National Indian Health Board

Submitted via: http://*www.regulations.gov*

September 14, 2016

Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

RE: CMS-2399-P, Medicaid Program; Disproportionate Share Hospital Payments – Treatment of Third Party Payers in Calculating Uncompensated Care Costs

Dear Centers for Medicare & Medicaid Services:

On behalf of the National Indian Health Board (NIHB), I write to provide comment on the notice of proposed rulemaking regarding the Medicare Program; Disproportionate Share Hospital Payments –Treatment of Third Party Payers in Calculating Uncompensated Care Costs.

Established in 1972, the NIHB is an inter-Tribal organization that advocates on behalf of Tribal governments for the provision of quality health care to all American Indians and Alaska Natives (AI/ANs). The NIHB is governed by a Board of Directors consisting of a representative from each of the twelve Indian Health Service (IHS) Areas. Each Area Health Board elects a representative to sit on the NIHB Board of Directors. In areas where there is no Area Health Board, Tribal governments choose a representative who communicates policy information and concerns of the Tribes in that area with the NIHB. Whether Tribes operate their entire health care program through contracts or compacts with IHS under Public Law 93-638, the Indian Self-Determination and Education Assistance Act (ISDEAA), or continue to also rely on IHS for delivery of some, or even most, of their health care, the NIHB is their advocate

On June 17, 2016, NIHB submitted comments on CMS-1655-P, Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Long-Term Care Hospital Payment System and Proposed Policy Changes and Fiscal Year 2017 rates, et al. In those comments, I noted concerns around the devastating financial impact that the change in methodology regarding Medicaid disproportionate share hospital (DSH) payments would have for Indian Country. I understand that this proposed rule would make clearer the interpretation that uncompensated care costs include only those costs for Medicaid eligible individuals remaining after accounting for payments received by hospitals by or on behalf of Medicaid eligible individuals, including Medicare and other third party payments that compensate the hospitals for care furnished to such individuals. As a result, the hospital-specific calculation would reflect only the costs for Medicaid eligible individuals for which the hospital has not received payment from any source (other than state or local governmental payments for indigent patients).

I would like to reiterate the concerns I raised in our June 17th's letter below.

The DSH payment is an add-on to the DRG. It represents a payment for serving a disproportionate number of low income patients. The formula for calculating this payment has remained constant until 2013. Payments were based on the low income percentage of patients treated at the hospital. The percentage was developed using the number of Medicaid eligible patients to total hospital patients.

In 2013, the DSH payment formula changed. 25% of the DSH payment is based on the previous methodology (Medicaid eligible patients to total). For the remaining 75%, Medicare allocates a pool of costs ($9.2B in 2014) to all hospitals based on the percentage of the hospital's uncompensated care to the national total uncompensated care.

Medicare intended to use the cost report Worksheet S-10 to allocate the 75% pool. When reviewed, it was found that some hospitals had not completed the worksheet, there were inconsistencies on how hospitals reported data and some fields were used incorrectly. Additionally, CMS had not audited the data for accuracy. As a proxy, Medicare is using the number of Medicaid days reported on the cost reports.

In August of 2015, during the Health Financial Systems (HFS) user group meeting it was stated that CMS was considering using the Worksheet S-10 for the 75% calculation. The problem for Indian Health Care Providers (IHCP) is that when this was reviewed CMS indicated that IHCP had no uncompensated care. The cost of patient care is provided through congressional appropriations, even though the appropriations only provide approximately 59% of health care need for American Indians/Alaska Natives[1], and therefore all IHCP patient care is considered compensated. If implemented, this removes IHCP hospitals from participation in the 75% pool.

For FY 2018, CMS proposes to begin incorporating uncompensated care cost data from Worksheet S-10 of the Medicare Cost report in the methodology for distributing these funds under Factor 3. The Factor 3 hospital payments represent 75% of the total amount for uncompensated care payments. The 32 IHS and Tribal hospitals (non-critical access hospitals) received $14.3 million during FY 2015 for what CMS describes as Factor 3 payments for uncompensated care. These payments were based on each hospital's number of low-income days as percentage of the nation's total low-income days.

CMS proposes to re-define uncompensated care costs for Factor 3 payments as the costs of charity care and non-Medicare bad debt and to incorporate Worksheet S-10 data over a three-year period, where insured low income day data will be averaged with uncompensated care cost data. For FY 2018, CMS proposes to use Worksheet S-10 data from FY 2014 cost reports in combination with insured low income days from the two preceding periods for determining the distribution of uncompensated care payments. Unless changes are approved by CMS on the allocation of Factor 3 funds, IHS Federal and Tribal hospitals could ultimately lose all payments under Factor 3 of the uncompensated care pool of funds.

[1] NATIONAL TRIBAL BUDGET FORMULATION WORKGROUP'S RECOMMENDATIONS ON THE INDIAN HEALTH SERVICE FISCAL YEAR 2017 BUDGET, 8 (2015)

Need for Tribal Consultation

Meaningful Tribal consultation must take place before this rule is finalized. Comments received through the rulemaking process are not enough and cannot be considered meaningful consultation within the scope of Executive Order 13175 which states that Tribal consultation must take place prior to the rulemaking process. In addition, CMS' own Tribal consultation policy that was approved on December 10, 2015, requires CMS to conduct Tribal consultation on policies that will have a substantial and direct effect on Indian Tribes. Additional consultation with the Indian Health Service and Tribes is necessary for CMS to ensure that IHS and Tribal facilities continue to access third party revenue for Tribal health programs.

We hope that CMS, in the spirit of its partnership and shared interest in improving American Indian and Alaska Native (AI/AN) access to its resources and services, will work with the Indian Health Service and Tribes to prevent harm to the Indian health care delivery system. We thank you for this opportunity to provide our comments and recommendations. Should you have any questions or concerns, please direct them to NIHB's Director of Federal Relations, Devin Delrow, at ddelrow@nihb.org.

Sincerely,

Lester Secatero
Chairman, National Indian Health Board