AMERICA'S ESSENTIAL HOSPITALS

August 28, 2017

Seema Verma
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-2394-P: Medicaid Program; State Disproportionate Share Hospital Allotment Reductions

Dear Ms. Verma:

America's Essential Hospitals appreciates the opportunity to comment on the above-mentioned rule, which proposes the methodology for making Affordable Care Act (ACA) reductions to Medicaid disproportionate share hospital (DSH) allotments on Oct. 1. DSH funds are critical to our members, who still incur disproportionate uncompensated costs to fulfill their mission of caring for Medicaid and other low-income patients and the remaining uninsured. As such, it is imperative that you target hospitals such as these with the shrinking resources that remain. We appreciate that CMS embraced this premise in its approach to the DSH reductions and ask that you continue to recognize the unique role of essential hospitals as you move toward a final methodology.

America's Essential Hospitals understands statute requires CMS to carry out these cuts, and we offer our comments in that context. However, we also continue to work with Congress to further delay or completely eliminate these reductions, which pose a dire threat to the stability of essential hospitals and access to care for their patients.

America's Essential Hospitals is the leading association and champion for hospitals and health systems dedicated to high-quality care for all, including people who face economic and social hardships. Filling a vital role in their communities, our more than 300 members provide a disproportionate share of the nation's uncompensated care (UC) and devote about half of their inpatient and outpatient care to Medicaid and 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 only our members can provide. Our members offer this care while operating on margins substantially lower than the rest of the hospital field. If our members were to stop

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receiving Medicaid DSH payments, they would face an aggregate operating loss of 3.6 percent.[1]

In addition, our members serve as cornerstones of care for everyone in their communities, providing specialized inpatient, outpatient, and emergency services—such as trauma, burn, and neonatal intensive care—often unavailable elsewhere. Our members' long experience caring for low-income, complex patient populations has given them the skill, passion, and commitment to apply and adapt proven models of care and to pioneer new models to meet their patients' specialized needs. The reality is that, given their patient mix and margins, essential hospitals absolutely depend on Medicaid funding to carry out their missions and remain viable. They are at the very heart of the Medicaid delivery system, providing access where none exists, innovating with populations others ignore, and depending on Medicaid support to stay afloat.

Under the ACA, CMS is charged with imposing a greater share of DSH allotment reductions on states with the lowest percentages of uninsured individuals or that do not target DSH payments at hospitals with high volumes of Medicaid inpatients and high levels of UC. We recognize the agency's thoughtful work and emphasis on targeting in previous rulemaking, and we are pleased CMS will use a similar approach for the impending, state-level Medicaid DSH allotment reductions.

As CMS finalizes the DSH health reform methodology (DHRM), we ask that it consider the following specific comments. These comments reflect key themes embodied in long-standing federal Medicaid DSH policy: to incentivize states to ensure that hospitals providing the disproportionately highest share of care to low-income individuals receive the disproportionate share of remaining DSH support; to balance state flexibility with the federal interest; and to minimize the impact of data barriers.

1. CMS should finalize its proposal to use total hospital costs in the denominator to determine the High Level of Uncompensated Care Factor (HUF).

CMS proposes to use total hospital costs in the denominator when determining which hospitals have high levels of UC. This proposal addresses a critical flaw in the previous methodology from 2013 and better achieves the statutory intent of giving states an incentive to target funds to hospitals with higher uncompensated costs.

Under the prior methodology, the HUF was calculated as the hospital's share of uncompensated costs for serving Medicaid and uninsured patients out of all total costs of serving only Medicaid and uninsured patients. This method would have accounted for the proportional uncompensated costs of a hospital's Medicaid and uninsured costs, but would not have adequately accounted for the magnitude of care provided by hospitals with a significant commitment to Medicaid and uninsured patients. Thus, it was possible that a hospital serving a small percentage of Medicaid and uninsured patients, but for which it received little reimbursement, could qualify as a HUF hospital, while a hospital serving a greater overall percentage of Medicaid and uninsured patients

[1] Ramiah K, Roberson B. *2015 Essential Data: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2015 Annual Member Characteristics Survey.* America's Essential Hospitals. June 2017. http://essentialdata.info/. Accessed July 2017.

