MISSOURI HOSPITAL ASSOCIATION

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August 25, 2017

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, D.C. 20201

RE: Medicaid Program; State Disproportionate Share Hospital Allotment Reductions (CMS-2394-P)

Dear Ms. Verma:

On behalf of its 145 hospital members, the Missouri Hospital Association offers the following comments in response to the Centers for Medicare & Medicaid Services' proposed rule.

CMS indicates that it intends to provide relief to states that have not expanded their Medicaid programs under the Affordable Care Act within the confines of the Medicaid DSH allotment statute. MHA applauds this policy stance. However, we believe there are several additional changes that can and should be made to further promote equity among the states.

DELAY OF THE PENDING MEDICAID DSH ALLOTMENT REDUCTIONS

The Medicaid DSH allotment reductions initially were slated to take effect in 2014. Congress has seen fit to delay those DSH allotment reductions on multiple occasions. MHA argues that they should be delayed again. The proposed rule was issued July 27, 2017, with a 30-day comment period, anticipating the imminent release of a final rule to be in effect by October 1, 2017. As noted in the American Hospital Association's comments, some of the data needed to assess the effect of the proposed regulation on the states will not be available until well after the final regulation is issued. The need for government and those it regulates to understand the specific implications of its regulatory proposals is sufficient grounds to delay the implementation of the DSH allotment reductions beyond October 1, 2017.

MHA's first-order recommendation regarding the proposed rule is that CMS delay the proposed state DSH allotment reductions using the broad rulemaking authority granted to the agency under federal law. If such a delay cannot be accomplished, we urge CMS to consider the following comments in refining its final order of rulemaking.

CMS SHOULD FIRST RECOUP UNUSED DSH ALLOTMENTS BEFORE APPLYING THE DSH HEALTH REFORM METHODOLOGY

The DSH Health Reform Methodology formula does not take into account each state's DSH utilization rate — the total percentage of its DSH allotment that each state actually uses. MHA argues that it should. For various reasons, states' current Medicaid DSH allotments sometimes are not in synch with their current DSH expenditures. When those allotments exceed actual expenditures, recouping the amount of unused allotment should be the first step taken in achieving the statutory amount of Medicaid DSH allotment reduction.

MHA recommends that CMS first reduce the fiscal year 2018 $2 billion statutory reduction by cutting all of the unused portions of state allotments, before applying the DHRM formula to apportion the remaining amount of the reduction.

This proposal supports CMS's policy goal to ensure that DSH reductions are fairly apportioned among all states, without placing states in jeopardy of losing their entire DSH allotment.

CMS SHOULD INCREASE THE WEIGHT OF THE UNINSURED PERCENTAGE FACTOR

MHA supports CMS's decision to increase the weight given to the Uninsured Percentage Factor from 33.3 percent to 50 percent. It certainly is a step in the right direction. However, MHA asserts that even more weight should be assigned to this factor, for the following reasons.

States like Missouri that have not expanded Medicaid under the ACA can expect to have a higher rate of uninsured when compared to Medicaid expansion states. Those nonexpansion states will have higher uncompensated care costs than their expansion state counterparts, and be more dependent on their Medicaid DSH allotments.

With CMS's proposal to increase the UPF factor to 50 percent, the high volume of Medicaid inpatients factor and the high level of uncompensated care factor still account for the other 50 percent of the DHRM formula. The HMF factor is intended to impose larger percentage reductions on states that do not target DSH payments to hospitals with the highest volumes of Medicaid inpatients. The HUF imposes larger percentage reductions on states that do not target DSH payments to hospitals with the highest levels of uncompensated care.

Although a number of states use the majority of their DSH funding to support safety net hospitals, the state of Missouri has made the policy choice to distribute its DSH funds in a more decentralized manner. Missouri's DSH payments are made exclusively to offset the cost of treating the uninsured. For several decades, Missouri has explicitly chosen not to target its DSH funds to a small number of hospitals. Rather, DSH payments are made to a broader range of hospitals within the state. This improves access to care — the uninsured who need hospital care can be treated at a nearby community hospital and do not need to be transported to a distant facility targeted to deliver a high volume of uncompensated care. Hospitals in Missouri receive

DSH payments based on the amount of charity care they deliver; the state's DSH allotment is distributed to eligible facilities based on their share of the total volume of charity care, subject to hospital-specific DSH audit limits.

