National Association of Public Hospitals and Health Systems

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February 17, 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, SW
Washington, DC 20201

Re: CMS-2315-P: Medicaid Program; Disproportionate Share Hospital Payments – Uninsured Definition

Dear Ms. Tavenner,

The National Association of Public Hospitals and Health Systems (NAPH) appreciates the opportunity to comment on the proposed rule to revise the auditing and reporting rule for disproportionate share hospital (DSH) payments. In the proposed rule, the Centers for Medicare & Medicaid Services (CMS) has taken action to mitigate some of the unintended consequences of policy changes made in the 2008 Disproportionate Share Hospital (DSH) Audit and Reporting Final Rule.[1] We support the proposal to revert to a service-specific definition of the uninsured that captures the costs of essential care beyond benefit limits in the hospital-specific limit calculation. This would ameliorate damaging reductions in funding to the hospitals and health systems that rely most on the DSH program. At the same time, we urge you to reconsider certain other policy changes in this proposed rule that could have significant consequences for the same providers you have sought to protect and their ability to serve as a true safety net for the nation's most vulnerable patients.

NAPH represents more than 140 major safety net hospitals and health systems that share the common mission of providing high-quality health care to all patients regardless of their ability to pay. Our members provide a range of services, from primary care to essential specialized services, and are significant providers of care to low-income and uninsured patients. Based on 2009 data, approximately 26 percent of outpatient visits and 36 percent of discharges provided by NAPH members are for Medicaid recipients, and another 31 percent of outpatient visits and 18 percent of inpatient discharged are for uninsured patients. NAPH members represent only 2 percent of the nation's acute care hospitals, but delivered 20 percent of the uncompensated care provided by hospitals nationwide. In addition, 16 percent of NAPH member hospital costs are

[1] 77 Fed. Reg. 2500 (Jan. 18, 2012). .

uncompensated—significantly higher than the national hospital average of 6 percent.[2] Since the beginning of the economic recession, NAPH members have provided 17 percent more uncompensated care to low-income populations—averaging more than $4.6 million per hospital in additional costs, with some hospitals incurring more than $30 million in additional costs.[3]

Over the years, the DSH program has become absolutely vital to many safety net hospitals. It provides the necessary support for safety net hospitals to continue providing care to current low-income patients and to prepare to meet increased demand in 2014. For NAPH members, the DSH program has provided funding for nearly a quarter of the cost of their unreimbursed care. Policy changes in this program, particularly changes with significant financial impacts, directly affect NAPH members' ability to provide essential access to services. Without the critical support of Medicaid DSH, the overall NAPH member margin would drop to -5.5 percent—a clear sign that DSH is essential to their overall financial viability.[4]

This proposed rule is an important step toward ensuring that the hospital-specific DSH limit reflects the full costs of providing hospital services to low-income patients. Particularly in anticipation of reductions to state DSH allocations beginning in 2014, hospital-specific limit calculations should reflect the burden on the safety net as accurately as possible, so that the remaining DSH funds may be used to fulfill the purposes of the program.

Consistent with this goal, NAPH urges CMS to revise or clarify certain proposed policies, as outlined in more detail in the attached, and to address NAPH's remaining concerns with other policy changes made in the 2008 final rule. Our members are coping with myriad changes under health reform while striving to serve as leaders in their communities to improve quality, efficiency, and access to care for all patients. At the same time, they are facing significant state-level cuts to their Medicaid programs due to budget deficits and are absorbing increasing burdens of uncompensated care. We urge CMS not to implement changes in DSH policy that further erode support to these providers by excluding legitimate costs that are tied to their role as the safety net.

NAPH appreciates the opportunity to submit these comments and looks forward to working with the agency as CMS continues to develop Medicaid DSH policy. If you have any questions, please contact Xiaoyi Huang, assistant vice president for policy, at 202-585-0127.

Sincerely,

Bruce Siegel, M.D., M.P.H.
President and Chief Executive Officer

[2] NAPH 2009 Annual Survey Results, Dec. 2010.
[3] NAPH Policy Brief, *Safety Net Health Systems: An Essential Resource During the Economic Recession,* Aug. 2010.
[4] NAPH 2009 Annual Survey Results, Dec. 2010.

