AMERICA'S ESSENTIAL HOSPITALS

August 28, 2014

Ms. Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Suite 314-G
Washington, DC 20201

Ref: Request to Issue Final Rule for CMS-2315-P: Medicaid Program; Disproportionate Share Hospital Payments—Uninsured Definition

Dear Ms. Tavenner:

America's Essential Hospitals writes to urge the Centers for Medicare & Medicaid Services (CMS) to issue a final rule on CMS-2315-P: Medicaid Program; Disproportionate Share Hospital Payments—Uninsured Definition[1] and to incorporate the recommendations described and submitted in our attached comment letter of February 17, 2012.

The Medicaid disproportionate share hospital (DSH) program is vital to our membership. Since its inception, we have supported efforts to ensure DSH funds are spent appropriately to support those essential hospitals with the highest burden of uncompensated care. For these reasons, we have supported the adoption of annual audit and reporting requirements,[2] which has led to increased transparency and accountability in the program. However, it is equally critical that CMS' rules for determining hospital-specific DSH limits capture as accurately and fairly as possible the actual burden of the uncompensated costs of providing services to Medicaid and uninsured patients.

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[1]Medicaid Program; Disproportionate Share Hospital Payments – Uninsured Definition, 77 Fed. Reg. 2500 (proposed Jan. 18, 2012) (to be codified at 42 C.F.R. pt. 447). (Hereinafter "Proposed Rule.")

[2]Medicaid Program; Dispoportionate Share Hospital Payments, 42 C.F.R. § 447 and § 455 (2008). (hereinafter "DSH audit and reporting final rule" or "2008 final rule").

The need for accuracy in accounting for uncompensated care is made all the more urgent because the data already being collected for fiscal year (FY) 2011 will result in the first disallowances under CMS' DSH audit and reporting final rule. And perhaps even more critically, the data will likely be used to implement the Affordable Care Act's (ACA's) DSH reductions beginning in FY 2017 under a methodology intended to target remaining DSH funds to states making payments to providers carrying the heaviest Medicaid and uninsured burdens**. America's Essential Hospitals therefore respectfully urges CMS to issue a final rule incorporating our recommendations as soon as possible to mitigate any negative impact that hospitals could face in the form of disallowances of FY 2011 DSH payments.**

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. Our almost 250 member hospitals fill a vital role in their communities, serving the uninsured and patients covered by public programs. Our members provide a disproportionate share of the nation's uncompensated care and devote more than half of their inpatient and outpatient care to uninsured or Medicaid patients. And they provide this care while operating on margins substantially lower than the rest of the hospital industry—with an aggregate operating margin of -0.4 percent, compared to 6.5 percent for hospitals nationally.

The Medicaid DSH program is critical to our members' ability to provide this level of care to low-income patients. Policy changes in this program, particularly changes with significant financial impacts, directly affect our members' ability to provide access to needed services. Without the critical support of Medicaid DSH, our members' aggregate operating margin would drop to -8 percent—a clear sign that DSH is vital to their overall financial viability.

<u>CMS Should Finalize CMS-2315-P, Incorporating the Following Recommendations</u>

In the above-captioned proposed rule, CMS has proposed action to mitigate some of the unintended consequences of policy changes made to the definition of DSH-eligible costs in the 2008 DSH audit and reporting final rule. We support CMS' proposal to revert to a service-specific definition of the uninsured and strongly urge CMS to finalize this proposal.

The 2008 final rule excluded from DSH-eligible uncompensated care the costs of many services that are provided to individuals with creditable coverage but that are outside the scope of such coverage. These costs include those for individuals who have exhausted their insurance benefits, reached annual or lifetime insurance limits for certain services, or who have high deductible plans and cannot afford the costs of services prior to meeting that deductible.

The recent implementation of the health insurance marketplaces (exchanges) could also add to the uncompensated care burden of essential hospitals. Many of the newly insured

are the low-income individuals our hospitals serve. Our members are concerned that these individuals may not be able to afford the cost-sharing responsibilities that come with certain health plans and may choose less expensive plans that exclude certain services. Our hospitals would still provide these services, resulting in uncompensated care costs. In addition, marketplace health plans are continuing to trend toward using narrow networks that don't include essential hospitals. Some individuals covered by these plans are nonetheless still coming to our members for care and are not turned away—again resulting in uncompensated care.

These are costs that many states had or would have previously included in the calculation of hospital-specific DSH limits. Excluding these costs under the 2008 final rule has reduced DSH payments to individual hospitals even before the ACA DSH cuts are implemented. Furthermore, even though CMS has expressed its intent for states to target remaining DSH payments to hospitals providing disproportionately greater DSH-eligible uncompensated care, excluding the costs of the underinsured unfairly disadvantages the very hospitals caring for these patients. CMS' proposal in CMS-2315-P to return to a service-specific definition of uninsurance is consistent with prior CMS policy and would ameliorate some of the damaging reductions in funding to essential hospitals that rely most on the DSH program. Specifically, we respectfully request the following changes (as described more fully in our original comment letter, which is attached).

<u>CMS Should Finalize CMS-2315-P, Subject to the Recommendations Below</u>

- CMS should **revise the definition** of "No source of third party coverage for a specific inpatient hospital or outpatient hospital service" in 42 C.F.R. § 447.295(b) so that individuals with high deductible plans or catastrophic coverage are treated as uninsured until patients meet the relevant limits.

