Illinois Health and Hospital Association

September 13, 2016

Mr. Andrew M. Slavitt
Acting Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW, Room 445-G
Washington, D.C. 20201

Re: CMS-2399-P, Medicaid Program: Disproportionate Share Hospital Payments – Treatment of Third Party Payers in Calculating Uncompensated Care Costs; Proposed Rule (Federal Register, Vol. 81, No. 157, August 15, 2016)

Dear Mr. Slavitt:

On behalf of our more than 200 member hospitals and 50 health systems, the Illinois Health and Hospital Association (IHA) is taking this opportunity to formally comment on the proposed rule addressing Medicaid disproportionate share hospital (DSH) payments regarding the treatment of third-party payers in calculating uncompensated care. The Medicaid DSH program provides essential financial assistance to our safety-net hospitals. These hospitals care for our nation's most vulnerable populations – the poor, the children, the disabled and the elderly. They also provide critically needed community services such as trauma and burn care, high-risk neonatal care, and adult and pediatric disaster preparedness resources.

It appears that CMS has characterized this rule as interpretive and a clarification of existing policy, rather than more accurately as substantive and the establishment of new policy, specifically with the intent of avoiding potentially unfavorable federal district court rulings.

The SUMMARY section in the preamble clearly states that "*the proposed rule addresses the hospital-specific limitation on Medicaid disproportionate share hospital (DSH)* ***payments****…and the application of such limitation in the annual DSH audits required….*" [emphasis added]

- **We request clarification that the proposed rule in no way affects the qualifying criteria for a hospital being deemed DSH, and that it ONLY applies to limit the financial benefit associated with such determination.**

The rule states that costs are "*defined as cost net of third-party payments, including but not limited to, payments by Medicare and private insurance*." Furthermore, the

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rule states that the coverage is to be done in the aggregate versus on a service-by-service basis. An example is provided which describes that payments in excess of the prevailing Medicaid rate for one service are to be used to off-set the Medicaid shortfall from other services. IHA strongly objects to this definition and approach.

- The rule does not specify that the source of private insurance must come from **private health insurance owned by the Medicaid beneficiary or a policy identifying the Medicaid beneficiary**.

- This lack of specificity raises the question of how to apply reimbursement associated with incidents under which an auto accident policy provides compensation to a hospital for a service rendered to a Medicaid beneficiary. In such cases the final payment may be more in line with usual and customary charges. The result for such cases is zero liability for the state Medicaid program as well as the federal program. Unfortunately, if these payments are to be interpreted as third-party payments in accordance with the rule, the more commercially aligned rate structure could serve to harm the Medicaid provider by diminishing the effective DSH payments. Furthermore, we do not believe the intent of the rule is to encourage such cross financial subsidization.

    - **We urge clarification that the definition of third party private insurance be limited to health insurance coverage owned by or specifically identifying the Medicaid beneficiary as the covered party.**

Additionally, we understand the goal of assuring that DSH payments are limited to hospital-specific uncompensated care cost attributed to the uninsured and Medicaid population on an annual basis. We would encourage consideration to permit a hospital to carry NET uncompensated care cost forward for one year, in the event that the following year a DSH qualified hospital realized an extraordinary TPL recovery year resulting in the hospital exceeding its hospital-specific limit.

- **Example:** Hospital A receives DSH payments associated with services in DSH rate year 1, but still recognized NET uncompensated care of $2 million. The following DSH rate year the hospital continues to receive DSH payments, but when completing the audit recognizes that NET costs are less than the amount of DSH payment received, largely due to exceptional TPL recoveries.

    - **We propose that the hospital be permitted to carry forward the short fall from the previous year to offset any excess DSH payment, only to the extent that DSH payments exceed NET costs.**
    - We believe this proposal creates year-to-year stability for providers as well as permits the DSH program to accomplish its goal of reimbursing DSH hospitals for uncompensated care costs.

- This proposal would not result in excessive DSH payment to providers within any specific state, as this approach would be handled retrospectively as part of the audit process.

CMS argues that the proposed rule is merely a “clarification” of existing policy. As such, it implies that this policy has been consistently understood. This is not the case. Therefore, because of the lengthy process associated with the Medicaid DSH audits, a retroactive change in policy could mean that many DSH hospitals would be facing possible recoupment. CMS itself noted how important it was to give states and hospitals sufficient time to adjust to new policy when it referenced the need for a transition period at the time the agency finalized the 2008 DSH audit and reporting rule. These same observations would apply if this rule is finalized.

- **IHA recommends that the Final Rule clearly state that CMS will only apply the policy prospectively to give states and hospitals sufficient time to make needed adjustments to ensure compliance.**

IHA respectfully disagrees and objects to certain CMS’ interpretations of the DSH program, the specified limits and associated auditing rules as noted above. Therefore, we recommend consideration of the interpretations and suggestions outlined in this letter.

Mr. Slavitt, thank you again for the opportunity to comment. If you or your staff has any questions on the comments, they should be addressed to Joe Holler at (217) 541-1187 or jholler@team-iha.org.

Sincerely,

A.J. Wilhelmi
President & CEO