NAUH
NATIONAL ASSOCIATION OF URBAN HOSPITALS

September 14, 2016

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244

Subject: Medicaid Program; Disproportionate Share Hospital Payments—Treatment of Third Party Payers in Calculating Uncompensated Care Costs

Attention: File Code CMS-2399-P

To Whom it May Concern:

I am writing on behalf of the National Association of Urban Hospitals (NAUH) to convey our views on the proposed regulation governing Medicaid disproportionate share hospital payments (Medicaid DSH) published in the *Federal Register* on August 15, 2016 (volume 81, number 157, pp. 53981-53985).

While the proposed rule seeks to clarify two aspects of the current regulation, NAUH addresses only one of those aspects in this letter: the treatment of payments from Medicare and third-party payers made on behalf of Medicaid-eligible individuals.

**Overview**

NAUH is familiar with the Medicaid hospital-specific DSH limit and how the Centers for Medicare & Medicaid Services (CMS) has long interpreted it and has long felt that CMS has not implemented this regulation in the manner Congress intended.

In NAUH's view, the hospital-specific DSH limit has come to penalize the very hospitals – including private urban safety-net hospitals – that Medicaid DSH payments were designed to support. As CMS notes in this proposed rule,

> In passing OBRA 93 and the hospital-specific DSH limit, the Congress contemplated that hospitals with large numbers of privately insured patients through which to offset their operating losses on the uninsured' may not warrant Medicaid DSH payments.

Despite this, we are increasingly seeing that private urban safety-net hospitals without large numbers of privately insured patients are finding their Medicaid payments limited by the DSH

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cap and that the Medicaid DSH payments that were supposed to ensure financial support to enable them to deliver much-needed care to low-income communities are no longer adequate because they are no longer receiving adequate reimbursement for administrative costs that are disproportionately associated with Medicaid, including enrollment support, translation services, and state-imposed taxes; increasing bad-debt costs associated with high-deductible insurance plans; and costs associated with subsidizing physicians to serve in low-income areas. NAUH understands that Congress created the Medicaid DSH limit for good reasons and that CMS is attempting to enforce what it believes is Congress's will. We also understand that the language of the statute does not allow for all of urban safety-net hospitals' costs to be reflected in the Medicaid DSH limit, no matter how reasonable and necessary those costs may be. What concerns NAUH at this time is CMS's apparent decision to rationalize and codify in regulations a narrower interpretation of the Medicaid DSH limit than what Congress described in section 1923(g) of the Social Security Act.

**The Rule as Proposed in 2005 and Finalized in 2008**

The following is the definition of "uncompensated care costs" proposed by CMS on August 26, 2005 (from the *Federal Register*, p. 50264):

> Uncompensated Care Costs. The State would indicate separately the total annual amount of uncompensated care costs for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals and to individuals with no source of third party coverage for the inpatient hospital and outpatient services they receive. The total annual uncompensated care cost equals the total cost of care for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals and to individuals with no source of third party coverage for the inpatient hospital and outpatient hospital services they receive less the sum of regular Medicaid rate payments, Medicaid managed care organization payments, supplemental/enhanced Medicaid payments, and indigent care revenue). Uncompensated care costs do not include bad debt or payer discounts.

This definition (with the exception of the last sentence) largely mirrors the statutory description of the hospital-specific DSH limit. Additionally, the proposed rule called for states to report the payment information necessary to perform this calculation. Specifically, the rule proposed that states report DSH payments, regular Medicaid rate payments, supplemental/enhanced Medicaid payments, and indigent care revenue. Like the statute itself, the proposed rule did not reference payments from Title XVIII (Medicare) or from third-party payers made on behalf of Medicaid-eligible individuals. Although NAUH commented at the time on several aspects of the proposed rule, we did not comment on whether Medicare payments should be included in the calculation because the rule appeared to propose what was an obvious interpretation of the statute: that Medicare reimbursement not be part of the calculation of the hospital-specific DSH limit.

When CMS issued the final rule NAUH was surprised and disappointed to read the following response to a commenter's assertion that costs attributable to dual-eligibles should be excluded from the calculation (*Federal Register*, December 19, 2008, p. 77912:

> We disagree; since Section 1923(g)(1) does not contain an exclusion for dually eligible individuals, we believe the costs attributable to dual eligibles should be included in the calculation of the uncompensated costs of serving Medicaid eligible individuals. But in calculating those uncompensated care costs, it is necessary to take into account both the Medicare and Medicaid payments made, since those payments are contemplated under Title XIX. In calculating the Medicare payment for service, the hospital would have to include the

> Medicare DSH adjustment and any other Medicare payment adjustment (Medicare IME and GME) with respect to that service.

