September 14, 2016

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2399-P
P.O. Box 8016
Baltimore, MD 21244-8016
Submitted electronically to http://www.regulations.gov

Re: CMS-2399-P, Medicaid Program; Disproportionate Share Hospital Payments – Treatment of Third Party Payers in Calculating Uncompensated Care Costs

Dear Mr. Slavitt,

On behalf of over 220 children’s hospitals across the country, the Children’s Hospital Association (CHA) appreciates the opportunity to provide comments on the proposed rule that would codify the Centers for Medicare and Medicaid Services (CMS) policy interpretation regarding how the Medicaid Disproportionate Share Hospital (DSH) payment program determines costs for Medicaid eligible patients that also have a third party source of coverage. As major Medicaid providers, the proposed rule directly impacts children’s hospital participation in the DSH program. We ask CMS to withdraw the proposed regulation and maintain the intent of the Medicaid DSH program to assist hospitals that treat large volumes of Medicaid patients.

Though children’s hospitals account for only 5 percent of hospitals in the United States, they provide 47 percent of the hospital care required by children covered by Medicaid. Children’s hospitals are regional centers for children’s health, providing care across large geographic areas and serving Medicaid children across state lines. Children’s hospitals serve the majority of children with serious illnesses and complex chronic conditions and most children in need of major surgical services. On average, children’s hospitals devote more than half of their inpatient care (55 percent of inpatient days) to children covered by Medicaid.

While we recognize the importance of ensuring that Medicaid DSH eligibility and payments are accurately determined, we are concerned that the proposed rule provides more than a clarification of the Medicaid DSH audit rules and instead implements new policy that is not supported by the Medicaid DSH statute. Specifically, we are concerned about the application of all payments received by third party payers for privately insured patients who are also Medicaid eligible at the rates the private insurers pay hospitals, even if the Medicaid program is not billed for any hospital services provided. We are concerned the proposed rule assumes that a Medicaid eligible child who may not be eligible for Medicaid payment should be included as a Medicaid covered individual for the purposes of determining DSH eligibility and payment. In addition, we do not believe the rule should be effective retroactively given the significance of this proposed policy.

We believe the proposed rule will disproportionately impact children’s hospitals that have relied on the Medicaid DSH program to care for our most vulnerable children. The implication of the proposed rule means that many children’s hospitals will have drastically reduced DSH payments or be excluded from DSH participation altogether.

We respectfully submit the following detailed comments about our concerns with the proposed rule. While we strongly believe the proposed policy is not supported by the Medicaid DSH statute, we also suggest recommendations in the event CMS moves forward with this rule.

Champions for Children’s Health
Medicaid DSH funding and children’s hospitals

Any changes and policy interpretations to the Medicaid DSH program should uphold the intent of the program to assist hospitals in treating large volumes of Medicaid patients.

Medicaid DSH payments are critical to children’s hospitals and their ability to provide health care to all of 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. While the number of uninsured children has been low, the number of children covered by Medicaid has grown in recent years. Medicaid is the largest source of coverage for children – covering one in three children nationally, and historically, half of all Medicaid beneficiaries are children.

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 77 percent of the costs of providing care including DSH payments. While the Medicaid DSH program does not make up the entire Medicaid shortfall experienced by children’s hospitals, it is one of the limited opportunities 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.

We believe this proposal disproportionately impacts children’s hospitals because of the number of children who have private insurance and are Medicaid eligible. 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. As you know, some children are eligible for Medicaid based on disability through Medicaid state options and waiver programs, even though their families’ incomes would not otherwise qualify them for Medicaid. These are very vulnerable children who may have private insurance, but require extensive and expensive health care services and supports not covered by their private insurance plan. States offer Medicaid wrap-around coverage to fill gaps in private insurance for these children and prevent families from seeking care for their children in more costly institutional settings and/or “spending down” to qualify for traditional Medicaid.

Children’s hospitals actively work to enroll qualified children in Medicaid so that families can afford a full range of needed services for their children. This is true even when families have private insurance as a primary payer that covers all of their child’s hospital expenses. These efforts by children’s hospitals ensure their patients have access to needed services once discharged that may not be covered by private insurance such as private-duty nursing, medical transportation, or durable medical equipment. These activities are one of the many ways children’s hospitals help ensure continuity of care for children.

We believe this rule runs contrary to the spirit of ensuring children are enrolled in the types of coverage that meet their individual health needs and instead penalizes hospitals that provide care to this medically needy group of children.

Inclusion of private insurance payments in DSH calculation

We ask that CMS work with states to improve Medicaid payment methodologies rather than expect negotiated private insurance rates to supplement Medicaid underpayment.

We are deeply concerned with CMS’s proposal to require states to include the days, costs, and revenues associated with a patient who has third party coverage and is Medicaid eligible in the determination of both the eligibility for DSH and the calculation of the Medicaid shortfall. Approximately 8.2 percent of children with special health care needs have both public and private coverage.1 With the exception of children with end stage renal disease, children’s hospitals do not treat individuals

1 Catalyst Center, State-at-a-Glance Coverage and Financing Charts, By State: US
who are covered by Medicare. Given that children’s hospitals tend to serve more children who have chronic or complex medical conditions, they are more likely to treat a patient with both Medicaid and private coverage.

