



February 16, 2012

VIA ELECTRONIC SUBMISSION

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-2315-P

**RE: CMS-2315-P
Medicaid Program; Disproportionate Share Hospital Payments—Uninsured
Definition**

Dear Sir/Madam:

The National Immigration Law Center (NILC) specializes in the intersection of health care and immigration laws and policies, offering technical assistance, training, and publications to government agencies, non-profit organizations and health care providers across the country. For over 30 years, NILC has worked to promote and ensure access to health services for low-income immigrants and their family members.

Medicaid Disproportionate Share Hospital (DSH) payments are critical funding streams for safety net hospitals that serve a high proportion of Medicaid-eligible, uninsured, and underinsured individuals. With the impending significant reductions in DSH funding as required under the ACA set to begin in 2014, consumer and patient advocates who are concerned about the stability of the safety net health care system, on which the sizable and diverse uninsured population that will remain after 2014 will continue to rely, are paying close attention to these proposed regulations, as well as future regulations and guidance on the implementation of Section 2551 of the Affordable Care Act.

Proposed change to definition of the uninsured

In general, NILC supports the definition of the uninsured contemplated in this proposed rule. A clearer and more specific definition of the uncompensated care costs eligible under a hospital's limitations on DSH payments improves the integrity of DSH payments by ensuring a more uniform accounting of such costs. Improved accountability of uncompensated care costs is even more crucial when HHS begins to develop a new methodology for allocating DSH payments after 2014. According to Section 2551 of the ACA, future allocations of DSH starting in fiscal year 2014 will depend on the number of uninsured residents in a state (determined, in part, by

data on hospitals' cost reports), or the extent to which a state targets their DSH payments to hospitals with a high volume of Medicaid inpatient services and uncompensated care costs (excluding bad debt). Hence, the definition of uninsured in this proposed rule is critical not only for determining the hospital-specific limitation on Medicaid DSH, but also for determining a state's future allocation of DSH payments.

Specifically, NILC supports the proposed definition of uninsured at Section 447.295(b) that "Individuals who have no health insurance (or other source of third party coverage) for the services furnished during the year means individuals who have no source of third party coverage for the specific inpatient or outpatient hospital service furnished by the hospital."

NILC also supports the clarification that "no source of third party coverage" for a particular service includes situations in which a service is not included in an individual's health benefits coverage as well as when services are beyond a lifetime or annual coverage limit imposed by a third party payer. Individuals with limited benefits are essentially uninsured for those services not covered by their insurance and this clarification helps HHS and providers realistically account for the growing number of individuals who have inadequate coverage.

In addition, NILC supports the provision that a hospital's bad debt costs not be included in its uncompensated care costs. To include bad debt, especially administrative denials of payment, would distort the goal and purpose of DSH funding to protect and ensure that services to the most vulnerable patients are able to be provided by safety-net providers.

Additional considerations for DSH for the underinsured

We note, however, that the number of underinsured individuals is increasing and includes individuals who cannot afford their out-of-pocket expenses. For instance, a Commonwealth Fund study indicates that not only are the number of underinsured is rising, but that underinsured individuals avoid needed health care because of financial concerns and have outstanding medical debt at almost the same rates as uninsured individuals.¹ Thus, in today's reality, safety net providers must be able to address the needs of both the uninsured and underinsured through uncompensated care pools.

As a result, we recommend that HHS consider allowing a hospital's uncompensated care costs for purposes of its DSH limitation to include unpaid deductibles, copayments or coinsurances of underinsured individuals who cannot afford their out-of-pocket expenses. In addition, HHS could target such DSH funding to low-income, underinsured individuals by including the unpaid out-of-pocket expenses from only those patients that a hospital has determined to be eligible for financial assistance.

More accountability needed for DSH funding to serve targeted populations

NILC strongly encourages HHS and CMS, when revising the DSH allocation methodology in the future as required by Section 2551 the ACA, to ensure DSH funding is better targeted to meet the

¹ C. Schoen, M. M. Doty, R. H. Robertson, and S. R. Collins, "Affordable Care Act Reforms Could Reduce the Number of Underinsured U.S. Adults by 70 Percent," *Health Affairs* Sept. 2011 30(9): 1762–71.

needs of the most vulnerable communities and provides specific incentives for safety net hospitals to more effectively serve the remaining uninsured patients and protect and strengthen the safety net system as a whole. Changes to the DSH allocation methodology that would be more patient focused would not only meet the goals of the ACA to promote healthy communities, but would also align DSH payments with the ACA's goals of connecting provider reimbursements to quality care and improved performance. Therefore, NILC recommends that future guidance regarding implementation of Section 2551 incorporate new standards of accountability to ensure that DSH payments are truly targeted towards and benefit uninsured and underinsured patients in that community rather than being used to fill in revenue gaps.