While CMS correctly noted that Section 1923(g)(1) does not contain an exclusion for dually eligible individuals, this interpretation introduces – without a statutory basis, NAUH believes – the notion that Medicare payments should be accounted for and subtracted from the calculation because "those payments are contemplated under Title XIX." There is no explanation of the basis for the assertion that the statute "contemplates" Medicare payment – and NAUH believes it does not do so.

Later, on page 77917 of the rule, CMS explains that "The hospital-specific DSH limit does not contemplate consideration of costs and revenues for services provided to Medicare beneficiaries except when those beneficiaries are dually eligible for Medicaid services." Again, there is no explanation of why a section of statute that makes no reference to the Medicare program at all specifically "contemplates" Medicare payments related to dually eligible individuals (which are also not referenced) but does not "contemplate" these payments for any other purpose.

Although CMS's articulates its position in a comment response that Medicare payments should be subtracted from Medicaid costs for dual eligible individuals, the regulations finalized in the rule enumerate and describe a calculation of the hospital-specific DSH limit that does not account in any way for payments made under Title XVIII. CMS later communicated through sub-regulatory guidance that states would be expected to subtract Title XVIII payments from hospital costs of providing care to individuals covered by Title XIX or who have no source of third-party coverage and has been enforcing that interpretation ever since by taking back the federal share of payments made to hospitals that would, under what NAUH believes would be a more reasonable interpretation of the statute and according to CMS's own regulations, have been eligible to receive them.

NAUH vehemently disagrees with this policy and would have expressed its grounds for doing so when the rule was first issued had there been a reasonable opportunity to do so.

**The Proposed Rule**

In the proposed rule, CMS is now attempting to codify in regulation its interpretation that has been explained through sub-regulatory guidance and enforced with financial take-backs not based on the unexplained premise that the phrase "payments made under this Title" "contemplates" payments made under a separate Title, but rather by "clarifying" that the term "costs" in fact means "costs net of third party payments" based on an interpretation of a statement included in section 1923(j)(2)(B) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 specifying that the DSH audits must verify that "Only the uncompensated care costs of providing inpatient hospital and outpatient hospital services to individuals described in paragraph (1)(A) of such subsection [1923(g) of the Act] are included in the calculation of the hospital-specific limits under such subsection."

According to the proposed rule, that statement went beyond requiring that CMS promulgate standardized audit methods and procedures to ensure compliance with the existing DSH-limit described in section 1923(g) and that it "provided clarity on how the hospital-specific limit

should be applied." CMS's interpretation is that the undefined term "uncompensated care costs" alters the calculation explicitly described in section 1923(g) of the Social Security Act. NAUH disagrees with this interpretation.

NAUH disagrees with CMS's assertion that the use of the phrase "Only the uncompensated care costs of providing inpatient hospital and outpatient hospital services to individuals described in paragraph (1)(A) of such subsection [1923(g) of the Act] are included in the calculation of the hospital-specific limits under such subsection" alters the calculation of the DSH-limit in 1923(g). To the contrary, the Medicare Modernization Act invokes the description of the hospital-specific DSH limit at Social Security Act 1923(g)(1)(A) to define "uncompensated care costs of providing inpatient and outpatient hospital services to individuals" to describe what the certified audit must verify; it does not alter the calculation of the hospital-specific DSH limit. CMS's interpretation assumes that Congress established a process to audit compliance with the DSH limit according to standards that are different than that limit. That section of the law goes on to require that the auditor certify that the state has documented and maintained records of Medicaid costs and payments and uninsured costs and payments (consistent with the definition of the DSH limit) but includes no such documentation requirement for Medicare or other third-party payments for Medicaid-eligible individuals. Surely, in NAUH's view, if Congress had intended to include Medicare and other third-party payers in this calculation it would have specified so in the enabling legislation.

For further support that Congress's use of the term "uncompensated care costs" refers to the results of the calculation at 1923(g), we need only look at CMS's own language from page 77921 of the 2008 final rule. A commenter was confused by CMS's use of the term "uncompensated care" to describe the result of the DSH limit calculation and asked that CMS alter the calculation to be more consistent with the definition of the term "uncompensated care" as used in the Medicare cost report. This was CMS's response:

> Medicare and Medicaid are separate programs. The Medicare program uses a different, broader, definition of uncompensated care than is authorized for purposes of the Medicaid DSH hospital-specific limit. It is important to note that the statutory provision at Section 1923(g)(1) of the Act does not use the term ''uncompensated care'' and we use it only because of its longstanding use in this context. The definition we have been using tracks the statutory requirements for the hospital-specific DSH limit.

