MHA Michigan Health & Hospital Association | Leading Healthcare

August 25, 2017

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

RE: CMS-2394-P: Proposed Rule: Medicaid Program; State Disproportionate Share Hospital Allotment Reductions, (Vol. 82, No. 144, July 28, 2017)

Dear Ms. Verma:

On behalf of its member hospitals, the Michigan Health & Hospital Association (MHA) appreciates the opportunity to provide comments to the Centers for Medicare & Medicaid Services' (CMS) regarding the proposed rule to implement the Affordable Care Act's (ACA) reductions to the state Medicaid Disproportionate Share Hospital (DSH) allotments. These national reductions, which will take effect Oct. 1, 2017, start at $2 billion annually, increasing by $1 billion annually resulting in a total cut of $8 billion in fiscal year (FY) 2024.

The MHA is concerned about the negative impact of these cuts on Michigan hospitals in fiscal year (FY) 2018 and future years. The Medicaid DSH program provides vital financial assistance to hospitals that provide care to Michigan's most vulnerable populations – children, the poor, the disabled and the elderly. In addition, hospitals provide critical community services including trauma and burn care, high-risk neonatal care, and disaster preparedness resources. As part of the ACA, the United States Congress cut Medicaid DSH payments, since they believed that hospitals would care for fewer uninsured patients as health coverage expanded. **The MHA continues to advocate for the repeal of the ACA Medicaid DSH allotment reductions. In addition, we urge the CMS to delay the implementation of the FY 2018 DSH allotment reductions due to our significant concerns with the underlying data proposed for use by the CMS.**

Our comments focus on the data sources used in the DSH Health Reform Methodology (DHRM), with a focus on the transparency, completeness and timeliness of the data.

DATA SOURCES

In the proposed rule, the CMS states that it intends to use data sources and metrics that are:

- consistent with the Medicaid statute;
- transparent; and
- readily available to the CMS, states and the public.

To generate the allotment reductions for FY 2018, the CMS plans to use the FY 2017 Medicaid DSH allotment determination, Medicaid Inpatient Utilization Rate (MIUR) data reported by states, and Medicaid DSH audit data reported by the states for state plan rate year (SPRY) 2013. None of the above data sources are publicly available and, therefore, do not meet the CMS intent to use transparent and readily available data. In addition, when the CMS issued the 2013 final rule on the DHRM, the agency indicated that it would provide states with technical guidance on the calculations and data sources to be used. To date, the CMS has not provided technical guidance to states or stakeholders. **The lack of transparency limits the ability to assess how the DHRM will impact the DSH allotment to Michigan, particularly for the first year of the ACA allotment reductions, FY 2018. We believe it is inappropriate that the CMS has not provided this detail given that FY 2018 begins in less than 40 days.** Our specific concerns follow.

MIUR. The ACA requires that the DHRM impose the largest percentage reductions for states that do not target their DSH payments to hospitals with high volumes of Medicaid inpatients and hospitals with high levels of uncompensated care. To determine hospitals with high-volume Medicaid inpatients, the CMS proposes to use the current Medicaid statutory definition for deeming DSH hospitals. That definition requires that states deem hospitals as DSH if their MIUR is one standard deviation above the mean of hospitals receiving Medicaid payments in that state.

The MHA believes that it's critical that the CMS have accurate MIUR data to ensure that states are treated equitably under the proposed formula. The DHRM, as proposed, would impose a greater percentage allotment reduction for states that target their hospital DSH payments to a lesser degree. The CMS would evaluate the extent to which a state targets its DSH funds in comparison to other states using the MIUR calculations. Although the CMS began requiring states to report the MIUR data after the publication of the 2013 final rule, many states have not reported their data as a result of the legislative delays in implementing the DSH allotment reductions.2 The proposed rule attempts to address this issue by including a proxy for missing data for states that failed to timely report their MIUR data. We are concerned that the potential gaps in the MIUR data could have a significant effect on how the DSH allotment reductions are distributed among states.

