June 12, 2017

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
P.O. Box 8011
Baltimore, MD 21244-1850

Subject: 42 CRF Parts 405, 412, 413, 414, 416, 486, 488, 489, and 495 [CMS-1677-P], RIN 0938-AS98, Medicare Program: Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2018 Rates; Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Electronic Health Record (EHR) Incentive Program Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Provider-Based Status of Indian Health Service and Tribal Facilities and Organizations; Costs Reporting and Provider Requirements; Agreement Termination Notices

Attention: File Code CMS-1677-P

Dear Administrator Verma:

I am writing on behalf of the National Association of Urban Hospitals (NAUH) to convey to the Centers for Medicare & Medicaid Services (CMS) our views on the proposed Medicare inpatient prospective payment system regulation for FY 2018 that was published in the *Federal Register* on April 28, 2017 (Vol. 82, No. 81, pp. 19796-20231).

NAUH would like to address six specific aspects of the proposed regulation:

- Medicare DSH and the S-10
- the hospital readmissions reduction program
- value-based purchasing
- proposed inpatient rates
- the area wage index
- quality reporting

We address each of these subjects individually below. We also offer a response to the Request for Information seeking stakeholder input on how to improve Medicare through enhanced transparency, flexibility, program simplification, and innovation; by reducing bureaucracy, complexity, and regulatory burden; and through ideas for regulatory, sub-regulatory, and policy and practice change and payment redesign.

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Medicare DSH and the S-10

A Proposed New Source of Data for Factor 2

One aspect of the proposed changes in the Medicare DSH uncompensated care payment program that NAUH supports is CMS's call for using data from the U.S. Department of Health and Human Services Office of the Actuary's National Health Expenditures Accounts instead of Congressional Budget Office estimates to determine the change in the rate of uninsured Americans since 2013 when calculating Factor 2. NAUH supports this change because we believe the former more accurately captures changes in the rate at which uninsured individuals have obtained health insurance in recent years.

A Proposed New Source of Data for Factor 3

In the proposed FY 2018 rule, CMS calls for using uncompensated care data from the Medicare cost report's S-10 worksheet to calculate each DSH-eligible hospital's relative share of overall uncompensated care among all DSH-eligible hospitals (Factor 3) for the distribution of Medicare DSH uncompensated care payments in FY 2018. NAUH opposes this proposal for a number of reasons, as detailed below.

Opposition to Using the S-10 in the Calculation of Medicare DSH Uncompensated Care Payments

CMS's proposal to shift from using the current low-income proxy to the S-10 in the calculation of eligible hospitals' Medicare DSH uncompensated care payments is not new: CMS made a similar proposal last year and then withdrew it in the face of considerable opposition from stakeholders – and its own reconsideration of the proposal. In withdrawing the proposal, CMS wrote in the final FY 2017 inpatient prospective payment system regulation that

> We believe additional time may be needed to make certain modification and clarifications to the cost report instructions for Worksheet S-10, as well as explore suggestions made by commenters for ensuring universal submission of Worksheet S-10 by hospitals when filing their cost reports (such as software edits to flag negative, unusual, or missing data or a missing worksheet S-10). As commenters recommended, we will consider issuance of FAQs and hosting of educational seminars for hospitals and MACs as appropriate, coinciding with the issuance of revised cost report instructions. We also intend to explore development of more specific instructions and more uniform review protocols for Worksheet S-10 data.

In NAUH's view, the situation today, with the exception of CMS's issuance of Transmittal 10 in November of 2016,[1] is unchanged. The form and the cost reporting instructions remain the same; CMS has not developed a system for generating software edits to flag potential reporting problems (such as those described below); there have been no FAQs or seminars; and the instructions and review protocols for the S-10 remain the same, including the lack of auditing of the manner in which hospitals complete the form.

