



August 24, 2017

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2394-P
P.O. Box 8016
Baltimore, MD 21244-8016

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 more than 400 members including 71 acute care hospitals, the New Jersey Hospital Association (NJHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule implementing the Affordable Care Act's (ACA) reductions to the state Medicaid Disproportionate Share Hospital (DSH) allotments.

The Medicaid DSH program provides essential financial assistance to hospitals that care for our nation's most vulnerable populations – children, the poor, the disabled and the elderly. These hospitals also provide critical community services such as trauma and burn care, high-risk neonatal care, and disaster preparedness resources. Congress cut Medicaid DSH payments in the ACA, reasoning that hospitals would care for fewer uninsured patients as health coverage expanded. However, the projected increase in coverage has not been fully realized due to the choice by some states not to expand Medicaid, as well as lower-than-anticipated enrollment in coverage through the Health Insurance Marketplaces. In addition many payers, particularly Medicaid, reimburse well below the cost of providing care. **For these reasons, NJHA continues to advocate for the repeal of the ACA Medicaid DSH allotment reductions. In addition, NJHA urges CMS to delay the implementation of the fiscal year (FY) 2018 DSH allotment reductions due to our significant concerns with the underlying data CMS proposes to use in the DSH Health Reform Methodology (DHRM).**

CMS's proposed rule implementing the ACA Medicaid DSH allotment reductions modifies the DHRM developed in 2013 by incorporating new and updated data sources. CMS's proposed DHRM involves a series of interacting calculations to achieve the annual aggregated federal DSH allotment reductions required by law. Central to the DHRM are three factors specified by the ACA:

1. the percent of uninsured in the state;
2. how well the state targets DSH payments to hospitals with high volumes of Medicaid inpatient utilization; and

3. how well the state targets DSH payments to hospitals with high levels of uncompensated care.

CMS would use the DHRM to derive states' DSH allotment reductions for FYs 2018 through 2025.

Our comments focus on two key issues within the proposed rule:

- the data sources used in the DHRM, with a focus on the transparency, completeness and timeliness of the data; and
- the proposed cap that would limit the reductions to only 90 percent of a state's DSH allotment.

DATA SOURCES

In the proposed rule, CMS states that the agency plans to utilize data sources and metrics that are: consistent with the Medicaid statute; transparent; and readily available to CMS, states and the public.¹ To generate the allotment reductions for FY 2018, CMS plans to use its 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. The first two of the above listed data sources are not publicly available and, therefore, violate CMS's stated intent to use transparent and readily available data. The third – Medicaid DSH audit data – was made publicly available only very recently, after publication of the proposed rule. In addition, when CMS issued its 2013 final rule on the DHRM, the agency indicated it would provide states with technical guidance on the calculations and data sources to be used. To date, no such technical guidance has been provided to states nor made available to stakeholders. **This lack of transparency significantly hampers state governments' and stakeholders' ability to assess how the DHRM will affect their state DSH allotment, particularly for FY 2018, the first year of the ACA allotment reductions.** 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, 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.

Having accurate MIUR data is critical to ensuring states are treated equitably under the proposed formula. The DHRM, as proposed, would impose a greater percentage allotment reduction for

¹ Federal Register, Vol. 82, No. 144, Friday, July 28, 2017 p. 35157 www.gpo.gov/fdsys/pkg/FR-2017-07-28/pdf/2017-15962.pdf

states that target their hospital DSH payments to a lesser degree. CMS would evaluate the extent to which a state targets its DSH dollars in comparison to other states using the MIUR calculations. While 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. The potential gaps in the MIUR data could have a significant effect on how the DSH allotment reductions are distributed across states.

Medicaid DSH Audit Data SPRY 2013. In addition to the MIUR, 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 agency 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 (e.g., there are no current data from the period following Medicaid expansion in 2014).”³

To further underscore the lack of timely data, the SPRY 2013 audit data that CMS proposes to use was made publically available barely a week before the comments were due to the agency. This late release does not allow sufficient time for the data to be evaluated.

