National Association of Public Hospitals and Health Systems

1301 Pennsylvania Avenue, NW
Suite 950
Washington, DC 20004
202 585 0100 tel / 202 585 0101 fax
www.naph.org

May 19, 2009

The Honorable Kathleen Sebelius
Secretary
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Sebelius:

The National Association of Public Hospitals and Health Systems (NAPH) writes to convey its continued serious concerns regarding the Centers for Medicare and Medicaid Services' (CMS) Medicaid Disproportionate Share Hospital (DSH) Audit and Reporting Rule ("the Rule"), which was finalized on December 19, 2008. We understand that the Medicare Modernization Act of 2003 (MMA) required implementation of new auditing and reporting requirements, and we support efforts to protect the integrity of the program. This Rule, however, went far beyond the requirements of integrity and the MMA to restrict the type and nature of the hospital costs that states can reimburse through DSH payments, dramatically altering the definition of DSH-eligible costs and the character of the program. ***We urge you to reevaluate the damaging policy changes implemented through the Rule and their estimated impact and burden on states and their safety net hospitals. As a necessary first step, we urge you to postpone the initial audit and reporting deadlines contained in the Rule and announce that policy changes will be delayed and only applied prospectively.***

NAPH represents over 130 of the largest metropolitan safety net hospital systems. Our members provide certain essential specialized services to their entire communities and are significant providers of care to low-income and uninsured patients. Approximately 27 percent of the inpatient and outpatient services provided by NAPH members is to Medicaid recipients and another 19 percent is provided to uninsured patients. The DSH program, over the years, has become the "lifeblood" of many safety net hospitals, reimbursing for the costs of nearly a quarter of the unreimbursed care provided by NAPH members. Policy changes in this program, particularly changes with significant financial impacts, directly affect their ability to provide essential access to care.

In 2005, CMS issued a proposed regulation implementing Medicaid DSH audit and reporting requirements included in the MMA. NAPH 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, 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.

The proposed Medicaid DSH reporting rule, however, went far beyond reporting and proposed to restrict the type and nature of the hospital costs that states can reimburse through DSH payments. Although the proposed rule lay dormant for over three years, CMS finalized it in the waning days of the Bush Administration without addressing the substantial concerns raised by states and providers. For example, the Rule excludes uncompensated costs related to services furnished to patients with insurance but no insurance for the service provided. It further excludes the uncompensated costs of physician services and pharmaceuticals provided and paid for by hospitals.

Under the Rule, initial audits (for state rate years 2005 and 2006) must be completed by September 30, 2009, with reports due by December 31, 2009. NAPH has heard an increasing number of concerns from its member hospitals about the estimated loss of DSH funds due to this Rule and the resulting impact on their ability to provide access to care. For example, the Louisiana State University (LSU) state teaching hospitals estimate a loss of $150 million in DSH payments due primarily to the proposed change to the definition of uninsured patients under the final rule. If LSU hospitals face a loss of this magnitude, they would be forced to close all but three of the ten LSU hospitals, which would have a devastating impact on access to services throughout the state.

We have also heard concerns about the burden of complying with the requirements by the upcoming deadlines and of the difficulty of retroactively applying new and rigid standards and methodologies for calculating cost to years already passed.

Based on these concerns, we urge you to reevaluate the damaging policy changes implemented through the Rule and their estimated impact and burden on states and their safety net hospitals. As a necessary first step, we ask that you postpone the initial audit and reporting deadlines. We further urge you (1) to clarify that the policy changes in the final rule are prospective and should not be applied to past rate years, (2) to delay implementation of such changes while you reevaluate the underlying policies (similar to your action related to health care related taxes final rule), and (3) to issue guidance and/or begin a new rulemaking process to address the policy changes of concern in the final regulations. CMS made some policy decisions in the preamble of the Rule that can be revised or reversed through guidance, while others will require a rulemaking process. The Administration should pursue both avenues, as appropriate, to establish its own approach to ensure that DSH may be used, as intended, to reimburse hospitals for the uncompensated costs of providing services to Medicaid and uninsured patients. The attached chart outlines the specific concerns raised by the Rule and our assessment of the means by which the Administration can address these concerns.

NAPH appreciates this Administration's demonstrated willingness to reconsider the policies of the previous Administration, in particular in the context of the Medicaid Outpatient Hospital Services rule, where the Administration recognized that a rule that was "previously perceived ... as having little impact ... could have an adverse impact on the availability of covered services for beneficiaries." We think that the Medicaid DSH rule poses a similar situation and urge you to

similarly address it. (In that vein, we also support reconsideration of policies contained in outstanding proposals related to a Medicaid Cost Limit for Providers Operated by Units of Government and Medicaid Graduate Medical Education. We specifically encourage you not to finalize the rules, consistent with the Sense of the Congress expressed in the American Recovery and Reinvestment Act, and to withdraw those proposed rules.) If you have any questions, please contact Lynne Fagnani at (202) 585-0111.

