



**American Hospital  
Association**

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July 2, 2013

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Administrator  
Centers for Medicare & Medicaid Services  
Hubert H. Humphrey Building  
200 Independence Avenue, S.W., Room 445-G  
Washington, DC 20201

***RE: CMS 2367-P Medicaid; State Disproportionate Share Hospital Allotment Reductions; Proposed Rule (Vol. 78, No. 94, May 15, 2013)***

Dear Ms. Tavenner:

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our nearly 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule implementing the *Patient Protection and Affordable Care Act* (ACA) aggregate reductions to state Medicaid Disproportionate Share Hospital (DSH) allotments.

**The AHA appreciates CMS's overall approach to implementing the ACA Medicaid DSH allotment reductions. The proposed rule would not discourage Medicaid expansion, nor would it cause undue harm to hospitals in states that have decided not to expand or in states that have yet to decide to expand their Medicaid programs. We also believe that the two-year time frame for the application of the proposed DSH allotment reduction methodology is a responsible approach. It would allow CMS, states, and stakeholders more time to fully assess CMS's approach and allow more time to explore opportunities for coverage expansion.**

**Moreover, the AHA strongly supports the *DSH Reduction Relief Act of 2013 (H.R. 1920)*, which would delay for two years cuts to the Medicare and Medicaid DSH programs.** The Congressional Budget Office (CBO) initially estimated that as a result of the ACA's coverage improvements, 32 million uninsured individuals would receive coverage. As a result of such expanded coverage, Congress determined that the level of supplemental payments, such as DSH, would change. But in the wake of the U.S. Supreme Court's ACA decision on Medicaid expansion and the uncertainty of coverage gains through the new health insurance marketplaces, CBO has reduced its coverage estimate from 32 million to 25 million. For hospitals treating a disproportionate share of



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these patients, they will see their payments reduced in ways unintended by policymakers. The two-year delay of DSH reductions proposed in H.R. 1920 would allow more time for health coverage expansions under the ACA to be more fully realized.

To prepare for CMS's implementation of the ACA Medicaid DSH allotment reductions, the AHA conducted a process to engage hospital members and affiliate state and metropolitan hospital associations. As a result, in July 2012, the AHA Board of Trustees adopted guiding principles for evaluating CMS's proposal for the ACA Medicaid DSH allotment reductions (Attachment).

#### **OVERALL IMPLEMENTATION APPROACH**

The ACA mandates specific aggregate reductions to state Medicaid DSH allotments totaling an estimated \$18.1 billion by fiscal year (FY) 2020. These federal aggregate reductions are phased in beginning in FY 2014 at \$500 million and increase sharply after FY 2016. The ACA instructs CMS to develop a methodology to reduce each state's DSH allotment so that the total federal savings are equal to the specified savings for each fiscal year. The methodology must ensure that low-DSH states receive a smaller percentage reduction in their DSH allotments. It also must include factors so that states with the lowest percentage of uninsured would receive the largest percentage reduction in DSH allotment funds. In addition, those states that do not target their DSH payments to hospitals with the highest volume of Medicaid inpatient utilization and to hospitals with the highest levels of uncompensated care cost, would receive the largest reductions in their DSH allotments. Finally, CMS must examine the extent to which states, with approved 1115 Medicaid coverage expansion waivers as of July 2009, used their DSH allotment funds in the waiver budget neutrality calculation.

CMS, in its proposed rule, adheres to these ACA requirements. It achieves the DSH allotment reductions through its proposed methodology known as the DSH Health Reform Methodology (DHRM). The DHRM, as described in the proposed rule, would be applied only during the first two years of the scheduled reductions – FYs 2014 and 2015 (\$500 million and \$600 million, respectively). CMS notes that it chose not to factor state government decisions on Medicaid program expansion into its proposal. The agency explains that it does not have sufficient information on the impact of state government decisions to implement expanded coverage. In addition, CMS notes that the two-year reduction methodology allows for further data refinement and methodology improvements before the ACA's larger DSH reductions are slated to begin. The agency plans to issue future rulemaking to implement the DSH reductions in FY 2016 and beyond.

