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Via Electronic Submission (www.regulations.gov)

September 14, 2016

Mr. Andrew Slavitt
Acting Administrator
Attention: CMS 2399-P
Centers for Medicare & Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Treatment of Third Party Payers in Calculating Uncompensated Care Costs for Medicaid Disproportionate Share Payments

Dear Mr. Slavitt:

The Association of American Medical Colleges (AAMC or Association) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS's or the Agency's) *Medicaid Program; Disproportionate Share Hospital Payments – Treatment of Third Party Payers in Calculating Uncompensated Care Costs; Proposed Rule,* 81 Fed. Reg. 53980 (August 15, 2016).

The AAMC is a not-for-profit association representing all 145 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems; and, 93 academic and professional societies. Through these institutions and organizations, the AAMC represents 160,000 faculty members, 83,000 medical students, and 115,000 resident physicians.

Among the missions of major teaching hospitals is the provision of care to large numbers of Medicaid and uninsured patients. Representing only five percent of all hospitals, major teaching hospitals are the sites for approximately a quarter of all Medicaid discharges and over 40 percent of all hospital charity care. Our nation's teaching hospitals and outpatient clinics also provide large amounts of ambulatory care in poor communities, often acting as the "family doctor" in areas where few individual practitioners exist.

In anticipation of a rapid reduction of uninsured Americans and uncompensated care costs, the Affordable Care Act included significant cuts to Medicaid disproportionate share hospital (DSH) payments. Though subsequent legislation has temporarily delayed these cuts, a loss of billions in funding looms in FY2018, despite 19 states still opting out of expanding Medicaid coverage. Varied

uptake of coverage, remaining uninsured populations including large communities of undocumented immigrants, and state-specific health care crises all demand that states be allowed as much flexibility as possible to direct remaining Medicaid DSH resources where they are most. While the AAMC understands the need for federal oversight of federal Medicaid resources, CMS must work with states in implementing its proposed policies to ensure that state priorities for supporting safety net providers can still be achieved.

The decline in DSH resources is further exacerbated when the stability of remaining funds is unclear. Inconsistent interpretations of CMS's existing regulations and informal guidance regarding calculations of Medicaid DSH payments have meant hospitals are unable to fully rely on the DSH dollars they still receive, worried that reinterpretations of the rules will lead to clawbacks of supposed overpayments. For this reason, the AAMC appreciates CMS's acknowledgment that its existing policies have not been sufficiently clear and require new rulemaking.

PROPOSAL REPRESENTS NEW POLICY; SHOULD ONLY BE APPLIED PROSPECTIVELY

In 2008, CMS issued a final rule entitled "*Medicaid Disproportionate Share Hospital Payments*" (73 FR 77904) to set forth guidance regarding the calculation of hospital-specific limits on Medicaid DSH payments and guidance for annual state reports and audits. The 2008 final rule clarified that Medicare payments for patients dually eligible for Medicare and Medicaid should be included in uncompensated care calculations, but the rule did not address other third party payers. Until now, the treatment of third party payments in uncompensated care calculations had only been addressed through subregulatory guidance. The vagaries of policy included both whether third party payments should be included and whether uncompensated care should be calculated at the patient level or aggregated at the hospital level. Though calculating uncompensated care at the aggregate hospital level was mentioned in the preamble of the 2008 rule, CMS never included the policy in regulatory text. In the current proposed rule, CMS proposes to establish its previous informal comments on both topics as official Agency policy.

By issuing the proposed rule, CMS cedes the notion that its policies on the treatment of third party payments had already been well established during the time periods for which hospitals are currently being audited. Therefore, the AAMC urges CMS to clarify that these new policies will apply prospectively from the issuance of a final rule.

Further, the AAMC recommends that CMS establish an official transition period – as the Agency did following the issuance of the 2008 rule – to allow for provider education. It also is important that these policies are only included in audits that review hospital practices after the policies' forthcoming implementation. The previous transition period lasted two years, which would be appropriate again in this case.

