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September 14, 2016

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

RE: Proposed Rule: RIN 0938-AS92 Medicaid Program; Disproportionate Share Hospital Payments – Treatment of Third Party Payers in Calculating Uncompensated Care Costs; (Vol. 81, No. 157, August 15, 2016)

Dear Mr. Slavitt:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule addressing how third-party payments are treated for purposes of calculating the hospital-specific limitation on Medicaid disproportionate share hospital (DSH) payments. The Medicaid DSH program provides essential financial assistance to hospitals that care for our nation's most vulnerable populations – the poor, the children, the disabled and the elderly. They also provide critical community services such as trauma and burn care, high-risk neonatal care, and adult and pediatric disaster preparedness resources.

The AHA requests that CMS withdraw this rule due to our significant concerns about its impact on Medicaid DSH hospitals. CMS has characterized that this rule is interpretive and a clarification of existing policy. But, in reality, the rule is substantive and establishes new policy, specifically with the intent of avoiding potentially unfavorable federal district court rulings. There are legal challenges, in two different federal district courts, that are in the final stages of deliberations.[1] These challenges focus

[1]United States District Court for the District of Columbia: Texas Children v Sec. Burwell Civ. No. 14-2060 (EGS); United States District Court for the District of Columbia: Missouri Dept. of Soc. Services v US Dept. of HHS Civ. No. 1:15-cv 01329 (EGS); United States District Court for the District of New Hampshire: New Hampshire Hospital Assoc. v Sec. Burwell, Civ. No. 15-cv-460-LM, Opinion No. 2016 DNH 053

on CMS's use of sub-regulatory guidance to advance its interpretation of the Medicaid statute pertaining to the treatment of third-party payment for purposes of calculating a hospital's Medicaid DSH limit. **The AHA supports the plaintiffs' arguments in these cases and believes that CMS's proposed rule, with a mere 30-day comment period, only creates more chaos and uncertainty for Medicaid DSH hospitals in the face of these pending court decisions.**

In addition, we are concerned about:

- CMS's application of sub-regulatory guidance that is not supported by the underlying statute or regulation;
- CMS's argument that the rule better "…ensures that the DSH payment reflects the real economic burden of hospitals that treat a disproportionate share of low-income patients…."[2]; and
- CMS's failure to apply the proposed policy change in a prospective manner.

Our detailed comments follow.

APPLICATION OF SUB-REGULATORY GUIDANCE NOT SUPPORTED BY THE UNDERLYING STATUTE OR REGULATION

At the heart of the legal challenges mentioned above is CMS's sub-regulatory guidance that addresses state Medicaid DSH audit and reporting requirements. Specifically, the challenges center on FAQs #33 and #34, which provide that, in calculating the hospital-specific limit on Medicaid DSH payments, a state must subtract payments received from private health insurance and Medicare for dually-eligible Medicaid patients from the costs incurred to provide hospital services to those patients.[3] **However, the policies set forth in these FAQs are inconsistent with both the statute and CMS's own regulation.**

The Medicaid statute limits how much any individual DSH hospital can receive in Medicaid DSH payments, known as the "hospital-specific limit." The statutory language states that DSH payments cannot exceed:

> … the costs incurred during the year of furnishing hospital services (as determined by the Secretary and net of payments under this subchapter (Medicaid), other than under this section, and by uninsured patients) by the hospital to individuals who either are eligible for medical assistance under the State plan or have no health insurance (or other source of third party coverage) for services provided during the year. For purposes of the preceding sentence, payments made to a hospital for services provided to indigent patients made by a

[2] https://federalregister.gov/a/2016-19107, p. 53984
[3] https://www.medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/downloads/part-1-additional-info-on-dsh-reporting-and-auditing.pdf

> State or a unit of local government within a State shall not be considered to be a source of third party payment (emphasis added). [4]

In 2008, CMS issued final regulations implementing legislation that required states to ensure, through audit and reporting requirements, that Medicaid DSH hospitals were not receiving DSH payments that exceeded their hospital-specific limit. The 2008 final rule specifically instructs states on how to calculate a hospital's total annual cost for individuals without health insurance and specifies only the subtraction of Medicaid payment; it does not call for the subtraction of payment for Medicare or private insurance:

