



AMERICA'S ESSENTIAL HOSPITALS

September, 14 2016

Mr. Andrew Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Ave. SW
Washington, DC 20201

Ref: CMS-2399-P: Medicaid Program; Disproportionate Share Hospital Payments—Treatment of Third-Party Payers in Calculating Uncompensated Care Costs

Dear Mr. Slavitt:

Thank you for the opportunity to submit comments on the above-mentioned proposed rule regarding the calculation of uncompensated care costs (UCC) used to determine the hospital-specific disproportionate share hospital (DSH) limit. As part of the Medicare Modernization Act of 2003, Congress required states to obtain independent certified audits of DSH payments to hospitals and report audit results to the Centers for Medicare & Medicaid Services (CMS) to ensure payments do not exceed unreimbursed Medicaid and uninsured costs (the hospital-specific DSH limit), as federal law requires. CMS finalized the rules implementing this requirement with the 2008 DSH audit rule, and audits have been ongoing since.¹ But in the course of issuing the rules governing the audits, CMS announced several new policies on calculating unreimbursed costs that have challenged providers and states. While we support CMS' efforts to protect the integrity of the Medicaid program, America's Essential Hospitals continues to have serious concerns regarding the agency's policies and the effect of these policies on hospitals that provide services to Medicaid patients and the uninsured.

America's Essential Hospitals is the leading association and champion for hospitals and health systems dedicated to high-quality care for all, including the most vulnerable. Filling a vital role in their communities, our nearly 275 member hospitals provide a disproportionate share of the nation's uncompensated care and devote approximately half of their inpatient and outpatient care to Medicaid or uninsured patients. More than a third of patients at essential hospitals are racial or ethnic minorities who rely on the culturally and linguistically competent care that only essential hospitals can provide. Our members provide this care while operating

¹ 73 Fed. Reg. 77904 (December 19, 2008)

on margins substantially lower than the rest of the hospital field—a zero percent aggregate operating margin compared with 8.3 percent for all hospitals nationwide.²

Members of America’s Essential Hospitals rely on multiple vital funding streams, such as Medicaid DSH, to provide needed care to their communities and serve the vulnerable populations that rely on them for quality, comprehensive care. In addition, they work closely with their state Medicaid offices to advance their states’ policy priorities and meet population health needs.

To ensure the continued integrity of the Medicaid DSH program, CMS should consider the following comments when finalizing the above-mentioned proposed rule.

- 1) CMS should not codify or enforce the proposed policy change, which a federal court has enjoined as likely inconsistent with the Medicaid DSH statute.

CMS proposes to codify its interpretation regarding the treatment of third-party payers in the calculation of UCC for the hospital-specific DSH limit. Specifically, the above-mentioned rule would make explicit that costs, for purposes of calculating the hospital-specific DSH limits, are net of any third-party payments received. Including these costs go beyond the Medicaid payments and payments by or on behalf of the uninsured – that are the only such payments identified in statute—which would be used to calculate hospital-specific DSH limits. This interpretation is under scrutiny in several lawsuits challenging CMS on both procedural and substantive grounds, and as a result of this litigation, DSH recoupments in three states are subject to preliminary injunctions to prevent CMS from enforcing the policy.³

Indeed, one court has already ruled that CMS likely does not possess the statutory authority to impose this policy.⁴ The court reasoned that the statute separately describes the payments that are subtracted from a hospital’s costs to obtain the Medicaid shortfall for determining the hospital-specific DSH limit. And the only such payments listed in the statute are payments under Title XIX; there is no mention of Medicare or third party payments. It is unlikely that Congress intended to grant CMS the discretion to include such other payments in the calculation of hospital “costs” to determine the Medicaid shortfall when it provided a separate statutory definition of “payments” that would otherwise be rendered meaningless.⁵ In addition, the court disagreed with CMS’ contention that “the Secretary has consistently interpreted the term ‘costs’ to include payments.”

The preamble to the proposed rule reiterates many of the arguments CMS raised in the litigation. But the courts will be the ultimate arbiters of CMS’ regulatory authority on this issue, so it is premature to begin a rulemaking process on an issue for which the agency’s authority is so ambiguous. If the federal courts ultimately conclude that CMS’ interpretation

² Landry C, Ramiah K, Rangarao S, Roberson B. 2014 Essential Data, Our Hospitals, Our Patients; Results of America’s Essential Hospitals 2014 Annual Member Characteristics Survey. America’s Essential Hospitals. June 2016. <http://essentialdata.info/>. Accessed August 2016.