Medicaid DSH Audit Data SPRY 2013. In addition to the MIUR, the CMS proposes to derive Medicaid payment and hospital uncompensated care costs from the state-reported Medicaid DSH audit data for the hospital targeting component of the DHRM. For the DSH allotment reductions that will take place in FY 2018, the CMS plans to use the SPRY 2013 DSH audit data for Medicaid payments, hospital uncompensated care costs, and total hospital costs.

The delay in the data is a significant limitation to the accuracy of the methodology. The Medicaid and CHIP Payment and Access Commission (MACPAC), in its 2016 Report to Congress, commented on the data limitations of the Medicaid DSH audit reports:

> Timely data are not available. Data are published about five years after payments are made, thus may not reflect current DSH payment policies and levels of uncompensated care.

To further demonstrate the lack of timely data, the SPRY 2013 audit data that the CMS proposes to use was publically released a week before the comments were due to the agency. Given the coverage changes that resulted from the ACA, we do not believe that FY 2013 data is reflective of today's Medicaid environment in states such as Michigan and other states that expanded Medicaid coverage.

In addition to data timeliness, the MHA remains concerned about the completeness of the Medicaid DSH audit data. For example, the MHA continues to oppose the CMS policy that addresses the treatment of third party payments in calculating the hospital-specific limit for DSH payments as a misinterpretation of the Medicaid statute.

Medicaid DSH Allotments for FY 2017. Based on the proposed rule, the CMS would determine the effective annual DSH allotment for each state by applying the state-specific allotment reduction amount to the state's unreduced DSH allotment amount. The unreduced DSH allotment for each state would be calculated by trending forward the prior year's allotment using the Consumer Price Index for urban consumers (CPI-U). For example, for FY 2018, the CMS would trend forward the FY 2017 Medicaid DSH allotments using CPI-U and then apply the state's reduction amount to arrive at the effective DSH allotment. In another example of insufficient transparency, the FY 2017 DSH allotments are not expected to be made public until after the beginning of FY 2018. The preliminary allotments for FY 2017 were not published until late October 2016, after the fiscal year began.

In summary, the key components of the DHRM, such as the assessment of how states target DSH payments and the determination of the base allotment amount, would be based on data that is old, incomplete and generally not available to the public. T**he MHA urges the CMS to delay the implementation of the FY 2018 DSH allotment reductions until the underlying data can be evaluated and publicly released.**

Other Data Issues. The CMS proposes to calculate a state's uninsured rate using total population and uninsured population data reported through the most recent one-year estimate from the American Community Survey (ACS). The ACS is the largest household survey in the U.S. and is conducted monthly. **The MHA supports the CMS use of the ACS and data source for measuring the rate of uninsured since it surveys the entire population, has the largest sample size, uses multiple methods to reach respondents, and has the highest response rate.**

However, the MHA is concerned that the ACS may not accurately count undocumented individuals who are uninsured. The MHA believes that the definition of uninsured should capture all populations regardless of citizenship status. Since hospitals serve all individuals who comes through their doors seeking health care services, without regard to insurance or citizenship status. As a result, the MHA believes that any DSH methodology should reflect this reality. The Pew Research Institute estimates the number of undocumented individuals based on Census data, and it makes an upward adjustment of between 10-15 percent to the rate of uninsured. **We recommend that the CMS work with the Pew Research Institute, the Census Bureau or other researchers to develop a methodology that accounts for all uninsured individuals regardless of citizenship status to ensure that the DSH methodology use the most complete and accurate data source for allocating these critical funds.**

SUMMARY

The Medicaid DSH program provides vital funding to hospitals that provide care to Michigan's most vulnerable residents. A**gain, the MHA urges the CMS to delay implementation of the FY 2018 DSH allotment reductions until the underlying DHRM data sources are properly vetted and publically released.**

We appreciate your consideration of our comments and believe that our recommended changes will have a positive impact on Michigan hospitals and the patients they serve. Please contact me at 517-703-8608 or via email vkunz@mha.org if you have questions or need additional information.

Sincerely,

Vickie R. Kunz
Senior Director, Health Finance