American Hospital Association™
Advancing Health in America

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January 23, 2019

Penny Thompson, MPA
Chair
Medicaid and CHIP Payment and Access Commission
1800 M Street, NW, Suite 650 South
Washington, DC 20036

RE: Proposed Changes to the Medicaid Disproportionate Share Hospital Program Allotments

Dear Ms. Thompson:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to comment on the Medicaid and CHIP Payment and Access Commission's (MACPAC) proposed recommendations related to the Medicaid Disproportionate Share Hospital (DSH) program.

MACPAC commissioners are currently debating approaches to address the impending implementation of the Affordable Care Act's (ACA) Medicaid DSH allotment reductions as well as contemplating significant changes to how DSH allotment funds are allocated to states. It is important to underscore that the Medicaid DSH program provides essential financial assistance to hospitals that care for our nation's most vulnerable populations – including children, the poor, the disabled and the elderly. These hospitals also provide critical community services such as trauma and burn care, high-risk neonatal care and disaster preparedness resources. Congress reduced Medicaid DSH payments in the ACA, reasoning that hospitals would care for fewer uninsured patients as health coverage expanded. However, the projected increase in coverage has not been fully realized due to the decision by some states not to expand Medicaid, as well as lower-than-anticipated enrollment in coverage through the Health Insurance Marketplaces. In fact, for the first time in nearly a decade, the number of uninsured children increased in 2017. For children losing coverage between 2016 and 2017, three-quarters live in states that have not expanded Medicaid coverage to parents and other

low-income adults.[1] **For these reasons, the AHA continues to advocate that the ACA Medicaid DSH allotment reductions should not be implemented.**

We appreciate the thoughtful and deliberative process MACPAC has undertaken to examine the Medicaid DSH program and the implications the ACA DSH reductions could have for hospitals as well as state Medicaid programs. We focus our comments on two of the three draft proposed recommendations the commissioners are deliberating, specifically the phasing in of the ACA DSH allotment reductions and the restructuring of the DSH allotments by using a new measure of low-income individuals living in a state.

Phasing-in DSH Allotment Reductions. The AHA continues to urge Congress to delay the ACA DSH reductions until more substantial coverage gains are realized. While we appreciate MACPAC's efforts to mitigate the impact of the DSH cuts beginning in fiscal year (FY) 2020 for hospitals and state Medicaid programs, we continue to believe eliminating the impending cuts is the better course of action.

Restructuring Medicaid DSH Allotments. The AHA opposes MACPAC's draft proposal to restructure the Medicaid DSH allotment methodology to be based on the number of low-income individuals in a state. While the draft proposal seeks to limit the restructuring to the ACA reduction allocation methodology, the AHA believes the proposed adjustment would represent a significant change to the overall DSH program. The recommendation introduces a new measure for allocating the DSH funds across states and moves away from the original statutory metrics, such as hospital uncompensated care and Medicaid shortfalls. This draft recommendation has the potential to create greater disruption for DSH hospitals and state Medicaid programs by shifting larger sums of money than the reductions alone. A change of this magnitude should not be made within the context of implementing the ACA DSH reductions as it requires more thoughtful deliberation and further analysis regarding its redistributive aspects. In addition, MACPAC, in previous reports to Congress, has raised concerns regarding the timeliness of state level DSH data, which further raises questions about moving forward with this restructuring approach in the context of implementing the ACA DSH reductions. Finally, at the December 2018 MACPAC meeting, it was noted that while this draft recommendation could lead to a reduction in DSH spending for hospitals, states have the opportunity to increase other types of hospital payments to make up for any losses incurred. According to AHA's most recent data, in 2017 hospitals received payment of 87 cents for every dollar of care provided Medicaid

[1] Alker, J, Pham, O. *Nation's Progress on Children's Health Coverage Reverses Cours*e, Georgetown University, Nov. 2018https://ccf.georgetown.edu/wp-content/uploads/2018/11/UninsuredKids2018_Final_asof1128743pm.pdf

patients.[2] This data suggests that states are either not willing or able to make up for the potential loss of Medicaid DSH funding.

The AHA appreciates this opportunity to share our comments with MACPAC. We look forward to working with the commission as it continues its important role to review beneficiary access and payment policies for Medicaid and the Children's Health Insurance Program (CHIP). Please contact me if you have questions or feel free to have a member of your team contact Molly Collins Offner, director of policy, at mcollins@aha.org or (202) 626-2326.

Sincerely,

/s/

Thomas P. Nickels
Executive Vice President

[2] American Hospital Association, Underpayment by Medicare and Medicaid Fact Sheet, January 2019. https://www.aha.org/system/files/2019-01/underpayment-by-medicare-medicaid-fact-sheet-jan-2019_0.pdf