In that response, CMS directly refuted the very position that it now asserts. It is clear that even to CMS (until the publication of this proposed rule) the result of the calculation at 1923(g) is referred to as uncompensated care and that is the clear sense in which the term was used in the Medicare Modernization Act.

CMS's interpretation that the Medicare Modernization Act language "provides clarity" implies that the statute describing the calculation of the DSH-limit is ambiguous. NAUH, to the contrary, does not find it ambiguous at all. The statute clearly describes the payments that should be subtracted from costs to identify the DSH-limit: Medicaid payments and payments made by or on behalf of the uninsured not including payments made by a state or local government indigent care program.

In addition to being contrary to the plain meaning of the statute, CMS's interpretation is also inconsistent. If, as CMS asserts, the Medicare Modernization Act's use of the term

"uncompensated care" alters the DSH-limit calculation and requires the Secretary to account for payments from Medicare and other third-party payers, then certainly it must also require that payments made by state or local indigent care programs must also be included – despite the DSH-limit's specific exception of those payments from the calculation.

**Implications for Urban Safety-Net Hospitals**

Private urban safety-net hospitals are faced with costs that many community hospitals are not. Urban safety-net hospitals that do not have "large numbers of privately insured patients through which to offset their operating losses" cannot rely on tax revenues to bridge the gap, as public hospitals can. As part of their mission, these hospitals often provide – at substantial cost – access to outpatient care in their low-income communities by subsidizing physicians that would not otherwise offer services for such low Medicaid reimbursement. These costs cannot be included in the DSH-limit calculation, nor can the shortfalls associated with the rise of bad debt due to the proliferation of high-deductible insurance in the commercial market. While there are significant costs that mission-driven DSH hospitals incur that are not recognized in the DSH limit calculation, NAUH believes that the calculation, as Congress described it, also does not recognize certain payments, such as payments from state and local government programs, Medicare payments for dual eligibles, and payments from third-party insurers in the rare instances in which a Medicaid patient also has some form of commercial coverage. If the Secretary interprets that the costs incurred furnishing hospital services should be net of payments beyond those described in the statute, we ask the Secretary also to interpret that the costs of furnishing hospital services should also include costs that safety-net hospitals incur that are beyond those described under the Medicare principles of cost reimbursement.

When urban safety-net hospitals qualify for Medicaid DSH payments because of the volume of Medicaid patients they treat and the high-cost, low-reimbursement services they offer that many other hospitals do not (obstetrics, behavioral health, burn centers, trauma centers, and more), they should receive their Medicaid DSH payments in their totality and not be limited by a DSH calculation that does not fully recognize the challenges they face. Continuing to apply an incorrect interpretation to the hospital-specific DSH calculation not only jeopardizes current and future payments but also threatens access to vital services in low-income urban communities for the patients who need and require the most care. Because of the approach it takes, the proposed rule poses just such a threat to the nation's private urban safety-net hospitals.

**NAUH's Recommendations**

NAUH believes that the policy CMS currently employs does not reflect what the statute intends, that the policy established in the proposed rule reflects that incorrect interpretation of the statute, and that the policy proposed in this rule seeks to codify that incorrect interpretation and has already been implemented without proper notice and rulemaking. For this reason, NAUH respectfully offers the following recommendations:

- withdraw the proposed regulation to remain consistent with the statute;
- direct that future DSH audits not require the auditor to certify that Medicare and other third-party payments have been subtracted from costs; and

- take steps to review and revise audits completed according to the inappropriate methodology that has been employed in recent years and return to the states any money identified as being improperly recouped from states.

**About the National Association of Urban Hospitals**

The National Association of Urban Hospitals advocates for adequate recognition and financing of private, non- profit, urban safety-net hospitals that serve America's needy urban communities. These urban safety-net hospitals differ from other hospitals in a number of key ways: they serve communities whose residents are much older and poorer; they are far more reliant on Medicare and Medicaid for revenue; they provide far more uncompensated care; and unlike public safety-net hospitals, they have no statutory entitlement to local or state funds to underwrite their costs. NAUH's role is to ensure that when federal officials make policy decisions, they understand the implications of those decisions for these distinctive urban safety-net hospitals. NAUH pursues its mission through a combination of vigorous, informed advocacy, data-driven positions, and an energetic membership with a clear stake in the outcome of public policy debates.

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NAUH appreciates the opportunity to present these comments and recommendations to CMS and invites questions about the concerns we have raised.

Sincerely,

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Executive Director