UNIVERSITY OF CALIFORNIA HEALTH

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Centers for Medicare & Medicaid Services (CMS),
Department of Health and Human Services (HHS)
Attention: CMS-2445-P
Submitted Electronically via https://www.regulations.gov
Medicaid Program; Disproportionate Share Hospital Third-Party Payer Rule (CMS–2445–P)

Dear Administrator Brooks-LaSure:

The University of California Health system ("UCH") is pleased to submit the following comments regarding the Center for Medicare & Medicaid Services' (CMS) Proposed Rule on Medicaid Third Party Payments.

UCH includes five academic health centers located at the Davis, Irvine, Los Angeles, San Diego, and San Francisco campuses, six medical schools, and fourteen other health professions schools. Together, UCH programs are the nation's largest health sciences and medical education training program, the fourth largest healthcare delivery system in California, the leading provider of certain specialty services and medical procedures, world leaders in clinical discoveries, one of the state's largest providers of care to Medicare patients, and the second largest provider of Medicaid inpatient services.

The UCH academic health centers include six, separately licensed Medicare and Medicaid "disproportionate share" (DSH) hospitals, and thus play a critical role in California's health care safety net. UCH hospitals offer services that are essential to the health and well-being of the uninsured and underinsured including a broad array of highly specialized services, such as cancer centers, geriatric and orthopedic centers of excellence, organ transplant programs, and world class primary and preventive care. UCH provides half of transplants and one-fourth of extensive burn care in California. All told, UCH hospitals and health care professionals provide more than 170,269 inpatient stays and more than 5.9 million outpatient visits each year.[1] ***Nearly 70 percent of our patients are publicly insured or uninsured***.

Specifically, in our fiscal year 2021-2022, approximately 22 percent ($3.6 billion) of UC hospital revenue came from care provided to Medicaid enrollees, who represented 35.2 percent of inpatient days. Costs associated with Medicaid patients are not fully covered by the program and generate significant financial burden for UC's hospitals. It is estimated that Medicaid reimbursement covers between 50 to 60 percent of the cost

of services per patient. Even after accounting for Medicaid Disproportionate Share Hospital (DSH) payments, UC hospitals provided more than $1.1 billion in unreimbursed care for people enrolled in Medicaid in the 2021-2022 fiscal year. That constitutes a 47 percent increase since 2015.

A significant proportion of those unreimbursed costs are related to the care that UC hospitals provide to "dual-eligible" Medicare-Medicaid patients. These individuals are among the nation's most vulnerable and expensive to care for – representing 14% of all Medicaid enrollees, but 30% of all Medicaid spending. And these individuals frequently need the kind of complex tertiary and quaternary care the University of California's hospitals and physicians specialize in. California has one of the highest dual-eligible beneficiary populations in the country. As a critical piece of the California safety net hospital system. All UC hospitals are typically in the 90th percentile and above of hospitals for the total Medicare SSI patients served each year.

While we recognize that CMS is constrained by the changes that Congress enacted in Section 203 of the Consolidated Appropriations Act of 2021 ("Section 203"), UC continues to object to the removal of Medicare-Medicaid duals from the calculation of Medicaid uncompensated care costs. This changes under Section 203 will lead to a reduction in DSH payments to safety hospitals that treat a significant number of dual-eligible patients, but that do not qualify for the "97th percentile" exception.

As amended, Section 1923(g)(2) of the Social Security Act protects certain qualifying hospitals from reductions in their DSH payments that may arise from the exclusion of uncompensated costs associated with Medicaid eligible patients having other third-party coverage. Specifically, qualifying hospitals for the fiscal year are "in at least the 97th percentile *of all hospitals* with respect to" the number of inpatient days or the percentage of total inpatient days that were made up of patients for those days were entitled to Medicare Part A benefits and were entitled to SSI benefits.

We appreciate CMS' interpretation that allows hospitals to qualify if they meet either of these criteria. In addition, we appreciate that the proposed rule seeks to appropriately base the calculation using the inpatient days associated with patients entitled to both Medicare Part A benefits and SSI benefits, and that it would make the determinations on a prospective basis.

We also appreciate CMS interpreting the October 1, 2021, effective date of the Section 203 changes to apply with respect to state plan rate years commencing on or after that date. However, in order to comply with the statutory requirements, we believe that CMS must develop a calculation of the 97th percentile that includes "all hospitals." We also believe that there are additional opportunities for CMS to increase the transparency of its decision-making and provide much-needed predictability for safety net hospitals that rely on DSH funding. We therefore respectfully request the following:

1. **CMS must include all hospitals in the 97th percentile calculation.**

Sec. 203 clearly states that the exemption applies to the "97th percentile of ***all hospitals***" (emphasis added). Limiting the collection of data to only hospitals that file a Medicare cost report or otherwise removing hospitals unlikely to meet the 97th percentile would inappropriately prevent some safety net hospitals from qualifying and deprive them of the relief provided by Congress. Moreover, the scope of the alternative approaches that CMS considered to avoid excluding hospitals was not sufficient. For example, if no or insufficient data is available for some hospitals, then CMS could impute the same data as the lowest ranking hospitals, or use a zero value, for those hospitals. We therefore urge CMS to develop a calculation of the 97th percentile that includes "all hospitals" in accordance with the statute.

2. **CMS should release the 97th percentile lists with all included hospitals expeditiously.**

Safety net hospitals that rely on DSH payments need predictable information about the amount of DSH funding that may be available to them. For that reason, we urge CMS to make public the FY22 and FY23 97th percentile exception list as soon as possible. Precedent exists for CMS to release these data elements prior to a final rule. Furthermore, the proposed rule only provides for the release of a list of those hospitals determined to be in the 97th percentile. For transparency, and to allow for a meaningful review by affected hospitals, CMS at a minimum should release the entire listing of hospitals, as well as their rank order. The complete data set being used in the calculation should also be available. ***We urge CMS to consider releasing such information, in preliminary form, at least 60 days prior to the applicable October 1.***

3. **CMS should work with Congress to avoid the cuts imposed by Section 203.**

Finally, UC respectfully requests that CMS work with Congress to prevent Section 203's unintended and drastic cut to some hospitals' Medicaid DSH payments, without harming those hospitals that qualify for the Section 203 exception. Unfortunately, the narrow exception in the statute does not go far enough to protect financially vulnerable hospitals from being harmed by Section 203, especially those hospitals – like ours—that treat a significant proportion of Medicare-Medicaid dual-eligible patients. Congress must ensure the exception methodology is extended to all who need the protection so that hospitals who serve low-income, medically complex patients, that are still financially struggling from the COVID-19 pandemic and workforce shortages, are not further harmed by this policy.

The University of California Health appreciates the opportunity to submit these comments. If you have questions, please contact Tam Ma, JD, Associate Vice President for Health Policy and Regulatory Affairs at Tam.Ma@ucop.edu.

Sincerely,

Carrie Byington

Dr. Carrie L. Byington
Executive Vice President
University of California Health