Safety-Net Association of Pennsylvania

July 10, 2013

Ms. Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244

Attention: CMS-2367-P

Subject: 42 CFR Part 447, RIN 0938-AR31, Medicaid Program; State Disproportionate Share Hospital Allotment Reductions

Dear Administrator Tavenner:

I am writing on behalf of the Safety-Net Association of Pennsylvania, a group of private Pennsylvania acute-care hospitals, to convey our views on the proposed regulation governing Medicaid disproportionate share (Medicaid DSH) allotments that was published in the *Federal Register* on May 15, 2013 (Vol. 78, No. 94, p. 28551).

On the whole, SNAP believes the Centers for Medicare & Medicaid Services (CMS) has done a commendable job on what was clearly a major undertaking. We also recognize that some of the specific aspects of the proposed methodology with which we disagree were dictated by the Affordable Care Act rather than chosen by CMS.

Before addressing our specific concerns, we would like to note that we support the provision in President Obama's proposed FY 2014 budget that calls for delaying all Medicare DSH and Medicaid DSH cuts for one year. In light of the enormous changes that our health care system will be undergoing in the coming years, SNAP believes it is better to take the measure of those changes before making any payment cuts rather than making payment cuts that could jeopardize providers' resources, and through those resources access to care, at a time when unprecedented numbers of Americans will have unprecedented access to the health care system.

A Brief Introduction to Pennsylvania's Safety-Net Hospitals

SNAP represents the interests of private, acute-care hospitals that play the leading role in caring for the poor, the disadvantaged, and the uninsured residents of Pennsylvania. These 61 hospitals provide a significant proportion of care to the state's more than one million uninsured residents and its 2.2 million Medicaid recipients.

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In Pennsylvania, safety-net hospitals provide more care to Medicaid patients than the state-wide average, which is 15 percent of inpatient days; they also either deliver babies and/or provide inpatient behavioral health services – the two most common reasons Medicaid recipients are admitted to the hospital – or, if they do not, at least 25 percent of their inpatient days must be in service to Medicaid patients.

Most important, Pennsylvania's safety-net hospitals are all private hospitals. Pennsylvania has no public acute-care hospitals, no official, governmental health care safety net. The state turned this responsibility over to the private sector many years ago, and these private, mission-driven hospitals have taken on the responsibility of providing a health care safety net for all Pennsylvanians, regardless of their ability to pay for the care they receive.

Areas of Agreement

SNAP supports the approach CMS has proposed in a number of areas. We agree with your decision that cutting state allotments appropriately implements the statutory provision; we agree with Factor 1, the low-DSH adjustment factor for high-DSH and low-DSH states; and we agree in general with dividing the formula into three other factors (Factor 2, Factor 3, and Factor 4).

SNAP's Concerns

Before proceeding, we again wish to note that we recognize that some aspects of the approach CMS has proposed were dictated by Congress in the Affordable Care Act. SNAP wishes to suggest that in some of these areas, DSH-eligible hospitals would be better served if CMS attempted to modify those aspects of the methodology or develop a proxy for what Congress required.

Factor Two: The Uninsured Percentage Factor

For Factor 2, the uninsured percentage factor, SNAP is concerned that Pennsylvania, like some other states, could be penalized because our state is not expanding its Medicaid program. This possibility was not anticipated by the Affordable Care Act's authors, and we feel confident in assuming that it was never their intention to penalize hospitals for the accident of being located in a state that chose against Medicaid expansion – or to penalize the patients served by those hospitals. Because states are sharing a fixed dollar amount of cuts, failure to recognize increases in the rate of insurance in some states necessarily increases the cuts to states that will not see such reductions in their uninsured populations. To adjust for the unexpected turn of events brought on by the Supreme Court decision making Medicaid expansion optional for individual states, SNAP recommends that CMS add to the Factor 2 measure an adjustment that reduces the uninsured value for states that have chosen to expand their Medicaid programs, thereby preventing the possible penalization of hospitals in states that choose not to expand those programs.

Factor Three: The High Volume of Medicaid Inpatient Factor

Factor 3, the high volume of Medicaid inpatient factor, identifies such hospitals based solely on their ratio of Medicaid-covered inpatient services and gives no weight to the volume of Medicaid-covered inpatient services hospitals provide. SNAP recognizes that this methodology is mandated by the Affordable Care Act, but we believe it paints an inaccurate picture of true safety-net hospitals. We believe this reflects the law's and the regulation's assumption that a relatively few hospitals in any given state are providing an overwhelming proportion of the Medicaid services in that state – a situation common in many places with

public hospitals and also in some states that have no public hospitals. This is not the case in Pennsylvania. Instead, Pennsylvania has many hospitals that provide significant amounts of inpatient care to Medicaid patients, yet Factor 3 treats them as virtually irrelevant. For example, our estimates of the MIUR methodology show that a hospital with roughly 3,000 Medicaid days would be considered high-volume Medicaid, while a hospital with roughly 94,000 Medicaid days would not. SNAP recommends that CMS address this by supplementing the methodology dictated by the Affordable Care Act and expanding the definition of high volume of Medicaid inpatient care to include all hospitals that provide an amount of care greater than one standard deviation from the mean for either Medicaid days or discharges. This, we believe, would constitute a much more complete definition of a high volume of Medicaid inpatient services.

Factor Four: The Uncompensated Care Factor

The uncompensated care factor, Factor 4, also poses problems, in SNAP's view. In determining the uncompensated care factor for states, CMS, with uncompensated care data only for hospitals that receive Medicaid DSH, creates a mean using only data for those hospitals. The more narrowly a state channels its Medicaid DSH money, the more it is hurt by this measure – an outcome that SNAP believes is counter-intuitive because it can place hospitals that provide significant amounts of uncompensated care below their state's mean. Uncompensated care data currently available through the state DSH reports, is often very flawed. CMS has acknowledged how inaccurate those reports are by assuring states that the initial reports would not be used to attempt recoveries. SNAP knows, for example, that the 2008 and 2009 Pennsylvania uncompensated care data CMS intends to use for this calculation is not very robust. In addition, Pennsylvania updated the manner in which it collects this data in order to comply with the DSH audit and reporting requirements, and the 2011 data, only recently released, shows a significant increase in the amount of uncompensated care the state's safety-net hospitals provide. SNAP urges CMS to refrain from using such poor data, to take steps to improve the quality of uncompensated care data reporting, and to use such data only when it has greater confidence in the data available to it. Until such data are available, SNAP would like to suggest that CMS apply less than a 33.3 percent weight to the uncompensated care factor when determining reductions to states' DSH allotments.

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Medicaid DSH is a vital part of how Pennsylvania's health care system works and a vital part of the foundation of the state's health care safety net, supporting the social mission of the private hospitals that serve the state's low-income residents. Without Medicaid expansion on the horizon and with no public hospitals, safety-net hospitals must continue to shoulder the primary burden of serving the state's low-income and uninsured residents. The proposed Medicaid DSH regulation would make that job harder. The Safety-Net Association of Pennsylvania urges CMS to consider this, and to consider ways to ameliorate the damage this proposed regulation could cause, in formulating the final Medicaid DSH regulation.

We appreciate your consideration of our views and welcome any questions you may have about the perspectives offered in this letter.

Sincerely,

Michael Chirieleison
President