Though throughout the proposed rule CMS represents its proposal as a clarification of existing policy, the Agency also notes that it has been the subject of multiple lawsuits from states and providers over the ambiguity of the policy and procedural violations. The AAMC is aware of numerous providers

subject to disparate interpretations by auditors regarding how hospital-specific DSH limits should be calculated. In the zero sum game of distributing limited state DSH funds, hospitals face material financial harm when ambiguous rules are applied differently to different institutions. The matter addressed by the proposed rule is not one of procedural updating but of meaningful policymaking.

PATIENTS FOR WHOM NO MEDICAID CLAIM IS FILED SHOULD BE EXCLUDED FROM CALCULATIONS OF HOSPITAL-SPECIFIC DSH LIMITS

The AAMC also urges CMS to clarify that auditors reviewing hospital-specific DSH limits patients with Medicaid as a secondary payer but for whom no Medicaid claim has been filed by the hospital should not be viewed as Medicaid patients. This issue is directly related to in the overall inclusion of third party payments in the calculation of uncompensated care for the purpose of hospital-specific DSH limits, and therefore should be addressed in the Agency's current rulemaking.

Patients with sufficient commercial coverage to cover all hospital expenses without any reliance on Medicaid billing should not, for these purposes, be considered Medicaid patients for whom DSH funds are meant to compensate. If a hospital submits no Medicaid claims for a particular patient, that patient's expenses should not count toward the hospital's overall Medicaid expenditures – nor should the commercial insurance payments for such a patient be included in calculations of revenues received on behalf of Medicaid patients. In essence, these patients should be removed from both the numerator and the denominator of a hospital's ratio of total compensation on behalf of Medicaid beneficiaries to total Medicaid expenditures.

HOLISTIC VIEW OF HOSPITAL "SITUATION" REQUIRES BROADER INTERPRETATION OF MEDICAID LOSSES

In the proposed rule CMS describes inclusion of third party payments as necessary to understanding a hospital's "situation" relative to the Medicaid and uninsured patients it serves, a term used in Section 1902(a)(13)(A)(iv) of the Social Security Act in establishing the intention of Medicaid DSH payments. CMS illustrates this point describing two hospitals seeing similar numbers of Medicaid and uninsured patients, only one of which receives any third party reimbursement. CMS uses this example to demonstrate that the "real economic burden of hospitals that treat a disproportionate share of low-income patients" is greater for the hospital without additional third party payments. CMS argues that including third party payments in calculations of uncompensated care reveals this difference in hospital "situation."

While this difference in "situation" is undeniable, the AAMC notes that other factors besides third party payments affect a hospital's situation relative to Medicaid uncompensated care losses. Many hospitals serving disproportionate numbers of Medicaid beneficiaries and uninsured patients are also responsible for generating large portions of the non-federal share for their own reimbursements, either through allowable provider fees or intergovernmental transfers (IGTs). This payment to the state in order to receive Medicaid reimbursement is often significant, and the difference in "situation" between

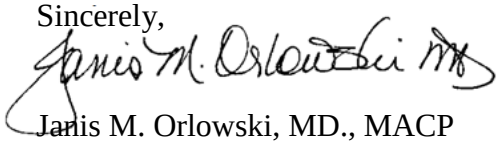
two hospitals - only one of which generates IGTs - may be of an even greater magnitude than the difference illuminated by inclusion of commercial and third party payments.

As CMS seeks to adopt a more holistic view of the "real economic burden of hospitals that treat a disproportionate share of low-income patients," the AAMC recommends that CMS also allow hospitals to include the economic burdens of Medicaid provider fees and other provisions of non-federal share in their calculations of uncompensated care costs for the purposes of Medicaid DSH hospital-level caps.

CONCLUSION

The AAMC appreciates your consideration of the above comments. Should you have any questions, please contact Ivy Baer at ibaer@aamc.org or Ayeisha Cox at aycox@aamc.org.

Sincerely,



Janis M. Orlowski, MD., MACP
Chief, Health Care Officer

cc: Ivy Baer, AAMC
Ayeisha Cox, AAMC