Charles N. Kahn III
President and CEO

August 28, 2017

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

SUBJECT: CMS-2394-P. Medicaid Program; State Disproportionate Share Hospital Allotment Reductions

Dear Administrator Verma:

The Federation of American Hospitals ("FAH") is the national representative of more than 1,000 investor-owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching full-service community hospitals in urban and rural parts of America, as well as inpatient rehabilitation, psychiatric, long-term acute care, and cancer hospitals. Our hospitals have long been a critical part of the health care safety net serving Medicaid and other vulnerable patients in urban and rural communities. The FAH appreciates the opportunity to comment to the Centers for Medicare & Medicaid Services ("CMS") about the referenced Notice of Proposed Rulemaking on the Medicaid Program; State Disproportionate Share Hospital Allotment Reductions ("Proposed Rule").

I. Reductions to Medicaid Disproportionate Share Hospital ("DSH") Allotments Will Have a Significant Negative Impact on Hospitals Throughout the Nation and Should Not Be Implemented

The Patient Protection and Affordable Care Act ("ACA") mandated cuts to Medicaid DSH allotments based on the assumption that the ACA would expand Medicaid coverage across all states to almost all low-income non-elderly adults. Had this expansion gone into effect as intended, it would have greatly reduced the number of uninsured individuals, and the cost to hospitals of caring for these individuals. As you know, however, following the Supreme Court

decision in National Federation of Independent Business v. Sebelius, which, in effect, made Medicaid expansion a state option, only 31 states have since expanded Medicaid. Approximately 2.6 million additional individuals would be eligible for Medicaid if all states expanded.

As originally structured, the ACA called for a total of $18.1 billion in Medicaid DSH cuts beginning in FY 2014, and continuing through FY 2020. These cuts were premised, however, on the notion that all states would, as the ACA intended, expand Medicaid. Following the Supreme Court decision, and recognizing the impact cuts to critical Medicaid DSH payments would have on hospitals, Congress took action several times to delay, extend, and modify the timetable and amount of the reductions. Cumulative reductions set to be imposed between FY 2018 and FY 2025 now reach $43 billion – a 138% increase. Given that the ACA prescribed $18.1 billion in reductions at a time when it was assumed that all states would expand Medicaid, it is unreasonable to believe that hospitals can sustain $43 billion in reductions to Medicaid DSH payments, especially if, as CMS notes, this could have the effect of eliminating or nearly eliminating Medicaid DSH allotments in a number of states.

According to data published by the Medicaid and CHIP Payment and Access Commission ("MACPAC"), FY 2018 federal DSH allotments are estimated to reach just over $12 billion. The first year's reduction, alone, will result in a cut of over 16 percent in federal Medicaid DSH funding. While the unreduced allotments will grow each year by the Consumer Price Index for All Urban Consumers ("CPI-U"), the inflation factor will hardly keep pace with the escalating reductions prescribed in law – reaching $8 billion in FY's 2024 and 2025. Taking into account the reductions, instead of barely keeping pace with inflation, DSH allotments will instead contract – leaving fewer and fewer funds available for caring for more uninsured and underinsured individuals.

Medicaid DSH cuts of this magnitude pose a significant risk to the hospital safety net at a time when demands on the program are growing and the responsibilities of hospitals to care for the uninsured have not abated. Moreover, these cuts will have a deleterious effect on hospitals with high Medicaid caseloads, as well as those with high uncompensated care, which is important to note as Medicaid DSH is also intended to help defray those hospitals costs. Medicaid continues to often pay below the actual cost of providing care which disproportionately impacts high Medicaid DSH hospitals in expansion states who now care for a larger number of Medicaid enrollees at inadequate reimbursement rates The DSH reductions will result in unreasonable and unfair cuts to hospitals who care for some of the most vulnerable populations, including Medicaid enrollees and the uninsured in their areas.