Sincerely,

Larry S. Gage
President

Attachment

cc: Rima Cohen
Jackie Garner

Medicaid Disproportionate Share Hospital Audit and Reporting Final Rule- 73 Fed. Reg. 77,904 (Dec. 19, 2008).

Issue	Concerns with the Rule/Explanation	Administrative Action
Deadlines for Audits and State Reports	Initial audits for state rate years 2005 and 2006 must be completed by September 30, 2009, with reports due by December 31, 2009. 42 CFR § 455.304(b). States are already designating independent auditors and scheduling hospital audits.	**Rulemaking necessary**, since the deadline is in the regulatory language. In a new rule, CMS could delay initial due dates for another year while policies are reconsidered.
Definition of Hospital Services	The Medicaid statute allows the hospital-specific limit to include costs of "hospital services." 42 USC § 1396r-4(g)(1)(A). The Final Rule narrows "hospital services" to inpatient hospital services and outpatient hospital services as defined and reimbursed under the state plan. 73 Fed. Reg. 77904, 77926 (Dec. 19, 2008). The new audit provision does require that audits verify that "only the uncompensated care costs of providing inpatient hospital and outpatient hospital services ... are included." 42 USC § 1396r-4(j)(2)(C); *see also* new 42 CFR §§ 455.304(d)(3), 447.299(c)(11),(14).	**Rulemaking necessary**, since inpatient and outpatient hospital services language is used throughout the rule, this would require rulemaking. In a new rule, CMS should interpret 42 USC § 1396r-4(j)(2)(C) to be consistent with "hospital services" as used in 42 USC § 1396r-4(g)(1)(A) and state explicitly that hospital services are to be interpreted broadly. An audit provision should not narrow the scope of costs that may be reimbursed through DSH.
	Exclusion of the cost of providing physician services to Medicaid and uninsured patients, even if those costs are incurred by a hospital and are a necessary component of providing inpatient or outpatient hospital services. 42 CFR § 447.299(c)(15) (definition of total uninsured IP/OP uncompensated care costs). Note that the regulatory language is more stringent than the preamble language, which allows for a narrow exception. 73 Fed. Reg. at 77925.	**Rulemaking necessary**, since physician services are explicitly excluded in the regulatory language. In a new rule, CMS should clarify that the hospital incurred cost of providing physician services to hospital patients may be included in the broad definition of hospital services in 42 USC § 1396r-4(g)(1)(A).
	Exclusion of any pharmacy service costs not billed as part of the inpatient hospital or outpatient hospital rates, even if those costs are incurred by a hospital and are a necessary component of providing inpatient or outpatient hospital services. 73 Fed. Reg. at 77915.	**Change possible through guidance**, since exclusion is only apparent from the preamble discussion and strict interpretation of inpatient and outpatient hospital services. CMS should clarify that hospital-incurred cost of providing pharmacy services to hospital patients may be included in the broad definition of hospital services in 42 USC § 1396r-4(g)(1)(A).
Interaction with moratorium on the outpatient hospital services rule	Because the rule limits DSH to inpatient and outpatient hospital services, the scope of DSH-allowable services is impacted by the recent moratorium until July 1, 2009 on the rule narrowly redefining Medicaid outpatient hospital services. The Administration should clarify that states are not required to apply this new definition of outpatient hospital services.	**Guidance may clarify** to define the scope of outpatient hospital services for DSH purposes. Rescission of the outpatient hospital service regulation would also clarify the inapplicability of the outpatient hospital services definitions.