Instead of basing the decision to move forward with using the S-10 on improvements of the form, CMS instead decided that it was ready for this use based on a correlation analysis of charity care reported by non-profit hospitals on the S-10 and to the IRS on its Form 990 – an analysis that, NAUH believes is worth noting, excludes for-profit and government hospitals that together constitute a meaningful proportion of acute-care hospitals. While this analysis found that consistency in charity care reporting between the two instruments has increased, it did not examine some of the remaining issues that had led both CMS and stakeholders to conclude that the S-10 was not suitable for use in calculating Medicare DSH uncompensated care payments. Specifically, this review did not identify instances of data reporting

[1] Changes in S-10 reporting described in this transmittal will first be seen in hospitals' 2016 cost reports.

that was defective on its face; anomalies, inconsistencies, and instances of implausible data reporting; underlying causes of inaccurate data reporting; and data that on its face simply defies reason. For these reasons, NAUH does not believe this correlation analysis reveals a "tipping point" in hospitals' S-10 reporting that suggests the S-10 is now suitable for use in Medicare reimbursement policy. To the contrary, NAUH believes the S-10 data remains incomplete, inaccurate, and subject to gaming and therefore does not yield the kind of results needed to justify replacing the current approach with S-10 uncompensated care data.

S-10 Uncompensated Care Data Remains Seriously Flawed

Based on our own analysis, NAUH finds the uncompensated care data that hospitals report on their S-10 to be seriously flawed.

1. Some Data Reporting is Defective on its Face

In NAUH's analysis of the S-10 reports submitted by hospitals nationwide, we identified situations in which the data reporting was clearly defective on its face. Examples include:

- Six hospitals reported providing more Medicare bad debt than total hospital debt.
- Fourteen hospitals reported insured charity care charges but no uninsured charity care charges.
- Fifty-one hospitals reported negative insured charity care charges after subtracting charges for days that exceeded a Medicaid or indigent care program length-of-stay limit.

Such reporting is clearly incorrect but could be corrected, prior to the data's use for payment purposes, if the Medicare Administrative Contractors applied simple edits upon the submission of data and alerted hospitals to such errors. Such a system is not in place at this time, however, such obvious errors are not identified and corrected, and such seriously flawed data could go on, if the proposed rule is adopted, to be used in the calculation of Medicare DSH uncompensated care payments.

2. Implausible Data Reporting

NAUH's analysis of hospitals' S-10 data reporting found trends in reporting anomalies and inconsistencies that are on one level troubling in and of themselves and on another level troubling because of the widespread data reporting problems they suggest. Especially troubling are significant changes in data reported between 2014 and 2015 – troubling because CMS proposes using FY 2014 data from the S-10 as the basis of FY 2018 Medicare DSH uncompensated care payments. It is difficult to accept that hospitals' data reporting has improved significantly when some hospitals reported enormous changes in how much uncompensated care they provided in just one year, from 2014 to 2015. These problems can be viewed from two perspectives: from that of nation-wide reporting trends and on an individual hospital basis.

Nation-wide, for example, NAUH's analysis of hospitals' S-10 reporting in 2014 and 2015 found that:

- 210 hospitals reported providing at least 50 percent less uncompensated care in FY 2015 than they did in FY 2014.
- 150 hospitals reported providing at least 50 percent more uncompensated care in FY 2014 than they did in FY 2015.
- 70 hospitals reported that their uncompensated care more than doubled between FY 2014 and FY 2015.

These broad trends emerged from the implausible uncompensated care data reported by many individual

hospitals, such as:

- Titus Regional Medical Center, in Texas, reported $534 million in uncompensated care in FY 2014 but only $9.8 million in FY 2015.
- The University of Virginia Medical Center reported $17.5 million in uncompensated care in FY 2014 and $141 million in 2015.
- Martin Medical Center, in Florida, reported $6.9 million in uncompensated care in FY 2014 and $44.1 million in FY 2015.
- Swedish Covenant Hospital reported $8.7 million in uncompensated care in FY 2014 and $31.4 million in FY 2015 even though Illinois, where it is located, expanded its Medicaid program.

NAUH can provide many other examples of data reporting that simply defies plausible explanation. Are they just cases of poor, inaccurate data reporting? Of different interpretations of the S-10's instructions from year to year? Of different people preparing the S-10 in different years? Of an attempt to fix a prior year's errors? Of deliberate attempts to game the system to receive larger Medicare DSH uncompensated care payments? Of a decision to stop attempting to game the system?

The bigger problem is that there needs to be a means of identifying such clearly flawed data when it is reported and initiating a process for correcting it, yet no such system exists today – not when data is reported and not when it is audited, because it is not audited. In the absence of such processes neither NAUH nor CMS can know the answer to this question, and while this is certainly worth exploring, it is almost irrelevant insofar as it points to the clear lack of readiness of hospitals' uncompensated care data reporting on their S-10 for use as a tool for the calculation of Medicare payments to hospitals.