Detailed Comments of the National Association of Public Hospitals and Health Systems
Proposed Rule CMS-2315-P:
Medicaid Program; Disproportionate Share Hospital Payments – Uninsured Definition

1. CMS Should Finalize the Proposal to Define Whether an Individual Is Uninsured on a Service-Specific Basis

NAPH strongly supports CMS' proposal to change the definition of whether an individual is uninsured to a service-specific definition for the purposes of including the costs of their care in the DSH limit calculation. This change is consistent with the Medicaid statute and CMS' previous policy in the 1994 State Medicaid Directors Letter (SMDL), relied upon in this rule. Section 1923(g)(1)(A) of the Social Security Act describes uninsured individuals as those ''who have no health insurance (or other source of third party coverage) *for the services furnished* during the year."[5] In this proposed rule, CMS reasonably interprets this language to mean that states should not examine whether an individual had any source of coverage, no matter how inadequate, but whether an individual was actually covered for the specific service provided by the hospital. This interpretation is consistent with CMS' pre-2008 policy expressed in the 1994 SMDL, explicitly stating that uninsured patients would include "individuals who do not possess health insurance which would apply to the service for which the individual sought treatment."[6] Consistent with previous NAPH recommendations, this proposed rule would specifically define "individuals who have no health insurance (or other source of third party coverage) for the services furnished during the year" so that inpatient and outpatient hospital costs associated with individuals who have creditable coverage but have reached annual or lifetime insurance limits or have otherwise exhausted covered benefits can be included in calculations of the hospital-specific DSH limit. This definition would also include the costs of services provided to individuals whose coverage excludes the hospital service provided.

We appreciate that CMS took into consideration the significant concern expressed by NAPH and other stakeholders regarding the fact that the 2008 final rule excludes significant costs to hospitals for providing services to underinsured patients with no means to pay for those services. As CMS notes in the preamble to the proposed rule, in the practical application of DSH payments, the 2008 final rule excludes from uncompensated care the costs of many services that are provided to individuals with creditable coverage but are outside the scope of such coverage—including costs for individuals who have exhausted their insurance benefits or reached annual or lifetime insurance limits for certain services, as well as those services that are not included in a benefit package but are Medicaid-covered hospital services (such as transplant services provided to a patients whose insurance covers inpatient care but excludes). The exclusion of such costs, which states previously could and did include in their calculations, is having a significant negative financial impact on safety net providers. Indeed, in anticipation of lower DSH limits as a result of the 2008 final rule, some states are implementing arbitrary, across-the-board cuts to DSH payments—even while NAPH members face increased uncompensated care costs as a result of the ongoing economic downturn.

[5] 42 U.S.C. § 1396r–4(g)(1)(A) (emphasis added).
[6] CMS State Medicaid Directors Letter (Aug. 17, 2004).

For American Indians and Alaska Natives, CMS proposes only to consider Indian Health Service (IHS) and tribal coverage as third-party coverage when services are received directly from IHS or tribal health programs (direct health care services) or when IHS or a tribal health program has authorized coverage through the contract health service program. NAPH members often serve as a safety net to members of tribal nations who have significant health disparities and face considerable barriers to accessing care due to IHS resource limitations. Yet, under the 2008 final rule, hospitals could not include the uncompensated costs of providing hospital services either excluded entirely by IHS or tribal health programs or unable to be funded by them. NAPH supports CMS' proposal as support for access to hospital services for this population.

On a technical note, CMS states in the proposed rule's preamble language that "costs associated with individuals who have creditable coverage but have reached annual or lifetime insurance limits *or have otherwise exhausted covered benefits* can be included in calculating the hospital-specific DSH limit." However, the language of the proposed definition of "No source of third party coverage for a specific inpatient hospital or outpatient hospital service" under § 447.295(b), mentions only annual or lifetime limits. **CMS should revise the regulatory language to explicitly capture costs for individuals who "have otherwise exhausted covered benefits."**

2. CMS Should Clarify That the Cost of Services to Individuals Who Exhaust Their Coverage During a Hospital Stay May Be Included in the DSH Limit

NAPH requests that CMS clarify its proposed guidance on defining a service for purposes of coverage to ensure that the DSH limit includes the uncompensated costs of services provided when a limit is reached or benefits are exhausted during a hospital stay. We appreciate and agree with CMS' language in the preamble that the costs of providing services to individuals with limited coverage plans or exhausted benefits should be DSH-eligible costs.[7] We urge CMS to apply this policy equally whether the benefits are exhausted before the start of the hospital stay or during the stay.

