thus, CMS determined that the cost of services provided to individuals with third-party coverage, but whose third-party coverage did not reimburse the hospital services the individual received, could be counted as uncompensated care costs. In making this determination, the agency was clearly looking at the costs associated with the uninsured and underinsured in implementing the hospital-specific DSH limit.

In 2002 guidance to state Medicaid programs regarding the hospital-specific DSH limit and the upper payment limit, CMS reaffirmed its 1994 DSH policy when it stated that the calculation of uncompensated care is "net of third party payments."

A number of state Medicaid programs include the costs of care provided to uninsured individuals for which no payment is made and the costs associated with the non-payment of copayments and deductibles for individuals with third-party coverage in determining a hospital's qualifying costs for the hospital-specific DSH limit. (Current Medicare policy requires that hospitals seek payment from all individuals – Medicare and non-Medicare – with the means to pay copayments and deductibles.) The approaches adopted by these state Medicaid programs to establish qualifying costs for setting the hospital-specific DSH limit are consistent with the statute, legislative history and established CMS DSH policy.

The explicit exclusion of bad debt from the definition of uncompensated care will be harmful to DSH hospitals that are struggling to meet the health care needs of the growing numbers of uninsured and underinsured. The recent growth of health plans and health savings accounts that impose high deductibles or have exclusion limits is putting new burdens on hospitals in terms of unreimbursed costs.

CMS' new definition of uncompensated care to exclude bad debt is inconsistent with the statute, legislative history and long-standing CMS DSH policy. **The AHA strongly recommends that CMS change its definition of uncompensated care by striking references to bad debt in 42 C.F.R. 447.299(c)(15) and in its place clarify that uncompensated care includes:**

- **the costs of services furnished to individuals with no health care insurance, third-party coverage or third-party payment;**
- **individuals with health savings accounts; and**

- **the costs of services furnished to insured individuals whose policies do not cover the services provided to the individual due to his/her health plan's exclusions, limits, copayments or deductibles.**

Physician Services. The proposed rule's preamble states that uncompensated care costs of physician services cannot be included in the calculation of the hospital-specific DSH limit. However, the statute does not specifically exclude physician services. In fact, the agency, in at least one communication to a state Medicaid program, allows for the inclusion of physician services in determining a hospital's unreimbursed costs. In this example, the costs associated with securing physicians to serve the hospital's Medicaid patient population are legitimate unreimbursed costs if the hospital does not separately bill for the services. The MMA does not require that CMS exclude physician services. This is another example of reaching beyond MMA statutory requirements to establish new CMS policy. **The AHA believes that physician costs associated with hospitals' services should be allowed and references to excluding physician costs in determining a hospital's uncompensated care costs in the preamble should be deleted.**

Section 1011

The preamble in the proposed rule directs state Medicaid programs to consider Section 1011 payments when determining a hospital's specific DSH limit. However, there is no statutory requirement to include Section 1011 payments when calculating the hospital's uncompensated care burden. Section 1011 payments are not Medicaid payments, health plan payments or payments from uninsured patients. Congressional intent, in enacting Section 1011, was to provide new resources rather than substitute existing resources for hospitals providing large volumes of uncompensated care to undocumented immigrants. Again, this reaches beyond statutory authority and sets new DSH policy. The consideration of Section 1011 payments would likely result in reducing needed DSH dollars to hospitals serving high numbers of undocumented immigrants. **The AHA recommends that CMS delete the language in the preamble that requires states to offset Section 1011 payments when establishing a hospital's DSH limit. In addition, CMS should clarify that Section 1011 payments should not factor into the calculation of the hospital-specific DSH limit regardless of whether the hospital is at or near its limit.**

Reporting Unduplicated Patient Count of Medicaid Eligibles and Uninsured Individuals

State Medicaid programs are required to report for each hospital an unduplicated count of Medicaid-eligible and uninsured patients. The AHA is concerned that states will look to hospitals to produce these patient counts. Many hospitals do not have the reporting systems in place that would allow them to generate unduplicated counts of patients served throughout the year that are Medicaid eligible or uninsured. Further, many questions arise as to how a hospital would classify certain patients, such as a patient that has Medicaid coverage for part of the year and is uninsured for part of the year. The proposed rule also fails to make the case as to why this information is necessary. **The AHA recommends that this unnecessary and burdensome reporting requirement be deleted.**