**The AHA appreciates CMS's approach not to factor states' decisions on Medicaid expansion into the DHRM. We also appreciate CMS's decision to apply the proposed DHRM only to the first two years of the ACA's scheduled DSH allotment reductions.** CMS's proposal implements the congressionally-mandated Medicaid DSH reductions in a responsible way given the uncertainty surrounding state government decisions regarding Medicaid expansion. **The proposed rule would not discourage**

**Medicaid expansion, nor would it cause undue harm to hospitals in states that have decided not to expand or in states that have yet to decide to expand their Medicaid programs. Applying the DHRM to only the first two years of the scheduled ACA DSH reductions enables CMS to assess the status of Medicaid expansion and revisit the hospital DSH targeting policies.**

#### **DSH HEALTH REFORM METHODOLOGY (DHRM) WEIGHTING FACTORS**

CMS's proposed DHRM involves a series of calculations to achieve the annual aggregated federal DSH allotment reductions. The interacting calculations of the DHRM result in state specific DSH allotment reductions that when summed equal the specified aggregate DSH allotment reduction. Central to the DHRM are the weights to be applied to three factors: the state's uninsured percentage and the two hospital DSH targeting factors – payments to hospitals with high volumes of Medicaid inpatient utilization and hospitals with high levels of uncompensated care. CMS proposes to assign each of these three factors the same relative weight within the DHRM. Thus, the uninsured percentage factor is weighted at one-third, the high volume of Medicaid inpatient utilization factor is weighted at one-third and the high level of uncompensated care factor is weighted at one-third. Taken together, the hospital DSH targeting factors would have a combined weight of two-thirds. CMS notes it remains committed to making certain that the DHRM – as proposed and in future rulemaking – is effective in tying the level of DSH allotment reductions to the targeting of DSH payments.

CMS considered different weight assignments among the three factors prior to its decision to assign equal relative weights. The agency notes that the proposed methodology would incentivize states to target DSH payments to such hospitals with high Medicaid inpatient utilization and high levels of uncompensated care. CMS further notes that this approach is consistent with the intent of the ACA. While the proposed rule would implement the ACA's favorable treatment of states that target DSH payments, states would retain considerable flexibility in determining DSH hospital eligibility, as well as how payments are distributed and how reductions are applied. CMS asks for comment on whether the weights are appropriate and whether alternative approaches should be considered.

**The AHA supports CMS's assignment of the equal relative weights for the three factors within the DHRM.** The AHA contracted with KNG Health Consulting LLC to conduct a thorough analysis of CMS's illustrative example of the FY 2014 DHRM with the proposed weighting factors. That analysis included replicating CMS's illustrative example and conducting a sensitivity analysis of the weighting factors to explore other alternative weighting approaches. After a careful examination of the analysis, the AHA board appointed advisory committee concluded that the equal relative weights of one-third applied to the three weighting factors was the most reasonable approach for the implementation of the first two years of the DSH allotment reductions.

## **DATA SOURCES**

CMS proposes to use data sources for the DHRM that are transparent and readily available to CMS, the states and the public. CMS proposes to use data from the Census Bureau's American Community Survey (ACS), existing DSH allotments, CMS Form-64 Medicaid Budget and Expenditures System data and the Medicaid DHS audit reports.

American Community Survey. CMS proposes to use the total population and uninsured population, as identified in the most recent ACS's one-year estimates, to calculate the state-level percent of the uninsured. The ACS is the largest household survey in the U.S., and it is conducted each month throughout the year. The ACS is characterized as a point-in-time survey, capturing a respondent's coverage status at the time of the interview, not over the span of a year. Other surveys, such as the Census Bureau's Current Population Survey (CPS) would consider a respondent insured if the individual was insured for any portion of the year. The ACS and the CPS are the only national surveys that provide state level estimates of uninsurance. **The AHA supports CMS's use of the ACS as a better data source for measuring the rate of uninsurance because it surveys the entire population; has the largest sample size; uses multiple methods to reach respondents; and has the highest response rate.**

However, we are concerned that the ACS may undercount undocumented individuals who are uninsured. The AHA's adopted DSH implementing principles underscore this concern and state: "The definition of uninsured should capture all populations regardless of citizenship status." Hospitals serve every individual who comes through their doors seeking health care services, without regard to insurance or citizenship status. We believe any DSH methodology should reflect this reality. The Pew Research Institute estimates the number of undocumented individuals based on census data, but it makes an upward adjustment of between 10-15 percent for undercounting. **We recommend that CMS work with the Pew Research Institute, the Census Bureau or other researchers to develop a methodology that accounts for all uninsured populations regardless of citizenship status through an adjustment to the data.**