For example, HHS could tie a hospital's DSH allocation to its compliance to already existing laws specifically designed to promote access to affordable health care for low-income uninsured patients. This would help ensure and incentivize a provider to meet its existing obligations to the uninsured and reward those providers who do so. For example, although many hospitals voluntarily provide free and low-cost care to patients who cannot otherwise afford to pay, reports have shown great variation in hospitals' approaches to patient billing, provision of charity care, and debt collection. These practices directly impact the ability of low-income uninsured individuals to seek and receive necessary health care services. A safety-net hospital's non-compliance with accepted practices can actually deter patients from seeking care. Thus, DSH funding should be allocated based on whether the hospital is truly trying to meet the needs of the uninsured in their service area and not whether they end up providing some care to the uninsured by happenstance.

In addition, the ACA includes new requirements that non-profit hospitals must meet to qualify for federal tax-exempt status (Section 9007). We encourage HHS to include new standards in which non-profit hospitals must demonstrate its required compliance with Section 9007 in order to receive its DSH allocation. To ensure equity, non-profit hospitals could be required to meet similar standards for its DSH allocation. Moreover, to encourage greater uniformity and transparency of uncompensated care data that providers must report, HHS could ensure that the DSH allocation methodology takes into account and compares the results of the states' audited reports on the states' DSH payments to hospitals, the hospitals' Internal Revenue Service (IRS) Forms 990 and Schedule H, as well as non-profit hospitals' compliance with its tax-exempt status.

Perform ongoing evaluation of DSH funding

Due to the expected and unexpected changes within the uninsured population and changes in the patient and payor mix at safety net hospitals, NILC recommends that HHS conduct an ongoing evaluation of how DSH funds are distributed within a state, and how funds are used by states and hospitals to adequately address the needs of the remaining uninsured patients. This will be increasingly important as the ACA coverage expansions go into effect starting in 2014 and DSH allocations begin to decrease.

It is important to remember that despite the millions of individuals who will gain coverage under the coverage expansions in the ACA, experts estimate 23 million individuals will continue to

remain uninsured after 2014 and must rely on DSH-supported hospitals. According to a report by Matthew Buettgens and Mark A. Hall, the majority of these uninsured will be citizens and lawfully present immigrants, who are possibly eligible for coverage but may be underinsured or find insurance unaffordable. Specifically, it is estimated that approximately 37% of the remaining uninsured will be eligible for Medicaid but not enrolled; 25% will be ineligible for health insurance based on their immigration status; 16% will be exempt from buying insurance because they cannot afford it; 8% will be under 400% of the Federal Poverty Level and eligible for tax credits but not enrolled; and 15% are expected to elect the tax penalty and not enroll.² Contrary to popular belief, the safety net must be strengthened and preserved after 2014 not only to serve the undocumented immigrant population excluded from the ACA, but all Americans who may continue to fall through the cracks for affordable health coverage.

While many hospitals currently receive DSH funding, not all of these hospitals are able to demonstrate a clear commitment to serving low-income and uninsured individuals in their communities. Moving forward, in order for existing safety net providers to continue to meet the needs of the remaining uninsured, it will be critical for HHS to ensure that the diminishing uncompensated care funding, like DSH, and related policies, is properly targeted and allocated to those providers who continue to serve the uninsured.

In conclusion, NILC supports the proposed regulation on the definition of the uninsured for Medicaid Disproportionate Share Hospital Payments. In addition, we recommend that HHS take steps now to assess the extent to which DSH funds directly benefit patients and communities. We encourage HHS develop new incentives and measurements in future DSH allocations to increase the effectiveness of limited DSH funding and target necessary funding to those safety net hospitals that most effectively serve Medicaid-eligible, uninsured, and underinsured patients per the proposed definition.

The National Immigration Law Center appreciates the opportunity to comment on proposed regulation CMS-2315-P. We hope these comments and recommendations are helpful. For more information, please contact Jenny Rejeske at 202-683-1994 or by email at rejeske@nilc.org.

Sincerely,

/s/

Jenny Rejeske

Heath Policy Analyst

National Immigration Law Center

² Buettgens, M. and Hall, M. *Who Will Be Uninsured After Health Insurance Reform?* March 2011.

