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VIA HAND DELIVERY

October 24, 2005

Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
Room 445-G
200 Independence Ave, S.W.
Washington, DC 20201

Attention: 2198-P

Dear Administrator McClellan:

The Association of American Medical Colleges (AAMC) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS or the Agency) proposed rule entitled *"Medicaid Program; Disproportionate Share Hospital Payments" 70* Fed. Reg. 50262 (August 26, 2005). The AAMC represents approximately 400 major teaching hospitals and health systems; all 125 accredited U.S. allopathic medical schools; 96 professional and academic societies; and the nation's medical students and residents. The Medicaid disproportionate share (DSH) program provides critical financial assistance to our teaching hospitals and academic clinical faculty, which serve as "safety net" providers for much of the nation's Medicaid population.

The proposed rule seeks to implement section 1001(d) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) which established new reporting and auditing requirements for state disproportionate share hospital payments. However, we believe there are a number of deficiencies in the proposal that, unless corrected, would go beyond the intent of section 1001(d) and have a serious detrimental impact on Medicaid DSH hospitals. These deficiencies include:

- Excluding bad debt in the calculation of uncompensated care costs,
- Excluding physician service costs in the calculation of the hospital-specific DSH limits,
- Including the receipt of 1011 payments in the calculation of the DSH limits, and
- The undue reporting burden that would be imposed on hospitals.

I. DEFINITION OF UNCOMPENSATED CARE COSTS

A. Bad Debt

One of the elements that states would be required to report to CMS is the level of uncompensated care costs incurred by each DSH hospital. The text of this proposed

requirement states, in part, that "Uncompensated care costs do not include bad debt or payer discounts." (proposed 42 C.F.R. § 447.299(c)(15)).

We strongly disagree that bad debt be excluded from the definition of uncompensated care costs. The statement is inconsistent with current law, which includes all costs related to individuals who "have no health insurance (or other source of third party coverage)" (42 U.S.C. §1396r-4(g)(1)(A)). In addition, the uncompensated costs associated with under-insured individuals and with patients having high deductibles or exclusion limits pose significant financial burdens on hospitals, burdens that historically have been recognized by state Medicaid programs. We urge CMS to rescind the exclusion of bad debt in the uncompensated care definition.

B. Physician Services

The preamble of the proposed rule states that uncompensated care costs of physician services cannot be included in the calculation of the hospital-specific DSH limit (70 Fed. Reg. 50265). We disagree strongly with this statement and urge the Agency to rescind it in the final rule.

There is nothing in either current law or the MMA that says physician costs cannot be included in the DSH limit calculation. The costs associated with securing physicians to serve the hospital's indigent patient population are legitimate unreimbursed costs and should be allowed. Inclusion of physician costs also is vital since many hospital operations include physician clinics that focus on providing primary care to underserved populations and generally operate at a financial loss due to inadequate medical reimbursement rates. The final rule should clarify that these costs can be included in the DSH limit calculation.

II. DSH LIMITS AND SECTION 1011 PAYMENTS

Under section 1011of the MMA, hospitals may be reimbursed for costs associated with emergency services provided to undocumented immigrants ("Section 1011 payments"). Although the preamble to the proposed rule states that the Agency believes receipt of Section 1011 payments will have no impact on DSH payments for hospitals that have not reached their DSH cap, it also states that for hospitals at or near their DSH limit "States will need to consider a section 1011 payment when determining the hospital's DSH limit, because the total DSH payments should not exceed the total amount of uncompensated care at the hospital." (70 Fed. Reg. at 50264).

Section 1011 payments should not be included in the reporting requirements. There is no statutory requirement to include them. The Medicaid statute requires only that uncompensated costs be offset by non-DSH Medicaid revenues or payments by uninsured patients--Section 1011 payments fall into neither of these categories.

III. HOSPITALS' ADMINISTRATIVE BURDEN

We believe that the proposed rule would place undue administrative burdens on hospitals. To help alleviate this burden, we urge the Agency to make the following changes in the final rule:

- Make the regulations effective prospectively (rather than FY 2005) so that states and hospitals have time to review, understand, and modify procedures to comply with the reporting instructions;

- Rescind the preamble requirement that audited DSH payments must be measured against actual uncompensated care costs in the same FY and continue to allow reasonable estimating methodologies to determine uncompensated care costs; and

- Delete the requirement that states must report, for each hospital, an unduplicated count of Medicaid eligible and uninsured patients because this reporting burden will likely fall to hospitals that do not have systems in place to generate these data.

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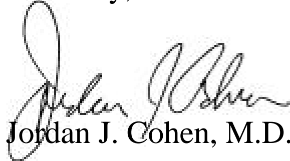
If you have questions concerning these comments, please feel free to call Robert Dickler, Senior Vice President, Health Care Affairs, or Karen Fisher, Senior Associate Vice President. These individuals may be reached at (202) 828-0490.

Sincerely,



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cc: Robert Dickler, AAMC
Karen Fisher, AAMC