AMERICA'S ESSENTIAL HOSPITALS

April 25, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue SW
Washington, DC 20201

RE: Medicaid Program; Disproportionate Share Hospital Third-Party Payer Rule (CMS-2445P)

Dear Administrator Brooks-LaSure:

America's Essential Hospitals appreciates the opportunity to comment on the above-captioned proposed rule implementing Section 203 of Title II, Division CC of the Consolidated Appropriations Act, 2021 (Section 203). A legislative solution is required to prevent significant unintended financial losses and uncertainty for essential hospitals as a result of the change in calculating payment limits for hospitals under Section 203. However, the Centers for Medicare & Medicaid Services (CMS) can act to lessen the effect on essential hospitals, including the proposed expeditious implementation of the exception to the policy.

America's Essential Hospitals is the leading champion for hospitals and health systems dedicated to high-quality care for all. Our more than 300 member hospitals fill a vital role in their communities. They provide a disproportionate share of the nation's uncompensated care, furnishing an average of nearly $63 million in uncompensated care in 2020, nearly eight times higher than the overall national average. Three-quarters of essential hospital patients are uninsured or covered by Medicare or Medicaid, and our members provide 27 percent of charity care nationwide. Essential hospitals provide state-of-the-art, patient-centered care while operating on an average margin about two-fifths that of other hospitals—3.2 percent compared with 7.7 percent for all hospitals nationwide.[1]

Essential hospitals' commitment to serving all people, regardless of financial means or insurance status, and their diverse patient mix pose unique challenges. A disproportionate number of their patients face socioeconomic and sociodemographic challenges to accessing health care, including poverty, homelessness, language barriers, and low health literacy. Seven

[1] Clark D, Ramiah K, Taylor J, et al. *Essential Data 2020: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2020 Annual Member Characteristics Survey*. America's Essential Hospitals. September 2022. https://essentialdata.info. Accessed March 6, 2023.

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and a half million people in communities essential hospitals serve have limited access to healthy food, and nearly 16 million live below the poverty line.[2]

Given their patients' complex medical and social needs, plus their financial challenges, essential hospitals rely on Medicaid disproportionate share hospital (DSH) funding. However, Section 203 changed the calculation of the Medicaid shortfall portion of the limit on DSH payments. Under prior law, Medicaid shortfall had included the costs and revenues associated with patients dually eligible for Medicaid and another third-party payer, including Medicare and commercial insurance. Under Section 203, the shortfall includes only the costs of patients for whom Medicaid is the primary payer, lowering the hospital-specific Medicaid DSH cap for many hospitals. The rule provides an exception for a narrow set of hospitals that have a high number or percentage of low-income Medicare patients.

The exception applies to hospitals at or above the 97th percentile of all hospitals with respect to one of two factors:

- The percentage of total inpatient days for patients entitled to Medicare Part A and supplemental security income (SSI) benefits.
- The number of inpatient days for such patients.

Hospitals qualifying for the 97th percentile exception will have a DSH limit equal to the higher of the limit prescribed in Section 203 or the previous regulatory limit, which included costs and payments for dual-eligible patients.

The exclusion of dual-eligible costs will result in significant hardship and substantial DSH cuts for some hospitals, particularly those with many dual-eligible patients for whom Medicare is the primary payer. For many hospitals, reimbursement received from Medicare and Medicaid is well below the cost of caring for those highly complex patients. While it appears that Congress recognized the negative effect Section 203 will have on some hospitals, its solution—creating an exception—is not targeted correctly. It includes hospitals that do not need the relief and excludes many that stand to lose tens of millions in desperately needed safety net funding.

Further, the year-to-year uncertainty of the exception disrupts short- and long-term budgeting. Without knowing whether they qualify for the exception, many essential hospitals will be unable to budget and use their DSH funding efficiently. Absent a legislative fix, Section 203 poses significant financial challenges to essential hospitals.

America's Essential Hospitals supports CMS' interpretation of the October 1, 2021, effective date as it will apply to the state plan rate year (SPRY) beginning on or after October 1, 2021. Further, we appreciate that the 97th percentile exception list applies prospectively, allowing hospitals more time to budget appropriately. Nonetheless, CMS can and should do all within its authority to lessen the provision's effect, as outlined below.

1. CMS should work with Congress to avoid the cuts imposed by Section 203.

The narrow exception in statute does not go far enough to protect financially vulnerable hospitals from being harmed by Section 203. The 97th percentile exception will help some essential hospitals maintain a higher Medicaid DSH cap but will subject others to millions in Medicaid DSH cuts due to a narrow and arbitrary cutoff. Several essential hospitals that suspect

[2] Ibid.

they fall below the 97th percentile mark estimate annual losses ranging from $20 to $40 million. Congress must ensure the exception methodology extends to all who need the protection so hospitals serving low-income, medically complex patients that still struggle financially from the COVID-19 pandemic and workforce shortages are not further harmed by this policy. **We encourage CMS to work with Congress to prevent Section 203's unintended and catastrophic cut to some hospitals' Medicaid DSH payments, without harming hospitals that fall into the Section 203 exception pool.**

2. **CMS should include all hospitals in the 97th percentile calculation.**

According to the proposed rule, CMS will identify the universe of hospitals to be included in the 97th percentile calculation as those that submit Medicare cost reports. CMS notes that it "[does] not anticipate this to be a problem" since hospitals that do not file Medicare cost reports are unlikely to qualify for the exception. However, this methodological choice inappropriately lowers the number of hospitals that will qualify for the exception by shrinking the pool of hospitals included in the analysis. The Section 203 statute provides the exception to hospitals in the 97th percentile of "all hospitals" with respect to their low-income Medicare patient volumes, not just those filing cost reports.

