February 15, 2012

Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
ATTN: CMS-2315-P
7500 Security Blvd.
Baltimore, MD  21244-8013

Dear Ms. Tavenner:

Re: Medicaid Disproportionate Share Hospital Payments Uninsured Definition Proposed Rule, File Code CMS-2315-P

The Association of American Medical Colleges (AAMC) welcomes this opportunity to comment on the Centers for Medicare and Medicaid Services’ (CMS’ or the Agency’s) proposed rule entitled Medicaid Program; Disproportionate Share Hospital Payments—Uninsured Definition. 77 Fed. Reg. 2500 (January 18, 2012). The Association’s Council of Teaching Hospitals and Health Systems (COTH) is comprised of nearly 300 general acute nonfederal major teaching hospitals and health systems. The Association also represents all 136 accredited U.S. medical schools; 94 professional and academic societies; 90,000 full-time clinical faculty; and the nation’s medical students and residents.

The nation’s major teaching hospitals are an integral and vital part of communities, and they provide a disproportionate amount of health care services for Medicaid beneficiaries. While the country’s 273 COTH institutions represent just six percent of all hospitals and 23 percent of all hospital admissions, they account for over one-quarter of all Medicaid discharges and 40 percent of all hospital charity care. The AAMC writes to commend CMS for the Agency’s decision to revise the definition of “uninsured” in the proposed rule.

How CMS defines the term “uninsured” is critical to establishing a hospital’s limit on Medicaid disproportionate share hospital (DSH) payments. The Social Security Act limits a hospital’s Medicaid DSH payments to the uncompensated costs of providing services to Medicaid-eligible individuals and individuals who “have no health insurance (or other source of third party coverage) for the services furnished during the year.” While a 1994 letter to State Medicaid Directors originally interpreted this requirement to include patients who were insured but lacked insurance for a particular service, the regulatory definition CMS adopted in the 2008 DSH final rule was individual-specific rather than service-specific.
February 15, 2012
Marilyn Tavenner, Administrator
Centers for Medicare & Medicaid Services

The proposed rule would revise the Agency’s current interpretation of the term uninsured to include not only patients who have no insurance, but also patients who lack insurance for the specific service provided. The revised definition would also include patients who have reached annual or lifetime insurance limits or have otherwise exhausted their covered benefits. Services rendered to these patients could then be included in the calculation of a hospital’s Medicaid DSH limitation.

The AAMC appreciates CMS’ reconsideration of this issue and supports the Agency’s decision to return to a service-specific approach to the definition of uninsured. The Association believes the proposed definition appropriately captures an important subset of uninsured patients and better reflects a hospital’s true uncompensated care costs. Given CMS’ recognition that the term uninsured should be defined on a service-specific basis, the AAMC strongly encourages CMS to make this proposed definition retroactive to the date of the 2008 DSH final rule.

The AAMC remains concerned, however, that the proposed definition of uninsured continues to exclude several critical categories of uncompensated care costs. Specifically, the AAMC urges CMS to include in the calculation of the hospital-specific DSH limit costs associated with unpaid coinsurance and deductibles. Individuals with high deductible plans, for example, may technically have a source of third party coverage, but the nature of their plans renders them virtually uninsured and often unable to pay for the costs of their care.

Additionally, the AAMC urges CMS to clarify that when a patient’s coverage is exhausted during a hospital stay, the costs associated with service provided after the exhaustion date may be included in the DSH limit. While 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 policy does not appear to take into account the complex patients often treated at teaching hospitals, who may exhaust coverage during a lengthy hospital stay. CMS should revise the proposed regulation to permit services to be reevaluated at the time an individual’s benefits are exhausted and should allow the patient to be considered uninsured after that point.

Thank you for the opportunity to present our views. We would be happy to work with CMS on any of the issues discussed above or other topics that involve the academic health center community. If you have questions regarding our comments, please feel free to contact Lori Mihalich-Levin, J.D., at 202-828-0599 or at lmlevin@aamc.org.

Sincerely,

Joanne Conroy, M.D.
Chief Health Care Officer

cc: Lori Mihalich-Levin, J.D., AAMC