



*A Passionate Voice for Compassionate Care*

August 28, 2017

Ms. Seema Verma  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health & Human Services  
Room 445-G  
Herbert H. Humphrey Building  
200 Independence Avenue, SW  
Washington, DC 20201

REF: CMS-2394-P

Re: Medicaid Program; State Disproportionate Share Hospital Allotment Reductions: Proposed Rule. (82 Fed. Reg. 35155-35171, July 28, 2017)

Dear Ms. Verma:

On behalf of the Catholic Health Association of the United States (CHA), the national leadership organization of more than 2,000 Catholic health care systems, hospitals, long-term care facilities, sponsors, and related organizations, I am pleased to submit these comments on the proposed rule implementing the state disproportionate share hospital (DSH) allotment reductions required by the Affordable Care Act (ACA).

The Medicaid & Medicare DSH programs are our nation's primary source of support for safety-net hospitals that serve the most vulnerable populations – Medicaid beneficiaries, low-income Medicare beneficiaries, the uninsured and the underinsured. DSH payments partially compensate hospitals for costs resulting from providing uncompensated care and many hospitals rely on Medicaid DSH payments to be able to keep their doors open. These funds also help support essential community services such as trauma and burn care; pediatric intensive care; high-risk neonatal care; and emergency psychiatric services, critical services that are not financially self-sustaining.

DSH funding reductions were included in the ACA because the law was designed to significantly reduce the number of uninsured in the U.S., which in turn would reduce hospital uncompensated care costs. Following the Supreme Court decision that the Medicaid expansion must be a state option, a number of states chose not to expand their Medicaid programs resulting in markedly lower uninsured reductions than anticipated. The corresponding reductions in uncompensated care were also not realized to the degree expected. **Given that the coverage expansions and uncompensated care reductions upon which the Medicaid DSH reductions were predicated did not occur in the manner intended by Congress, CHA believes Congress should repeal**

**the Medicaid DSH reductions. In the meantime, and in light of concerns with the data sources outlined below, we urge CMS to delay implementing the DSH reductions until Congress acts or, if it does not, until the data issues are addressed.**

The ACA instructs the Secretary to develop a methodology for distributing the reductions among the states that imposes the largest percentage reductions in DSH allotments on states that have the lowest percentage of uninsured or that do not target their DSH payments on hospitals with high volumes of Medicaid beneficiaries and hospitals with high levels of uncompensated care. We have concerns with the data sources that will be used in this methodology.

CMS proposes to use DSH Medicaid Inpatient Utilization Rate (MIUR) data to allot state reductions based on the degree to which a state targets DSH payments to high volume Medicaid hospitals. While CMS proposes a proxy for missing MIUR reports, it is essential to have correct MIUR data for all states to implement this factor fairly. Without accurate data, states that do in fact target payments to high Medicaid hospitals could be unfairly denied needed DSH dollars. Because of the legislative postponements of implementing the cuts, states have not all fully complied with the new requirement to report their MIUR data to CMS and it will take time to close that gap.

CHA is concerned with the overall timeliness of the state's DSH audit data that CMS proposes to use for the other important factors in the DSH health reform methodology (DHRM). Most of the reduction factors that CMS is required by statute to use in the DHRM are proposed to be estimated based on state DSH audit data. The audit data lag behind by several years so that for 2018, for example, the most recent audit data available are for 2013 state reporting periods. This means that for 2018 DSH reductions, estimates of a hospital's Medicaid utilization, Medicaid shortfall, and uncompensated care reflect a period that was largely before the coverage expansions of the ACA were implemented. For example, most Medicaid coverage expansions did not take place until 2014 and 2015 and subsidies for health care purchased on Exchanges did not become available until 2014. Therefore, DSH reductions based on hospitals' early experiences under the ACA will not have a strong relationship to actual Medicaid coverage, uninsurance and uncompensated care. If DSH reductions are implemented, CMS must step up its data collection efforts so that implementation is based on more timely information and better reflects the coverage and economic conditions in states in the years in which the reductions apply.

However, as already expressed, CHA believes it would be more appropriate for CMS to delay implementation of the DSH reduction until the accuracy of the data can be ensured. If CMS intends to proceed with finalizing the proposal, we suggest CMS implement the proposed DHRM for a limited period of time after which the methodology and the effect of the reductions on hospitals and state Medicaid programs can be evaluated. CMS intended the 2013 final rule, never implemented because of subsequent legislative action, to be in effect for two years while CMS assessed the methodology. Should CMS decide to proceed now, using this approach would allow for an evaluation of how well or how poorly the formula impacts hospitals, states,

Ms. Seema Verma  
August 28, 2017  
Page 3 of 3

coverage and programs; to make adjustments to the methodology over time; and to evaluate the data sources to ensure they provide the timely and accurate information needed to accurately assess the statutory factors.

CHA does support the use of data from the Census Bureau's American Community Survey to measure the state-level percentage of uninsured. However, we are concerned that the ACS data may not accurately reflect the number of uninsured undocumented individuals in our country. Catholic hospitals provide care for those who need it, without regard to their insurance or immigration status. We urge CMS to develop a methodology to measure a state's level of uninsurance that will account for all of the uninsured, whatever their immigration status.

CHA also supports the proposal to limit a state's reduction amount to 90% of a state's unreduced DHS allotment. Given the magnitude of the expected reduction amounts in FY 2018 and after, this provision will ensure that no state would lose entirely the ability to provide DHS payments to its hospitals.

In closing, thank you for the opportunity to share these comments in regard to the proposed Medicaid DSH reduction proposed rule. If you have any questions about these comments or need more information, please do not hesitate to contact me or Kathy Curran, Senior Director Public Policy, at 202-721-6300.

Sincerely,

A handwritten signature in black ink that reads "Michael Rodgers". The signature is written in a cursive style with a long horizontal flourish at the end.

Michael Rodgers  
Senior Vice President  
Public Policy and Advocacy