Medicaid DSH Audit Data. CMS proposes to use the data mined from state Medicaid DSH audit reports for the development of each state's DSH targeting factors – high volume Medicaid inpatient utilization and the high volume of uncompensated care costs. CMS notes that there are limitations with the Medicaid DSH audit data, specifically that the audits do not collect total hospital costs. "Total hospital cost" is a critical value in the calculation of the high volume of uncompensated care cost factor. The proposed rule includes several examples of how the lack of total hospital cost data could skew the targeting calculation for certain hospitals. CMS's proposed remedy is for the states, through the DSH audit process, to collect from hospitals their total cost data as reported on their Medicare cost reports. **The AHA recommends that CMS's Medicaid and Medicare staff work to obtain hospital total costs from CMS's Medicare cost report rather than have states separately report them through the Medicaid DSH audit process.** The added step of having states collect Medicare cost report data from hospitals instead of CMS relying on its own internal access to the Medicare cost report data is

overly burdensome to hospitals and states and could lead to potential reporting errors.

CMS notes that it plans to issue further guidance to states regarding improvements in the Medicaid DSH auditing reporting process. **The AHA supports improving the audit process, such as including a hospital's Medicare provider number in the audit reports. However, we are concerned that CMS has not finalized its pending Medicaid DSH audit regulation clarifying the definition of hospital uncompensated care costs. The AHA strongly urges CMS to finalize its 2012 Medicaid DSH audit rule that would improve the definition of hospital uncompensated care costs by allowing unreimbursed costs for those individuals with minimal health care coverage.** In addition, the pending audit regulation also would clarify that all costs incurred in providing hospital services to Medicaid patients should be counted in the determination of the hospital-specific DSH limit.

**The AHA recommends that CMS make every reasonable attempt to use data for hospitals and state Medicaid DSH programs that are from the same time period so that accurate and appropriate comparisons can be made. In addition, the AHA recommends that CMS be transparent about its data sources and make the data publicly available when the DSH allotment reductions for FYs 2014 and FY 2015 are published.** CMS proposes to use the most recent Medicaid DSH audit data in "useable form," but notes that it may not be the most recently submitted audit data. So it is not clear whether the agency would be using data from a uniform time period for all states as it calculates the DHRM. For example, the proposed rule does not indicate which data year CMS used to develop the illustrative example for FY 2014, nor does it indicate whether CMS used audit data for certain states from different fiscal years. Some states have completed their audit submissions for FY 2010 while other states are still working on FY 2009. The wide variability in time periods for completed DSH audit data raises concerns that the data to be used in the DHRM may not be drawn from the same period. In addition, CMS proposes to supplement missing data from the Medicaid DSH audit reports with Medicare cost report data, but it does not address whether the Medicare and Medicaid data would be from the same time period.

**The AHA also recommends that CMS consider, for future rulemaking, using an updated Medicare hospital cost report worksheet S-10 for determining hospital uncompensated care costs.** The S-10 worksheet is relatively new and has been used only for payment purposes in relatively restricted ways, such as the Medicare Electronic Health Record incentive payments. However, if reported in an accurate and consistent manner, the S-10 data have the potential to serve as more exact measures of the treatment of uninsured patients. The Medicaid DSH audit program is largely intended to make certain that state Medicaid DSH payments do not violate the Medicaid statutory hospital-specific limit for DSH payments, which is a hospital's uncompensated care cost (excluding bad debt) plus the hospital's unpaid Medicaid costs (Medicaid shortfall). As a result, the audit process may not capture a hospital's total uncompensated care costs, but only enough data on Medicaid shortfalls and unreimbursed costs to determine if the hospital is within its Medicaid hospital-specific DSH limit. In addition, because each

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state administers its own DSH audit program subject to federal guidelines, there is a greater potential for variation in the definition of uncompensated care costs. The S-10, if modified and improved, potentially offers greater consistency in terms of definition of costs and could prove to be a better source of hospital uncompensated care data than the Medicaid DSH audit data. **The AHA urges CMS to review and improve the S-10 form and its instructions as quickly as possible so that the data could be used for future making.**

