American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

April 19, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

CMS-1788-P

Re: Medicare Program; Medicare Disproportionate Share Hospital (DSH) Payments: Counting Certain Days Associated with Section 1115 Demonstrations in the Medicaid Fraction

Dear Administrator Brooks-LaSure:

On behalf of our 40,000 members, the American College of Emergency Physicians (ACEP) appreciates the opportunity to comment on the "Medicare Program; Medicare Disproportionate Share Hospital (DSH) Payments: Counting Certain Days Associated with Section 1115 Demonstrations in the Medicaid Fraction" proposed rule.

CMS is proposing to revise regulations on the counting of days associated with individuals eligible for certain benefits provided by section 1115 demonstrations in the Medicaid fraction of a hospital's disproportionate patient percentage (DPP). In order for days associated with section 1115 demonstrations to be counted in the DPP Medicaid fraction numerator, the statute requires those days to be of patients who can be "regarded as" eligible for Medicaid. CMS is proposing to modify its regulations to explicitly state its long-held view that only patients who receive health insurance through a section 1115 demonstration where State expenditures to provide the insurance may be matched with funds from title XIX can be "regarded as" eligible for Medicaid. Furthermore, CMS is proposing to include in the DPP Medicaid fraction numerator only the days of those patients who receive from the demonstration (1) health insurance that covers inpatient hospital services or (2) premium assistance that covers 100 percent of the premium cost to the patient, which the patient uses to buy health insurance that covers inpatient hospital services. Finally, CMS is proposing stating specifically that patients whose inpatient hospital costs are paid for with funds from an uncompensated/undercompensated care pool authorized by a section 1115 demonstration are not patients "regarded as" eligible for Medicaid, and the days of such patients may not be included in the DPP Medicaid fraction numerator.

In all, hospitals in six States would no longer be eligible to report days of patients for which they received payments from uncompensated or undercompensated care pools authorized by the States' section 1115 demonstration for use in the DPP Medicaid fraction numerator: Florida, Kansas, Massachusetts, New Mexico, Tennessee, and Texas. CMS roughly estimates that overall payments to these hospitals will be reduced by $348.7 million if the proposal is finalized.

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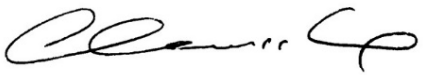
ACEP understands the rationale for this proposal but is concerned with the effect the payment cuts would have on the financial viability of hospitals in these six states, especially those in rural areas that depend on DSH payments. According to a study conducted by Chartis, an estimated 143 rural hospitals have closed from 2010 through January 2023, peaking with a high of 19 in 2020 just as the pandemic hit. Another 453 are vulnerable to closure.[1] When a hospital closes, mortality rates and readmission rates increase at hospitals near to where the hospital closed, particularly at high-occupancy bystander hospitals that are sensitive to changes in the availability of emergency care in neighboring communities.[2] In other words, access to emergency care decreases especially for time-sensitive cases. Patient outcomes also decline with hospital closures, with one study indicating that inpatient mortality increases for time sensitive conditions such as stroke and acute myocardial infarction patients (4.4 percent increase in inpatient mortality), and within these diagnoses Medicaid patients and racial minorities had the highest mortality increases (11.3 percent and 12.6 percent, respectively).[3] Finally, hospital closures cause long-term staffing and recruitment issues, limiting patient access and choice in the surrounding area.

While CMS states that if this proposal were finalized, the agency could still ensure "access to high quality health care for Medicare beneficiaries," it provides no quantitative assurances or analyses to back up this assertion. If CMS were to finalize this proposal, it must include a much more detailed impact analysis that will help guarantee that the payment cuts do not contribute to even more hospital closures or reductions in critical, life-saving services.

We appreciate the opportunity to share our comments. If you have any questions, please contact Jeffrey Davis, ACEP's Director of Regulatory and External Affairs, at jdavis@acep.org.

Sincerely,



Christopher S. Kang, MD, FACEP

ACEP President

[1] The full report can be found at https://www.chartis.com/sites/default/files/documents/chartis_study_rural_health_safety_net_under_renewed_pressure_as_pandemic_fades.pdf.

[2] Hsai R. and Shen Y. Emergency Department Closures And Openings: Spillover Effects On Patient Outcomes In Bystander Hospitals. Health Affairs VOL. 38, No. 9 September 2019. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2019.00125.

[3] Gujral K. and Basu A. Impact of Rural and Urban Hospital Closures on Inpatient Mortality. The National Bureau of Econiv Research. NBER Working Paper No. 26182. August 2019, Revised in June 2020. https://www.nber.org/papers/w26182.