April 18, 2023

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

SUBJECT: CMS-1788-P, Medicare Disproportionate Share Hospital Payments: Counting Certain Days Associated with Section 1115 Demonstrations in the Medicaid Fraction (Vol 88, No 39) February 28, 2023

Dear Administrator Brooks-LaSure:

On behalf of our 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 updating Medicare regulations related to allowable Medicare disproportionate share hospital (DSH) days. **Given soaring financial pressures and immediate concerns about access to care being eroded, CHA strongly opposes any changes that would further threaten patients' ability to receive the care they need.**

Specifically, CHA opposes this proposal because:

- It would disproportionately impact Medicare beneficiaries in historically disadvantaged areas.
- Patients receiving insurance or uncompensated care (UCC) under an 1115 waiver should be treated equally.
- CMS has provided no evidence to support its conclusion that UCC funds are improperly used.
- CMS can more accurately prevent "double dipping" by requiring hospitals to offset Section 1115 payments on Worksheet S-10.

California 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 increased 25%,[1] driven by a 22% increase in labor costs, an 18% increase in supply expense, and an 19% increase in pharmaceutical costs. Medicare's base payment rate has only increased by a paltry 8%, falling woefully short of covering the actual cost of care. In

[1] https://www.kaufmanhall.com/insights/research-report/california-hospital-financial-impact-report-april-2023-update?

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addition to contributing to the recent closure of Madera Community Hospital,[2,3] this chronic underfunding is forcing many others to shutter financially unsustainable services in an attempt to ensure the facility as a whole can remain open. Despite these efforts, more hospital closures are anticipated; Kaufman Hall, a nationally renowned consulting firm, estimates 20% of California's hospitals are currently at financial risk.[4]

This financial risk doesn't just threaten access to care for Medicare beneficiaries — it impacts all members of the affected community. When a hospital closes, patients are forced to travel farther for care, often to hospitals that are already overcrowded. This profoundly impacts patient outcomes for the worse. In fact, 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.

Despite this mounting financial pressure, which will further exacerbate inequitable health outcomes, CMS proposes changes to the Medicare DSH calculation that would reduce the amount of funding available for payments to safety-net hospitals through the Medicare UCC DSH program. Even more concerning, CMS claims it cannot determine the financial impact of these changes. **As we have in a prior comment letter in response to similar proposals, CHA strongly opposes these changes. Our specific concerns are detailed below.**

CMS' Proposal Would Disproportionately Impact Medicare Beneficiaries In Historically Disadvantaged Areas

CMS proposes that a Section 1115 demonstration inpatient day may only be included in the numerator of the Medicaid fraction if the patient:

- Receives health insurance authorized by the Section 1115 demonstration that provides inpatient hospital benefits; or
- Buys health insurance with premium assistance provided to them under a Section 1115 demonstration, where state expenditures to provide the health insurance or premium assistance receive federal matching funds

Under CMS' proposal, patients whose inpatient hospital costs are paid for with funds from a UCC pool authorized by a Section 1115 demonstration are not "regarded as" eligible for Medicaid, and thus, their inpatient days may not be included in the disproportionate patient percentage Medicaid fraction numerator for purposes of calculating hospitals' Medicare DSH payments.

CHA continues to strongly oppose this proposal. The days in the numerator of Medicaid fraction are a proxy for the volume (and associated costs) of care provided to low-income individuals. Given this, CHA believes — and multiple court rulings have confirmed — that CMS' existing policy of including these days in the numerator of the Medicaid fraction is the appropriate treatment under statute, even when the Medicaid payment partially offsets providing UCC instead of health insurance coverage.

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[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

This policy would negatively impact hospitals beyond those states that have UCC pools funded using Section 1115 waivers by inappropriately reducing the empirical DSH payments to hospitals in waiver states. This in turn would reduce the overall DSH projection used to calculate Factor 1 of UCC DSH. Given the financial challenges hospitals continue to face because of the COVID-19 public health emergency and inflation, we are deeply concerned about any policy that will further reduce payments to safety-net providers. This payment reduction would unintentionally harm access to care for Medicare beneficiaries who live in historically disadvantaged areas. **Therefore, CHA strongly opposes CMS' proposed policy related to Section 1115 waiver days.**

