



June 21, 2010

The Honorable Kathleen Sebelius
Secretary, U.S. Department of Health and Human Services (HHS)
200 Independence Avenue, SW
Washington, DC 20201

Secretary Sebelius:

On behalf of the members of the American Hospital Association (AHA), the Association of American Medical Colleges (AAMC), the Catholic Health Association (CHA), the Federation of American Hospitals (FAH), the National Association of Children's Hospitals (N.A.C.H.) and the National Association of Public Hospitals and Health Systems (NAPH), we write to request a delay in the implementation of the enforcement provisions related to the Medicaid Disproportionate Share Hospital (DSH) program audit and reporting regulation issued in December 2008.

The DSH Audit and Reporting Final Rule was issued in the waning days of the prior Administration and implements reporting requirements from the *Medicare Modernization Act (MMA) of 2003*. The hospital community supports reporting and auditing requirements that help ensure that DSH payments are paid in accordance with federal rules. Such transparency will provide assurances to Congress, the Centers on Medicare & Medicaid Services (CMS), states and the public that DSH funds are being used to fulfill their intended statutory purpose to assist hospitals that serve a disproportionate share of low-income individuals. This objective becomes even more important as you implement the Medicaid DSH provisions in the *Patient Protection and Affordable Care Act (PPACA)*.

The Medicaid DSH reporting rule was developed long before the economic recession and before the passage of the new health care reform law. States and providers raised substantial concerns with policy changes included in the initial proposed rule in 2005, but such changes were incorporated into the final rule. For example, the rule excludes uncompensated costs related to services furnished to patients with insurance, but without insurance for the specific service provided. It also excludes the uncompensated costs of physician services and pharmaceuticals provided and paid for by hospitals. The rule seems to run counter to the health care reform movement toward integrating care delivery by not allowing uncompensated physician costs in the DSH calculation. Hospitals often employ or subsidize physician costs to ensure that Medicaid beneficiaries will have access to needed health care services. On top of these concerns, the final rule's enforcement provisions impose potential liabilities

on states as they face severe budget constraints and before CMS can examine the true impact of the policy changes contained in the rule.

DSH payments are critical to the mission of safety net hospitals which provide essential access to care for the poor and uninsured. Policy changes in this program, particularly changes with significant economic impacts, directly affect their ability to provide this access. Specifically, we request that CMS extend the enforcement transition period so that states are not subject to disallowance risk based on the results of the audits ordered by the regulation and so that CMS can review state audits and consider the impact of the regulation's policy changes. CMS should further request that states specify in their audit reports excluded costs that would previously have been included in the DSH calculations.

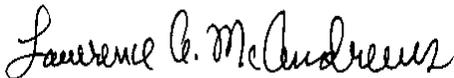
As you and your staff work to expand coverage secured by PPACA, the safety net health system is working to continue to ensure access for Medicaid, uninsured, and under-insured patients. The DSH Audit and Reporting Rule needlessly reduces the ability of safety net hospitals to receive DSH payments, impeding the ability of safety net hospitals to ensure access and conflicting with the overall policy goals of the Administration.

We urge you to hold states and safety net health systems harmless from disallowances based on this rule until state audits can be reviewed and the policy changes assessed. Thank you for your attention to this important issue.

Sincerely,



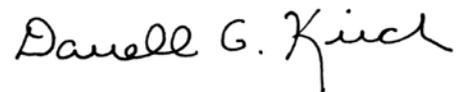
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