#### **FUTURE RULEMAKING**

CMS notes that the proposed two-year reduction methodology would allow for further data refinement and methodology improvements before the ACA's larger DSH allotment reductions are slated to begin. The agency plans to issue future rulemaking to implement the ACA DSH reductions in FY 2016 and beyond. **The AHA recommends that CMS engage the provider community in future changes to the DHRM prior to formal rulemaking. In addition, CMS should be as transparent as possible on the issues regarding data refinement and methodology improvements.**

Thank you for your consideration of our comments. We look forward to working with you and your staff on the further implementation of the ACA Medicaid DSH allotment changes. If you have any questions, please contact me, or Molly Collins Offner, director of policy development, at (202) 626-2326 or [mcollins@aha.org](mailto:mcollins@aha.org).

Sincerely,

/s/

Rick Pollack  
Executive Vice President

*Enclosure*

# Allied Advisory Committee on Health Care Reform Implementation Principles for Implementing the Affordable Care Act's (ACA) Medicaid and Medicare Disproportionate Share Hospital Payment Provisions

## Setting the Stage:

**The Medicaid and Medicare Disproportionate Share Hospital (DSH) programs have,** since their inception in the early 1980's, provided vital financial support to hospitals that serve the nation's most vulnerable populations – Medicaid beneficiaries, low-income Medicare beneficiaries, the uninsured and the underinsured. Even with this critical supplemental funding, it is important to note that hospital costs for providing care to these vulnerable populations are not fully met.

**The last 30 years** have been marked by yearly increases in the number of individuals without health insurance coverage and the levels of uncompensated care provided by hospitals treating the uninsured. The Affordable Care Act (ACA) is changing that trajectory by expanding public and private health care coverage to 32 million more Americans by 2019.

**With expanded health care coverage,** Congress determined that the need for and purpose of supplemental payments like DSH would change. The ACA balances the improvements in health care coverage and the subsequent reduction in hospital uncompensated care by reducing federal funding for both the Medicaid and Medicare DSH programs. The ACA's Medicaid DSH reductions are phased-in beginning in Fiscal Year (FY) 2014, totaling an estimated \$14.1 billion by 2019. For the Medicare DSH program, the ACA's reductions begin in FY 2014, totaling an estimated \$22.1 billion by 2019. During the course of the ACA debate, several proposals were considered to either eliminate or vastly reduce hospital DSH payments. In the end, the DSH hospital payments were retained in the ACA, which is an acknowledgement that hospitals will continue to treat the remaining uninsured and those with health care coverage not sufficient to meet their health care needs (the "underinsured"). The Congressional Budget Office (CBO) projects that, even with the ACA coverage improvements and expansions, 23 million individuals will remain uninsured in 2019. For the Medicare DSH program, the ACA more clearly changes the distribution of payments for Medicare DSH hospitals through the creation of a new DSH funding pool. For the Medicaid DSH program, the direct impact on hospitals is less clear because of the state role in designating DSH hospitals. But for both programs, the ACA introduces the concept of targeting some of the DSH funds to hospitals that have high levels of uncompensated care even after the implementation of expanded public and private insurance.

**The following principles** are intended to serve as guidelines for responding to the implementation of the ACA Medicaid and Medicare DSH changes for use by the American Hospital Association (AHA), the state and metropolitan hospital associations, and most importantly, our hospital members.

## ACA Medicaid Disproportionate Share Hospital (DSH) Program Implementation Principles

Currently the federal government sets the following parameters for the Medicaid DSH program:

- the amount of federal DSH funds available to each state through DSH allotments;
- the amount of state DSH allotment funds that can be spent on state-owned Institutions of Mental Diseases (IMDs);
- the minimum standards for designating eligible hospitals; and
- the maximum amount of DSH funds individual hospitals can receive (hospital-specific DSH limit).

CMS also requires states to report and audit their Medicaid DSH programs to ensure that the state DSH payments comply with the individual hospital-specific DSH limits (defined as Medicaid shortfall plus uncompensated care excluding bad debt). Beyond these federal parameters, states have tremendous flexibility in the design and financing of their Medicaid DSH programs.