We appreciate that these harmful cuts were enacted during a prior Administration, however, given their implementation will pose considerable hardship on Medicaid beneficiaries and the hospitals that care for them, we urge you to work with Congress to delay this year's proposed DSH cuts and ultimately, rescind these harmful cuts to hospitals.

II. CMS Should Delay Implementation of the Medicaid DSH Reductions

In light of the significant, harmful impacts that the reductions will have on hospitals

and their ability to treat Medicaid and uninsured patients, CMS should exercise its authority to delay implementing the reductions while it works with Congress to permanently rescind the reductions. As noted earlier, recognizing the strain on hospitals, Congress has already delayed the cuts on multiple occasions.

In addition, a delay is warranted so that CMS can address important deficiencies with its data sources, including the transparency and timeliness of the data and outstanding legal questions impacting the data. If not addressed prior to implementation, these issues will have a material impact on the distribution of the reductions across states.

As detailed in the Proposed Rule, CMS will be relying on data compiled from a number of different sources. As such, CMS notes that "the data used for the methodology may not be the most recent data, but instead the most recent data...in usable form." It is not clear from the Proposed Rule what is meant by "the most recent data" with regard to consistency across states and across data sources. For instance, will CMS use the most recent data from one year across all states, or will it use data from different reporting years for different states, relying on the "most recent data...in usable form" for each state?

Importantly, it is not clear that all the data used by CMS to calculate the reductions will be publicly available at the time CMS is determining the reductions. For example, CMS proposes to rely on the mean and one standard deviation of the Medicaid inpatient utilization rate ("MIUR") for hospitals receiving DSH payments in each state as required to be reported by the states to CMS under 42 CFR 447.294(d). As required by CMS, those calculations are reported by June 30th of each year, with a three-year lag. This suggests that states have just reported State Plan Rate Year ("SPRY") calculations for 2014. (However, as we know from work done by MACPAC, many states have not reported this data[1]) While CMS proposes to use MIUR calculations from the same year as that of the DSH audit data being used in the reduction calculations, neither the mean MIUR or standard deviation calculations for 2013 or for 2014 are publicly available. And, while the DSH audit data that is publicly available may be used to approximate those amounts, without the calculations being publicly available, there is no way to review and confirm their accuracy. The use of non-public data weakens confidence in the overall reduction calculations and should not be used.

CMS should also delay the implementation of these reductions until legal challenges to CMS's DSH reporting rules are resolved. Specifically, in April 2017, CMS finalized a controversial rule which modified the way in which "costs" for purposes of calculating hospital-specific DSH limits are calculated. CMS's Final Rule asserted that such costs are net of third-party payments received. Prior to the issuance of the Final Rule, CMS had relied on Frequently Asked Questions ("FAQs") that were not promulgated using notice-and-comment rulemaking to support the policy made final in the April 2017 Final Rule. Multiple successful legal challenges

[1] MACPAC, Report to Congress March 2016 https://www.macpac.gov/wp-content/uploads/2016/03/March-2016-Report-to-Congress-on-Medicaid-and-CHIP.pdf

have been brought challenging the FAQs' validity.[2] Litigation challenging the Final Rule is also pending.[3]

The ultimate outcome of these legal challenges—all of which have so far been adverse to CMS—are important in the context of this Proposed Rule. CMS finalized in the April 2017 rule a definition of uncompensated care costs that was first described through FAQs. In fact, in the initial year of the reductions (FY 2018), CMS has proposed that it will rely on uncompensated care cost data reported under the FAQs – FAQs which have now been vacated by multiple courts. By doing so, CMS is using a definition of uncompensated care costs that has been rejected by the courts. Doing so also creates great uncertainty for both states and hospitals on how ongoing legal challenges may impact DSH reductions both retroactively and prospectively.

Because the DSH audit and reporting data remains the only comprehensive reported data that is available and as such is a key to calculating the DSH reductions, it is imperative that CMS use the legally correct version of that data. As a result, CMS should wait until legal challenges impacting this data are resolved prior to proceeding with the Proposed Rule policy.

