AMERICA'S ESSENTIAL HOSPITALS

July 12, 2013

Cindy Mann, JD
CMS Deputy Administrator/Director
Center for Medicaid and CHIP Services
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-2367-P
P.O. Box 8016
Baltimore, MD 21244

Ref: CMS-2367-P: Medicaid Program; State Disproportionate Share Hospital Allotment Reductions

Dear Ms. Mann:

America's Essential Hospitals, formerly the National Association of Public Hospitals and Health Systems (NAPH), appreciates the opportunity to comment on the above-captioned proposed rule implementing the Affordable Care Act (ACA) cuts to Medicaid disproportionate share hospital (DSH) allotments. While we support the ACA's goal of expanding coverage and aligning payment incentives to improve patient care, we are opposed to the Medicaid DSH cuts in the law. Congress included these reductions in the ACA, in part, because it expected mandatory coverage expansion through the Medicaid program and the exchanges to reduce the amount of uncompensated care (UC) hospitals would have to provide, and thus the need for DSH payments. However, this assumption fails to take into account fully the original intent behind the Medicaid DSH program—i.e., Medicaid payments to hospitals must take into account the greater burden shouldered by hospitals serving a disproportionate number of low-income patients. Moreover, rather than tying the level of Medicaid DSH reductions to the actual need for DSH payments, Congress listed each year's reduction amount in the law, creating a fixed reduction instead of one that adapts to need.

Since the U.S. Supreme Court's 2012 decision rendering the ACA's Medicaid expansion provision optional, a considerable number of states with a large number of uninsured

residents have indicated they will not expand their Medicaid program. Regardless of the accuracy of Congress' original assumptions behind the level of DSH cuts, after the Court's decision, the level of cuts no longer reflects the continued need for DSH payments. In particular, members of America's Essential Hospitals, which provide care to low-income, vulnerable, and underserved populations, will likely still see a considerable amount of UC. To this end, we ask the Centers for Medicare & Medicaid Services (CMS) to recognize the unique role of our hospitals in providing care when implementing the ACA-mandated DSH reductions.

America's Essential Hospitals represents more than 200 hospitals and health systems that provide access to high-quality health care for all patients, regardless of insurance status, income level, or health status. As essential providers in their communities, our members are committed to serving all patients and meeting the ever-present need for health care in their communities. In 2010, the average member hospital saw five times the volume of non-emergency outpatient visits and three times the volume of inpatient admissions as other acute care hospitals in the country.

Members of America's Essential Hospitals predominantly serve the uninsured and patients covered by public programs. In 2010, more than half of all discharges and outpatient visits were either for uninsured or Medicaid patients. While our members represented only 2 percent of the nation's short-term, acute care hospitals, they delivered 20 percent of the UC provided by U.S. hospitals.[1] Also in 2010, 16 percent of our members' costs were uncompensated, compared with 6 percent of costs for hospitals nationally.

Our members serve diverse communities. More than half of patients receiving care at our hospitals are racial or ethnic minorities. To best care for these populations, our members offer culturally and linguistically appropriate care. They also establish generous financial assistance programs, invest in care coordination and quality improvement, and provide specialized services that would otherwise be lacking in their community, such as level I trauma centers, transplant services, emergency psychiatric facilities, and burn units. Despite their limited financial resources, our hospitals demonstrate an ongoing commitment to serving their communities, including their most vulnerable members.

Given our members' essential role in their communities and in serving their patients and CMS' responsibility to implement current law, we ask CMS to consider the following specific comments in finalizing the rule to determine state-level Medicaid DSH allotment reductions. These comments reflect key themes that embody longstanding federal Medicaid DSH policy to balance state flexibility with the federal interest in ensuring that hospitals with the highest share of low-income care receive DSH payments. Specifically,

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[1]O. Zaman, L. Cummings, and S. Laycox, "America's Safety Net Hospitals and Health Systems, 2010: Results of the Annual NAPH Hospital Characteristics Survey," National Association of Public Hospitals and Health Systems, May 2012, http://www.naph.org/Main-Menu-Category/Publications/Safety-Net-Financing/2010-NAPH-Characteristics-Report.aspx?FT=.pdf.

we urge CMS to incentivize states to target their DSH dollars to hospitals with high levels of uncompensated care and Medicaid inpatients and adopt a phased approach to incorporating DSH cuts that would allow the agency to reevaluate its methodology when data reflecting the impact of health reform are available.