³ *Texas Children’s Hospital v. Burwell*, Civil Action No. 14-2060 (EGS) (D.D.C. 2014); *Missouri Dep’t of Social Services v. Burwell*, Civil Action No. 1:15-cv-01329-EGS (D.D.C. 2015); *New Hampshire Hosp. Ass’n v. Burwell*, D.N.H., No. 1:15-cv-460-LM (filed Nov. 11, 2015).

⁴ *New Hampshire Hosp. Ass’n v. Burwell*, D.N.H., No. 1:15-cv-460-LM, Opinion No. 2016 DNH 053 (Mar. 11, 2016).

⁵ *New Hampshire Hosp. Ass’n v. Burwell*, D.N.H., No. 1:15-cv-460-LM, Opinion No. 2016 DNH 053 (Mar. 11, 2016).

exceeds its authority and conflicts with the language of the statute, CMS cannot implement this policy through informal guidance or regulation.

Given the pending litigation, we believe it would be more appropriate for CMS to halt enforcement in all states until the litigation is decided. As such, America's Essential Hospitals urges CMS not to codify the above-mentioned rule and to cease any ongoing enforcement.

2) If CMS nonetheless finalizes the policy, the proposed policy change certainly should not apply to services for which there has no Medicaid claim is submitted.

CMS proposes to change the DSH audit regulations to require that "all costs and payments associated with dual eligibles and individuals with a source of third-party coverage must be included in calculating the hospital-specific DSH limit."⁶ CMS fails to note, however, that there are instances in which a patient's third-party coverage fully covers all hospital expenses and a Medicaid claim is not submitted. These patients should not be considered Medicaid patients for which DSH funds are meant to compensate. For example, especially in the case of children who can become Medicaid-eligible regardless of family income, there are instances in which a patient enrolled in a state Medicaid program also will have coverage through private health insurance.⁷ Services that are paid for by the private coverage are not then also paid for by Medicaid. As expressly noted in the agency's January 2010 frequently asked questions (FAQs), Medicaid is the payer of last resort.⁸ Similarly, in the case of dual eligibles, the Medicaid statute provides states flexibility to opt not to pay beneficiary cost sharing to the extent that such payments would result in reimbursement in excess of the Medicaid rate for that service.⁹ As a result, hospitals often do not bill Medicaid for services provided to dual eligibles.

According to CMS' interpretation, states are directed to include the days, costs, and revenues associated with patients eligible for Medicaid who also have private insurance or Medicare. To the extent that such payments exceed the cost of care, the inclusion of these claims in the DSH cap calculation serves to offset DSH-eligible costs. As the plaintiffs in *Texas Children's Hospital v. Burwell* argued, "Such private insurance payments are simply not attributable to Medicaid-allowable costs. Private insurance pays for hospital services that are covered by agreement under patient purchased, non-governmental commercial insurance, which pays without reference to whether the patient is eligible to receive Medicaid coverage or which hospital costs Medicaid would consider eligible for reimbursement."¹⁰

There is no reasonable justification for Medicare or third-party payments to offset DSH-eligible uncompensated costs when no claim has been submitted to or paid by the Medicaid program. Moreover, CMS justifies its policy of offsetting uncompensated costs with such Medicare and third-party revenue by asserting that it "ameliorates the real economic burden

⁶ CMS-2399-P: Medicaid Program; Disproportionate Share Hospital Payments – Treatment of Third Party Payers in Calculating Uncompensated Care Costs, 81 Fed. Reg. 53980, 53983 (Aug. 15, 2016) (hereinafter "Proposed Rule" or "above-mentioned rule").

⁷ See, e.g., *Texas Children's Hospital (TCH) Complaint* (filed Dec. 5, 2014).

⁸ Additional Information on the DSH Reporting and Auditing Requirements. January 2010.

<https://www.medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/downloads/part-1-additional-info-on-dsh-reporting-and-auditing.pdf>. Accessed August 2016.

⁹ 42 U.S.C. §1396a(n).