and incurring a higher amount of uncompensated care would not. To address this issue and account for total hospital costs in the future, CMS modified the DSH reporting requirements to collect total hospital costs from Medicare cost report data for all disproportionate share hospitals. With that data now available, the HUF calculation can better account for a hospital's UC costs. **As such, we urge the agency to finalize its proposal to use total hospital costs in the denominator to determine the HUF.**

2. CMS should implement a reduction cap methodology to protect state DSH allotments from total elimination.

CMS recognizes the magnitude of the DSH reductions might put states at risk of losing their entire allotment. The agency proposes a reduction cap methodology that would preserve at least 10 percent of each state's DSH allotment. **America's Essential Hospitals is pleased the agency recognizes that states might face elimination of their DSH allotments, especially in later years. The association encourages CMS to pursue a reduction cap methodology that works to minimize the impact on states and, ultimately, providers.**

3. CMS should monitor the impact of DSH audit data limitations and continue work to ensure the accuracy and timeliness of data sources.

We appreciate that CMS has taken steps to improve the accuracy of data in the DHRM (for example, adding total hospitals costs to the DSH audit reports). That said, we remain concerned about certain limitations of the DSH audit data. Most critical is the impact of data lag. Specifically, the Medicaid DSH audit and reporting data currently has a five-year lag. This lag undermines the accuracy and timeliness of data used to implement DSH reductions. As such, America's Essential Hospitals recommends moving toward a prospective DSH audit methodology.

Before the 2008 DSH audit rules, CMS let states determine hospital-specific DSH limits prospectively. That is, at the beginning of the year, states would calculate the hospital-specific limits based on prior year data. DSH payments during the year would be limited by that prospectively determined DSH cap. In the 2008 audit rule, CMS for the first-time required states to recalculate the DSH limit retrospectively, after the end of the year, based on audited (or if not available, as-filed) cost reports for the year in which the DSH payments were made. This requirement introduced a substantive policy change that has placed a massive and costly administrative burden on both states and hospitals for a relatively modest gain in oversight, transparency, and accountability. Moreover, this has created a significant data lag in the public reporting of provider-specific Medicaid DSH payments and DSH limits. CMS must objectively weight this burden against the minimal additional accuracy gained by retroactively calculating the DSH limit based on audited cost data rather than relying on projected cost data. Again, we believe the statutory flexibility delegated to the Secretary to determine "costs incurred during the year" is sufficient to permit such an interpretation.

Moving toward a prospective audit methodology would work to streamline the process and minimize the burden and challenges. This approach would allow completion of audits in a much timelier fashion and give CMS access to more up-to-date, audited data.

Having access to the most up-to-date data is extremely important for purposes of the DHRM. To the extent that relying on estimated costs based on prior year data might cause payments to differ from actual costs, as determined through subsequent audits, future DSH computations would correct for those variances. Moreover, the financial exposure for the federal government using estimated, rather than reconciled, data would not be significant, as total DSH expenditures are limited by the statewide DSH allotment. Therefore, the disadvantages of the retrospective reconciliation mandate far exceed its benefits.

In addition, DSH audit data only include data for hospitals that actually receive DSH payments. This smaller dataset skews the appearance of targeting across states. For example, because the DHRM determines mean UC levels by looking only at hospitals receiving DSH payments (i.e., those in DSH audits), a highly targeted DSH state will be penalized by having a higher mean UC level and therefore more DSH payments falling below the mean and subject to cuts. Moving forward, this methodology undermines CMS' intended incentives to target payments, because if states target their programs, data will be available for fewer hospitals and the mean becomes higher and higher. The more a state targets DSH, the more difficult it becomes to target DSH in future years. Instead, the association urges CMS to require states to collect UC data on **all** hospitals in the state, so a more accurate mean can be calculated, and a more effective targeting incentive implemented.

We urge CMS to continue refining the underlying data sources used in the DHRM, refining the methodology based on new information to better reflect the needs of hospitals and the patients who rely on Medicaid for their care. Specifically, this approach can help ensure DSH funds in later years—when more than half of the program's funds will be cut—are allocated among states in a way that creates incentives to target remaining funds at hospitals that have a high need for DSH. We look forward to serving as a resource to the agency in this effort.