1. CMS should finalize its proposal to develop the methodology for determining DSH allotment reductions in multiple stages.

CMS should finalize its proposal to develop the DSH allotment reduction methodology in multiple stages so the agency can assess and refine its methodology prior to fiscal year (FY) 2017, when the reductions become much larger. CMS proposes to determine each state's allotment reduction amount for FYs 2014 and 2015 only using its proposed DSH health reform methodology. We support CMS' decision to adopt a methodology for only the first 2 years. This staged approach would allow CMS to later refine 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 as much as 45 percent of the program's funds will be cut, are allocated among states in a way that incentivizes targeting the payments at hospitals that have a high need for DSH. Therefore, **CMS should finalize its proposal to adopt the proposed DSH health reform methodology for only FYs 2014 and 2015.**

2. CMS should finalize its proposal to use state-specific thresholds when ranking hospitals based on the targeting factors.

CMS proposes to determine the extent to which states target their DSH payments by the amount of DSH payments each state makes to hospitals that have a high volume of Medicaid inpatients and hospitals with a high level of UC. CMS will identify these hospitals by comparing their Medicaid volume and UC level with those of other DSH hospitals in the same state. Given the difference between state Medicaid programs, which have been tailored over the years to meet the unique needs of each state's population, this state-based comparison is a more accurate gauge of a hospital's true level of Medicaid volume and UC than a national comparison would be. For this reason, **CMS should finalize its proposal to determine high Medicaid volume hospitals and high UC hospitals using state-specific, rather than national, thresholds.**

For cuts in FY 2016 and later, CMS should explore using other data sources, such as worksheet S-10 of the Medicare cost report, so that the agency can calculate the state-specific threshold for the UC-based factor using data for all hospitals in a state. As proposed, CMS intends to accomplish the comparison based on UC levels by using data from DSH audit reports, which does not include UC information for non-DSH hospitals. By not including non-DSH hospitals, this proposal would result in artificially high average UC levels for the states, thus potentially preventing some hospitals with a significant amount of UC from being classified as high UC hospitals. **For cuts in later years, CMS should explore using other data sources so that the agency can calculate**

the state-specific threshold for the UC-based factor using data for all hospitals in a state.

3. CMS should finalize its proposal to weigh the targeting factors more heavily than the uninsured percentage factor (UPF).

CMS should finalize its proposal to weigh the two targeting factors in its DSH health reform methodology more heavily than the UPF. One of the targeting factors is based on Medicaid inpatient volume (the Medicaid inpatient utilization rate [MIUR]) and the other is based on Medicaid and uninsured UC (total UC). CMS notes that these factors account for the amount of DSH payments made to hospitals that meet the MIUR and total UC thresholds. The ACA provides that the secretary of the U.S. Department of Health and Human Services must develop a methodology that imposes the largest percentage reductions on states that (1) have the lowest percentages of uninsured individuals (the UPF) or (2) do not target their DSH payments at (i) hospitals with high volumes of Medicaid inpatients as defined by the MIUR and (ii) hospitals that have high levels of UC.[2]

In the rule, CMS proposes to implement the ACA provision by giving equal weight to all three factors. This means that the targeting factors, when taken together, account for two-thirds of the total weight, and the UPF accounts for one-third. We support CMS' decision to give more weight to the targeting factors, especially since none of the data CMS plans to use to implement the DSH reductions for FYs 2014 and 2015 will reflect states' efforts with respect to the Medicaid expansion. In the absence of such information, **CMS should focus on the goals of the program and incentivize states to direct more DSH payments to hospitals that meet the MIUR and total UC thresholds.**

4. CMS should give equal weight to the care provided to Medicaid and uninsured patients and ensure the two targeting factors incorporate data on the volume of care provided to these two populations in an equitable manner.

