Illinois Health and Hospital Association

August 28, 2017

Ms. Seema Verma
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW, Room 445-G
Washington, D.C. 20201

Re: CMS-2394-P, Medicaid Program: State Disproportionate Share Hospital Allotment Reductions; Proposed Rule (*Federal Register*, Vol. 82, No. 144, July 28, 2017)

Dear Ms. Verma:

On behalf of our more than 200 member hospitals and nearly 50 health systems, the Illinois Health and Hospital Association (IHA) is taking this opportunity to formally comment on the proposed rule establishing new policies implementing the Medicaid state disproportionate share allotment reductions. 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. IHA has strong concerns with several provisions in the proposed rule, and presents the following comments for your consideration.

OVERALL IMPLEMENTATION APPROACH

The Affordable Care Act (ACA) amended section 1923(f) of the Social Security Act (the Act) by setting forth aggregate reductions to state Medicaid disproportionate share hospital (DSH) allotments annually from fiscal year (FY) 2014 through FY 2020. In its proposed rule, the Centers for Medicare & Medicaid Services (CMS) acknowledge that subsequent legislation has delayed the start of the reductions until FY 2018. These reductions will run through FY 2025. This proposed rule delineates the DSH Health Reform Methodology (DHRM) to implement annual Medicaid allotment reductions identified in the statute. This rule proposes a DHRM that accounts for relevant data that was unavailable to CMS during prior rulemaking for DSH allotment reductions originally set to take place for FY 2014 and FY 2015.

DATA SOURCES

CMS proposes to use data sources for the DHRM that are transparent and readily available to CMS, states and the public. CMS proposes to use data from the Census Bureau's American Community Survey (ACS), existing DSH allotments, CMS Form-64 Medicaid Budget and Expenditures System data, and the Medicaid DHS audit reports.

222 S. Riverside Plaza
Suite 1900
Chicago, IL 60606
312.906.6000

1151 East Warrenville Rd.
P.O. Box 3015
Naperville, IL 60566
630.276.5400

700 South 2nd St.
Springfield, IL 62704
217.541.1150

400 North Capitol St. N.W.
Suite #585
Washington, DC 20001
202.624.7899

www.team-iha.org

Medicaid DSH Audit Data. CMS proposes to use the data derived from state Medicaid DSH audit reports for development of each state's DSH targeting factors – high volume Medicaid inpatient utilization and the high volume of uncompensated care costs. For FY 2018 CMS anticipates using the State Plan Rate Year (SPRY) 2013 DSH audit. The 2013 DSH audit is not publicly available, and we believe the agency should not rely on non-public data as a source. ***IHA recommends that CMS be transparent about its data sources and make the data publicly available prior to when the when the DSH allotment reductions for FY 2018 are published.***

American Community Survey. CMS proposes to use the total population and uninsured population, as identified in the most recent ACS one-year estimates, to calculate the state-level uninsured percentage. The ACS is the largest household survey in the U.S., conducted monthly throughout the year. However, IHA is concerned that the ACS may undercount undocumented individuals who are uninsured. 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 Center estimates the number of undocumented individuals based on Census data, and it makes an upward adjustment of 10-15 percent to the rate of uninsured.[1] ***We recommend that CMS work with the Pew Research Center, the Census Bureau or other researchers to develop a methodology that accounts for all uninsured individuals regardless of citizenship status.***

DSH HEALTH REFORM METHODOLOGY (DHRM) WEIGHTING FACTORS

CMS' proposed DHRM involves a series of calculations to achieve the annual aggregated federal DSH allotment reductions. The interacting calculations of the DHRM result in state-specific DSH allotment reductions that, when added up, equal the specified aggregate DSH allotment reduction. Central to the DHRM are weights to be applied to three factors: the state's uninsured percentage factor (UPF) and the two hospital DSH targeting factors – payments to hospitals with high volumes of Medicaid inpatient utilization (HMF) and hospitals with high levels of uncompensated care (HUF). CMS is proposing to assign a 50 percent weight to the UPF and a 50 percent combined weight for the two DSH payment targeting factors (a 25 percent weight for the HMF, and a 25 percent weight for the HUF). ***IHA reemphasizes our concern that the ACS may undercount undocumented individuals and others who are uninsured, especially since the proposed rule allocates a 50 percent reduction weight to the UPF.***

DHRM Allotment Reduction Cap

CMS proposes to limit or cap a state's DSH reduction to 90 percent of the state's unreduced DSH allotment. The purpose of this cap would be to ensure that no state would be in jeopardy of having their entire DSH allotment eliminated. The DHRM would be adjusted as needed when the cap is applied to ensure that the statutory aggregate DSH reduction amount is satisfied.

[1] 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/

IHA commends CMS for ensuring that no state would be in jeopardy of having their entire DSH allotment eliminated.

In closing, with a recurring discussion at the national level regarding the future of the Affordable Care Act in its current form, ***IHA continues to recommend a repeal or delay of the Medicaid DSH allotment reductions. At minimum, the final rule should acknowledge this uncertainty, and include provisions for a reversal of any reductions, if changes to the ACA are approved.*** As stated in Executive Summary of the proposed rule, the reductions outlined were accounted for in the Affordable Care Act and based on an anticipated lowering of the uninsured levels and lowering of uncompensated care cost for hospitals. If the coverage assumptions and associated shifting financial models envisioned in the ACA are modified, so should the reductions.

Reductions in the level of permitted Medicaid coverage or reductions in the level of Federal Financial Participation for states which choose to continue coverage under the ACA will have dramatic effects on state resources. These increased pressures will likely result in an overall diminishment of Medicaid programs at the state level. Further reducing federal support by reducing the DSH allotment would compound the financial pressures on hospitals, especially those hospitals serving the most vulnerable communities.

While any reduction in funding of the Medicaid program presents its challenges, the ACA is highly interdependent on each piece. ***Therefore, if the ACA coverage is repealed or reduced, or if the states' costs increase beyond that envisioned in the ACA, we believe that reductions in the DSH allotment should cease. Furthermore, we encourage CMS to acknowledge this interdependent financial relationship, and provide for a reversal of reductions in its final rule, if the current ACA financing model changes***.

Ms. Verma, thank you again for the opportunity to comment. If you have any questions or comments regarding this letter, please contact Joe Holler, Vice President Finance, at 217-541-1189 or jholler@team-iha.org.

Sincerely,

A.J. Wilhelmi
President & CEO
Illinois Health and Hospital Association