National Alliance of Safety-Net Hospitals

October 2, 2020

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244-1850

Subject: 42 CFR Part 412, CMS-1739-P, RIN 0938-AU24, Medicare Program; Treatment of Medicare Part C Days in the Calculation of a Hospital's Medicare Disproportionate Patient Percentage

Attention: File Code CMS-1739-P

To Whom it May Concern:

I am writing on behalf of the National Alliance of Safety-Net Hospitals (NASH) to convey to the Centers for Medicare & Medicaid Services (CMS) our views on the proposed regulation governing the treatment of Medicare Part C days in the calculation of a hospital's Medicare disproportionate share percentage that was published in the *Federal Register* on August 6, 2020 (Vol. 85, No. 152, pp. 47723-48828).

NASH opposes adoption of the proposed regulation.

In 2004, CMS proposed to interpret that individuals enrolled in Part C plans are not entitled to benefits under Medicare Part A. In 2005, however, CMS finalized and implemented a policy that was completely contrary to its 2004 proposal. In response to legal challenges, the courts concluded that from 2005 through 2014 CMS implemented its 2005 interpretation, that individuals enrolled in Part C plans remain entitled to benefits under Part A, without having subjected that interpretation to proper notice and comment by stakeholders.

In NASH's view, retroactive implementation of a CMS policy that was never subject to public notice and comment completely undermines federal requirements for notice and comment. If CMS can simply change policy unilaterally and then remedy its transgression by retroactively subjecting its policy change to comment along with an assertion that the change would have no financial impact because it only reflects codification of an already-improperly implemented policy, then the value of notice and comment rule-making and financial impact analyses is effectively undermined as a result of this new, unprecedented mechanism of asking forgiveness rather than permission. In short, CMS's proposal suggests that there are no practical consequences associated with the agency's failure to comply with the Administrative Procedure Act (APA) and would establish a dangerous precedent.

While it is inconvenient to set things right for the long period during which CMS underpaid hospitals because it implemented a new policy in an improper manner, not doing so – that is, not setting things right – is not an option. The best solution that maintains the integrity of the APA is to implement for this period – from 2005 to 2013 – the only policy that was properly proposed and subjected to public comment in 2004: that individuals enrolled in Part C plans are not entitled to benefits under Medicare

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Part A. As a result, when calculating DSH patient percentages during this period, days attributable to individuals enrolled in Medicare Part C should be included in the numerator of the Medicaid Fraction for dual-eligible individuals and excluded in their entirety from both the numerator and denominator of the Medicare Fraction.

For this reason, NASH opposes the proposed regulation and urges CMS not to adopt it.

Sincerely,

Ellen Kugler, Esq.
Executive Director

**About the National Alliance of Safety-Net Hospitals**

The National Alliance of Safety-Net Hospitals advocates for adequate recognition and financing of private safety-net hospitals that serve America's neediest communities. These private safety-net hospitals differ from other hospitals in a number of key ways: they serve communities whose residents are older and poorer; they are more dependent on Medicare and Medicaid for revenue; they provide more uncompensated care; and unlike public safety-net hospitals, they have no statutory entitlement to local or state funds to underwrite their costs. NASH's role is to ensure that when federal officials make policy decisions, they understand the implications of those decisions for these distinctive private safety-net hospitals. NASH 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. Until 2019 NASH was known as the National Association of Urban Hospitals, and its evolution into NASH reflects its members' recognition that private safety-net hospitals can be found serving communities not only urban but also rural and suburban across the country.