CMS should give equal weight to data representing the amount of care DSH hospitals provide to Medicaid and uninsured patients. As noted above, CMS proposes to include two targeting factors—one based on the MIUR and the other based on total UC—in its DSH reduction methodology. CMS further proposes to weigh the two targeting factors equally—i.e., each factor would account for one-third of the total weight. (The UPF would account for the final one-third of the weight.) However, since the MIUR accounts for Medicaid inpatient volume and the total UC factor includes both Medicaid and uninsured UC, both factors include data that reflect the amount of care hospitals provide to Medicaid patients. Thus, the combined effect of the two targeting factors weighs care provided to Medicaid patients more than care to the uninsured. **CMS should**

[2]The ACA also directs the secretary to impose smaller reductions on low DSH states and to account for the extent to which DSH allotment for a state was used for a coverage expansion approved under section 1115 as of July 31, 2009.

increase the weight of the UC factor and reduce the weight of the MIUR factor so care provided to Medicaid and uninsured patients each accounts for roughly half of the combined weight of the MIUR and UC factors.

Because CMS proposes to use DSH audit data to implement its DSH health reform methodology, the agency should seek to ensure the data on the DSH audit reports reflect actual UC as much as possible. Accurate data is important since CMS proposes to implement the two targeting factors by comparing hospitals' relative levels of Medicaid inpatient volume and UC. Thus, as part of this effort, **CMS should also finalize its proposed rule, CMS-2315-P: Medicaid Program; Disproportionate Share Hospital Payments-Uninsured Definition**, which proposes to define uninsured at the service level such that the cost of services provided to underinsured individuals would count as UC if the services are not covered and the patients cannot pay.

In addition, **CMS should clarify what data source the agency intends to use for the MIUR factor for FY 2014 reductions**, which begin on October 1, 2013. CMS proposes to require states to submit their average MIUR to the agency by June 30 of each year. However, this requirement would not begin until June 30, 2014, which is nine months after the start of FY 2014. We urge CMS to clarify as soon as possible so that states can plan accordingly.

5. CMS should weigh each hospital's UC level by its Medicaid and uninsured costs so data used to determine each state's average UC level capture the disproportionate nature of each hospital's commitment to Medicaid and uninsured patients.

To identify a state's targeted DSH payments based on the total UC factor, CMS should weigh each hospital's UC level by its Medicaid and uninsured costs so data used to determine each state's average UC level capture the magnitude of each hospital's commitment to Medicaid and uninsured patients. CMS proposes to calculate each hospital's UC level by dividing the uncompensated cost to the hospital of treating Medicaid and uninsured patients by the total cost to the hospital of treating Medicaid and uninsured patients. CMS further proposes to determine each state's average UC level by taking the average of every hospital's UC level in the state. Based on this average, CMS will identify payments made to high UC hospitals as targeted payments. CMS' proposed method for calculating each state's average UC level accounts for the proportion of a hospital's Medicaid and uninsured costs that is uncompensated, but does not adequately account for the magnitude of care provided by hospitals with significant commitment to Medicaid and uninsured patients. In order to adequately take into account the magnitude of hospitals with significant commitment to Medicaid and uninsured patients, after determining each hospital's UC level, **CMS should further adjust this UC level by applying an additional weight to each hospital's UC level using each hospital's total Medicaid and uninsured costs for purposes of determining each state's average UC level.**

6. CMS should allocate the share of each FY's total DSH allotment reduction amount to institutions for mental disease (IMDs) that is proportional to the amount of DSH payments IMDs receive.

As a first step in its DSH health reform methodology, CMS should divide the reduction amount for each FY between IMDs and all other DSH hospitals so the non-IMD DSH hospitals—including safety net hospitals—do not have to absorb a higher proportion of the cuts than they receive in payments. Preserving funds for the non-IMD DSH hospitals will ensure their patient populations can continue to access much needed care. For these reasons, **CMS should allocate to the IMDs a share of DSH cuts equal in proportion to the share of DSH payments they receive.** CMS should make this allocation at the national level, prior to applying the proposed low DSH state factor, which distributes each FY's DSH reduction amount between low DSH states and non-low DSH states accordingly. For the IMDs' share of each FY's DSH reduction amount, CMS could distribute the IMDs' share across states proportionate to each state's share of total DSH payments made to IMDs.

7. CMS should clarify how it will identify the portion of a state's DSH allotment that was not used for coverage expansion.