Consistent with this policy, **NAPH requests CMS clarification that costs for inpatient hospital services provided when benefits are exhausted during a hospital stay would be properly included in the DSH limit calculation as costs of services for which an individual has no source of third-party coverage**.[8] The inclusion of the cost of services provided after benefits are exhausted should not depend on the timing of when those benefits are exhausted. It would be irrational, for example, to adopt a policy that would include the costs of a 14-day hospital stay for an individual who had reached a day limit prior to admission but not for an individual who had 1 day of coverage left upon admission. In both cases, the hospital has provided services that are uncompensated and to an individual without coverage.

[7] 77 Fed. Reg. at 2506.

[8] Such a policy would apply explicitly and only to situations in which the coverage has been exhausted during the hospital stay, as opposed to a situation where the coverage simply did not cover the full cost of care, for example, when a plan's per diem rate does not cover the full cost of care for that day.

NAPH member health systems are often left to treat the sickest, most vulnerable—and thus most costly—patients. This is particularly true in the case of NAPH members providing specialized services, such as burn care, or serving as the main trauma hospital in their area. Insurance coverage, particularly for those patients who are underinsured, will often cover only a small fraction of the time that such patients must remain in the hospital. Other hospitals could address this issue by transferring these patients to safety net facilities that by mission will continue to treat them. NAPH members are those safety net facilities and will keep these patients for as long as their services are needed. CMS should clarify that the cost of services provided to individuals who have exhausted their coverage may be included regardless of when the coverage is exhausted. Safety net hospitals caring for these patients should not be penalized for continuing to provide care after the insurance runs out.

The proposed regulation at 447.295(c)(1) states, "The service-specific coverage determination can occur only once per individual per service provided and applies to the entire service, including all elements as that service, or similar services, would be defined in Medicaid." In addition, the preamble states, "The intent is that the hospital will generally determine that an individual is either insured or not insured for a given hospital stay, and will not separate out component parts of the hospital stay based on the level of payment received."[9] Given the highly variable length of inpatient stays and the nature of the patients served, CMS should allow an inpatient hospital service to be reevaluated at the point that a benefit limit or dollar limit is reached or benefits are otherwise exhausted. CMS should revise the proposed regulation at 447.295(c)(1) to read, "*The service-specific coverage determination* applies to the entire service, including all elements as that service, or similar services, would be defined in Medicaid. **However, the service-specific coverage *may be reevaluated during an inpatient stay only if a benefit limit or dollar limit is reached or the individual's benefits are otherwise exhausted, in which case the individual may be treated as uninsured for that portion of the stay.***

3. CMS Should Treat Individuals With High Deductible Plans or Catastrophic Coverage as Uninsured Until Patients Meet the Relevant Limits

NAPH supports CMS' policy in the proposed rule to regard certain costs of treating individuals with coverage subject to benefit limitations as DSH-eligible. CMS also proposes to treat IHS beneficiaries as uninsured for certain services based on the reasoning that the limited funding under the program limits benefits. In both cases, CMS has determined that when a hospital provides services for an insured patient whose insurance does not pay for the service provided, the uncompensated costs are included in the DSH limit. In order to be consistent with the policy in these two proposals, CMS also should include patients with high-deductible plans/catastrophic plans as uninsured for services until they meet their deductible or spending limit. Such plans are essentially the inverse of plans with initial coverage that is quickly exhausted. To the extent that individuals do not have a third-party payer source for those uncovered services, CMS should treat the uncompensated costs of services before the deductible is met just as it treats the costs of services after annual or other benefit limits are reached. To the extent that an individual does make any payments for services prior to reaching the limit (through a health savings plan or otherwise), the hospital would have to report the payments, which would offset uninsured

[9] 77 Fed. Reg. at 2504.

uncompensated care costs in the DSH limit calculation. The low-income populations treated by DSH hospitals are less likely to pair such a limited coverage plan with a health savings account or to have other resources available to cover the costs of their services. Because an individual may meet and exceed their deductible limit such that a portion of a service would be eligible for coverage, CMS should implement the regulatory changes above so that the individual would be treated as having no source of coverage for a portion of the service and a source of coverage for the rest.