Finally, we urge CMS to conduct a more robust impact analysis than is offered in the proposed rule. The illustrative example does not indicate the impact of various weighting methodologies across a wide range of hospitals which could vary widely depending on a number of state decisions, including whether to expand. This analysis will offer a transparent and tangible marker for CMS and all stakeholders to understand how hospitals are affected by these cuts, especially DSH hospitals with high Medicaid caseloads.

III. CMS Should Publish A Preliminary File With All Data Elements Used In The DHRM And Allow An Opportunity For Corrections Before DSH Allotment Reductions Are Finalized

CMS is proposing to use data from a number of different sources to compile the necessary information for the DHRM, including Medicaid DSH data required by section 1923(j) of the Social Security Act and derived from the DSH audit and reporting data. As noted by CMS, state-submitted DSH audit and reporting data is the only comprehensive source of data consistent with Medicaid program requirements, and is a source for many data elements for the DHRM. However, as also noted by CMS, this data is

> "…subject to detailed CMS review to ensure quality and accuracy and requires significant resources to compile and prepare

[2] *See, e.g., Children's Health Care v. Burwell*, No. 0:16-cv-04064 (D. Minn. June 26, 2017); *Tenn. Hosp. Ass'n v. Price*, No. 3:16-cv-03263, 2017 WL 2703540 (M.D. Tenn. June 21, 2017); *Children's Hosp. of King's Daughters, Inc. v. Price*, No. 2:17-cv-00139, 2017 WL 2936801 (E.D. Va. June 20, 2017); *N.H. Hosp. Ass'n v. Burwell*, No. 1:15-cv-00460, 2017 WL 822094 (D.N.H. Mar. 2, 2017); *Tex. Children's Hosp. v. Burwell*, 76 F. Supp. 3d 224 (D.D.C. 2014).

[3] *See, e.g., Children's Hosp. Ass'n of Tex. v. Price*, No. 1:17-cv-00844 (D.D.C.); *Mo. Hosp. Ass'n v. Price*, No. 2:17-cv-04052 (W.D. Mo.).

> for use in the proposed DHRM. This means that the data used for the methodology may not be the most recently submitted data, but instead the most recent data available to us in usable form."

The FAH contracted with KNG Health Consulting LLC to analyze and replicate the DHRM using the data sources and methods described in the Proposed Rule. We recognize the challenges of collecting and analyzing Medicaid DSH and other data from multiple sources for purposes of calculating the DHRM, and appreciate the efforts of both the states and CMS to ensure that the data is accurate and comprehensive. However, the FAH believes further steps can and should be taken to ensure the data is complete and accurate, particularly because data errors could unintentionally lead to an incorrect distribution of DSH allotment reductions among the states. The FAH therefore recommends that:

> (1) CMS further clarify what is meant by "usable form," and outline the quality control measures and processes it will rely on to ensure the data is complete and accurate; and,
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> (2) CMS publish, possibly in a comprehensive single file, the hospital and state level data used to calculate the various factors and determine the state-specific DSH allotment reductions. States and providers should then be permitted to review the data and provide CMS with any necessary corrections before the DSH allotment reductions are finalized.

We believe these additional measures will help to achieve CMS's goal of high quality, accurate data.

IV. CMS Should Broadly Apply the 1115 Budget Neutrality Factor ("BNF")

The Section 1115 BNF is required by statute and recognizes that the DHRM should take into account DSH funding used for state coverage expansions. The BNF is intended to recognize states that took the initiative to expand coverage and implement health coverage reforms prior to the passage of the ACA. As such, CMS should ensure that the final DHRM gives full consideration to this statutory provision and does not unfairly penalize these leader states, which already are well on their way towards achieving the critical coverage goals of the ACA.