CMS should issue guidance clarifying how the agency plans to identify the portion of a state's DSH allotment that was not used for coverage expansion via a section 1115 waiver approved as of July 31, 2009. CMS proposes to exclude the portion of this allotment that was used for coverage expansion from reduction determinations based on the MIUR and total UC factors. However, CMS proposes to include the portion *not* used for coverage expansion in the allotment reduction determinations and use an average MIUR and total UC factor based on the group the state falls under—i.e., low DSH state group or non-low DSH state group. Given that CMS proposes to consider funds for UC pools and safety net care pools as amounts not used for coverage expansion, **CMS should clarify how it plans to identify the portion that is used for coverage expansion.** In addition, given that waivers are approved for at most five years, CMS should also clarify how the agency plans to treat a state once its eligible coverage expansion waiver expires.

Additionally, section 447.294(e)(12) defining the section 1115 budget neutrality factor (BNF) calculation under the DHRM methodology, references "the specific fiscal year subject to reduction pursuant to an approval on or before July 31, 2009." Section 447.294(e)(12)(i) references "budget neutrality under section 1115 as of July 31, 2009, (without regard to approved amendments since that date)..." Given that waivers are approved for at most five years, CMS should clarify how it will treat extension and amendments of such waivers, including the application of the BNF to states with eligible waivers that have been extended or amended.

8. CMS Should Make the Following Technical Corrections to the Proposed Regulatory Language

To ensure consistency and clarity, we request that CMS make the following technical changes and corrections to the language of the proposed regulations.

447.294(b) Definitions

The proposed definition of "Mean HUF reduction percentage" is confusing and it appears that there is at least one grammatical error. We suggest, for ease of understanding, breaking the definition into two steps—first defining the term "HUF reduction percentage" and then using that term to define "mean HUF reduction percentage." For example, the two definitions could be as follows:

> *"HUF reduction percentage* means, for each state, its HUF reduction amount divided by its unreduced allotment amount."
>
> *"Mean HUF reduction percentage* means the average HUF reduction percentage for all states within a State group."

In addition, we suggest technical clarifications to other terms defined in this section as follows (indicated by underlining):

> *"Effective DSH allotment* means the amount of DSH allotment determined by subtracting the State-specific DSH allotment reduction from a State's unreduced DSH allotment."
>
> *"State group* means either the low DSH state group or non-low DSH state group, as defined in § 447.294(e)(1) ~~similarly situated States that are collectively identified by DHRM~~."
>
> *"Total Medicaid cost* means the amount reported for each DSH in accordance with § 447.299(c)(10)."
>
> *"Uncompensated care cost* means the amount reported for each DSH in accordance with § 447.299(c)(16)."

447.294(d) and (f) Applicable years

In describing data submission requirements (§ 447.294(d)) and the application of the allotment reduction (§ 447.294(f)), CMS refers to "each [fiscal] year identified in paragraph (c) of this section." Paragraph (c) does not directly identify any particular year, but rather cross references section 1923(f)()(A)(ii) of the Social Security Act, the statutory provision specifying aggregate allotment reductions for each of fiscal years 2014-2020. As a result, the reader would conclude that both the data submission requirements and the application of the allotment reductions apply for those seven years.

Instead, we believe CMS intended for both to apply only for FYs 2014 and 2015. Paragraph (e) specifically references those two fiscal years. We suggest, therefore, that these two provisions be changed to reference "paragraph (e)" rather than "paragraph (c)" of this section.

447.294(e) DHRM Methodology

Section (4)(iii) currently includes two subsections that should be separated after the semicolon. The second part should be renumbered from (iii) to (iv).

The main text of (5) should be edited to read as follows:

> "(5) *Reduction factor allocation.* CMS will allocate the aggregate DSH allotment reduction amount for each state group to three core factors by multiplying the aggregate..."

In section (6), add "the" after "uninsured in."

In section (10), the reference to "HMF" in the first sentence should be "HUF."

In section (12)(iii) and (iv), the reference to "(e)(10)" should be "(e)(12)" and in (v), the first reference to "(e)(10)" should be "(e)(12)."

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We appreciate the opportunity to submit these comments. If you have questions, please contact Xiaoyi Huang, assistant vice president for policy, at (202) 585-0127.

Sincerely,

Bruce Siegel, MD, MPH
President and Chief Executive Officer