Please Provide Responses to the Fields Below Electronically to be Accepted

Medicare Red Tape Relief Project

Submissions accepted by the Committee on Ways and Means, Subcommittee on Health

Date: August 25, 2017
Name of Submitting Organization: Safety-Net Association of Pennsylvania
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Statutory ☒ **Regulatory** ☒

Please describe the submitting organization's interaction with the Medicare program:

The Safety-Net Association of Pennsylvania is the state's leading voice for hospitals that play the most prominent role in serving low-income and medically vulnerable residents of the commonwealth, many of whom are served by Pennsylvania's Medicaid program and the Medicare program.

Please use the below template as an example of a submission regarding statutory or regulatory concerns, and submit any further concerns past those listed below in a separate Microsoft Word document in the same format. Submissions must be in the requested format or they will not be considered.

In the case of listed Appendices, please attach as PDF files at the end of the submission, clearly marked as "Appendix [insert label]" **Appendix Attached**

In the case of a multitude of submissions, it is recommended that they be submitted in order of priority for the submitting organization or individual.

Short Description: Provide for the prospective use of state DSH reports and audits in the calculation and enforcement of the hospital-specific limitation on federal financial participation in Medicaid DSH payments.

Summary: Historically, the federal government monitored the appropriateness of state Medicaid DSH payments to individual hospitals through attestations of compliance submitted by states, who in turn performed their own calculations to determine hospitals' DSH limits. In 2008, however, CMS published a new regulation requiring states to submit to CMS a different report of hospital costs and payments and to engage the services of a third-party auditor to ensure compliance with a new national standard for calculating hospitals' DSH limits. While many states previously attested to compliance based on the results of prospectively calculating hospital-specific DSH limits by trending forward the best available historic data, the new standard requires that limits be calculated according to actual historic data from the year in which payments were made. While this seems logical, it is in fact, impractical.

Because such data is not available until four years after payments are made, the retroactive nature of this approach has proven expensive, time-consuming, and burdensome for hospitals and states. It takes years to complete, hampers hospital accounting and bookkeeping, and is employing armies of auditors and lawyers to address contested findings.

Related Statute/Regulation: - SSA 1923(g)/42 C.F.R. §455.304

Proposed Solution: Require CMS to give states the option of demonstrating compliance with the limitation on federal financial participation described at SSA 1923(g) through state-prepared, CMS-approved prospective DSH limit calculations rather than requiring a retrospective determination of the limit.

Safety-Net Association of Pennsylvania

Appendix: Changing Medicaid DSH Reviews from Retrospective Audit to Prospective Calculations

Recommendation

Require CMS to give states the option of demonstrating compliance with the limitation on federal financial participation described at SSA 1923(g)/ 42 C.F.R. §455.304 through state-prepared, CMS-approved prospective DSH limit calculations rather than requiring a retrospective analysis and payment adjustment.

Background

The federal government participates in funding supplemental payments, known as Medicaid disproportionate share hospital payments, or Medicaid DSH payments, to hospitals that meet certain criteria for caring for significant proportions of low-income patients. Federal law limits how much federal funding is available for Medicaid DSH payments individual hospitals may receive in any one year; this is known as a hospital's hospital-specific DSH limit. Distribution of Medicaid DSH money is left to the states, and individual states do this in different ways. To ensure that no matching funds are spent in excess of this limit, the federal government monitors state Medicaid DSH payments to hospitals. Once the necessary data are available (four years after the payment year) CMS and the states establish each hospital's DSH limit.

Although the hospital-specific DSH limit is technically a limit on the availability of federal matching funds for state Medicaid expenditures, as a practical matter, it is also a limit on actual DSH payments to hospitals. While the retroactive application of this limit currently required by CMS is not particularly inconvenient to reconcile via the funding mechanisms between CMS and states, it is hugely inconvenient to reconcile via the funding mechanisms between states and hospitals.

The Problem and the Solution

Historically, the federal government monitored the appropriateness of state Medicaid DSH payments to individual hospitals through attestations of compliance submitted by states, who in turn performed their own calculations to determine hospitals' DSH limits. In 2008, however, CMS published a new regulation requiring states to submit to CMS a report of hospital costs and payments and to engage the services of a third-party auditor to ensure compliance with a new national standard for calculating hospitals' DSH limits. While many states previously attested to compliance based on the results of prospectively calculating hospital-specific DSH limits by trending forward the best available historic data, the new standard requires that limits be calculated according to actual data for the year in which payments are made.

Because such data is not available until four years after payments are made, the retroactive nature of this

approach has proven expensive, time-consuming, and burdensome. It takes years to complete, hampers and creates unpredictability in hospital accounting and bookkeeping, and is employing armies of auditors and lawyers to address contested findings. Allowing states to use a reasonable estimate instead of requiring them to use actual data could put an end to these legal disputes over the validity of the underlying data used to perform the calculation. In addition to leading to protracted disputes over the validity of the underlying data, the process is an accounting nightmare. Disproportionate share hospitals cannot know for certain whether they will be able to keep their payments until many years after they are received. In the end, CMS's retroactive process shows every sign of leading (in the aggregate) to virtually the same results that prospective DSH calculations would produce.

The prospective calculations performed in the past by state governments to comply with federal law – and certainly by Pennsylvania's state government, where our hospitals are located – worked well. Contractors hired by the state's Medicaid office made their calculations by taking data from a base year and trending it forward to prospectively establish hospitals' limits. Despite the new federal requirement, Pennsylvania continues to perform prospective calculations for advisory purposes and experience with retrospective auditing so far suggests that the final results will not vary much now that the prospective calculations are based on historical data that is reported and audited according to the new national standard.

Even if there are discrepancies between the prospective and retrospectively calculated limits, there is no practical need to retroactively recoup payments, because the retrospectively calculated limit would become the basis for the new prospective limit thus limiting DSH payments in the current year. For all the required effort, accounting inconvenience, and legal challenges involved in retroactively recovering these payments, there does not appear to be any discernable benefit.

For this reason, the Safety-Net Association of Pennsylvania encourages Congress to compel the Centers for Medicare & Medicaid Services to enable states to choose to use prospective calculations, which would be subject to CMS review and approval, to establish the hospital-specific DSH limit with certainty and finality instead of requiring reconciliation four years after the fact.

About the Safety-Net Association of Pennsylvania

The Safety-Net Association of Pennsylvania is the state's leading voice for hospitals that play the most prominent role in serving low-income and medically vulnerable residents of the commonwealth, many of whom are served by Pennsylvania's Medicaid program. These safety-net hospitals provide a significant proportion of care to the state's one million uninsured residents and its 2.9 million Medical Assistance recipients. Because of the patients they serve, these Pennsylvania safety-net hospitals face a significant and continuing challenge to their financial health.

All of these safety-net hospitals serve unusually large numbers of low-income Pennsylvanians, but they are diverse in several important ways: they are large, small, and medium-sized hospitals; among them are community hospitals, teaching hospitals, children's hospitals, and academic medical centers; they can be found in urban, suburban, and rural areas located in the eastern, western, and central parts of Pennsylvania; and they are located in 24 of Pennsylvania's 67 counties.