Targeting DSH funds to a few safety net hospitals restricts ready access to care. Travel is not always easy in Missouri. Travel distances can be extensive, but more importantly, so can travel times. Negotiating a winding two-lane highway through the Ozark Mountains behind a logging truck can be difficult for anyone, let alone someone who is poor, sick and likely to have limited access to reliable transportation. Even though Missouri does not restrict its DSH payments to a small number of safety net hospitals, most of its DSH funds still go to hospitals that serve the majority of our state's uninsured. Missouri should not be penalized by its decision to ensure greater access to care for Medicaid enrollees.

Accordingly, MHA proposes that CMS adjust its formula so that the UPF factor accounts for 80 percent of the DHRM formula, and the HMF and HUF factors each account for 10 percent. We believe this weighting would more fairly allocate DSH allotment reductions to states that expanded Medicaid. It also would reflect the benefits of a decentralized distribution of DSH funds in enhancing access to care, while still following the directives of the DSH allotment reduction statute.

CALCULATE THE UNINSURED PERCENTAGE FACTOR USING THE MOST RECENT AVAILABLE DATA AT THE TIME FINAL ALLOTMENTS ARE CALCULATED

In calculating the UPF factor, CMS proposes to rely on the most recent American Community Survey data available at the time the calculation of the annual DSH allotment reduction amounts, in part, because ACS data is collected and published annually, and can provide the most recent and accurate snapshot of a state's uninsured rate. MHA supports CMS' goal of relying on the most recent available data in calculating the UPF factor.

Using the most recent data available at the time the final DSH allotments are calculated also furthers CMS' goal of fair treatment of nonexpansion states. MHA has determined there would be a particularly acute effect on nonexpansion states in the first round of DSH reductions (2018), if CMS uses 2014 ACS data, rather than the data available at the time of publication of the final DSH allotments. The 2014 ACS data does not fully reflect the impact of the ACA's Medicaid expansion, which gradually increased coverage in expansion states such that the full impact was not seen until 2015, or even later. By the time that the final 2018 allotments are calculated, CMS will be able to use 2015 or 2016 ACS data, which will more accurately reflect the impact of the ACA's Medicaid expansion.

CMS does not make clear, however, whether it intends to use the most recent ACS data available when calculating a State's *preliminary* DSH allotment, or when calculating a State's *final* DSH allotment. **Because there is often a significant lag between CMS's preliminary and final DSH allotment calculations (up to 18 months or longer), MHA urges CMS to use the most**

recent ACS data available when calculating a state's *final* DSH allotment for purposes of determining a state's uninsured rate. This policy would best support CMS' justification in using ACS data, as states can (and often do) experience significant changes in uninsured populations from year to year.

EXCLUSION FOR COVERAGE EXPANSION WAIVERS

Missouri's "Gateway to Better Health" is a Section 1115 waiver demonstration project operating in St. Louis City and County, which provides health care coverage to nearly 22,000 low-income uninsured individuals. The Gateway waiver was first approved by CMS on July 1, 2010, and has continuously operated since July 1, 2012. CMS has renewed the waiver multiple times, most recently in August 2017 for a five year period.

Gateway is primarily funded by the diversion of $25 million from Missouri's DSH allocation. CMS's proposed regulation would threaten the state's capacity to continue funding the Gateway program. Although the rule is crafted to protect coverage expansions funded with DSH, as is Gateway's, the rule limits this protection to waivers that were approved as of July 31, 2009. Because the Gateway waiver was approved after this date, the DSH funding that supports Gateway would be subject to statutory reductions as the proposed rule is currently drafted.

The underlying statute requires the Secretary to extend the statutory protection to Section 1115 waiver demonstrations approved as of July 31, 2009. Nothing precludes CMS from taking a more expansive stance to include DSH-funded coverage expansion waivers approved after that date. Except for its approval date, Missouri's Gateway waiver is exactly the type of DSH-funded initiative the rule seeks to protect. **We therefore urge CMS to exclude from the DHRM DSH funding that is diverted to Section 1115 coverage expansion waivers that were approved any time between July 31, 2009, and the effective date of the new regulation, or at a minimum, such waivers that were approved on or before July 31, 2012.**

Thank you for the opportunity to comment. If you have any questions, please feel free to contact me at 573/893-3700, ext. 1349, or dlandon@mhanet.com.

Sincerely,

Daniel Landon
Senior Vice President of Governmental Relations

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