- CMS should clarify that the **costs of services to individuals after they exhaust their coverage may be included as DSH-eligible costs, whether the individual exhausts coverage before or during the hospital stay**. Our member health systems are often left to treat the sickest, most vulnerable—and thus most costly—patients. This is particularly true when members provide specialized services, such as burn care, or serve as the main trauma hospital in their area. Insurance coverage, particularly for those patients who are underinsured, will often cover only a small fraction of the time that such patients must remain in the hospital. While some hospitals address this issue by transferring these patients, our members continue to treat them.

- CMS should **define patients with high-deductible plans/catastrophic plans as uninsured for services until they meet their deductible or spending limit.** To the extent individuals do not have a third-party payer source for those uncovered services, CMS should treat the uncompensated costs of services before the deductible is met just as it treats the costs of services after annual or other benefit limits are reached.

- CMS should **treat individuals whose only source of coverage is an excepted benefit plan**, defined at 45 C.F.R. 148.220 (e.g., auto insurance), or **a legally liable third party** whose liability cannot be established on a service-specific basis (e.g., a tort settlement) as **uninsured** for purposes of the DSH limit calculation.

In addition, America's Essential Hospitals urges CMS to reconsider certain other policy changes in the proposed rule that could have significant negative consequences for essential hospitals, which fill a safety net role for the nation's most vulnerable patients and are the very providers CMS has sought to protect.

- CMS should clarify that it does not intend to narrow the scope of inpatient and outpatient hospital services as defined in section 1905 of the Social Security Act for purposes of determining DSH-eligible costs. The proposed regulatory language supports the policy that the costs of hospital services defined in section 1905 may be included in the DSH calculation regardless of any limitations a state's Medicaid plan has placed on coverage of such care. CMS should clarify this intent when finalizing the rule and should retract and/or clarify statements in the preamble that could be read to suggest a limiting definition of these services (for more detailed discussion, see pages 7-8 of attached comment letter).[3]

- CMS should retract its preamble statements suggesting that Medicaid federal financial participation is not available for care provided to inmates unless they have been released from secure custody. In the context of clarifying that inmates in a public institution are not considered uninsured for DSH purposes, the preamble discussion appears to suggest that an "inmate" cannot be a "patient."[4] Such a distinction could render meaningless the existing statutory exception permitting Medicaid eligibility for inmates receiving inpatient hospital services and would leave many of our members with a huge burden of uncompensated care without any DSH support.

Finally, America's Essential Hospitals urges CMS to finalize the rule, incorporating the changes above, as soon as possible. When the proposed rule was issued in January 2012, CMS intended the changes to the definition of the uninsured be effective "for purposes of calculating the hospital-specific DSH limit effective for 2011,"[5] as FY 2011 reports are the first for which CMS will recoup overpayments. By reverting to the pre-2008 DSH audit

[3] In reference to costs for uninsured and Medicaid patients, the preamble references services "which are identified in section 1905 of the Act and covered under the approved Medicaid State Plan" (77 Fed. Reg. at 2503) and "inpatient and outpatient costs associated with Medicaid eligible individuals authorized under section 1905 of the Act and covered under the approved Medicaid State Plan." (77 Fed. Reg. at 2502).

[4]Medicaid Program; Disproportionate Share Hospital Payments – Uninsured Definition, 77 Fed. Reg. 2500 (proposed Jan. 18, 2012) (to be codified at 42 C.F.R. pt. 447).

[5]Medicaid Program; Disproportionate Share Hospital Payments – Uninsured Definition, 77 Fed. Reg. 2500 (proposed Jan. 18, 2012) (to be codified at 42 C.F.R. pt. 447).

and reporting rule service-specific definition of uninsured prior to the due date for FY 2011 reports, CMS proposed "avoiding any unintended, and potentially significant, financial impact resulting from the 2008 DSH final rule."[6] Unfortunately, given the amount of time that has passed since the proposed rule was issued, the FY 2011 audits are being conducted now, and the reports are due to CMS this December. America's Essential Hospitals urges CMS to fulfill the agency's intent to mitigate negative financial consequences for hospitals serving underinsured patients. If FY 2011 disallowances are linked to policy changes resolved by finalizing this proposed rule, CMS should not pursue disallowances for FY 2011 or should reduce disallowances to the extent they would have been mitigated by the inclusion of underinsured services. At the very least, CMS should finalize the proposal as soon as possible so the rules are clear to states and auditors for the FY 2012 audit and reporting cycle.

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America's Essential Hospital's appreciates your consideration of this letter and our attached comment letter on the proposed rule, including proposed regulatory language and more detailed and technical analysis of our recommendations. We again respectfully urge your prompt action to avoid additional unintended financial impact to the hospitals disproportionately caring for the most vulnerable patients. If you have any questions, please contact Xiaoyi Huang, director of policy, at 202-585-0127.

Sincerely,

/s/

Bruce Siegel, MD, MPH
President and CEO

[6]Medicaid Program; Disproportionate Share Hospital Payments – Uninsured Definition, 77 Fed. Reg. 2500 (proposed Jan. 18, 2012) (to be codified at 42 C.F.R. pt. 447).