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Advancing Health in America

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April 25, 2023

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

RE: (CMS-2445-P) Medicaid Program; Disproportionate Share Hospital Third-Party Payer Rule* (*Vol. 88, No. 37), February 24, 2023

Dear Administrator Brooks-LaSure:

On behalf of the American Hospital Association's (AHA) nearly 5,000 member hospitals, health systems and other health care organizations, including approximately 90 that offer health plans, and our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, we appreciate the opportunity to comment on the Disproportionate Share Hospital (DSH) Third-Party Payer proposed rule. The proposed rule implements Section 203 of Title II of the Consolidated Appropriations Act of 2021, which allows certain hospitals to calculate their DSH hospital-specific limit by using the higher value of either the hospital-specific limit as determined by Section 203 or the amount determined as in effect on Jan. 1, 2020. This exception applies to hospitals in the 97th percentile of all hospitals with respect to inpatient days made up of patients who were entitled to Medicare Part A and to supplemental security income (SSI) benefits.

Medicaid DSH hospitals provide care for a disproportionate share of low-income and uninsured patients, and Medicaid DSH payments are an important source of funds for these over 2,500 hospitals and health systems.[1] The Medicaid program has historically paid less than cost of providing care to Medicaid patients; Medicaid paid 88 cents for every dollar spent by hospitals caring for Medicaid patients in 2020 including DSH and non-DSH supplemental payments.[2] Across all hospitals, this added up to $24.8 billion in Medicaid shortfall for 2020. Moreover, uncompensated care rose to $42.67 billion in

[1] https://www.macpac.gov/publication/march-2023-report-to-congress-on-medicaid-and-chip/
[2] https://www.aha.org/fact-sheets/2020-01-07-fact-sheet-underpayment-medicare-and-medicaid

2020.[3] Medicaid DSH funds are critical for hospitals and health systems who seek to provide high quality care to low-income and uninsured individuals.

AHA remains committed to ensuring the sustainability of the DSH program. We will continue our advocacy to advance Medicaid DSH policies that are consistent with efficiency, economy, and promoting access to high quality care for Medicaid beneficiaries and low-income individuals, including efforts to address the upcoming Affordable Care Act DSH reductions.

The AHA continues to be concerned about the underlying statutory changes to the treatment of third-party payments in calculating hospital-specific DSH limits. For many hospitals and health systems, this policy has or will lower the hospital-specific DSH limit at a time when hospitals can least afford it. The policy was based in-part on the flawed notion that hospitals receive the entirety of a Medicare or Medicaid payment rate. In reality, most state Medicaid programs pay the lesser of the states' Medicaid payment rate and the Medicare rate. That means that many hospitals are not paid the full payment for care provided to patients dually eligible for Medicare and Medicaid. At the same time, the rise of high deductible health plans, and cost-sharing more generally, has meant that underinsurance is a growing concern for care provided to commercially insured patients as well.

The AHA understands that changing the flaws in the statute is beyond the scope of the proposed regulation, which interprets the statute faithfully. However, AHA would like to raise two issues for the agency's consideration.

Identifying Hospitals that Meet the 97th Percentile Criteria

The proposed regulatory language (§495(b)(ii)) would require the Centers for Medicare & Medicaid Services (CMS) to publish a list identifying which hospitals meet the 97th percentile annually in advance of Oct. 1 of each year. However, in the preamble, the agency appears to discuss releasing a different data set. Specifically, in the preamble, CMS establishes its intention to publish a data set that could include data elements from Healthcare Cost Report Information System, Medicare Provider Analysis and Review files, and Supplemental Security Income eligibility data from the Social Security Administration. This data set would enable a hospital and health system to verify whether it meets the 97th percentile criteria. We seek clarity on whether CMS sees these data sets as one and the same or distinct. We encourage the agency to clarify that both the list of hospitals that meet the 97th percentile and the underlying data will be made publicly available. Without the underlying data set, hospitals and health systems lack the ability to validate the agency's calculations and, as a result, their hospital-specific DSH limit.

[3] https://www.aha.org/fact-sheets/2020-01-06-fact-sheet-uncompensated-hospital-care-cost

The AHA is concerned about this potential gap between what is described in the preamble and the regulatory language, and we look forward to working with CMS to help inform what data elements may be necessary, and how these could be published in a way that protects potentially identifiable data.

Balancing Transparency and Administrative Burden

The proposed regulation also recommends eliminating the requirement that CMS publish Medicaid DSH and Children's Health Insurance Program (CHIP) state allotments in the Federal Register, in favor of a requirement to publish on Medicaid.gov (or a successor website) and in the Medicaid Budget and Expenditure System/State CHIP Budget and Expenditure System (MBES/CBES). CMS proposes to make this change to reduce the administrative burden and redundant publication efforts.

State DSH and CHIP allotment data serve many purposes. Academics and others may use these to understand and analyze trends in federal spending, and for oversight purposes. Other stakeholders may use these data for planning and financial modeling purposes.

The AHA is concerned that removing the publication of these state allotments from the Federal Register will threaten CMS commitment to greater transparency in public program expenditures. First, MBES/CBES are not publicly accessible. Second, data published on Medicaid.gov can be removed or changed without public notice. In addition, removing the requirement to publish these data in the Federal Register, which the agency has done for many decades, could create problems for stakeholders using allotment data for any of the research and analytical purposes described above.

The AHA understands the need to balance administrative burden with transparency. However, while the current administration has demonstrated a commitment to transparency, the regulatory framework around transparency should consider that future administrations may have differing objectives. We therefore support retaining the publication of the state allotments in the Federal Register, and we believe that the importance of the federal record outweighs the additional administrative burden.

In conclusion, the AHA appreciates CMS' efforts to implement new statutory requirements in the Medicaid DSH program. We thank the agency for this opportunity to share our comments and look forward to collaborating with you to ensure that the Medicaid DSH program continues to provide access to needed services for patients in our community, and communities across the country.

Please contact me if you have questions, or feel free to have a member of your team contact, Benjamin Finder, AHA's director for policy research and analysis, at bfinder@aha.org, or Molly Collins Offner, AHA's director for policy development, at mcollins@aha.org.

Sincerely,

/s/

Ashley Thompson
Senior Vice President