PATIENTS RECEIVING INSURANCE OR UCC UNDER AN 1115 WAIVER SHOULD BE TREATED EQUALLY

In the proposed rule, CMS responds to prior criticism of its proposal to remove Medicaid days paid from a Section 1115 waiver-funded UCC pool from the DSH calculation. The agency attempts to articulate a clear difference between inpatient days where a patient is provided with insurance through an 1115 waiver and where the 1115 waiver compensates hospitals for UCC. For the former, CMS argues that the patient receives a direct insurance benefit, while for the latter the hospital is being compensated for an uninsured patient's costs and the patient is not receiving any direct health insurance benefit; the former patient is "regarded" as eligible for Medicaid while the latter is not. **This is a distinction without a difference.** California's Medicaid program, Medi-Cal, uses UCC pool funding to pay for its 1115 Waiver Global Payment Program, which offers preventative care services (i.e., full-scope health care) to individuals served by public hospitals. While this pool does pay for some inpatient days, it is actually designed to minimize inpatient hospital days and support broader access to preventative care for those at risk of inequitable outcomes.

In this example, the result would be the same regardless of whether a patient's hospital stay is covered by a health insurance plan paid for by Medicaid funds from a Section 1115 waiver or from a UCC pool funded with Medicaid dollars from a Section 1115 waiver: the hospital stay was paid with Title XIX funds and therefore the patient is eligible for Medicaid coverage for that stay.

CMS HAS PROVIDED NO EVIDENCE TO SUPPORT ITS CONCLUSION THAT UCC FUNDS ARE IMPROPERLY USED

In the proposed rule, CMS also asserts that it would not be proper to include Section 1115-funded UCC days, as some patients whose stays are covered by funds from the UCC pool and are therefore eligible for Medicaid may not necessarily be low income. However, CMS does not provide any examples of states using UCC pool funds to cover hospital stays for individuals who are not considered low income. **Without proof this is occurring, CHA finds this to be a spurious argument. It is difficult to accept that a state would put up matching dollars to draw down federal funds to cover care for a patient who is not low income, much less that CMS would approve a demonstration that was structured to allow the use of Title XIX federal matching dollars in a manner that would fund care for individuals who are not low income.**

CMS SHOULD PREVENT "DOUBLE DIPPING" BY REQUIRING HOSPITALS TO OFFSET SECTION 1115 PAYMENTS ON WORKSHEET S-10

Finally, CMS attempts to justify excluding Section 1115 inpatient days from UCC pools in the Medicaid fraction because it would advantage states with relatively broad pools, even though the burden of UCC may be no different between the states. CHA agrees with this concern and proposes that the agency easily mitigate the issue by including these payments on Worksheet S-10 of the Medicare Cost Report.

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Commensurate with continuing to count all Section 1115 Medicaid waiver days in the numerator of the DSH fraction, CMS must take steps to ensure that hospitals in states with UCC pools funded by a Section 1115 waiver do not also include costs associated with these patients in the UCC data used to calculate Factor 3, which would result in "double-dipping." UCC pool payments received from the Medicaid program, such as waiver payments, are reported on line 2 or line 5 of Worksheet S-10, while the costs of providing care could be recorded as charity care write-offs on line 22 (assuming these patients are covered under the hospital's charity care policy). In this situation, the hospital would essentially be paid twice for that care: once under the 1115 waiver and a second time because, if the hospital's charity care policy covers it, the hospital is reporting it as an uncompensated cost. This would entitle the hospital to a bigger share of the limited Medicare DSH UCC pool.

To prevent the situation described above, CHA asks CMS to require hospitals that receive Section 1115 Medicaid UCC pool payments and have a charity care policy that applies to patients who would be covered by the 1115 UCC pool to offset any payments received from the Section 1115 waiver on Worksheet S-10 of the Medicare cost report. This approach would strike the right policy balance by capturing all "regarded as eligible" patient days in the numerator of the Medicaid fraction as required by Congress, allowing for an accurate calculation of the overall DSH projection that is a key component of the Medicare UCC DSH formula. At the same time, it would prevent hospitals in states that have UCC pools funded by Section 1115 waiver days from drawing down more Medicare UCC DSH than they are entitled to.

CHA appreciates the opportunity to comment on the proposed rule related to the inclusion of Section 1115 waiver days in the Medicare DSH 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