April 18, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

SUBJECT: CMS-2445-P, Medicaid Program; Disproportionate Share Hospital Third-Party Payer Rule (Vol 88, No 37) February 24, 2023

Dear Administrator Brooks-LaSure:

On behalf of its more than 400 member hospitals and health systems, the California Hospital Association (CHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule implementing the legislative changes to the hospital-specific Medicaid disproportionate share hospital (DSH) limit included in section 203 of the Consolidated Appropriations Act (CAA) of 2021.

California's hospitals, like other hospitals across the nation, continue to face unprecedented financial pressure as a result of COVID-19's impact on the labor market and the health care supply chain. From 2019 to 2022, costs per adjusted discharge rose 25%[1] (driven by increases in labor costs +22%, supply expenses +18%, and pharmaceuticals +19%). However, base payment rates for Medicare and Medi-Cal have failed to keep pace with input price inflation. Chronic underfunding by government payers contributed to the recent closure of one hospital in California — Madera Community Hospital[2,3] — and has forced many others to eliminate financially unsustainable services to ensure the facility can remain open. And, unfortunately, more hospital closures are expected to follow. Kaufman Hall, a nationally renowned consulting firm, estimates 20% of California's hospitals are currently on the financial brink.[4] The financial challenges facing hospitals threaten access to care for not just Medi-Cal beneficiaries, but all members of the affected community. Following hospital or service line closures, patients are forced to travel farther distances for care in already overcrowded hospitals, resulting in negative outcomes. Research shows that rural hospital closures increase inpatient mortality by 8.7%, with Medicaid patients and racial minorities bearing the brunt of negative outcomes — 11.3% and 12.6% increases in mortality, respectively. The changes to the Medicaid hospital-specific DSH limit calculation will reduce the amount

[1] https://www.kaufmanhall.com/insights/research-report/california-hospital-financial-impact-report-april-2023-update
[2] https://calmatters.org/health/2023/01/hospital-closure/
[3] https://abc30.com/madera-commuity-hospital-remains-closed-emergency-services-residents/12922392/#:~:text=Ashraf.-,Madera%20Community%20Hospital%20closed%20its%20doors%20in%20December%20of%20last,Madera%20for%20over%20forty%20years.
[4] Based on preliminary analysis of 2022 data from Kaufman Hall

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of funding available for payments to safety-net hospitals. This will further perpetuate and exacerbate inequitable health outcomes and endanger hospitals' mission of providing care to those with limited access options. Below are our specific concerns related to this proposed rule.

Changes to the Hospital-Specific Medicaid DSH Limit Calculation
Effective Oct. 1, 2021, section 203 of the CAA (2021) modified the calculation of the Medicaid portion of the hospital-specific DSH limit to include only costs and payments for services furnished to beneficiaries for whom Medicaid is the primary payer for those services. Thus, the hospital-specific DSH limit excludes costs and payments for services furnished to Medicaid beneficiaries with other sources of coverage, such as Medicare and commercial insurance. While CHA appreciates that CMS is faithfully implementing this legislative change to the hospital-specific Medicaid DSH limit, we continue to disagree with excluding costs and payments from beneficiaries with other sources of coverage. **We are deeply concerned that this methodology change will have a significant, negative impact on hospitals that serve society's most vulnerable — children, those with disabilities, and the elderly.**

Exception for Hospitals in the 97th Percentile of Individuals Entitled to Medicare and SSI
Section 203 provided an exception to this rule for hospitals in the 97th percentile of all hospitals nationwide — with respect to inpatient days made up of patients who, for such days, were entitled to Medicare Part A benefits and supplemental security income (SSI) benefits. The exception applies to hospitals that are in the 97th percentile, either with respect to the number of inpatient days or the percentage of total inpatient days that were made up of such days.

Under the proposed rule, for each Medicaid state plan rate year beginning on or after Oct. 1, 2021, CMS would prospectively identify the 97th percentile hospitals using Medicare cost reporting and claims data sources, as well as SSI eligibility data provided by the Social Security Administration. It would also publish lists identifying each 97th percentile hospital annually in advance of Oct. 1. **CHA asks CMS to publish this list as soon as possible. This will allow for more accurate financial forecasting and planning for hospitals that may qualify for an exception. This increased degree of financial certainty will help preserve access to services provided by safety-net hospitals in communities that have historically suffered from inequitable outcomes.**

New DSH Reporting Requirements
In the rule, CMS proposes to add a new data element to the existing DSH reporting requirements. For purposes of this requirement, an audit finding would mean an issue identified in the independent certified audit required under §455.304 about the methodology for computing the hospital-specific DSH limit or the DSH payments made to the hospital. This includes compliance with the hospital-specific DSH limit as defined in §447.299(c)(16).

The proposed rule notes that auditors would have the professional discretion and the flexibility to determine how to best quantify these amounts in the audit findings. However, if the actual financial impact could not be calculated, CMS would require a statement of the estimated financial impact for each audit finding identified in the independent certified audit that is not reflected in the other data elements identified in §447.299(c). In past instances where CMS has afforded its contractors "discretion and flexibility" to quantify an amount that will have a material financial impact on a hospital, it has in many instances led to differing amounts, depending on which audit firm was involved. Providing this level of flexibility will arbitrarily advantage or disadvantage a hospital depending on which auditor and audit

firm is performing the calculation. And it will likely unnecessarily result in increased administrative expenses for CMS, states, and hospitals related to appeals and litigation. **Therefore, CHA strongly encourages CMS to provide its contractors with additional, standardized guidance to help auditors quantify any overpayment amounts in a consistent manner. This will ensure all hospitals are on a level playing field and reduce unnecessary administrative expenses.**

CHA appreciates the opportunity to comment on the proposed rule implementing the CAA's changes to the hospital-specific Medicaid DSH limit calculation. If you have any questions, please contact me at cmulvany@calhospital.org or (202) 270-2143.

Sincerely,

/s/
Chad Mulvany
Vice President, Federal Policy