August 28, 2017

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S. W., Room 445-G
Washington, DC 20201

Regarding: Proposed Rule: Medicaid Program; State Disproportionate Share Hospital Allotment Reductions [CMS-2394-P]; Federal Register (82 FR 35163) July 28, 2017.

Dear Ms. Verma:

The California Disproportionate Share Hospital (DSH) Task Force (Task Force), comprised of California's public and private safety-net hospitals, appreciates the opportunity to provide comments on the Centers for Medicare & Medicaid Services (CMS) proposed rule establishing a methodology for implementing annual reductions in the state Medicaid DSH allotments as required by Section 2551 of the Affordable Care Act (ACA).

California's hospitals proudly serve nearly 14 million individuals enrolled in Medi-Cal, the state's Medicaid program. That's 1 in 3 Californians that depend upon Medi-Cal to meet their health care needs. These patients, among the most vulnerable in California, deserve access to timely health care services in the right setting. An estimated 4 million new residents in the state received coverage through the Medicaid expansion authorized under the ACA. Medi-Cal represents the working poor, families with children living in poverty and young adults.

Poverty is one of the greatest threats to good health and well-being, and California has the highest poverty rate of all states. An estimated 6.3 million Californians, including 1.9 million children, live in poverty. Moreover, California has a disproportionately high rate of poverty. The United States Census Bureau estimates that while the national poverty rate is 16 percent, California's poverty rate is 23.8 percent – the highest in the nation.

Under section 1923 of the Social Security Act, state Medicaid programs must provide DSH payments to eligible hospitals for serving a disproportionate share of low-income patients. Low-income patients can be uninsured or can be enrolled in the Medicaid program. The formula for DSH reductions in the proposed rule will adversely affect low-income Californians, and the safety-net hospitals that provide care to millions of vulnerable individuals. **For these reasons, the Task Force recommends that CMS make the following changes to only the proposed rule and finalize it for only two years, allowing additional time to strengthen the DHRM**

methodology. Below are additional comments and discussion in support of this recommendation.

1. Concerns with Relative Weights Used in the DSH Health Reform Methodology

The DSH Task Force very much appreciates CMS' re-evaluation of the approach to develop the DSH Health Reform Methodology (DHRM) that is proposed to be used to distribute the DSH reductions; however, we continue to have some concerns about this overall approach.

The Medicaid DSH program provides $1.2 billion in funding primarily to California's public safety-net hospitals – funding that is vital to these hospitals and health systems serving the most vulnerable populations, including children, low-income working families, seniors and people with disabilities. Millions of Californians remain uninsured and rely on the hospital safety-net for access to the medically necessary health care services and treatment they need.

Nationwide, the rule proposes to reduce aggregate annual DSH allotments by $2 billion in FFY 2018, by an additional $1 billion every year through 2024, and by a total of $8 billion in 2025. Under the proposed rule, California's annual DSH allotment would decrease over $150 million in the first year, with half of the allotment wiped out in six years. The cumulative cut to California's public safety-net hospitals would be over $3.2 billion by 2025.

The California Medicaid DSH allotment is almost entirely targeted to hospitals that meet the federal deeming requirements for DSH eligibility. These public hospitals provide an essential role in serving low-income and uninsured Californians and are an important and necessary component of the state's safety-net. In addition, our federal allotment is statutorily linked to the private supplemental Medi-Cal payments provided to private safety-net DSH hospitals - that also meet the federal deeming requirements; serving the state's low-income communities and children.

The CMS proposed DHRM involves a series of calculations to achieve the annual aggregated federal DSH allotment reductions. Central to the DHRM are the following weights to be applied to three factors:

1) 50% based on the Uninsured Percentage Factor (UPF);
2) 25% based on the High Level of Uncompensated Care Factor (HUF); and,
3) 25% based on the High Volume of Medicaid Inpatients Factor (HMF).

This approach puts greater emphasis on the UPF, compared to the approach that was finalized in 2013 where each of the factors had an equal weight of one-third. As a result, it reduces the impact of the DSH reductions on states with higher rates of uninsured individuals. It also fails to recognize the number of low-income Californians that are enrolled in Medi-Cal and de-emphasizes the value of targeting DSH payments to high-Medicaid and high-uncompensated care hospitals. **The Task Force supports an equal weight of 33 percent for each of the three factors (UPF, HUF, and HMF).**

2. Proposed Rule Penalizes States that Target DSH Payments

The Task Force recommends that CMS consider additional steps to ensure that states are protected from cuts when they are successfully targeting DSH payments to those hospitals most in need. Under federal law, certain hospitals are deemed to be Medicaid DSH hospitals if (1) they have a Medicaid inpatient utilization factor (MIUR, or Medicaid share of inpatient days) that is at least one standard deviation above the statewide average or (2) they have a low-income utilization rate (LIUR) of 25 percent or more.

California operates its program according to the stricter federal standard. As a result, only 50 out of 442 hospitals in California (11%) received Federal DSH in FY14-15. The state's strict DSH eligibility criteria recognize only three additional hospitals that do not meet the federal deeming standard, and each of these is a public hospital affiliated with the same governmental entity that operates a DSH hospital. As a result, over 95 percent of the state's $1.2 billion DSH allotment is directed to hospitals with deemed DSH status, which have the highest volume and levels of Medicaid inpatients and/or care to low-income patients.