Issue	Concerns with the Rule/Explanation	Administrative Action
Definition of Uninsured	Exclusion of costs related to services provided to patients with no insurance for the service rendered, but who do have "creditable coverage." In particular, in the preamble, CMS states that "the only costs relevant to the calculation of the hospital-specific limit are costs of furnishing hospital services to individuals who are Medicaid eligible or who have no health insurance (or other third party coverage)." 73 Fed. Reg. at 77916. By contrast, a 1994 Letter to State Medicaid Directors stated that "it would be permissible for States to include in this definition [of uncompensated care costs] individuals who do not possess health insurance which would apply to the service for which the individual sought treatment." Letter to State Medicaid Directors, Aug. 17, 1994, at page 4.	**Change possible through guidance.** Although the preamble language is clear, the regulatory reporting language is ambiguous: "individuals with no source of third party coverage for the hospital services they receive." 42 CFR §§ 447.299(14),(15),(16). CMS should clarify that despite the preamble language, it will permit inclusion of all costs related to services provided to patients with no insurance for the service rendered, even if the patient has insurance that covers other services.
	Exclusion of exhausted benefits. As a subset of the category of patients with no insurance for the service rendered, the regulatory reporting requirement clearly excludes "unreimbursed costs associated with inpatient and/or outpatient hospital services provided to individuals with those services in their third party coverage benefit package." 42 CFR § 447.299(c)(15).	**Rulemaking necessary**, since the exclusion of exhausted benefits is in the regulatory language. In a new rule, CMS should permit inclusion of all costs related to services provided to patients with no insurance for the service rendered.
Unpaid Co-payments and Deductibles	Exclusion of "unpaid co-pays or deductibles for individuals with third party coverage for the inpatient and/or outpatient hospital services they receive." 42 CFR § 447.299(c)(15). Particularly for persons with a high deductible plan who essentially have no insurance (before the deductible is satisfied), it seems inappropriate to exclude unpaid co-payments or deductibles.	**Rulemaking necessary**, since the exclusion of unpaid co-pays and deductibles is in the regulatory language. In a new rule, CMS could permit inclusion of unpaid co-payment amounts and deductibles as unreimbursed costs.
Definition of Cost	The Final Rule requires the prescriptive cost calculation methodology contained in the "General DSH Audit and Reporting Protocol" issued at the same time as the Final Rule. This is a significant retrenchment from the CMS's 1994 guidance, which indicated that CMS generally "would permit the State to use the definition of allowable costs in its State plan, or any other definition ...." Letter to State Medicaid Directors, Aug. 17, 1994, at page 3. The protocol requires use of departmental cost-charge ratios and will be particularly onerous for hospitals.	**Change possible through guidance.** Although use of the protocol is referenced in 42 CFR § 455.301, the substance of the protocol could be revised to be less prescriptive through guidance. CMS should either make the protocol permissive, revise the protocol, or withdraw the protocol and allow states discretion in determining costs.
Offset for Section 1011 Payments	The Final Rule requires States to offset Section 1011 payments for inpatient and outpatient hospital services to undocumented uninsured immigrants against the unreimbursed cost of providing services to uninsured patients. 42 CFR § 447.299(c)(16). This interpretation is not supported by statutory authority, as the statute requires a reduction only for Medicaid payments and payments "by uninsured patients."	**Rulemaking necessary**, since the requirement is included in the regulatory language. In a new rule, CMS should permit Section 1011 payments to not offset the costs of providing services to the uninsured.

Issue	Concerns with the Rule/Explanation	Administrative Action
Retrospective reconciliation	The Final Rule requires that States conduct retrospective reconciliations of DSH payments to the DSH limit for each year using actual costs and reduce payments that exceed the revised limit. 42 CFR § 455.304(d)(2). Many states currently use prospective estimates of the hospital-specific DSH cap and do not conduct subsequent reconciliations.	**Rulemaking necessary**, since the requirement is included in the regulatory language. In a new rule, CMS should prescribe alternative methodologies for determining actual costs, including trending forward costs from prior years.
Clarification regarding post-audit adjustments	The Final Rule provides ambiguous guidance regarding treatment of post-audit adjustments.	**Change possible through guidance.** CMS should clarify consistent treatment of post-audit adjustments.
Clarification Needed Related to Liability Based on New DSH Reporting During the Transition Period	The Final Rule is ambiguous regarding the impact of findings for State reports and audits for state plan years 2005-2010. The regulatory language states that "findings ... will not be given weight except to the extent that the findings draw into question the reasonableness of State uncompensated care cost estimates used for calculations of prospective DSH payments for Medicaid State plan year 2011 and thereafter." 42 CFR § 455.304(e). On the other hand, the preamble emphasizes that its policy does not "preclude review of DSH payments and discovery of overpayments prior to Medicaid State plan rate year 2011 . . . independent of the State audit process" and that "the information disclosed by the audit and reporting requirements may reveal the need for retroactive adjustments to account for payments that are improper" and that "this is no different from any other audit situation." 73 Fed. Reg. at 77908.	**Change possible through guidance.** CMS should clarify that it will not issue disallowances, particularly for rate years that have already ended, based on new policies in the Final Rule.
Burden Related to Periods that Have Already Ended	It will be difficult if not impossible for some hospitals to report for previous years using the new requirements. CMS should clarify that hospitals should make best efforts to provide this information for rate years 2005-2010, but acknowledge that this data might not be available and that hospitals and states will not be penalized in those circumstances.	**Change possible through guidance.** CMS should clarify that it will expect compliance with the new reporting beginning in rate year 2010 (which for most states starts this year).
Cost of audit	In response to a comment expressing "concern that the State Medicaid programs will pass on [the] additional costs [associated with the audit] to DSH hospitals," CMS responded that "States are responsible for the administration of their Medicaid programs and the successful completion of the DSH audit as part of that administration." 73 Fed. Reg. at 77938-39. We continue to hear that states intend to pass the audit cost through to hospitals.	**Through guidance,** CMS can reiterate that states should not pass the additional cost of the audits through to hospitals and that FFP is available to the state at the administrative matching rate.