For similar policy reasons, NAPH requests that CMS also treat individuals whose only source of coverage is an excepted benefit plan, defined at 45 C.F.R. 148.220, as uninsured for purposes of the DSH limit calculation. For example, if a patient has an extended stay in an NAPH member's trauma center after a serious car accident, and that patient's only coverage is through limited medical care payments under an auto insurance plan (e.g., a per-accident amount), the hospital should be able to include as uncompensated costs the significant services provided once the per-accident limitations are exceeded. Hospitals would offset the uncompensated costs of treating these patients by any payments received for their care. This is similarly true for individuals whose only source of coverage is a legally liable third party whose liability cannot be established on a service-specific basis (e.g., a tort settlement). Particularly when the liability is contested, the patient is effectively uninsured when receiving the services.

To implement these changes, CMS should revise the definition of "No source of third party coverage for a specific inpatient hospital or outpatient hospital service" in 447.295(b) to read:

> No source of third party coverage for a specific inpatient hospital or outpatient hospital service means that the service is not included in an individual's health benefits coverage through a group health plan or health insurer, and for which there is no other legally liable third party. When a lifetime or annual coverage limit is imposed by a third party payer, specific services beyond the limit would not be within the individual's health benefit package from that third party payer. For American Indians/Alaska Natives, IHS and tribal coverage is only considered third party coverage when services are received directly from IHS or tribal health programs (direct health care services) or when IHS or a tribal health program has authorized coverage through the contract health service program (through a purchase order or equivalent document). ***For individuals with high deductible health plans (as defined under the Internal Revenue Code at 26 U.S.C. 223(c)(2)), such plans are only considered third party coverage once the individual reaches the necessary deductible or spending requirements. Individuals whose only source of coverage is an excepted benefit plan, as defined at 45 C.F.R. 148.220, or a legally liable third party whose liability cannot be established on a service-specific basis, should be treated as uninsured, and any payment received from such plan should be offset against the costs of the services provided to these individuals.*** Administrative denials of payment, or requirements for satisfaction of deductible, copayment, or coinsurance liability, ***other than under high deductible health plans***, do not affect the determination that a specific service is included in the health benefits coverage.

4. <u>CMS Should Clarify That It Does Not Intend to Narrow the Scope of Inpatient and Outpatient Hospital Services as Defined in Section 1905(a) of the Social Security Act for Purposes of Determining DSH-Eligible Costs</u>

CMS should clarify that hospital services included within the federal definition of inpatient or outpatient hospital services may be included in the DSH calculation regardless of any limitations on coverage of such care incorporated into the State Plan.

In the preamble to the proposed rule, the scope of the hospital services provided to the uninsured for which costs may be included in the DSH limit is explicitly linked to services "which are identified in section 1905 of the Act and *covered under the approved Medicaid State Plan*."[10] In parallel language related to the costs of services to Medicaid beneficiaries, the preamble describes "inpatient and outpatient costs associated with Medicaid eligible individuals authorized under section 1905 of the Act *and covered under the approved Medicaid State Plan*."[11] This language is not incorporated into the regulatory provisions. NAPH requests that CMS clarify that this preamble reference to coverage "under the approved Medicaid state plan" is not intended to be a significantly limiting factor in the scope of costs that can be included in the DSH cap.

We assume that CMS agrees with our interpretation, based on other preamble language explaining that inpatient and outpatient costs associated with Medicaid eligible individuals should be included in the DSH limit "regardless of whether those beneficiaries or hospitals were entitled to payment as part of the Medicaid benefit package under the State plan"[12] and that the costs of providing inpatient and outpatient hospital services to Medicaid beneficiaries should be included "regardless of whether the individual's benefits have been exhausted or whether coverage limits have been reached."[13] However, we ask CMS to clarify its intent. **Specifically, we request that CMS make this clarification when it finalizes this rule, and implement a policy that costs for services meeting the federal definition under Section 1905 of the Social Security Act should be included in the DSH cap.**

A particularly striking example of the potential impact of a policy that limits DSH-eligible services to a potentially limiting interpretation of those covered under the Medicaid State Plan is the case of transplant services. CMS uses this example in the preamble in the context of a patient with limited commercial coverage:

> An example of such a situation would involve an individual with basic hospitalization coverage that has an exclusion for transplant services. Should the individual need the excluded service, the cost of that service could be included in the Medicaid hospital specific DSH limit.[14]

[10] 77 Fed. Reg. at 2503.
[11] 77 Fed. Reg. at 2502.
[12] 77 Fed. Reg. at 2502.
[13] 77 Fed. Reg. at 2503.
[14] 77 Fed. Reg. 2503.