In addition to data timeliness, NJHA continues to have concerns over the completeness of the Medicaid DSH audit data. The American Hospital Association (AHA) continues to oppose CMS’s policy for addressing how third-party payments are treated for purposes of calculating the hospital-specific limit for DSH payments as a misinterpretation of the Medicaid statute.⁴ NJHA agrees with the AHA on this issue.

Medicaid DSH Allotments for FY 2017. According to the proposed rule, 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.⁵ The unreduced DSH allotment for each state would be calculated by trending forward the prior year’s allotment using

² MACPAC, Report to Congress March 2016, p. 65 www.macpac.gov/wp-content/uploads/2016/03/Improving-Data-as-the-First-Step-to-a-More-Targeted-Disproportionate-Share-Hospital-Policy.pdf

³ Ibid. p. 58

⁴ American Hospital Association Letter to CMS Administrator Andrew Slavitt, Sept. 14, 2016, <http://www.aha.org/advocacy-issues/letter/2016/160914-cl-medicaid-dsh.pdf>

⁵ Ibid. p. 35158

the Consumer Price Index for urban consumers (CPI-U). For example, for FY 2018, 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 start of FY 2018. The preliminary allotments for FY 2016 were not published until late October 2016, well after the start of the fiscal year.

In summary, the key components of the DHRM, such as the assessment of how well states target DSH payments and the determination of the base allotment amount, would be based on data that is not only old and incomplete but largely unavailable to the public. **For these reasons, NJHA urges CMS to administratively delay the implementation of the FY 2018 DSH allotment reductions until such time that the underlying data can be evaluated and made public.**

Other Data Issues. 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. **NJHA supports CMS's use of the ACS as a better data source for measuring the rate of uninsured 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 under-count undocumented individuals who are uninsured. In 2013, the AHA adopted principles related to the implementation of Medicaid DSH that 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, and it makes an upward adjustment of between 10-15 percent to the rate of uninsured.⁶ **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 individuals regardless of citizenship status.**

MEDICAID DSH ALLOTMENT REDUCTION CAP

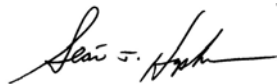
NJHA supports CMS's proposal to cap DSH allotment reductions at 90 percent of a state's allotment. CMS's proposal to cap the allotment reduction would prevent any state from losing their entire DSH allotment. By preserving some portion of a state's DSH allotment, the state would be able to receive an allotment after FY 2025. As CMS notes in the proposed rule, the number of affected states is likely to be small. Given that, NJHA suggests that CMS consider applying a lower cap to the DSH reductions.

⁶ Pew Research Center, Sept. 20, 2016, FACTTANK, <http://www.pewresearch.org/fact-tank/2016/09/20/measuring-illegal-immigration-how-pew-research-center-counts-unauthorized-immigrants-in-the-u-s/>

The Medicaid DSH program remains an essential financial tool for hospitals providing access to care for our nation's most vulnerable populations. **NJHA again urges CMS to delay the implementation of the FY 2018 DSH allotment reductions until such time as the underlying DHRM data sources are properly vetted and made public.**

The New Jersey Hospital Association appreciates the opportunity to comment on CMS's proposed rule implementing the ACA's reductions to the state Medicaid DSH allotments. If you have any questions, please contact me at 609-275-4022 or shopkins@njha.com, or Roger Sarao, vice president, Economic & Financial Information, at 609-275-4026 or rsarao@njha.com.

Sincerely,



Sean J. Hopkins
Senior Vice President, Federal Relations & Health Economics
New Jersey Hospital Association



Your comment was submitted successfully!

The **Centers for Medicare Medicaid Services (CMS)** Proposed Rule: **Medicaid Program: State Disproportionate Share Hospital Allotment Reductions**

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