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Association**

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February 16, 2012

Marilyn Tavenner  
Acting Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Room 445-G  
Hubert H. Humphrey Building  
200 Independence Avenue, S.W.  
Washington, D.C. 20201

***RE: CMS 2315-P: Medicaid; Disproportionate Share Hospital Payments-Uninsured  
Definition, (Vol. 77, No. 11) January 18, 2012***

Dear Ms. Tavenner:

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our 42,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule that expands the definition of uninsured for purposes of calculating the hospital-specific limitation for Medicaid disproportionate share hospital (DSH) payments.

The Medicaid DSH program provides critical financial assistance for safety net hospitals serving our nation's most vulnerable populations. The AHA supports greater transparency and accountability in how the state Medicaid DSH programs function. The Medicaid DSH Audit program could be a useful tool toward that end. However, the AHA has expressed repeatedly concern about CMS's implementation of the audit program, particularly in how unreimbursed costs are defined. The AHA is pleased that in this proposed rule, CMS begins to address some of those concerns through changes in the definition of uninsured and the clarification that all costs incurred in providing hospital services to Medicaid patients should be counted. But the agency needs to do more work to improve the audit program. Our comment letter focuses on those areas where further clarification is needed or the definition of uninsured costs should be expanded. We also make recommendations concerning the rule's effective date and DSH audit oversight.



## COMMENTS SPECIFIC TO THE PROPOSED REVISIONS

### DEFINITION OF UNINSURED

The AHA appreciates CMS's efforts to further clarify the definition of uninsured for purposes of calculating each hospital's specific DSH limit. We strongly support the agency's proposal to allow unreimbursed costs for those individuals with minimal health care coverage in the hospital-specific limit. Additionally, the AHA asks CMS to make further clarifications and modifications to the definition of uninsured and uncompensated care costs with respect to:

- Service-specific coverage determination;
- The Indian Health Service (IHS) or tribal health contract health services program;
- Unreimbursed cost of hospital-based physician services; and
- Unpaid high-deductible plan costs.

**Service-Specific Coverage Determination.** The AHA urges CMS to consider **uncompensated care provided after benefits are exhausted as "uninsured" uncompensated costs.** The proposed rule clarifies that the determination of an individual's third-party coverage status is a service-specific measure based on the coverage and benefit exclusions of the health insurer. Thus, if an individual did not have insurance for the particular hospital service provided, the hospital can count those unreimbursed costs as uncompensated care costs. The rule also clarifies that hospitals can include as uncompensated care costs services provided to individuals who may have exhausted their benefit coverage, or reached annual or lifetime insurance limits. But, the draft regulatory language appears less flexible than the preamble language. The proposed regulatory language states that: "The service-specific coverage determination can occur only once per individual per service provided and applies to the entire service..." This language seems to exclude situations where individuals exhaust their coverage during a lengthy hospital stay, such as patients in a neonatal or burn unit. **The AHA requests that for service-specific coverage, CMS allow for redeterminations during the stay if the individual's benefits are exhausted during the stay, at which point the individual would be treated as uninsured for the remainder of the stay.**

**Indian Health Service.** The AHA urges CMS to change the regulatory language to allow **hospitals to count unfunded and unreimbursed costs attributed to contract health services (CHS) toward the hospital-specific DSH limit.** The rule's preamble notes that CHS are services provided outside of IHS or the tribal facility. CHS appropriations are discretionary and coverage determinations for CHS are based on a priority system. The proposed rule language states that "...IHS and tribal coverage is only considered third-party coverage when services are received directly from IHS or tribal health programs... or when IHS or a tribal health program has authorized coverage through a contract health services program (through a purchase order or equivalent document)..." Hospitals participate in the CHS program through a formal arrangement that includes a purchase order or its equivalent. Because CHS are funded through discretionary appropriations and coverage determinations are made on a priority system for as long as funding lasts, hospitals often provide services to the populations served by IHS or tribal health programs that go unreimbursed. A strict reading of the regulatory language suggests that hospitals' formal arrangements with the CHS program would disqualify those unreimbursed

costs as eligible to be counted for purposes of calculating the DSH limit, and CMS should clarify that these unfunded services would be eligible costs.

**Hospital-Based Physician Services. The AHA believes that unreimbursed physician costs associated with hospital services should be counted in determining a hospital's DSH limitation.** In previous correspondences, the AHA has argued that CMS has sufficient flexibility to include the uncompensated costs of services provided by a hospital's salaried physicians. The statute grants interpretative authority to the Secretary to define "hospital services." Most recently, in our August 2010 letter to CMS, the AHA suggested two options for CMS to use to interpret "hospital services" to include physician services:

- The state could define the terms to include the services of physicians employed by hospitals as "hospital services;" or
- CMS could allow a hospital to include the costs of its salaried physicians in its DSH costs as long as those salaries were not greater than what is allowed under the Medicare program.

These costs associated with securing physician services to serve a hospital's Medicaid population are legitimate unreimbursed costs if the hospital does not separately bill for these services. Because the statute does not require CMS to exclude these costs, the AHA urges CMS to reverse its policy and permit hospitals to include these costs in their DSH limits .

**High-Deductible Plan Costs. The AHA urges CMS to expand its treatment of underinsured costs for purposes of calculating the hospital-specific DSH limit to include unreimbursed costs associated with non-payment of copayments and deductibles, particularly for high-deductible plans.** The proposed rule goes a long way toward recognizing unreimbursed hospital costs associated with health insurance that may have benefit exclusions or annual or lifetime limits. But hospitals also are bearing the burden of unreimbursed costs associated with high-deductible or catastrophic health plans where the individual has no means of paying the deductible amounts. These are legitimate uncompensated care costs and should be included in the DSH limit calculation.

## **ADDITIONAL RECOMMENDATIONS**

### **EFFECTIVE DATE**

**The AHA urges CMS to apply these proposed changes to the definition of uninsured on a retrospective basis, at a minimum, to audit year fiscal year (FY) 2009.** The effective date for the proposed changes suggests that they would apply, in most cases, to audit year FY 2011. Since states have not completed FY 2009 audits, the AHA recommends that CMS apply these definitional changes to that audit year. These changes will be critical in determining whether hospitals have reached their DSH limit and should be applied as soon as possible to the audit determinations.

**DSH AUDIT OVERSIGHT**

**The AHA urges CMS to provide greater oversight to the Medicaid DSH Audit program.** A number of hospitals and state hospital associations have told the AHA that the DSH Audit program is beset with poor communication between audit contractors and hospitals. We have heard the program lacks transparency regarding the audit findings, and many hospitals never receive any final audit results. A more transparent process would be in keeping with CMS's objective to ensure Medicaid DSH dollars are spent appropriately.

The AHA looks forward to working with CMS staff to improve the Medicaid DSH Audit program. If you have any questions regarding our comments, please contact me or Molly Collins Offner, director of policy development, at 202-626-2326 or [mcollins@aha.org](mailto:mcollins@aha.org).

Sincerely,

Rick Pollack  
Executive Vice President