We agree with CMS that hospitals should be able to receive support from the DSH program for the costs of these critical services if a patient's coverage (whether commercial, Medicaid, or other) excludes them. Transplant services are clearly Medicaid inpatient services under Section 1905. If a particular state decides to discontinue coverage for transplants in its approved state plan, that decision should not disqualify these costs from DSH coverage. The DSH program was designed to support the **uncompensated** costs that a state does not pay for through its Medicaid program, as well the costs of the uninsured. As long as the service meets the federal definition under Section 1905, it should be included in the DSH cap.

A policy that recognizes the costs of providing inpatient and outpatient hospital services under Section 1905—even if payment for a service is excluded or coverage has been exhausted through day limits, outpatient visit limits, etc., under the state plan—is critical to capturing the full costs of treating Medicaid and uninsured patients. Furthermore, as Medicaid coverage expands in 2014, the uncompensated costs of Medicaid services will become an even more critical component of the DSH limit calculation to ensure support for the providers CMS will rely on to expand access. NAPH members are left with significant uncompensated costs of providing care to Medicaid patients because, consistent with their missions to treat socially and economically vulnerable patients and their roles as providers of specialty care such as trauma and burn care, these hospitals often care for the most challenging cases. For example:

- One NAPH member recently treated a patient with multiple comorbidities who had a tracheotomy with extended mechanical ventilation. The patient was hospitalized for 442 days. Medicare and Medicaid covered only 221 days, leaving $893,055 in costs.

- In another example from a member hospital, the state Medicaid agency covered 2 days of hospital treatment to resolve a patient's immediate acute care need. However, the patient's Huntington's disease and related behavioral challenges made it impossible to find suitable placement for the patient in a nonhospital setting. The patient remained hospitalized for an additional 203 days. Because the patient had Medicaid coverage for 2 days of care valued at $1,800, none of the services delivered to the patient in the subsequent 203 days could be considered a cost of the uninsured. The value of that care, at cost, was approximately $190,000.

The hospital in each of these examples was providing an ongoing hospital stay and could not, whether by state law or the requirements of their mission, discharge the patient to an inappropriate setting, despite the fact that Medicaid would no longer pay for the costs of the services. As long as the patient was properly admitted and retained because the hospital had no way to appropriately discharge the patient, the uncompensated costs of the services should be included in the DSH limit.

We urge CMS to ensure that all costs for services meeting the federal definition under Section 1905 of the Social Security Act may be included in the DSH cap regardless of limits in the State Plan. In implementing this policy, CMS should clarify that it also permits inclusion of the costs of patients whom hospitals are unable to discharge to appropriate settings.

5. <u>CMS Should Not Change Existing Policy on Medicaid Eligibility of Inmates Receiving Inpatient Hospital Services or the Inclusion of Their Costs in the Medicaid Portion of the DSH Calculation</u>

CMS should retract its preamble statements suggesting that federal financial participation (FFP) is not available for care provided to inmates unless they have been released from secure custody.

In the proposed rule, CMS purports to clarify current policy that, for DSH purposes, inmates in a public institution are not considered *uninsured*, but rather are considered to have a third-party source of coverage because the relevant government enforcement agency is liable for their coverage. Therefore, the costs of uninsured inmates cannot be included in the uninsured portion of the DSH limit calculation. This position was expressed in a State Medicaid Directors Letter of August 16, 2002, and we acknowledge it has been CMS policy.

However, in the preamble to the proposed rule, CMS goes well beyond the purported scope of the proposed rule and misstates longstanding policy on the treatment of Medicaid-eligible inmates receiving inpatient hospital care. CMS appears to reinterpret the current exception permitting FFP for inmates when they are patients in a medical institution in a way that would render the existing statutory exception meaningless and would leave many of NAPH's members with a huge burden of uncompensated care without any DSH support. **CMS should not change existing policy on Medicaid eligibility of inmates receiving inpatient hospital services or the inclusion of their costs in the Medicaid portion of the DSH calculation, consistent with the treatment of costs for hospital services for any Medicaid patient, and should retract the related statements in Section II.D. of the preamble.**