V. CMS Should Use the Medicaid DSH Audit and Reporting Data as Source of Data for Uncompensated Care Costs

Notwithstanding our earlier comments regarding the need to address legal challenges that have an impact on the uncompensated care cost data reported through the Medicaid DSH audits before CMS proceeds to enact the DSH reductions, the FAH agrees with CMS that the DSH audit and reporting data should be the source of uncompensated care costs data for use in the DHRM.

Further, given CMS's reference to considering use of data from Medicare Form CMS-2552, which we assume is a reference to data collected on Worksheet S-10, the FAH strongly discourages the use of this Medicare uncompensated cost data in the DHRM. Specifically, due to a wide range of structural defects, including unclear and ambiguous instructions, which we

documented in the attached comments to the FY 2018 IPPS Proposed rule (see pages 19 – 48), the form does not yet yield fair, accurate, uniform, and audited data, and is not ready to be deployed.

Most importantly, Worksheet S-10 does not define uncompensated care consistent with a policy designed to capture the actual cost of uninsured patients or consistent with Medicaid's policy of capturing these costs. In fact, the instructions to prepare the S-10 worksheet could not be clearer that the form does not produce an estimate of the cost of treating the uninsured consistent with Medicaid DSH requirements:

> "Note that this worksheet does not produce an estimate of the cost of treating uninsured patients required for disproportionate share payments under the Medicaid program." PRM-II, Chapter 40, section 4012, for Form CMS 2552-10

Medicaid policy explicitly, and properly, includes all discounts given to uninsured patients in the uncompensated care cost calculation, whereas Medicare policy expressed through the S-10 excludes discounts to uninsured patients unless they conform to a hospital's charity care policy. For Medicaid, CMS, through regulation has been clear about how uninsured discounts are to be treated:

> The commenter recommends a revision to clarify that discounts for the uninsured are not applied to reduce the hospital's uncompensated care costs. The full cost should be recognized as uncompensated notwithstanding the discount or allowance process. Response: *We agree that the amount of calculations of uncompensated care* ***should not*** *be reduced by amounts that are not paid because of a provider discounted charge.* The statute provides for costs of furnishing services to uninsured patients to be reduced only by the amount of payments received from or for those patients, except for payments for care to indigent patients from a State or unit of local government within a State. We have clarified the data elements in this final rule, and we believe they more clearly track those statutory elements.

For these reasons, it would be inappropriate for CMS to utilize uncompensated care data reported for Medicare purposes for use in the DHRM unless and until Worksheet S-10 is adjusted to fully account for uninsured patient discounts and data developed under that revised S-10 is available. We support CMS's proposal to utilize Medicaid DSH audit data.

VI. CMS Should Clarify the HUF Methodology

We support CMS's proposed change to the methodology for calculating the HUF. The preamble describes (page 35162, column 3) a change in the denominator of the HUF from total "Medicaid and uninsured inpatient and outpatient hospital service costs" (as finalized in 2013) to a hospital's "total hospital cost." This change is meant to address concerns that the former methodology could result in a scenario in which a hospital would not have been considered to have a higher level of uncompensated care even though it provided a higher percentage of services to Medicaid and uninsured individuals and had greater total qualifying uncompensated care costs than another hospital that did qualify as having a high level of uncompensated care. While we support the change, we are concerned that CMS has left this

modification somewhat unclear by indicating earlier on the same page (bottom of column 1 to top of column 2) that "any hospital that exceeds the mean ratio of uncompensated care costs to t*otal and Medicaid and uninsured inpatient and outpatient hospital service costs* within its state is considered a hospital with a high level of uncompensated care." We request clarification of the HUF methodology.

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The FAH appreciates the opportunity to comment on the Proposed Rule If you have any questions regarding our comments, please do not hesitate to contact me or Paul Kidwell, VP, Policy on my staff at (202) 624-1500.

Sincerely,

Attachment: FAH FY 2018 IPPS Proposed Rule Comments