The ACA keeps in place these federal parameters as well as retains state flexibility in program design. Included in these retained federal parameters is a limit on states restricting how much of the DSH allotment funds can be spent on IMDs, though states have flexibility within this limit. The ACA does reduce overall federal funds flowing to states by specific dollar amounts on a phased-in basis beginning in FY 2014. And the ACA instructs the Secretary of Health and Human Services (HHS) to consider how the ACA statutory reductions should be allocated across the states.

In terms of administering the ACA reductions, the HHS Secretary must give consideration to states based on three existing categories: High DSH States; Low DSH States; and 1115 Waiver Expansion States. The ACA also instructs the Secretary to impose a "smaller percentage reduction" on Low DSH states. In addition, the Secretary must take into consideration two factors when establishing the methodology for distributing DSH payment reductions: 1. a state's percentage of remaining uninsured; or 2. whether a state targets DSH payments to hospitals serving a high volume of Medicaid inpatients and hospitals that have high levels of uncompensated care (excluding bad debt).

Continued



## Five Medicaid Implementation Principles:

- 1. Medicaid DSH payments should continue because the need for such assistance remains as hospitals are called on to provide unreimbursed care for those individuals without health insurance coverage or other means to pay for their care.** CBO projects that in 2019, after the implementation of the ACA coverage expansions and improvements, 23 million people will remain uninsured.
- 2. The definition of uninsured should be based on the best available and most recent national data survey sources and could include an algorithm that combines the data from several surveys. The definition of uninsured should capture all populations regardless of citizenship status. The definition should be reviewed periodically to make certain it reflects changes in insurance levels.** There are several surveys that determine levels of insurance coverage and no one survey captures all the data needed to be truly reflective of uninsured levels.
- 3. State governments should retain maximum flexibility in the design of their Medicaid DSH program, including how those funds should be targeted, as long as DSH funds are spent on patient care services.** The current program allows states to determine hospital eligibility for DSH payments as long as the state meets the federal minimum standards.
- 4. State governments should have the maximum flexibility in determining how to raise their state share of Medicaid DSH funds.** In addition to general revenue funds, states can use a variety of funding arrangements, such as provider assessments, certified public expenditures and intergovernmental transfers, to fund their share of Medicaid DSH funds.
- 5. The ACA Medicaid DSH funding reductions should be restored if the promised health care coverage improvements are not realized.**

## ACA Medicare Disproportionate Share Hospital (DSH) Program Implementation Principles

The ACA Medicare DSH provision will reduce DSH payments to 25 percent of what hospitals would have received under the current formula beginning in (FY) 2014. This level represents what the Medicare Payment Advisory Commission (MedPAC) has empirically calculated as the added costs associated with serving a low-income population. The basic elements of the Medicare

DSH program -- the designation criteria, the payment calculation methodology and the application of payment to the DRG -- remain.

Some of the savings generated by this change will be used to supply a new pool of funds for Medicare DSH hospitals. The size of the new DSH pool would be based on the decrease in the non-elderly

uninsured. Medicare DSH hospitals will receive additional payments from the new DSH pool based on their share of national uncompensated care for all Medicare DSH hospitals. To implement this new policy, the HHS Secretary will have to make two critical policy decisions: how to measure the change in the percentage of uninsured and how to define uncompensated care.

## Five Medicare Implementation Principles:

- 1. Medicare DSH payments should continue because the need for additional assistance remains as hospitals are called on to provide unreimbursed care for those individuals without health insurance coverage or other means to pay for their care.** CBO projects that in 2019, after the implementation of the ACA coverage expansions and improvements, 23 million people will remain uninsured.
- 2. The definition of uninsured should be based on the best available national data survey sources and could include an algorithm that combines the data from several surveys. The definition of uninsured should capture all populations regardless of citizenship status. The definition should be reviewed periodically to make certain it reflects changes in insurance levels.** There are several surveys that determine levels of insurance coverage and no one survey captures all the data needed to be truly reflective of uninsured levels.
- 3. Hospital uncompensated care data should be based on the best available and most current data sources. Those data sources should be reviewed and updated periodically.**
- 4. The components of hospital uncompensated care data should reflect the true uncompensated care costs of hospitals including bad debt, charity care and government payment shortfalls from Medicaid and other non-Medicaid state and local government programs.**
- 5. The ACA Medicare DSH funding reductions should be restored if the promised health care coverage improvements are not realized.**

