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August 28, 2017

The Honorable Thomas E. Price, MD
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

RE: CMS-2394-P Medicaid Program; Disproportionate Share Hospital Allotment Reductions

Dear Secretary Price:

The Medicaid and CHIP Payment and Access Commission (MACPAC) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule, Medicaid Program; Disproportionate Share Hospital Allotment Reductions, 82 Fed. Reg. 35155 (July 28, 2017). Since 2015, MACPAC has devoted considerable time to analysis of Medicaid disproportionate share hospital (DSH) payments, given its statutory requirement to report annually on these payments and their relationship to the number of uninsured individuals, levels of hospital uncompensated care, and other factors identified by Congress.

The proposed rule updates the methodology for applying DSH allotment reductions that were put in place by the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) under the assumption that increased health coverage would lead to reductions in uncompensated care and lessen the need for DSH payments. Although the reductions have been delayed several times, under current law, federal DSH payments will be reduced by \$2 billion in fiscal year (FY) 2018, a 17 percent reduction from states' unreduced DSH allotments. The amount of the reductions is scheduled to increase each year, up to \$8 billion in FY 2025, an amount that is more than half of states' unreduced DSH allotments.

The Commission supports CMS's effort to provide more clarity about how pending DSH allotment reductions will be applied. Based on our prior work on DSH spending, we provide comments below on several aspects of the proposed rule, including:

- the desirability of reducing the effects of pending DSH allotment reductions on providers by applying reductions to unspent DSH funding first;
- the effects of changing the relative weight of the uninsured percentage factor;



- the value of establishing a maximum allotment reduction percentage;
- support for redefining the high level of uncompensated care factor;
- concerns regarding the calculation of DSH targeting factors; and
- the need for hospital-specific data to improve the calculation of the Section 1115 budget neutrality factor.

Limiting the total amount of allotment reductions

The proposed rule solicits comments on approaches to limiting the total amount of allotment reductions that states would receive. DSH payments have historically been an important source of revenue for hospitals that serve a high share of Medicaid and low-income patients, and that need continues. In our March 2017 report to Congress, the Commission reviewed new data on the effects of the ACA coverage expansions on hospital uncompensated care, finding that total hospital uncompensated care fell by about \$4.6 billion between 2013 and 2014, with the largest declines in states that have expanded Medicaid to adults under the age of 65 with incomes at or below 138 percent of the federal poverty level. However, during the same period, Medicaid shortfall (the difference between Medicaid payments and hospitals' costs of providing services to Medicaid-enrolled patients) increased alongside the rise in Medicaid enrollment. In addition, hospitals reported increases in bad debt from individuals with private insurance coverage. Although hospital margins (one measure of institutions' financial health) improved for all types of hospitals in 2014, deemed DSH hospitals, which are statutorily required to receive DSH payments because they serve a high share of Medicaid and low-income patients, continued to report negative operating margins before DSH payments in both expansion and non-expansion states.

While we recognize that the amounts by which DSH funds will be cut are set in statute, applying reductions to unspent DSH funding first would limit the effects of reductions on hospitals that are currently receiving DSH payments. In FY 2014, approximately \$1.3 billion in federal DSH allotments were unspent, which is more than half of the amount of DSH allotment reductions currently scheduled for FY 2018.

There are two reasons why states do not spend their full DSH allotments. First, they may lack state funds to provide the non-federal share. Second, in some states, the DSH allotment exceeds the total amount of hospital uncompensated care. In FY 2014, two-thirds of unspent DSH funds were attributable to six states (Connecticut, Louisiana, Maine, Massachusetts, New Hampshire, New Jersey, and Pennsylvania), all of which had DSH allotments (including state and federal funds) that were larger than the total amount of hospital uncompensated care in the state reported on 2014 Medicare cost reports.

One approach to applying larger reductions to states with unspent DSH allotments would be to consider unspent DSH funding when calculating the two targeting factors in the reduction methodology—the high volume of Medicaid inpatients factor and the high level of uncompensated care factor. In the proposed rule, these factors measure the amount of DSH payments to hospitals that do not meet the targeting criteria and do not include unspent DSH funds. If unspent funds were included as non-targeted payments, then states with larger unspent DSH funds would receive a larger reduction from these factors. Although this approach would not eliminate all unspent DSH allotments immediately, applying larger reductions to states with unspent DSH allotments would help to reduce the amount of unspent DSH funds over time.



Changing the relative weight of the uninsured percentage factor

Compared to CMS's prior methodology, the proposed rule increases the relative weight of the uninsured percentage factor from 33 percent to 50 percent, increasing DSH allotment reductions for states with lower uninsured rates. The notice of proposed rulemaking indicates that one rationale for this proposed change is that, in CMS's view, states with higher uninsured rates have greater need for DSH funding because hospitals in those states have higher levels of unpaid costs of care for the uninsured.