The Medicaid statute states that "medical assistance" does not include "any such payments with respect to care or services for any individual who is an inmate in a public institution (except as a patient in a medical institution)."[15] In the proposed rule, CMS suggests that this statutory framework focuses on a "*distinction* between an 'inmate' and a 'patient,'" and limits the exception to the prisoner rule to situations "when the individual is no longer in secure custody by law enforcement or a corrections agency and thus can be admitted as a 'patient' rather than an 'inmate.'"[16] However, the statute does not make a mutually exclusive distinction between these two terms. Rather, the statute refers to situations where an inmate is also a patient—in which case, services provided are within the definition of medical assistance. To read the statute such that an "inmate" can never be a "patient" is inconsistent with the statutory language of the exception Congress clearly stated that medical assistance includes care provided for Medicaid-eligible patients in a medical institution regardless of whether they are also an inmate, and it is contrary to the Medicaid statute to impose a narrower interpretation on the term "patient in a medical institution."

Furthermore, CMS' previous guidance on this issue has consistently referred to inmates as being eligible for medical assistance. These individuals are eligible not because they are no longer inmates, but because they have become patients upon admission to a medical institution.

[15] SSA § 1905(a)(28).
[16] 77 Fed. Reg. at 2505 (emphasis added).

- In a December 12, 1997 letter to state regional administrators, the Health Care Financing Administration stated, "*Inmates of a public institution may be eligible for Medicaid* if the appropriate eligibility criteria are met… An exception to the prohibition of FFP is permitted *when an inmate becomes a patient* in a medical institution. This occurs when the *inmate is admitted as an inpatient in a hospital*, nursing facility, juvenile psychiatric facility, or intermediate care facility. Accordingly, FFP is available for any Medicaid covered services *provided to an 'inmate' while an inpatient in these facilities* provided the services are included under a State's Medicaid plan and the 'inmate' is Medicaid-eligible."[17]

CMS recently confirmed this interpretation of the exception in a December 2, 2008 letter from the Denver Regional Office, in which the office "consulted with CMS Central Office" to provide the following excerpted response (among others):

> [Question] If an individual is incarcerated in a state prison or county jail and then transferred to a nursing facility setting, is the individual considered an inmate under 42 CFR § 435.1010 and ineligible for FFP? Does the response change if the inmate is hospitalized or in the nursing facility for an indefinite amount of time? For example, the individual requires a ventilator and remaining in a state prison or county jail is no longer medically feasible.
>
> [CMS Response] If *the inmate becomes an inpatient* of a nursing facility or a hospital, FFP is available for that individual under the exception of the inmate provision. This continues as long as the individual is an inpatient of the medical facility. Federal policy and regulations do not place a time limit for FFP availability as long as individual continues to be eligible for Medicaid and residing as an inpatient in the medical facility.[18]

The Denver Regional Office again confirmed this interpretation in a letter from August 16, 2010:

> While Federal law at 1905(a)(A) of the Social Security Act prohibits FFP for medical care or services for inmates in a public institution there is the exclusion when the inmate who is otherwise Medicaid eligible receives medical care in a medical institution…. [I]f the inmate becomes an inpatient of a nursing facility or a hospital, FFP is available for that individual under the exception of the inmate provision. This continues as long as the individual is an inpatient of the medical facility."[19]

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[17]HCFA, Center for Medicaid and State Operations, Letter to All Associate Regional Administrators, Clarification of Medicaid Coverage Policy for inmates of a Public Institution (Dec. 12, 1997) (emphasis added), available at http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1247146939485.

[18] HCFA Region VIII, Letter to Colorado Department of Health Care Policy and Financing (Dec. 2, 2008), available at http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1247146939485.

[19]HCFA Region VIII, Letter to Colorado Department of Health Care Policy and Financing (Aug. 16, 2010), available at http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1247146939485.

Thus, the new interpretation of this exception, which CMS proposes in the preamble, is a significant deviation from CMS' longstanding interpretation of the statute.