¹⁰ *TCH Complaint* (filed Dec. 5, 2014) at 17.

faced by hospitals that treat a disproportionate share of low income patients,” yet in reality it penalizes such hospitals.¹¹ Hospitals serving higher income Medicare and commercially insured patients—who are not dually eligible for Medicaid—are not required to offset their uncompensated costs by their Medicare and third party revenues, making them eligible for higher DSH payments than hospitals with lower income patients. America’s Essential Hospitals urges CMS to exclude services for which no Medicaid claim was submitted from calculations to determine hospital-specific DSH limits.

- 3) CMS should only impose this policy prospectively, if finalized, and provide an adequate transition period to allow states to change their payment methodologies.

To date, CMS guidance on this issue has been inconsistent, undermining the agency’s characterization that the proposal merely clarifies existing policy and therefore does not require prospective application and a transition period. The requirement to offset Medicaid and uninsured costs by third-party and Medicare payments was not included in the section of the statute establishing the hospital-specific DSH limit, the section of the statute outlining the DSH audit and reporting requirements, or the regulatory language implementing the DSH reporting requirements. The policy has been issued only through inconsistent preamble language in the 2008 rule and a subsequent FAQ document. Furthermore, the U.S. District Court for the District of Columbia found inconsistencies in CMS’ interpretation throughout the preamble language on which the agency relies.¹² CMS cannot persuasively argue that these inconsistent references amount to an existing policy.

The agency’s interpretation was first outlined in the January 2010 FAQ. Up to now, the courts have found that the plaintiffs challenging this interpretation likely will succeed on their arguments that the agency’s change in policy on inclusion of third-party payments should have been implemented through notice and comment rulemaking. The U.S. District Court for the District of Columbia recently issued an injunction against the agency in *Texas Children’s Hospital and Seattle Children’s Hospital v. Burwell et al.* The injunction reasons that because the FAQ makes a substantive change to the calculation, binds state Medicaid agencies, and effectively amends the 2008 audit rule, it likely establishes a final agency action that should be implemented through notice and comment rulemaking.¹³ The New Hampshire District Court issued its injunction based on the same reasoning.¹⁴

In addition to the inconsistent nature of CMS guidance regarding this issue, the agency’s proposed change to its interpretation of the UCC calculation is significant and has direct financial impact on hospitals’ DSH payments. CMS concludes that there is no significant impact requiring analysis, but this conclusion is based on the inaccurate characterization that the proposed rule is not a change in policy. To the contrary, the general prospect of recoupments of DSH overpayments as a result of this calculation and the magnitude of the payments at issue in the pending lawsuits is evidence of the looming financial impact. A policy

¹¹ 81 Fed. Reg. at 53982.

¹² *New Hampshire Hosp. Ass’n v. Burwell*, D.N.H., No. 1:15-cv-460-LM, Opinion No. 2016 DNH 053 (Mar. 11, 2016) (Sec. 1.B.1(b)(iv), outlining several of examples of CMS’ inconsistent statements through the preamble to the 2008 DSH rule).

¹³ *Texas Children’s Hospital v. Burwell*, Civil Action No. 14-2060 (EGS), Memorandum Opinion (Dec. 29, 2014).

¹⁴ *New Hampshire Hosp. Ass’n v. Burwell*, D.N.H., No. 1:15-cv-460-LM, Opinion No. 2016 DNH 053 (Mar. 11, 2016).

that will result in hospitals repaying funds received years ago and receiving lower payments going forward cannot be implemented without an opportunity for meaningful notice and comment, as well as proper agency consideration of impact. As such, if CMS implements the proposed change to the audit regulations, it should do so prospectively—effective, at minimum, for the first state fiscal year that begins after the date of the final rule.

Moreover, when CMS implemented the 2008 audit rule, it provided a transition period during which the limits calculated based on the new audit rules were not enforced. The recoupments did not begin for several years to allow states to change their payment methodologies. Otherwise, providers would be subject to recoupment based on rules that were not properly in place at the time the state actually made the DSH payments. CMS should provide a similar transition period if this proposed change to the UCC calculation is implemented. For example, CMS should not take recoupments based on this policy until audits have been completed of payments for the first rate year after the regulation is finalized and has taken effect, when states have had sufficient notice about the changed policy.