4. <u>CMS should ensure that each fiscal year's total DSH allotment reduction amount will be allocated equitably to institutions for mental disease (IMDs).</u>

We ask CMS to require states to allocate the reduction amount for each fiscal year between IMDs and all other DSH hospitals so that non-IMD DSH hospitals—including essential hospitals—do not have to absorb a higher proportion of the cuts than they receive in payments. We recognize the importance of IMDs as providers in the continuum of care for some of our most vulnerable patients. To ensure access to non-IMD DSH hospitals, as well as IMDs, reductions should be allocated equitably, such that IMDs receive a share of DSH cuts proportional to the share of DSH payments they receive.

The DSH statute imposes limits on DSH payments that may be made to IMDs, equal to the lesser of the 1995 IMD payment amount or a percentage of the state's allotment.[2] To the extent that the 1995 amount is less than the applicable percentage, it appears that states could protect IMDs entirely from the cuts, and require acute-care hospitals to

[2] 42 U.S.C. §1396r-4(h).

absorb the entirety of the reduction. We urge CMS to require states to allocate a proportional share of the cuts to IMDs to preserve the intent of the IMD restriction.

5. CMS should identify the states to which the budget neutrality factor (BNF) will be applied in the allotment reduction calculation.

CMS, by statute, must consider the extent to which a state's DSH allotment was included in the budget neutrality calculation for a coverage expansion waiver approved as of July 31, 2009, under Section 1115 of the Social Security Act. CMS proposes to implement this provision by excluding from the state's allotment reduction amount determination (based on the High Volume of Medicaid Inpatients Factor and HUF) the portion of a qualifying state's DSH allotment that was used specifically for coverage expansion. In the proposed rule, the agency provides detail about how it will apply the Budget Neutrality Factor (BNF). But CMS does not note which states' allotments would be impacted by application of the BNF. **To promote transparency and allow states to accurately estimate the state-specific impact of the proposed methodology, we ask the agency to identify which states will have the BNF applied to their allotment reduction calculation.**

6. CMS should clarify the amount excluded under the BNF calculation.

In the preamble of the proposed rule, it appears CMS proposes to change the amount excluded from the DSH allotment under the BNF based on changes to the waiver budget neutrality since July 31, 2009 (the cutoff date for states to have had DSH as part of expansion excluded from the DSH reductions). The preamble says, "To qualify annually, CMS and the state would have to have included the state's DSH allotment in the budget neutrality calculation for a coverage expansion that was approved under section 1115 of the Act as of July 31, 2009, and the coverage expansion would have to still exist in the approved section 1115 demonstration at the time that reduction amounts are calculated for each FY. If a state had an amount for coverage expansion approved under a section 1115 of the Act as of July 31, 2009, but subsequently reduced this amount, the approved amount remaining under the section 1115 would not be subject to reduction."[3]

But CMS did not propose to change the regulation, which says "(e)(12)(i) For States whose DSH allotment was included in the budget neutrality calculation for a coverage expansion that was approved under section 1115 as of July 31, 2009, (**without regard to approved amendments since that date**) determining the amount of the State's DSH allotment included in the budget neutrality calculation for coverage expansion for the specific fiscal year subject to reduction. This amount is not subject to reductions under the HMF and HUF calculations."[4] The regulatory language can be interpreted in such a way to allow CMS to determine the amount actually in the BNF calculation "for the specific fiscal year subject to reduction," as the agency proposes in the preamble. However, the bolded language above in the regulation is then superfluous and could be

[3] 82 Fed. Reg. 35163 (July 28, 2017).
[4] 42 C.F.R. §447.294.

confusing, leading to misinterpretation or uncertainty. **As such, we ask that CMS clarify its proposal regarding the amount excluded under the BNF calculation.**

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America's Essential Hospitals appreciates CMS' consideration of these comments and welcomes the opportunity to provide additional information to the agency. If you have questions, please contact Director of Policy Erin O'Malley at 202-585-0127 or eomalley@essentialhospitals.org.

Sincerely,

Bruce Siegel, MD, MPH
President & CEO