NAUH
NATIONAL ASSOCIATION OF URBAN HOSPITALS

August 28, 2017

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
P.O. Box 8011
Baltimore, MD 21244-1850

Subject: 42 CFR Part 447, [CMS-2394-P], RIN 0938-AS63, Medicaid Program; State Disproportionate Share Allotment Reductions
Attention: File Code CMS-2394-P

Dear Administrator Verma:

I am writing on behalf of the National Association of Urban Hospitals (NAUH) to convey to the Centers for Medicare & Medicaid Services (CMS) our views on the draft regulation describing how CMS proposes reducing state Medicaid DSH allocations in keeping with the mandate to do so in the Affordable Care Act. This regulation was published in the *Federal Register* on July 28, 2017 (Vol. 82, No. 144), pp. 35155-35171).

NAUH appreciates the complexity of the challenge CMS faces in implementing this Affordable Care Act mandate and also appreciates the degree to which, in many situations, the agency's options are limited by the 2010 health care reform law's language. With this in mind, we would like to convey our interests and concerns in several specific areas. They are:

1. the basis for future Medicaid DSH spending cuts
2. the calculation of the low DSH adjustment factor
3. the data proposed for use in Medicaid DSH calculations

We address each of these issues individually below.

The Basis for Future Medicaid DSH Spending Cuts

NAUH recognizes that in determining how to reduce future Medicaid DSH spending, CMS had a choice between basing such cuts on state allotments or state spending. We appreciate your decision to base future spending, and future cuts, on DSH allotments rather than DSH spending and thank you for doing so.

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The Calculation of the Low DSH Adjustment Factor

The Affordable Care Act requires CMS to allocate future Medicaid DSH reductions so that states deemed low-DSH states absorb a smaller percentage of reduction of future cuts than states deemed non-low-DSH states. In NAUH's view, the multi-step process CMS proposes to calculate these reductions would be overly beneficial to low-DSH states and overly harmful to non-low-DSH states. Specifically, the average DSH allotment reduction for non-low-DSH states under the proposed methodology would be 17.24 percent while the average DSH allotment reduction for low-DSH states would be just 4.64 percent. Thus, the average reduction for non-low DSH states would be more than three times the average for low-DSH states. While the statute calls for non-low-DSH states to absorb a greater proportion of Medicaid DSH cuts than low-DSH states, it does not call for the differences in these reductions to be as great between the two groups as this proposed regulation envisions.

Under the proposed methodology for calculating the low-DSH adjustment factor, CMS calls for dividing the average calculated in step 3 of that methodology for low-DSH states by the average calculated in step 3 for the non-low DSH state group. The result is a ratio of: 1) the average DSH allotment as a percentage of total Medicaid service expenditures for low DSH states, and 2) the same figure for non-low DSH states.

To address the inequity NAUH believes this approach yields, NAUH respectfully asks CMS to consider an alternative methodology for calculating the low-DSH adjustment factor. We suggest that CMS institute a flat five percent reduction of low-DSH state allotment reductions rather than basing the adjustment factor on a ratio. Alternatively, dividing the average for low-DSH states identified in step 3 of the proposed methodology by the average *for all states* – not just non-low-DSH states – would yield a less redistributive and, in our view, fairer result.

NAUH believes CMS has considerable discretion under the statute on this matter and urges CMS to consider the alternative calculation methodologies outlined above or to pursue other approaches to achieving what we think would be a fairer and more equitable outcome. We would welcome an opportunity to meet with CMS staff to discuss our alternative methodologies in greater detail.

The Data Proposed for Use in Medicaid DSH Calculations

NAUH has a number of concerns about the sources of the data CMS proposes using to calculate Medicaid DSH allotments for FY 2018.

- While the proposed rule notes CMS's intention to use data sources that are transparent and readily available to stakeholders, the proposed data sources include three sources that are not readily available to stakeholders: CMS's FY 2017 Medicaid DSH allotment determinations, Medicaid Inpatient Utilization Rate (MIUR) data reported to CMS by states, and Medicaid DSH audit data reported by the states to CMS for the 2013 state Medicaid plan year.
- NAUH understands that many states have not yet reported MIUR data to CMS for their 2013 state Medicaid plan year. To address this problem, CMS proposes using a proxy for the missing data from such states. NAUH opposes this: employing a proxy for such an important measure could have significant and potentially damaging financial implications for states, and hospitals in states, that have provided accurate data. We oppose the use of proxy data for some states for such an important measure.
- NAUH is concerned about both the timeliness and accuracy of the 2013 Medicaid DSH audit data CMS proposes using for future Medicaid DSH calculations. 2013 data is old, it was made

publicly available only a week before comments on this proposed regulation are due, and serious questions remain about whether some aspects of the data such audits collect are consistent with federal Medicaid law.

- Data on Medicaid DSH allotments for FY 2017, an important part of the proposed Medicaid DSH calculation for FY 2018, will not be available publicly under after FY 2018 has already begun.
- While NAUH generally supports CMS's proposal to use American Community Survey data to calculate states' uninsured rates, we fear that this data may not accurately capture undocumented individuals who are uninsured.

Without access to the necessary data, hospitals cannot model CMS's proposed methodology to evaluate its workings and implications or propose possible alternatives. This problem, together with the issues outlined above, suggests to NAUH a need to step back and reconsider how CMS will undertake calculations that will have such a potentially significant impact on the nation's private, non-profit urban safety-net hospitals.

Conclusion

NAUH urges CMS to reconsider the methodology described in the proposed regulation for reducing Medicaid DSH allotments to the states for FY 2018 and to exercise its discretion under the law to minimize the extent to which the results of the final methodology deviate from an equal percentage cut applied to all states. Between this and the data issues we have identified, we also urge CMS to consider delaying implementation of the proposed rule until all of these matters can be satisfactorily addressed.

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 to CMS and welcomes any questions you may have about the concerns we have raised.

Sincerely,

Ellen J. Kugler, Esq.
Executive Director