



11 Beacon Street, Suite 710  
Boston, MA 02108  
Phone: 617-723-6100  
Fax: 617-723-6111  
www.cobth.org

**Via Electronic Submission at [www.regulations.gov](http://www.regulations.gov)**

August 28, 2017

Ms. Seema Verma, Administrator  
Centers for Medicare and Medicaid Services  
**ATTN: CMS-2394-P**  
7500 Security Blvd.  
Baltimore, MD 21244-8016

Dear Administrator Verma:

On behalf of the Conference of Boston Teaching Hospitals (COBTH) I am pleased to offer comment on the Centers for Medicare & Medicaid Services' proposed rule entitled "*Medicaid Program: State Disproportionate Share Hospital Allotment Reductions*," 82 Fed. Reg. 35155. By way of background, COBTH is an organization of thirteen Boston area teaching hospitals that work together to advance our mission of providing quality care, medical research and education, and serving vulnerable populations.

The Medicaid DSH program provides essential financial support to our hospitals that care for our most vulnerable populations – children, the poor, the disabled and the elderly. Under the rule as currently proposed, hospitals in Massachusetts would see a reduction of \$105M in Medicaid DSH payments beginning in FY18. These significant cuts will have a severe negative impact on our hospitals and the patients and communities they serve. Additionally, Massachusetts would see a reduction of more than 31% in Medicaid DSH funding, the highest of any state in the nation. The currently proposed weighting of the Hospital Medicaid Factor and the Uncompensated Care Factor disproportionately impacts Massachusetts as compared to all other states. This disproportionate negative impact is primarily the result of two aspects:

1. **Weighting of the Uninsured Factor:** CMS proposes to weight the Uninsured Percentage Factor (UPF) higher than the other two statutorily required factors - the High Level of Uncompensated Care Factor (HUF) and the High Volume of Medicaid Inpatient Factor (MHF) the other factors. This new weighting method (50%, 25%, and 25% respectively) is different than the proposed 2013 rule, which provided equal weighting to all three groups (33.3%). We strongly oppose this change as it heavily and unfairly weights the factors related to the uninsured.

Medicaid DSH funding has always been recognized as crucial support for care provided to Medicaid and low-income uninsured patients. Base rate payments for medical services are typically well below the cost of providing care to Medicaid patients. Supplemental payments, therefore, always have been recognized as a needed source of funding to support safety net hospitals that do not have means to cost-shift these losses. In Massachusetts, the Massachusetts Health and Hospital Association estimates that the state fee-for-service rates only cover 75% of the acute hospital expenses to care for Medicaid patients.

**2. Implementation of the 1115 Budget Neutrality Factor:** When considering how to apply DSH reduction, CMS is required to give consideration to states that expanded coverage (through a waiver using state DSH funding as of July 31, 2009), as proposed in the 1115 Budget Neutrality Factor (BNF). We are concerned that the proposed rule would categorically exclude Safety Net Care Pools from coverage expansion consideration. Safety net care pools are crucial to providing health care coverage to those previously uninsured. We believe it is contrary to the statutory intent to automatically designate all safety net care pools and uncompensated care pools as not contributing to coverage expansion purposes. **CMS should re-examine the definition of "coverage expansion purposes" as it applies to the BNF to include safety net care pools and uncompensated care pools that are established as part of broader efforts to expand coverage.**

**We respectfully recommend that the full amount of a state's DSH allotment (included in the budget neutrality calculation for the 1115 Demonstration in effect on July 31, 2009) be excluded from reduction.** This treatment is consistent with the statute and recognizes safety net care pools and uncompensated care pools can serve to support comprehensive coverage expansions. In Massachusetts, use of the state's DSH allotment in the safety net care pool to support the provision of essential services is inseparable from the primary purpose of enabling coverage expansion. Massachusetts' safety net care pool is an example of one that should be eligible for the reduction exemption.

