Catholic Health Association of the United States

A Passionate Voice for Compassionate Care

July 12, 2013

Ms. Marilyn B. Tavenner
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–2367–P

Re: Medicaid Program; State Disproportionate Share Hospital Allotment Reductions: Proposed Rule.

Dear Ms. Tavenner:

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. Since the Supreme Court ruling made the State Medicaid expansion optional, it is now unclear how many low-income uninsured individuals will gain access to coverage in 2014. We believe it is, therefore, critical to postpone the DSH funding reductions for at least two years

until we know the full impact of state Medicaid expansion decisions on the number of uninsured, the enrollment of uninsured in private health insurance coverage through Exchanges, and the resulting level of reductions in hospital uncompensated care. To that end, we are strong supporters of the *Disproportionate Share Hospital (DSH) Reduction Relief Act of 2013*, H.R. 1920, which would eliminate the 2014 and 2015 Medicaid DSH cuts and delay Medicare DSH cuts contained in the Patient Protection and Affordable Care Act (ACA) for two years, until 2016.

In the meantime, we acknowledge CMS' obligation to propose regulations to implement the Medicaid DSH cuts. We appreciate the approach CMS has taken in proposing a methodology for fiscal years 2014 and 2015 and planning to address the reductions in FY 2016 and beyond through future rulemaking. This will allow CMS, hospitals, states and other stakeholders to identify any issues with the initial methodology and to see how Medicaid expansions proceed. We are generally supportive of the proposed initial two-year methodology, but would like to offer the following comments.

We support CMS' proposal not to factor in to the initial methodology whether or not a state plans to expand its Medicaid program. This decision, along with the proposal to return to rulemaking in two years, will allow time for additional efforts to expand coverage and for hospitals and states to assess the impact of non-expansion and how that decision may interact with the Medicaid DSH reduction.

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. CHA believes that CMS' proposal to weight each of these factors equally in the initial methodology is a reasonable approach for the initial implementation of the DSH reductions.

CHA supports 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.

To determine whether a state is targeting its DSH payments to hospitals with high levels of uncompensated care, CMS proposes to use Medicaid DSH audit and reporting data. CMS notes issues with this data source that could in some cases underreport the true level of uncompensated care provided by a given hospital, because the audits do not report total hospital costs. To address this issue, CMS proposes to modify the DSH audit and reporting process so that states provide it with total hospital cost from Medicare cost report data for all DSH hospitals. For years FY 2016 and after, CMS intends to propose in future rulemaking substitute total cost for

the denominator in step 1 of the HUF calculation. Instead of asking states to obtain this data from hospitals to provide to CMS, CHA recommends that CMS' Medicaid staff work with its Medicare office to get the total cost data from the Medicare cost reports. This will be a simpler approach and would avoid imposing additional reporting burdens on states and hospitals.

CHA also suggests that CMS explore using an updated and improved Medicare hospital cost report worksheet S-10 for determining hospital uncompensated care costs in future rulemaking. Similarly, in our June 25, 2013 comment letter on the proposed FY 2014 Inpatient Prospective Payment system rule we recommend that CMS work on improving the quality of the S-10 data to provide data on uncompensated care for use in implementing the Medicare DSH reductions also required by the ACA.

In closing, thank you for the opportunity to share these comments in regard to the proposed Medicaid DSH reduction proposed rule. We look forward to working with CMS on future rulemaking in this area. We thank you and your staff for all work in implementing the ACA and offer our assistance in any way possible 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,

Michael Rodgers
Senior Vice President
Public Policy and Advocacy