Furthermore, CMS wrongly claims that "hospitals… cannot, within the scope of their conditions of participation, subject patients to restraints or seclusion."[20] The Medicare conditions of participation at 42 C.F.R. § 482.13(e) clearly state that restraint or seclusion may be "imposed to ensure the immediate physical safety of the patient, a staff member, or others…"[21] It is reasonable, and permissible, that hospital providers would determine that an inmate may be a threat to the safety of hospital staff and other patients. Again, there is nothing in the Conditions of Participation suggesting that a hospital cannot admit as a patient an inmate who is subject to some form of restraint or seclusion. Nor does the use of restraints or other security measures mean that the care provided is "outside the function of the institution as a Medicaid-participating hospital" such that the inmate cannot be "treated as [a] 'patient.'"[22] The hospital remains a "medical institution," the inmate is a "patient," and therefore the services provided are within the scope of the statutory exception. CMS guidance also explicitly permits law enforcement personnel to use various forms of restraint, such as handcuffs or shackles, to maintain custody of a prisoner who has been admitted to the hospital, and the hospital remains responsible to care for "its patient" under these circumstances.[23]

Despite the very significant retrenchment of longstanding policy suggested in the preamble, CMS fails to even mention this issue in its analysis of the "Effects on Providers." For numerous NAPH members, this change in policy will shift significant costs of inpatient stays for those inmates who are Medicaid-eligible to the hospitals.

CMS' proposed interpretation is contrary to statute, is not necessary to implement the provision on treatment of the costs of uninsured inmates, and is a significant change in policy with consequences that CMS has not adequately considered. **Therefore we urge CMS not to change existing policy on Medicaid eligibility of inmates receiving inpatient hospital services or the inclusion of their costs in the Medicaid portion of the DSH calculation, and to retract the related statements in Section II.D. of the preamble.**

6. CMS Should Clarify the Audit and Reporting Years to Which the Policies Would Apply

The preamble states that the proposed rule defines "individuals who have no health insurance (or other source of third party coverage) for the services furnished during the year" for purposes of calculating the hospital-specific DSH limit effective for 2011."[24] Because 2011 is the first year for which CMS intends to recoup overpayments, NAPH thanks CMS for recognizing that it is critical that any policy changes meant to mitigate unintended consequences be applied to 2011.

[20] 77 Fed. Reg. 2505.
[21] 42 C.F.R. 482.13(e).
[22] 77 Fed. Reg. 2505.
[23] CMS, State Operations Manual, Appendix A-0154.
[24] 77 Fed. Reg. at 2506.

CMS also states in the preamble that, "This proposed clarification would be effective for DSH audits and reports submitted following the effective date of the rule, thus avoiding any unintended, and potentially significant, financial impact resulting from the 2008 DSH final rule."[25] If CMS were to issue a final rule sufficiently prior to fall 2012, when the 2009 DSH audits are due, this timing would permit states to implement the rule changes beginning with audits for 2009. We encourage CMS to meet this timeline, clarify that the changes put forward in this rule apply to 2009 audits, and extend the deadline for states to submit audited 2009 data to CMS, so that accurate data on DSH costs and payments will be available from as early a date as possible. Among other reasons, the availability of accurate data will be crucial as CMS looks to implement the Medicaid DSH reductions from the Affordable Care Act. Furthermore, as mentioned above, some states are withholding a portion of their current DSH payments to providers based on the results of the audited reports. Making these changes effective as soon as possible will hopefully result in states' willingness to make the appropriate level of DSH payments throughout the year, rather than withholding crucial support until the post-year-end reconciliation.

Finally, because the 2008 final rule became effective in the middle of fiscal year 2009, and this proposed rule should in its final form apply to 2009 audits, CMS should clarify that the 2008 final rule definition of uninsured for all practical purposes has never been in effect.[26]

7. CMS Should Consider Consequences of Other Policy Changes in 2008 Final Rule

NAPH understands that the proposed rule focuses on the definition of uninsured for purposes of calculating the hospital-specific DSH limit, but asks that CMS reconsider other policy changes in the 2008 final rule that also have significant consequences for the DSH funding available to our members. We believe it is within CMS' authority to make these changes and is consistent with the flexibility in the 1994 State Medicaid Director's Letter guidance on which CMS has relied for the proposed rule. We refer you to the previous NAPH comment letter on these issues, which is attached.

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[25] 77 Fed. Reg. at 2504.

[26] Note that a clarification that the policy did not change might be particularly important to states that have Medicaid waivers spanning the time period between the 2008 Final Rule and this rule, or that are currently negotiating waivers, and provide support for uninsured care that is tied to the definition of uninsured for purposes of Medicaid DSH.

National Association of Public Hospitals and Health Systems

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May 19, 2009

The Honorable Kathleen Sebelius
Secretary
Department of Health and Human Services
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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.