COBTH has other significant concerns about certain provisions of the proposed rule. Our comments below focus on:

- The definition of "uninsured"
- The use of DSH audit and reporting data
- The High Uncompensated Care Factor (HUF)
- Reduction cap methodology

**We believe the best course of action is an administrative delay in the implementation of the proposed reductions until the following issues are addressed.**

### **THE DEFINITION OF "UNINSURED"**

We believe that the definition of "uninsured", which is critical to the allotment methodology, is too narrow and fails to reflect a hospital's true uncompensated care costs.

**The term "uninsured" should be considered on a service-specific basis and include patients who lack insurance for the specific services provided, rather than only individuals who have no insurance.** This would be more consistent with the SSA requirement, which limits a hospital's Medicaid DSH payments to the uncompensated costs of providing services to Medicaid eligible individuals and individuals who "have no health insurance (or other source of third party coverage) for the services furnished."

We recommend that the definition of uninsured also include costs associated with unpaid coinsurance and deductibles. As teaching hospitals, COBTH member hospitals treat many highly complex patients who may exhaust their benefits during a hospital stay or lengthy course of treatment. We recommend that CMS take these patients into account to determine whether the individual is insured for the services furnished throughout an entire hospital stay or course of treatment.

COBTH member hospitals and hospitals across the country provide treatment to patients independent of their ability to pay and their citizenship status. We are concerned that using the American Community Survey to measure the rate of insurance among undocumented individuals, the total number of uninsured will not be accurately reflected and will be underreported. Because it is likely that undocumented individuals lack insurance coverage, we strongly recommend that CMS work to develop a methodology that can take into account undocumented individuals.

### **USE OF DSH AUDIT AND REPORTING DATA**

In the proposed rule, CMS recognizes that when calculating the High Medicaid Volume Factor and the High Uncompensated Care Factor, there is a tradeoff between relying on audited data and the significant time lag that often results from using audited data. The proposed rule highlights that FY18 DSH allotments will be calculated using FY13 figures. We encourage CMS to commit to revise this methodology, should a more timely source of audited data become available. We trust that CMS will continue to work with states to expedite the flow of accurate, audited data so the 5-year data delay can be reduced.

CMS also must make data available with sufficient time to for states to evaluate it, yet the recent release of data to be used for FY18 calculations does not allow for this. **Therefore, we urge CMS to administratively delay the implementation of the FY18 DSH allotment reductions to provide adequate time for state evaluation and feedback regarding the data.**

### **HIGH UNCOMPENSATED CARE FACTOR**

The ACA requires CMS impose larger percentage DSH allotment reductions on states that do not target DSH payments to hospitals with high levels of uncompensated care based on the high level of uncompensated care factor (HUF). CMS proposes ranking hospitals within a state according to their uncompensated care as a proportion of their *total cost of care*, and using that ranking determine how well a state allocates its Medicaid DSH funds.

**COBTH is concerned that by using total cost of care, teaching hospitals and academic medical centers will be disadvantaged.** The added mission-related costs of a teaching hospital - training residents, maintaining emergency stand-by capacity, operating disaster preparedness units, and other highly specialized services - result in being considered higher cost settings than their peers. With these higher costs included in the total cost of care, the portion of uncompensated care provided at our hospitals is diluted. We urge CMS to work to develop a methodology that addresses this issue.

### **REDUCTION CAP**

CMS proposed to cap future cumulative DSH cuts between FY18 and FY25 to 90% of the original allotment of a state. We support the concept of capping cuts, as there will always be uninsured and underinsured populations and hospitals that serve them, but we encourage CMS to work with states hit hardest by the cuts, including Massachusetts, to gauge the ongoing needs for DSH funding and revise this cap as necessary.

## **CONCLUSION**

Some of our concerns, such as those related to the definition of "uninsured," can be addressed in the rule making process between now and the start of the new fiscal year. Other issues, such as those related to data auditing and reporting, cannot be addressed in that timeframe and we believe warrant a delay in implementation.

We strongly encourage CMS delay implementation of this rule and work with stakeholders in the hospital community and state Medicaid offices to address these issues.

Sincerely

A handwritten signature in black ink that reads "John Erwin". The signature is written in a cursive style with a large initial 'J' and 'E'.

John Erwin  
Executive Director  
Conference Boston Teaching Hospitals