3. Data Reporting That Defies Reason

All hospitals provide at least some uncompensated care; some provide more – much more – than others. Hospitals are able to provide uncompensated care and still keep their doors open because they generate revenue in excess of expenses for the care for which they do receive payments. Some hospitals, however, report on their S-10 providing so much uncompensated care that it is not reasonable to believe they can possibly manage to keep their doors open. Consider:

- Eight hospitals reported providing more than $500,000 worth of uncompensated care *per bed* in FY 2014.
- One hospital reported charity care and bad debt costs that amounted to more than eight times its total operating expenses in 2014.
- While the amount uncompensated care most hospitals provide typically accounts for about four to five percent of their operating expenses, 18 U.S. hospitals reported that their uncompensated care amounted to *more than 25 percent* of their operating expenses – and three hospitals said their uncompensated care amounted to *more than 50 percent* of their operating expenses.

Hospitals that absorb enormous losses like these cannot survive; their doors would have closed long ago. This means one thing: they are receiving compensation for costs they are reporting, and that this policy has defined, as uncompensated care. Whether through failure to follow the S-10's instructions, misinterpretation of those instructions, incompetence, an intentional effort to report as much uncompensated care as possible to enable them to receive larger Medicare DSH payments, or (most likely) the S-10 form instructing them to report payments made to offset this care in lines that are not used in the calculation of line 30, they reported far, far more uncompensated care than they actually could have provided if that care were, in fact, uncompensated.

Yet the uncompensated care reported by these and other hospitals would, under CMS's proposal, be used to calculate their FY 2018 Medicare DSH uncompensated care payments.

It should not be, in NAUH's view. The data is simply not ready to be used in this manner.

Problems With the Current S-10

NAUH believes that in its current form, the S-10 poses two kinds of problems: first, it is confusing and too subject to the interpretation of the individuals and hospitals completing it; and second, the form itself has limitations.

When completing the S-10, hospitals have difficulty identifying where they should report non-patient-specific payments they receive to offset their charity care and bad debt. Typically, such payments come from the federal government or their state or local government. Some hospitals interpret the S-10 to suggest that they should subtract these payments from their charity care and bad debt, leaving a figure that constitutes net charity care. Others, however, appear not to report such revenue as offsetting their charity care costs as well. The significant degree to which public hospitals report providing implausible amounts of uncompensated care suggests that they, in particular, choose not to report revenue they receive from their state or local government to help them care for uninsured patients. Of 18 hospitals that reported charity care and bad debt costs exceeding 25 percent of their operating expenses in 2014, 12 were public hospitals – the continuation of a trend NAUH has observed ever since we began analyzing hospital uncompensated care data reporting more than eight years ago. Of those 18 hospitals, moreover, ten are located in just two states: Texas and Louisiana. Both problems suggest systemic challenges that have never been satisfactorily addressed.

Another problem with the S-10 is that its instructions define overlapping categories for reporting charges that are not mutually exclusive, such as charity care for Medicaid cost-sharing. Hospitals must decide for themselves how to avoid reporting charges in multiple categories, if they attempt to avoid it at all.

A bigger problem is that the uncompensated care costs to be reported on line 30 of the S-10 are driven largely by charity care, a measure that is both unique to every hospital and subject to change by every hospital as it wishes.

In addition, the S-10 itself, in its current form, has serious limitations. The form applies a whole hospital cost-to-charge ratio to combined inpatient and outpatient charges even though costs differ considerably between those two settings and the proportions of outpatient and inpatient services hospitals provide are constantly shifting. There are numerous problems associated with data reported by all-inclusive rate hospitals because they do not use charges to track patients' resource consumption. Finally, the S-10's instructions do not define the reported data elements in a manner that enables them to be compared to any other reported data, making the S-10 extremely difficult to report, audit, and validate.

The result of all of these problems is that the S-10 cannot be relied upon to do one basic but essential thing: report how much uncompensated care hospitals provide. In its current form, it does not consistently report how much charity care hospitals provide and how much bad debt they incur and then it does not accurately report all of the revenue hospitals receive to offset that charity care and bad debt – in other words, their *net uncompensated care*. If the purpose of Medicare DSH uncompensated care payments is to help offset some of the uncompensated care DSH-eligible hospitals provide, they cannot do so until policy-makers know, for certain, how much of that uncompensated care – *that net uncompensated care* – hospitals actually provide. Today they do not, which makes the S-10 in its current form not suited for this use.