The change in methodology is small relative to the total amount of reductions but may still be important to affected states. Compared to the prior rule, 24 states and the District of Columbia would have larger DSH allotment reductions, and the total amount of reductions for these states in FY 2018 would be \$66 million higher than under the prior rule. Conversely, 25 states would have smaller DSH allotment reductions and the amount of reductions for these states in FY 2018 would be \$66 million lower than under the prior rule. Overall, the change in DSH reductions for these states is about 3 percent of the total amount of reductions scheduled for FY 2018 (\$2 billion).

Establishing a maximum allotment reduction percentage

The preamble of the proposed rule discusses limiting the total amount of state DSH allotment reductions to 90 percent of a state's original unreduced allotment; this would ensure that a state's DSH allotment is not completely eliminated in future years as the amount of DSH allotment reductions increases.

The Commission supports the establishment of an upper limit on DSH allotment reductions as it would preserve the ability of states to make DSH payments in future years, including payments to deemed DSH hospitals, which are required by statute. We support the agency's inclusion of this element in the final rule.

Redefining the high level of uncompensated care factor

In addition, the proposed rule modifies the calculation of the high level of uncompensated care factor to measure uncompensated care relative to total hospital cost (rather than measuring uncompensated care relative to hospital costs for only Medicaid and uninsured patients). The Commission supports the proposed change, which would be consistent with how MACPAC and many researchers typically report on a hospital's level of uncompensated care. This change also results in smaller reductions for states that target DSH payments to deemed DSH hospitals. In 2012, only one-third of deemed DSH hospitals qualified as high uncompensated care hospitals under CMS's prior definition, but about half of deemed DSH hospitals would qualify based on the proposed definition.

Improving the calculation of DSH targeting factors

The high volume of Medicaid inpatients and the high level of uncompensated care factors are intended to apply larger reductions to states that do not target DSH funds to hospitals that do not meet the specified criteria. In general, the Commission supports targeting and has noted in its reports to Congress that DSH payments should be targeted to the hospitals that serve a disproportionate level of Medicaid and uninsured patients and have a high level of uncompensated care, consistent with the original statutory intent. In particular, our work has highlighted the large financial challenges facing deemed DSH hospitals,



which are statutorily required to receive DSH payments, and the important role that these hospital play in providing access to care for Medicaid and uninsured patients.

The Commission is concerned that the proposed definition of the high volume of Medicaid inpatients factor could apply larger reductions to some states that target DSH payments to deemed DSH hospitals. Specifically, although this factor applies lower reductions to states that target DSH payments to deemed DSH hospitals that meet one of the statutory criteria, a Medicaid inpatient utilization rate one standard deviation above the mean in the state, it applies larger reductions to states that target DSH payments to deemed DSH hospitals that meet the other statutory criterion, a low-income utilization rate above 25 percent. About half of deemed DSH hospitals qualified on the basis of their low-income utilization rate alone in 2012; these institutions face similar challenges as other deemed DSH hospitals, including high levels of hospital uncompensated care and low operating margins before DSH payments.

In order not to penalize states for statutorily required payments to deemed DSH hospitals, the calculation of the high volume of Medicaid inpatients factor could be changed in two different ways. First, DSH payments to all deemed DSH hospitals could be considered to be payments to high-volume Medicaid hospitals. Second, DSH payments to deemed DSH hospitals that qualify on the basis of their low-income utilization rates alone could be excluded from the calculation of this factor, thus ensuring that these payments do not affect states' DSH allotment reductions.

Improving the calculation of the Section 1115 budget neutrality factor

In the proposed rule, CMS notes that it is unable to accurately calculate the DSH targeting factors for states that use DSH funds to make uncompensated care pool payments through their Section 1115 demonstrations because of a lack of hospital-specific data. CMS proposes to estimate the targeting of Section 1115 payments for these states by using DSH data from other states as a proxy but does not provide a plan or a timeline for replacing the proxy with actual hospital-specific data. While this approach may be a suitable short-term solution, a better approach in the long term would be to collect hospital-specific data on these payments to calculate the DSH targeting factors for these states directly. MACPAC has long noted the need for hospital-specific data, and in 2016 the Commission recommended that CMS collect data on all payments that hospitals receive in a form useful for analysis and policymaking. This is a good example of the utility of such data.

Conclusion

We appreciate the opportunity to comment on the proposed rule, and we hope that our ongoing analyses will continue to be useful to inform the discussion.

Sincerely,



Penny Thompson, MPA
Chair

cc:

The Honorable Orrin G. Hatch, Chairman, Committee on Finance, U.S. Senate

The Honorable Ron Wyden, Ranking Member, Committee on Finance, U.S. Senate

The Honorable Greg Walden, Chairman, Committee on Energy and Commerce, U.S. House of Representatives

The Honorable Frank Pallone Jr., Ranking Member, Committee on Energy and Commerce, U.S. House of Representatives

The Honorable Michael Burgess, Chairman, Subcommittee on Health, Committee on Energy and Commerce, U.S. House of Representatives

The Honorable Gene Green, Ranking Member, Subcommittee on Health, Committee on Energy and Commerce, U.S. House of Representatives



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