- 4) America's Essential Hospitals remains concerned that CMS' existing interpretations of the costs included in the calculation of the hospital-specific DSH limit go beyond the procedural aspects of reporting and auditing.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) put in place additional auditing and reporting requirements for the Medicaid DSH program. CMS' 2008 final audit rule and subsequent informal issuances, including the January 2010 FAQs, implemented those requirements. However, the association is concerned that the agency's interpretation of the costs included in the calculation of the hospital-specific DSH limit outlined in the final audit rule and subsequent issuances goes beyond the procedural aspects of reporting and auditing to reduce the appropriate level of DSH payments to hospitals.

CMS' policies regarding the calculation of the hospital-specific DSH limit exclude important, real costs to the hospitals providing services to uninsured and Medicaid patients, such as the following.

- Hospital Costs of Ensuring Physician Services

The association continues to object to the exclusion of a hospital's physician costs from the UCC calculation. Allowing for inclusion of these costs is logical, particularly with regard to uninsured patients, as many hospitals must compensate physicians for providing indigent care hospital services to ensure that the hospital services are available. Thus, without incurring costs for physicians providing care to the uninsured, hospitals would be unable to provide hospital services to this underserved population. Particularly for hospitals that serve a disproportionate share of low-income patients, hospital services would not be available without payments by the hospital to physicians.

- Addressing Uninsured Patients

CMS continues to disregard the true extent of unreimbursed costs incurred by hospitals treating the most vulnerable patients. For example, any unreimbursed costs for services to

patients with high-deductible plans/catastrophic plans also should be included as uninsured care until they meet their deductible or spending limit. The low-income populations treated by DSH hospitals are less likely to have other resources available to cover the costs of their care. In addition, costs for inpatient hospital services provided when benefits are exhausted during a hospital stay should be properly included in the DSH limit calculation as costs of services for which an individual has no source of third-party coverage. Under current CMS policy, the DSH limit would include the costs of a multi-day hospital stay for an individual who had reached a day limit before admission but not for an individual who had one day of coverage left upon admission. In both cases, the hospital has provided services that are uncompensated to an individual without coverage.

CMS' position on these issues is not dictated by the statutory language and conflicts with sound, underlying policy justifications for allowing inclusions of these costs. As such, America's Essential Hospitals remains concerned about CMS' interpretation of the hospital-specific DSH limit and urges the agency to reconsider exclusion of costs to hospitals providing needed care.

- 5) America's Essential Hospitals encourages CMS to consider the appropriate balance between the benefits to program integrity of detailed reporting, auditing, and payment reconciliation requirements and the enormous resources necessary for providers and government agencies to compile, review, and act upon such requirements.

America's Essential Hospitals supports transparency and accountability throughout the Medicaid program, including for provider payments. We believe that it is important to have accurate information on how providers are paid, including on a provider-specific basis, and to ensure that payments do not exceed applicable statutory and regulatory limits. However, the appropriate balance between detailed reporting and auditing and resources required must be considered. At some point, the regulatory burden on all involved outweighs any incremental benefit in transparency and accountability and diverts scarce financial and human resources away from providing and paying for care to beneficiaries. The implementation of the DSH auditing requirements presents a prime example of such an imbalance.

As an example, DSH payments now are retrospectively reconciled against the actual unreimbursed costs incurred in that same audited payment year based on final Medicare cost reports, rather than allowing states to implement the DSH limits using projected unreimbursed costs based on prior-year data. This requirement has placed a massive, costly administrative burden on states and hospitals for a relatively minimal gain in oversight, transparency, and accountability. Moreover, this has created a significant data lag—at least four years—in the public reporting of provider-specific Medicaid DSH payments and DSH limits. This burden must be objectively weighed against the additional accuracy gained by retroactively calculating the DSH limit based on audited cost data, rather than projected cost data.

The required audited reconciliation of DSH payments to actual unreimbursed costs creates an unnecessary and costly administrative burden on states, hospitals, and, ultimately, the federal government, and neither improves quality or access nor makes measurable gains in accuracy or transparency. This is a particularly troubling outcome, given efforts by Congress and the administration to maximize efficiencies in Medicaid. America's Essential Hospitals urges

reconsideration of the retrospective Medicaid DSH audit and reporting, as well as movement toward a process that eliminates the significant data lag and vastly improves program transparency.

The association appreciates the opportunity to submit these comments and looks forward to additional opportunities to work with CMS on this vital issue. If you have questions, please contact Erin O'Malley, policy director, at 202-585-0127 or eomalley@essentialhospitals.org.

Sincerely,