February 17, 2012

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–2315–P
P.O. Box 8016
Baltimore, MD 21244–8016

Re: Medicaid Program; Disproportionate Share Hospital Payments—Uninsured Definition

Dear Sir/Madam:

On behalf of 220 member children’s hospitals across the country, the Children’s Hospital Association appreciates the opportunity to comment on “Medicaid Program; Disproportionate Share Hospital Payments—Uninsured Definition,” as published by the Centers for Medicare and Medicaid Services (CMS) on January 18, 2012. While we support the policy change proposed in the regulation, there are several issues important to children’s hospitals that remain unaddressed regarding the calculation of hospital-specific disproportionate share hospital (DSH) limits.

Children’s hospitals are a vital safety net for all children, treating uninsured, underinsured and publicly covered children across the country. Although children’s hospitals are only 3.5 percent of all hospitals, they account for 47 percent of all pediatric Medicaid admissions. Children’s hospitals serve the majority of children with serious illnesses and complex chronic conditions and most children in need of major surgical services. As regional centers of care, children’s hospitals also work to meet children’s primary and preventive health care needs.

The Association supports the proposed change to the definition of “uninsured” for the purpose of determining hospital-specific DSH payment limits. The current definition of uninsured, which is based on creditable coverage, underestimates the cost of a hospital’s uncompensated care by excluding the cost of serving persons with insurance but without coverage for a specific service. Implementing a service-specific definition of uninsured, as proposed by this rule, would allow for a more accurate calculation of the true cost of uncompensated care provided by children’s hospitals.

While we applaud the proposed change to the definition of uninsured, a number of issues critical to children’s hospitals remain unaddressed. We ask that CMS consider revising current policies related to calculation of the hospital-specific DSH limit. These include the exclusion of uncompensated care costs for hospital-based physicians; treatment of payments and costs for patients who have dual coverage under private insurance and Medicaid; and the exclusion of unpaid deductibles and co-payments.
Hospital-based Physician Services

The 2008 DSH final rule excluded uncompensated care costs associated with hospital-based physicians from the hospital-specific limit, except in cases where physician services are part of a bundled hospital payment. Exclusion of physician uncompensated care in the DSH calculation has had a detrimental financial impact on children’s hospitals. The policy also fails to recognize the increasingly important role of hospital-based physicians in guaranteeing access to primary and specialty care for low-income and vulnerable children. We therefore ask that CMS include uncompensated care costs associated with hospital-based physicians in the hospital-specific limit.

Access to timely pediatric care is critical for all children, but particularly for children with chronic and life threatening conditions - a large proportion of whom are Medicaid beneficiaries. However, many private practice pediatricians and specialists limit their Medicaid patient population because: 1) reimbursement generally does not cover costs, making it challenging to devote appointment slots to this population; and 2) due to various circumstances, Medicaid patients have a higher “no show” rate than privately insured patients. In a private practice setting, a missed appointment represents critical lost revenue.

Hospital-based physicians, as compared to community physicians, are less concerned with the low Medicaid reimbursement rates because these often significant financial losses are absorbed by the hospital. Additionally, hospital-based physicians cannot cherry pick patients based on insurance status – they are bound by their employer’s policies and contracts. In a children’s hospital, this means accepting all patients regardless of insurance status and ability to pay.

Recent data from the American Hospital Association show that hospitals employed roughly 211,500 physicians in 2010, up 34 percent since 2000. The findings indicate that hospitals now employ about 25 percent of all active physicians. This number is expected to increase as new health care delivery models such as Accountable Care Organizations enter the market. It is critical that CMS recognize the ever-increasing safety net role that children’s hospitals play in guaranteeing access to physician care for low income and vulnerable children and the associated financial losses the hospital absorbs.

For example, Children’s National Medical Center in Washington, DC, employs more than 600 pediatricians and pediatric specialists. This health care delivery model helps to ensure access to primary and specialty care for the more than 76,000 children enrolled in the District of Columbia’s Medicaid program and the thousands of Medicaid beneficiaries in Maryland and Virginia who seek care at the hospital and its outpatient centers each year. Between July 1, 2009, and June 30, 2010, Medicaid shortfalls for physician services at Children’s National exceeded $20 million. We believe very strongly that these Medicaid shortfalls should be eligible for inclusion in the hospital specific limits as calculated under the 1923(g) definition because they represent losses incurred by a DSH eligible hospital for services rendered to Medicaid beneficiaries.

Children’s National specialists are the safety net for kids in the Greater Washington Metro, representing nearly 90 percent of all pediatric specialists in the District of Columbia. The limited supply of specialists in vulnerable communities within the District combined with Medicaid reimbursement rates that discourage private practice physicians to accept Medicaid patients (compared to what private insurance pays) mean that Children’s National is not only a safety net for Medicaid beneficiaries, it is a safety net for physician services as well.
Inclusion of Costs for Medicaid Eligibles

Another issue of particular importance to children’s hospitals is the treatment of individuals with private coverage who are also Medicaid-eligible. A CMS document, “Additional Information on the DSH Reporting and Audit Requirements,” states that “costs and revenues associated with patients that are eligible for Medicaid and also have private insurance should be included in the calculation of the hospital-specific DSH limit.” The effect of this policy is that application of payments from commercial insurance may artificially lower a hospital’s DSH limit if the hospital serves a high percentage of patients who have dual coverage under private insurance and Medicaid.

This effect is particularly troublesome for children’s hospitals. Because of the extended coverage of children under the Medicaid program, children are more likely than other populations to have dual coverage under private health insurance and Medicaid. In addition, many children’s hospitals work to actively enroll qualified children in Medicaid even when they have private insurance as a primary payor. This proactive enrollment helps children and their families avoid potential gaps in coverage such as might arise if a children’s primary insurance reaches its limit due to prolonged chronic or acute medical care. However, children with dual coverage under private insurance and Medicaid may never actually utilize their Medicaid benefits. In that case, it is inequitable to require inclusion of costs and payments under private insurance with the effect of artificially lowering a hospital’s specific DSH limit. Doing so contradicts the intent of DSH payments to help support safety net hospitals, such as children’s hospitals, that care for significant numbers of patients who rely on Medicaid.

We ask that CMS remedy this situation by adopting a similar approach to that in the proposed regulation, in which the consideration revolves around payment for a specific service rather than a patient’s coverage status. Under this approach, costs and payments for services would only apply toward the hospital-specific DSH limit if those services were billed to Medicaid. For patients with private insurance who are also eligible for Medicaid, costs and payments for services billed solely to private insurance should not count toward the DSH-specific limit.

Unpaid Deductibles and Co-payments

We ask that CMS reconsider the exclusion of unpaid deductibles and co-payments from the calculation of the hospital-specific DSH limits. Specifically of concern are children in high deductible health plans who essentially are not covered by their insurer until the extensive cost sharing threshold is met. Unpaid deductibles, as well as unpaid copayments, directly contribute to the unreimbursed care that a children’s hospital must absorb.

Once again, we would like to reiterate the Association’s support for the amended definition of uninsured in the proposed rule. We believe this change will help to ensure that all children continue to have access to the high quality care provided by children’s hospitals, regardless of their ability to pay. However, we also ask that CMS consider revising current policy related to exclusion of uncompensated care costs for hospital-based physicians; treatment of payments and costs for patients who have dual coverage under private insurance and Medicaid; and exclusion of unpaid deductibles and co-payments.
We appreciate the opportunity to provide feedback on this proposed rule. If you have any questions regarding our comments, please contact Melissa James at 703-797-6085 or mjames@nachri.org.

Sincerely,

M. James Kaufman, PhD
Vice President, Public Policy