Texas Hospital Association

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Via electronic submission
http://www.regulations.gov

Seema Verma
Administrator
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-1739-P,
Mail Stop C4-26-05,
7500 Security Boulevard,
Baltimore, MD 21244-1850

RE: CMS-1739-P, Medicare Program: Treatment of Medicare Part C Days in the Calculation of a Hospital's Medicare Disproportionate Patient Percentage.

Dear Ms. Verma:

On behalf of our more than 465 member hospitals and health systems, including rural, urban, children's, teaching and specialty hospitals, the Texas Hospital Association appreciates the opportunity to provide comments on the above-referenced proposed rule for the Treatment of Medicare Part C Days in the calculation of a hospital's DSH percentage.

We *oppose* CMS' proposal to include MA patient days in the Medicare fraction for fiscal years before FY 2014 and to apply this policy retroactively to any cost reports that remain open for cost reporting periods starting before October 1, 2013. We *support* CMS' alternative proposal to include MA patient days for dually eligible beneficiaries in the numerator of the Medicaid fraction for those fiscal years.

Based on an analysis of CMS' Supplemental data file, Texas hospitals will benefit based on CMS' **alternative** proposal.

- Overall decrease – 16 hospitals – Total loss ($437,629)
- Budget neutral – 33 hospitals
- Overall increase – 157 hospitals – total increase ($55,154,946)

Arguments **against** CMS' proposal include the following:

1. CMS does not have the authority to issue a retroactive rule to place Part C Days in the Medicare Fraction. Section 1872(e) of the Social Security Act gives the Secretary only limited authority to promulgate retroactive rules. The Secretary must determine that retroactive application of a substantive change is necessary to comply with statutory

requirements - or - that failure to apply the change would be contrary to the public interest. This proposal contradicts the latter because the retrospective application of Part C days in the Medicare fraction causes significant loss in Medicare DSH reimbursement for almost all hospitals nationwide. As CMS is proposing to establish this policy retroactively, it would cover cost reporting periods for which many cost reports have already been final settled.

2. Placing Part C days in the Medicare Fraction is contrary to Congressional intent to compensate hospitals for treating indigent patients and thus improve such patients' access to care and health outcomes. The Proposed Rule admits that most hospitals would be better off if Part C days were counted in the Medicaid fraction (while underestimating the benefit of placing the days in the Medicaid fraction). Accordingly, the proposal to count Part C days in the Medicare fraction is designed to save Medicare money, and not to fulfill Congress's intent.

3. CMS has significantly underestimated the loss of reimbursement to hospitals that will occur if the proposal is finalized. In the proposed rule, CMS estimates that counting Part C days in the Medicaid fraction (instead of in the Medicare fraction as proposed) would result in a 6 percent increase for the hospitals in the aggregate. A six percent loss of reimbursement is significant enough, but CMS's estimate is faulty and significantly understates the loss of reimbursement that many hospitals will incur if the proposal is finalized.

Background:

The Affordable Care Act revised the Medicare DSH payment by introducing Medicare DSH uncompensated care payments. For FY 2014 and each year after, hospitals that would otherwise receive a DSH payment made under SSA § 1886(d)(5)(F) receive two separate payments:

1. 25 percent of the amount they previously received for DSH (''the empirically justified amount'')
2. An additional payment for the DSH hospital's proportion of uncompensated care, determined as the product of three factors:
    i. 75 percent of the payments otherwise made under SSA § 1886(d)(5)(F)
    ii. 1 minus the percent change in the percent of individuals uninsured (minus 0.2 percentage point for FYs 2018 and 2019). For FY 2020 and after, there is no reduction.
    iii. A hospital's uncompensated care amount relative to the uncompensated care amount of all DSH hospitals expressed as a percentage

In general, the FY 2020 IPPS final rule defined the uncompensated care amount to be charity care and non-Medicare and non-reimbursable Medicare bad debt, based on provider's cost reports Worksheet S-10.

The Medicare DSH adjustment provision under section 1886(d) (5) (F) of the Act was enacted by section 9105 of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 and became effective for discharges occurring on or after May 1, 1986. According to section 1886(d) (5) (F) of the Act, there are two methods for a hospital to qualify for the Medicare DSH adjustment. The primary method is for a hospital to qualify based on a statutory formula that results in the DSH patient percentage. The DSH patient percentage is equal to the sum of the percentage of Medicare inpatient days attributable to patients eligible for both Medicare Part A and Supplemental Security Income (SSI), and the percentage of total inpatient days attributable to patients eligible for Medicaid but not Medicare Part A. The DSH patient percentage is defined as:

DSH Patient Percent = (Medicare SSI Days / Total Medicare Days) + (Medicaid, Non-Medicare Days / Total Patient Days)

Thank you for your consideration of these comments. We look forward to working with you on these issues. Should you have any questions or comments, please email me at rschirmer@tha.org.

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