AUDIT REQUIREMENTS

The MMA requires that state Medicaid programs have their DSH programs independently audited and submit this independent certified audit to the Secretary on an annual basis. The proposed rule does not address how the audits will be paid for and there is a concern that the state Medicaid programs will pass on these additional costs to DSH hospitals. The cost for hospital audits can reach as high as \$50,000 per hospital. This estimate clearly suggests that the economic impact, if audit costs are passed on to hospitals as expected, will trigger the test of a major rule under Executive Order 12866 (September 1993 Regulatory Planning and Review) and should require a regulatory impact analysis. These safety net hospitals are not in the financial position to absorb these added audit costs. **The AHA recommends that CMS state affirmatively that the cost of the audits should not be passed on to hospitals.**

Definition of Independent Certified Audit

The proposed rule defines an independent certified audit as an audit conducted with generally accepted government auditing standards as defined by the Government Accountability Office. Most private sector audits use generally accepted accounting principles (GAAP) to audit hospital financial data. Applying a different set of auditing standards than GAAP to hospital financial data will result in an unnecessary burden on the hospitals trying to comply with information requests from the auditors. **The AHA recommends that state Medicaid programs be allowed to use GAAP standards in the independent certified audits.**

Retroactive Audit

The proposed rule retroactively applies the new reporting and auditing requirements to each state's fiscal year (FY) 2005. Most state fiscal years for 2005 have ended. The imposition of the new and substantive reporting and auditing requirements would make it impossible for state Medicaid programs to comply because they would have to retroactively identify the requested data. While the MMA required that CMS impose reporting and auditing requirements beginning in FY 2004, CMS has delayed implementation beyond the date specified in the MMA. The retroactive application of these new reporting and auditing requirements makes little sense now and will impose a hardship for state Medicaid programs and DSH hospitals. **The AHA strongly recommends that retroactive application of the reporting and auditing requirements be deleted from the rule and that the reporting and auditing requirements be tied to the first state fiscal year beginning after the rule is finalized.**

Reduce Uncompensated Care Costs by DSH Payments

The audit verification #1 requires that a state's audit report verify that each hospital receiving DSH payments has reduced its uncompensated care costs for furnishing inpatient and outpatient hospital services to Medicaid eligible individuals and individuals with no source of third-party coverage for the services in order to reflect the total amount of claimed DSH expenditures during the SFY. The DSH statute defines uncompensated care costs as the cost of serving Medicaid and uninsured patients net of Medicaid payments and payments made by uninsured individuals, excluding DSH payments. The statutory language is clear that uncompensated care costs are not offset by DSH payments. Verification #1 requirement, which reduces a hospital's

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uncompensated care costs by claimed DSH expenditures, is contrary to the statute. **The AHA recommends that verification #1 be changed to require that the total amount of claimed DSH expenditures for each DSH hospital in the state is no more than the hospital's uncompensated care costs.**

Same Year Actual Costs

The audit verification #2 requires that the DSH payments comply with the hospital-specific DSH limit by stating that the DSH payments made in the audited state fiscal year (SFY) be measured against the actual uncompensated care cost in the same audited SFY. This would require that states reconcile DSH payments to ensure such payments do not exceed actual costs. However, the MMA does not require that payments be based on actual audited costs. Current CMS DSH policy allows states to use a prospective methodology to estimate current year uncompensated care costs for purposes of establishing the hospital's specific DSH limit (*the maximum amount that a hospital may receive in DSH payments*). The verification, through an audit, of DSH payments with the same year actual uncompensated care costs will place an enormous strain on hospitals through new burdensome and costly audits and increase the administrative costs for each state Medicaid program. This is another example of where the proposed rule substantively changes current Medicaid DSH policy, without statutory authority.

The AHA strongly recommends that CMS delete the requirement in the preamble and the regulatory language that audited DSH payments must be measured against actual uncompensated care cost in the same audited SFY. The AHA further recommends that CMS clarify that states be allowed to continue to use reasonable estimating methodologies to determine uncompensated care costs for purposes of establishing the hospital's specific DSH limit.

Conclusion

The AHA appreciates this opportunity to comment on the proposed rule to implement the Medicaid DSH reporting and auditing requirements of the MMA. While the AHA has long advocated for greater transparency in the operation of the Medicaid DSH program and more consistent federal standards, the proposed rule fails to achieve these goals and makes substantive policy changes that clearly exceed congressional intent. The Medicaid DSH program is a lifeline to many safety net hospitals across the country. The proposed rule, as presently drafted, will have a significant negative impact on these institutions. The AHA stands ready to provide any assistance to remedy the concerns outlined. If you have any questions about our comments, please contact me or Molly Collins Offner, senior associate director of policy, at (202) 626-2326 or mcollins@aha.org.

Sincerely,

Rick Pollack
Executive Vice President