Texas Hospital Association

Submitted Electronically

August 28, 2017

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW.
Washington, DC 20201

Re: CMS-2394-P; Medicaid Program; State Disproportionate Share Hospital Allotment Reductions; July 28, 2017 *Federal Register*

Dear Ms. Verma,

On behalf of our nearly 500 hospital and health system members, the Texas Hospital Association (THA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' proposed rules implementing reductions to Medicaid Disproportionate Share Hospital (DSH) allotments.

The proposed reductions to Texas' Medicaid DSH allotment would create challenging and potentially unsustainable financial circumstances for the state's approximately 180 safety-net hospitals. Under the proposed rules, Texas' Medicaid DSH allotment is estimated to decrease by $148.1 million, or 14.1 percent, in 2018 and $592.3 million in 2024. The estimated cumulative loss for Texas is $3.2 billion from 2018 through 2025. These proposed Medicaid DSH cuts would significantly increase the uncompensated care burden for safety-net hospitals and could result in reduced access to essential health care for uninsured and low-income Texans.

THA urges the permanent repeal of the impending cuts to Medicaid DSH allotments. As CMS acknowledges in the proposed rules, the Medicaid DSH reductions were included in the Affordable Care Act (ACA) in anticipation of lower uninsured rates and levels of hospital uncompensated care. These reductions have not been realized in all states. Texas continues to have the largest number of uninsured individuals in the country – a number that is affected by population growth that exceeds most other states. In addition, Texas' uncompensated care costs have increased. Health Management Associates estimates that Texas hospitals' uncompensated care costs will total $9.6 billion in 2017, well beyond our current Medicaid DSH allotment and uncompensated care funding through the Medicaid 1115 Transformation Waiver.

Permanently repealing these Medicaid DSH reductions is necessary to give Texas safety net hospitals financial stability, especially given the uncertainty surrounding the future of Medicaid federal funding. It remains unclear whether ACA repeal and replace legislation will be enacted that may impact health care coverage and costs for the uninsured and low-income. Texas' Medicaid 1115 Transformation Waiver, which provides critical federal funding for uncompensated care, also expires at the end of this year. While Texas and CMS are working diligently to extend the waiver, future federal funding levels for uncompensated care are undetermined. In this environment, maintaining current Medicaid DSH funding is crucial to supporting safety-net hospitals and their vital work in communities across the state.

If CMS proceeds with the proposed rules, THA recommends that CMS add a category to the DSH Health Reform Methodology (DHRM) for non-expansion states. For this category, CMS would apply no reduction to Medicaid DSH allotments or use a separate methodology to lower Medicaid DSH reductions. This approach is consistent with House and Senate proposals to delay or eliminate the Medicaid DSH cuts for non-expansion states. It also acknowledges the higher uncompensated care costs of these states and the federal funding disparity between expansion and non-expansion states.

In the absence of specific consideration for non-expansion states, THA supports the proposed changes to increase the weight for the uninsured percentage factor in the DHRM. Consistent with the ACA, this reduces the impact of the DSH allotment cuts for states with high uninsurance rates. As we indicated in our comments on the 2013 proposed rules, THA supports allocating additional, much-needed DSH funding to states with higher rates of uninsured residents. Typically, these states – like Texas – not only have fewer Medicaid coverage options for low-income residents, but also have historically lower Medicaid rates. They cannot afford to narrowly target DSH payments and must make DSH payments to a broader array of providers to compensate for low base Medicaid payments and high uninsured levels.

Thank you for your consideration of our comments. We are available to work with you and your staff on the further implementation of the Medicaid DSH allotment methodology. If you have any questions, please contact me at sstephens@tha.org or Richard Schirmer at rschirmer@tha.org.

Sincerely,

Stephanie Stephens

Stephanie Stephens
Senior Director, Health Care Policy Analysis
Texas Hospital Association