CMS' proposal would be a significant problem for hospitals just below the 97th percentile that would have qualified if "all hospitals" were included in the list, thus expanding the number of hospitals in the 97th percentile. While it is true that CMS would not have accurate data for hospitals that do not file cost reports, it would not need the data. It could simply add those hospitals to the bottom of the list for a more accurate calculation of the true number of hospitals in the 97th percentile. CMS' proposed exclusion of a subset of "all hospitals" unnecessarily subjects some essential hospitals to significant DSH cuts and financial hardship. **CMS should include all hospitals in the 97th percentile calculation to comply with the statute and reduce unintended cuts to Medicaid DSH funding for financially strapped hospitals.**

3. **CMS must expeditiously release the 97th percentile lists with all included hospitals.**

Section 203 implementation challenges hospitals as they develop future budgets and plan to deliver patient care. Hospitals do not know if they will qualify for the exception or where they will land in the rankings. Due to this uncertainty, some hospitals may have to give back millions of dollars they have already spent or cut services they have already included in future budgets.

a. <u>CMS should publish the fiscal year (FY) 2022 and 2023 exception lists as soon as possible.</u>

Due to the effective date of Section 203 on October 1, 2021, and the yet-to-be-finalized 97th percentile exception formula, hospitals are unaware if they qualify for the exception for FYs 2022 and 2023. Currently, essential hospitals are in the untenable position of not knowing whether they will be able to retain their Medicaid DSH payments for these years or if states will redistribute the funding. The longer they wait, the more difficult financial planning becomes. While some essential hospitals already suspect their hospital-specific Medicaid DSH limit will be reduced, others are uncertain. This uncertainty makes it difficult for hospitals to plan and budget, not knowing whether they will be able to retain DSH funding budgeted for the first two SPRYs affected by the legislation. Some essential hospitals will have to scramble to make up

millions of dollars in their budgets on months' notice. They must consider either shrinking service lines or cutting them altogether; either option would reduce access to care.

These lists must be posted as soon as they are finalized. Hospitals not qualifying for the exception will face a significant short-term financial loss and must adjust their upcoming budgets accordingly. **CMS must make public the FY 2022 and 2023 97th percentile exception list as soon as possible.**

b. CMS should release the entire ranking list of hospitals in the 97th percentile calculation.

The proposed rule leaves hospitals below the 97th percentile cutoff in the dark on how close they are to qualifying for the exception. Eligibility for the exception could change from year to year for hospitals on the cusp. Conversely, for hospitals further down the list, knowing their ranking (and the probability that they will not qualify for the exception in the future) would provide more certainty in budgeting. Publishing the full ranked list would help hospitals budget more accurately for upcoming years. Further, states could also better plan, knowing that, depending on the year, they may be able to target DSH funding to specific hospitals according to the state's priorities. **CMS must post the entire ranking list of hospitals included in the 97th percentile calculation.**

4. CMS should withdraw its proposal to require auditors to estimate DSH overpayments to serve as the basis for recoupments.

CMS proposes to require DSH auditors to estimate the financial impact of each audit finding resulting from incomplete or missing data or lack of documentation. The estimates, relying on unspecified "alternative source documentation," will become the basis for a potential overpayment finding, requiring states to recoup the estimated amount from hospitals. The proposal appears to be based on a Government Accountability Office analysis finding incomplete data in the 2010 DSH audits of 2007 DSH payments—payments made before the 2008 DSH audit rule was finalized and before audit findings were enforceable. Given the significant effect of DSH recoupments on essential hospitals and their patients, the association objects to the use of estimates to form the basis of an overpayment obligation. Furthermore, the risk of this negative effect cannot be justified by supposed improvements in program integrity where CMS has not attempted to analyze the current extent of missing data or documentation, even after more than a decade during which CMS, states and auditors have implemented and refined the DSH audit process. **CMS should withdraw its proposed use of estimates not based on reliable data sources listed in the current 42 C.F.R. § 566.304(c) to form the basis of DSH overpayment findings.**

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America's Essential Hospitals appreciates the opportunity to submit these comments. If you have questions, please contact Senior Director of Policy Erin O'Malley at eomalley@essentialhospitals.org or 202-585-0127.

Sincerely,

Bruce Siegel, MD, MPH
President and CEO