States which adopt less stringent DSH-eligibility standards will necessarily distribute DSH payments more broadly among hospitals and, therefore, in a less targeted manner. The DHRM should account for these differences when making the relative comparisons of the hospitals to which states distribute DSH payments.

For example, CMS describes a scenario in which a state makes DSH payments up to the hospital-specific limit to all hospitals with high Medicaid volume, and then applies its remaining DSH allotment to hospitals that have lower MIURs. However, due to California's targeting, the vast majority of the allotment distributed to hospitals with lower MIUR is distributed based on the other federal deeming criteria (i.e., with LIURs at or above 25 percent).

Another example of how the proposed rule fails to fully recognize state targeting consistent with federal eligibility criteria involves the calculation of the high level of uncompensated care factor (HUF). Under the proposed rule, a state's high level of uncompensated care factor (HUF) would be based on the extent to which a state targets DSH payments to hospitals that have above average uncompensated care levels compared with other hospitals that receive DSH payments. The Task Force is concerned that this factor fails to sufficiently recognize the extent to which states, like California, are targeting DSH payments to high uncompensated care level hospitals. CMS proposes that the state's mean uncompensated care level would be calculated using data only from those hospitals that are receiving DSH payments. As a result, even if a state targeted all its DSH payments to a handful of hospitals with the very highest rates of uncompensated care in the state, the proposed rule would identify some DSH payments in that state as going to hospitals with uncompensated care levels below the mean and, therefore, would reduce the state's DSH allotment.

3. Concerns with Data Sources Proposed to be Incorporated into the DHRM

CMS proposes to incorporate the DSH MIUR data, the Medicaid DSH Audit and Reporting Data, and the U.S. Census Bureau data (the American Community Survey (ACS) data), into the DHRM. The Task Force has the following concerns on this approach:

CMS proposes to use "the most recent and useable" DSH audit data for calculating both of the DSH targeting factors – the high volume of Medicaid inpatient utilization and high volume of uncompensated care costs. The proposed rule also acknowledges that the DSH audit data vary in quality and accuracy across states.

We request that CMS explain how it will address this variation in the DSH audit data prior to finalizing the rule. We note that the publicly available DSH audit data for California include hospitals that have closed and a number of hospitals for which the uncompensated care level is negative. (In the latter case, a hospital may have a negative value because Medi-Cal claims payments were received subsequent to halting service for Medi-Cal beneficiaries within the same reporting year.) The treatment of these hospitals and their relative values in the calculations should be transparent. We are particularly concerned about how CMS will treat negative values for the purpose of calculating a statewide average uncompensated care level from the DSH audit data.

Under California's current DSH program, only a small targeted number of hospitals receive DSH payments and therefore perform DSH audits. Since the HUF calculation uses the mean uncompensated cost ratio from the DSH audit report, excluding the majority of California hospitals creates an artificially high mean. This is further illustrated by applying the HUF calculation to older DSH audit years, when more hospitals participated in the federal DSH program. This analysis, using 2008 DSH audit data, shows that including more hospitals in the DSH program lowers California's mean from .25 to .35. Excluding these hospitals, and using the .35 mean, would incorrectly place an additional $231 million dollars in payments into the "untargeted" payment category. As you can see from this example, using DSH audit data under the proposed HUF methodology would be insufficient to identifying untargeted payments because it does not include the majority of hospitals in the state.

4. Concerns with the Calculation to Determine the Funding Pools for Low-DSH States and Regular DSH States

The statute requires that CMS allocate the reductions so that low-DSH States (LDS) absorb a smaller percentage reduction than non low-DSH states. However, the multi-step process that CMS uses to calculate the size of the reductions in this proposed regulation leads to a calculation that is overly beneficial to those low-DSH states. The results of this calculation are that the average percent of allotment cuts for regular DSH states is 17.24% while the average percent of allotment cut for low-DSH states is 4.64%. In as this extra step results in regular DSH states being cut by more than 300% of the percentage reduction for low-DSH states, we believe that the formula used exceeds the statutory requirements and results in cuts that are unreasonable.

Rather than do the calculations in step three and four of the low-DSH section of the proposed regulation, the DSH Task Force recommends that CMS pursue a more equitable distribution, which could be by calculating the proportion of each group's annual Medicaid expenditures to total Medicaid expenditures.

We urge CMS to continue refining the data sources for the DHRM. As discussed earlier, we urge CMS only finalize this rule for two years to allow for improvements in the methodology. Finally, the Task Force commends CMS for its proposal to use the Census Bureau American Community Survey (ACS). CHA supports the use of the ACS survey and urges CMS to work with the Census Bureau on developing the uninsured questions to both attain the point-in-time estimate as well as a determination of whether an individual was uninsured at any point during the past year. We are grateful for the increased sample size of this survey.

We appreciate the opportunity to comment. Thank you for your consideration of our suggested changes.

Sincerely,

C. Duane Dauner
President/CEO
California Hospital Association

Ann-Louise Kuhns
President and CEO
California Children's Hospital Association

Erica Murray
President and CEO
California Association of Public Hospitals and Health Systems

Catherine Douglas
President and CEO
PEACH, Inc.

Sherreta Lane
Vice President, Finance Policy
District Hospital Leadership Forum

/s/
Allan Wecker
Chief Financial Officer
Los Angeles County Department of Health Services

/s/
Angela Gilliard
Legislative Director
UC Health