> The total annual uncompensated care cost equals the total cost of care for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals and to individuals with no sources of third party coverage for the hospital services they receive less the sum of regular Medicaid FFS (fee-for-service) payments, Medicaid managed care organization payments, supplemental/enhanced Medicaid payments, uninsured revenues, and Section 1011 payments… (emphasis added).[5]

CMS, however, put forth a different policy in 2010 when it issued sub-regulatory guidance, specifically FAQs #33 and #34. The 2010 guidance specifically instructs states to calculate hospital-specific DSH limits by subtracting not only the payments enumerated in the 2008 rule above, but also payments received from private insurance for Medicaid-eligible patients and Medicare payments for dually-eligible patients.

CMS, in its court filings, attempted to argue that FAQs #33 and #34 reflect current policy, even though the policy is not supported by the underlying statute or regulation. This argument is continued in the proposed rule, which cites several sub-regulatory sources including, the FAQs referenced earlier and an Aug. 16, 2002 letter to state Medicaid directors. While CMS further claims its policy is reflected in the 2008 DSH audit and reporting final rule, it fails to provide a single citation from that rule's regulatory text.

In addition, the proposed rule states that all third-party payments must be subtracted from a hospital's uncompensated care, regardless of what the incurred cost is for treating the Medicaid-eligible individual.[6] We believe such a policy is unreasonable because it would apply to individuals eligible for Medicaid and with third-party coverage, but for which the Medicaid program was never billed. Such is often the case for children with complex health care needs where private insurance pays the hospital bill and the hospital does not bill the Medicaid program. Other examples also could include settlements where a Medicaid patient is hospitalized as the result of an automobile accident and his/her hospital care is paid for by the insurance of the driver responsible for the accident. In this

[4] https://www.law.cornell.edu/uscode/text/42/1396r-4
[5] www.law.cornell.edu/cfr/text/42/447.299
[6] https://federalregister.gov/a/2016-19107 p. 53983 FR

case, the hospital does not bill Medicaid for the care, yet the proposed rule would require that the third-party payment received count for purposes of determining the hospital-specific DSH limit.

DSH PAYMENT SHOULD REFLECT THE REAL ECONOMIC BURDEN OF HOSPITALS THAT TREAT A DISPROPORTIONATE SHARE OF LOW-INCOME PATIENTS

CMS contends in the proposed rule that its treatment of third-party payment would better ensure that Medicaid DSH payments reflect the "real economic burden" of hospitals that treat a disproportionate share of low-income patients. **If this is, in fact, the agency's intent, we continue to urge it to include the uncompensated costs of services provided by a hospital's salaried physicians when determining a hospital's DSH limitation.**[7] For many academic medical centers that employ their physicians, these unreimbursed costs for physician services provided to the uninsured can be significant.

FAILURE TO APPLY THE NEW POLICY CHANGE IN A PROSPECTIVE MANNER

CMS argues that the proposed rule is merely a "clarification" of existing policy. As such, it implies that this policy has been consistently understood. Yet, this is not the case. Therefore, because of the lengthy process associated with Medicaid DSH audits, a retroactive change in policy would mean that many DSH hospitals would be at risk for possible recoupment. CMS itself noted how important it was to give states and hospitals sufficient time to adjust to new policy when it referenced the need for a transition period at the time the agency finalized the 2008 DSH audit and reporting rule. These same observations apply if this rule is finalized. **The AHA recommends CMS withdraw this proposed rule. However, if it goes forward with finalizing a change in policy in the calculation of the hospital-specific DSH limitation, it must do so prospectively to give states and hospitals sufficient time to make needed adjustments to ensure compliance. Given the current litigation pending in federal court, to do otherwise is to create unnecessary confusion for state Medicaid programs and DSH hospitals.**

Please contact me if you have questions or feel free to have a member of your team contact Molly Collins Offner, director of policy, at mcollins@aha.org or (202) 626-2326.

Sincerely,

/s/

Thomas P. Nickels
Executive Vice President

[7] AHA Comment Letters: October 25, 2005 regarding CMS 2198-P; and February 16, 2012 regarding CMS 2315-P