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Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-0057-P
P.O. Box 8013
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RE: CMS-2445-P. Medicaid Program; Disproportionate Share Hospital Third-Party Payer Rule

On behalf of over 220 children's hospitals across the country, the Children's Hospital Association (CHA) appreciates the opportunity to provide comments on this proposed rule, which would implement the disproportionate share hospital (DSH) related provisions of the Consolidated Appropriations Act (CAA), 2021. Children's hospitals are major Medicaid providers, and the proposed rule directly impacts children's hospital participation in the DSH program. Most importantly, we appreciate CMS moving forward with the proposed change to the Medicaid shortfall calculation methodology as required in the Consolidated Appropriations Act of 2021 and look forward to your partnership with states to ensure implementation.

Medicaid, on average, provides health insurance coverage for half of children's hospitals patients and for some children's hospitals patient mix, closer to three-quarters. Though children's hospitals account for only 5% of hospitals in the United States, they account for about 45% of all hospital days for children on Medicaid. Children's hospitals are regional centers for children's health, providing care across large geographic areas and serving Medicaid children across state lines. In addition, children's hospitals serve the majority of children with serious illnesses and complex chronic conditions and most children in need of major surgical services.

This third-party payer policy is critical to children's hospitals, who rely heavily on Medicaid DSH payments to continue providing critical health care to millions of children. Because they serve so many patients on Medicaid, children's hospitals face financial challenges related to Medicaid reimbursement. The proposed policy change to the Medicaid shortfall calculation methodology is an important step forward in ensuring that children's hospitals receive DSH payments that reflect the care they provide to their many Medicaid patients. We strongly support the implementation of this policy and encourage CMS to work with states to implement the proposed changes in a timely manner.

The Importance of Medicaid DSH Funding and Children's Hospitals

Medicaid DSH payments are critical to children's hospitals and their ability to provide health care to all children, regardless of income. Congress created the Medicaid DSH program to provide financial help to hospitals that treat a large number of Medicaid and uninsured patients, including children's hospitals. The number of children covered by Medicaid has grown in recent years, especially due to the increases in enrollment during the COVID-19 pandemic. Medicaid is the largest source of coverage for children – providing coverage for 38 million of the almost 78 million children in the United States.

Inadequate Medicaid reimbursement poses serious ongoing financial challenges to children's hospitals. The Medicaid DSH program plays an important role for children's hospitals in addressing Medicaid underpayment. Medicaid currently reimburses children's hospitals an average of only 79% of the cost of providing care, including DSH payments. The Medicaid DSH program does not make up the entire Medicaid shortfall experienced by children's hospitals, but it is one of the limited sources

of funding available to help children's hospitals stretch scarce resources to care for our most vulnerable children. Until state Medicaid programs cover the cost of care, DSH payments to children's hospitals are necessary to ensure they are able to provide comprehensive care, advance pediatric medicine and keep pace with cutting edge developments in medicine and technology – activities that benefit all children.

Proposed Changes to the Calculation Methodology for Medicaid Shortfall

We support the proposed changes to the methodology for calculating the Medicaid shortfall portion of the hospital-specific limit (HSL), to only include costs and payments for hospital services furnished to beneficiaries for whom Medicaid is the primary payer.

This proposed change to the Medicaid shortfall calculation is very important for children's hospitals. Medicaid eligibility requirements for children tend to be more generous compared to adults, especially those children with complex or chronic conditions who rely on children's hospitals to meet their specialized health care needs. This results in children who are Medicaid eligible not actually being enrolled in Medicaid because their private insurance coverage meets their needs at least while they are in the hospital.

An individual child only qualifies for Medicaid payment if the patient enrolls in the Medicaid program and the services that are provided qualify and are paid for by the Medicaid program. Including the costs and payments for services provided to those for whom Medicaid is the primary payer in the HSL calculation ensures that children's hospitals would receive DSH payments that coincide with the services being provided to their Medicaid patients. Therefore, we support the proposed changes that would lead to a Medicaid shortfall calculation that would accurately reflect the costs associated with treating a large number of children that are covered by Medicaid as their primary payer.

In addition, we encourage CMS to work with states in a timely manner to implement this change to the Medicaid shortfall calculation. This would ensure that children's hospitals are receiving DSH payments based on a more accurate methodology as soon as possible and can continue to provide care to the millions of children covered by Medicaid.

Other Considerations:

We outline the following additional aspects of the proposed rule for CMS's consideration.

Requirement for Independent Auditors to Quantify Financial Impact of Data Deficiencies

We urge CMS to consider the potential impacts of the proposed requirement for independent auditors to quantify the financial impact of any data deficiencies in their audits, in particular, data on out of state care. Children's hospitals provide care to many children who come to their facilities from out-of-state and are therefore covered by Medicaid in another state. For example, some children's hospitals receive payments for Medicaid services to children from at least 25 other states, and sometimes up to 40 states. Children's hospitals have reported facing challenges in obtaining data from multiple out-of-state Medicaid agencies for auditing purposes. This typically leaves data deficiencies in the state DSH audit reports. CMS should consider these challenges in relation to this reporting requirement, to ensure that children's hospitals are able to comply with the proposed changes.

We encourage CMS to work with states and providers to determine the best means of collecting the required data, to ensure that children's hospitals are not penalized for this missing state data. Children's hospitals are providers with high out-of-state claims, and collaboration between CMS, states and providers would help to address the challenges that these hospitals may face in attempts to provide the required data. This would reduce administrative burden on the children's hospitals and states, in addition to making certain that they are able to comply with this proposed reporting requirement.

Hospital Exception Data Reporting Requirements
We encourage CMS to consider less burdensome reporting requirements regarding the 97th percentile hospital exception. The proposed rule would require any hospital that submits a Medicare cost report to be included in the data set to determine which hospitals qualify for this exception. Children's hospitals are unlikely to fall under this exception, and as a result, this reporting requirement would not affect their DSH payments. Regardless, children's hospitals would still be required to submit Medicare data to CMS. We ask CMS to consider reporting requirements that would impose less administrative burden on children's hospitals, who are unlikely to meet this exception but would be required to report their Medicare data to CMS.

In conclusion, we appreciate your work to improve the Medicaid DSH program and the significant impact it has on children's hospitals. We look forward to working with you to further improve this program so that children's hospitals can continue to provide critical care to the millions of children covered by Medicaid. Please contact Milena Berhane at milena.berhane@childrenshospitals.org or (202) 753-5521 with any questions.

Sincerely,

Aimee Ossman
Vice President, Policy
Children's Hospital Association