The proposed application of the full payment of private insurance in the calculation of Medicaid costs, regardless if the Medicaid program is billed and payment received, is not consistent with the Medicaid DSH statute. The Medicaid statute supports that DSH payments cannot exceed the cost of providing services to Medicaid and uninsured patients minus payments received from Medicaid and on behalf of the uninsured patient. This requirement does not include third party coverage let alone the full amount of private insurance payments made to the hospital for Medicaid eligible patients with third party coverage.

The rule is essentially requiring the private insurance payment of one patient to count as an offset for the Medicaid shortfall a hospital experiences from all Medicaid patients. This is especially problematic when the full private insurance payment is applied for patients who never should be considered a Medicaid covered individual because either the patient is not enrolled in Medicaid or the Medicaid program is never billed.

**Determining Medicaid eligible patients**

*Medicaid covered individuals for the purposes of the Medicaid DSH program should only be those patients who are enrolled in the Medicaid program and for whom a hospital bills and receives payment under the Medicaid program.*

We believe CMS should focus on individuals enrolled in Medicaid when the Medicaid program is billed to determine a hospital’s eligibility for DSH and the amount of a hospital’s Medicaid shortfall. The proposed rule assumes that a Medicaid eligible child who may not be eligible for Medicaid payment should be included as a Medicaid covered individual for the purposes of determining DSH eligibility and payment. Some children are Medicaid eligible by virtue of diagnosis (e.g. low birth weight, transplant cases). Not all of these children are actually enrolled in Medicaid because their private insurance coverage meets their needs. As mentioned above, in many instances, private insurance takes care of the hospital visit for these children, but their Medicaid coverage provides needed supports in the community.

While a group of children may be Medicaid eligible, it does not mean that the individual child qualifies for Medicaid payment. This only occurs once a patient enrolls in the Medicaid program and the services that are provided qualify and are paid for by the Medicaid program. The proposed rule does not consider this important step when applying the formula to calculate DSH eligibility and payment. If the Medicaid program never actually pays for services provided in the hospital, we do not believe the payment qualifies as a Medicaid payment for the calculation. It is not reasonable to include children who are not enrolled in Medicaid or when the hospital never bills Medicaid and never receives program payments as Medicaid covered individuals for the purposes of the Medicaid DSH program. We instead recommend these patients be excluded from the DSH calculation altogether if CMS decides to move forward with this rule.

**Effective date**

*Given the magnitude of the proposed policy change, the effective date should not be retroactive*

We are concerned the rule is more than a clarification of DSH policy, which is especially problematic if the policy is effective retroactively to the implementation date of the Medicaid DSH audit rules. The proposed rule codifies existing guidance that was presented in a January 2010 frequently asked question (FAQ) document. Many states and hospitals were not aware of this policy until after the release of their 2011 DSH audit results once CMS auditors took into account the guidance issued in the 2010 FAQ. We believe the guidance in the FAQ document signifies a new policy interpretation, rather than a clarification, that is not supported by statute, and CMS appears to acknowledge this policy is more than a clarification by going through the rule making process at this time.
The retroactive nature of this rule puts funds that have already been received and spent subject to recoupment. Several children’s hospitals have been significantly impacted by enforcement of the FAQ once they received their 2011 DSH audit results. Consequently, states have been expected to recoup considerable amounts of DSH funds that were already distributed to and spent by these hospitals in prior years. While we do not support finalization of this rule as proposed, we strongly believe any similar finalized policy should be effective going forward and should not be made retroactive given the magnitude of the change.

Recommendations

We strongly believe the proposed rule is not consistent with nor supported by the statute. We urge CMS to reconsider its position and withdraw the proposed rule. In the event CMS does not reconsider its position, we would then suggest the following recommendations which we believe will help maintain the intent of the DSH program while ensuring any final rule does not eliminate the role of DSH funding for hospitals that treat large volumes of Medicaid patients.

1. We first recommend that both days and payments associated with patients with both Medicaid and private coverage be excluded from the DSH cost report and Medicaid shortfall calculation when the Medicaid program is not billed and subsequently no Medicaid payment is received by the hospital. This would ensure that those patients included in the days, costs, and payments associated with DSH eligibility and payments are those that are utilizing the Medicaid program to receive inpatient and outpatient services.

2. Alternatively, if recommendation one cannot be achieved, we recommend the days, costs, and payments be included for Medicaid and privately covered individuals, but the payments should only be included at the rate the Medicaid program would have paid the hospital had Medicaid been billed. This is equivalent to the Medicaid allowable payment and results in a neutral impact to the program while maintaining the recognition of the significant services provided by children’s hospitals. This would allow recognition of payments associated with Medicaid covered patients while ensuring there is no reported Medicaid shortfall for the individual patient. The result does not alter the actual value of the Medicaid shortfall and accurately reflects the costs associated with treating a large number of vulnerable children as outlined in the Medicaid DSH statute.

We appreciate the opportunity to provide comments on this proposed rule. We are willing to continue to work with CMS to find an alternative solution to ensure the integrity and viability of the Medicaid DSH program in a manner that recognizes the important role of DSH payments in addressing Medicaid underpayment for children’s hospitals. If you have questions or need additional information, please contact Shannon Lovejoy at (202) 753-5385 or shannon.lovejoy@childrenshospitals.org.

Sincerely,

Jim Kaufman
Vice President, Public Policy
Children’s Hospital Association