Why This Matters

With a finite pool of funds for Medicare DSH uncompensated care payments, the Medicare DSH uncompensated care payment program is a classic zero-sum game: for every dollar one hospital gains in additional Medicare DSH uncompensated care payments, another hospital, or other hospitals, must lose a dollar. This means that the amount of uncompensated care reported by one hospital affects the eventual payment to every other DSH-eligible hospital, with one hospital's questionable or inaccurate reporting having a domino effect on every other hospital.

Under any circumstances the Medicare DSH uncompensated care program will be redistributive, but under current circumstances, that redistribution would have no basis in reality if the S-10 were to be used for this purpose and would not be redistributive in the manner Congress intended. Congress directed CMS to make Medicare DSH uncompensated care payments based on hospitals' uncompensated care, but CMS is currently employing a definition of uncompensated care that does not account for certain kinds of compensation.

NAUH's analysis of how using the S-10 to calculate Medicare DSH uncompensated care payments found that under the approach CMS proposes, winners would gain $2.3 billion and losers would lose a collective $2.3 billion, with the top ten percent of winners seeing their share of the overall Medicare DSH uncompensated care pool rising from 18.8 percent to 44.5 percent of that pool, or 77 percent of that $2.3 billion in gains. This, quite simply, defies reason. In both cases – for winners and for losers – there is little reason to believe that their wins and their losses have any foundation in how much uncompensated care they – and other hospitals – actually provide to their patients. In addition, the Secretary of Health and Human Services' determinations in these matters are not subject to administrative or judicial review.

Auditing

All of these problems, both real and potential, point to the need for rigorous auditing to ensure the quality of hospitals' data reporting – and to ensure, once the instructions for the S-10 are eventually improved, that hospitals understand those improved instructions and are able to follow them precisely.

The value of auditing data, in NAUH's view, cannot be overstated. When Medicaid DSH reporting standards were modified some years ago, audits uncovered significant problems in hospitals' initial filings and many hospitals needed to revise their filings in keeping with the auditors' findings. This is a natural aspect of the evolution of data reporting: even though the hospitals were being diligent, their understanding of the new requirements was incomplete and required the guidance of auditors. The anomalies in S-10 data reporting presented above, as well as the many more that can be found, illustrate what can happen when unclear instructions are combined with lack of accountability. This auditing, moreover, must be rigorous: audits comparable in thoroughness to those CMS employs to review wage index data reporting, as opposed to the less rigorous HITECH audits. That auditing might even be used as part of the kind of "probe and educate" approach CMS has used in the past, with the new policy to be implemented only when the agency is satisfied that hospitals are now ready to meet the challenge of providing the data CMS needs to implement this important public policy. Again, this is similar to the policy CMS employed with the Medicaid DSH audits, allowing a grace period before the results of the audits had financial consequences.

For these reasons, NAUH disagrees with aspects of the proposed rule governing S-10 auditing.

First, we disagree with the proposal for CMS to engage in no S-10 auditing until 2020. For data reporting to improve, hospitals need the guidance that auditing would give them. In the absence of auditing, we fear reporting will not improve.

Second, we disagree with the proposal to employ only desk audits beginning in 2020. Desk audits, in NAUH's view, will not be sufficient in light of the size of the challenge CMS faces in working to prepare hospitals to report their uncompensated care data accurately and in a uniform manner nation-wide.

Third, we disagree with CMS's intention not to share the audit criteria with hospitals. If CMS wants hospitals to report their data accurately – an objective NAUH supports – then this process would best be served by making unmistakably and unambiguously clear to hospitals the standards they must meet.

Fourth, we disagree with CMS's stated intention not to attempt to update the instructions for the S-10 or to clarify instructions until 2020. If the problem is at least in part the instructions, then this problem will not go away, the situation will not improve, and S-10 data reporting will remain mistake-filled until CMS acts affirmatively both to improve instructions that are not clear and clarify those that years of history of data reporting suggest that hospitals are finding unclear.

And fifth, we believe that S-10 data should not be used in the calculation of Medicare DSH uncompensated care payments until that S-10 data is audited.

Rather than resolving confusion and increasing uniformity in reporting, the proposed audit policy simply leads to an additional layer of interpretation – that of the Medicare Administrative Contractors – in what data is supposed to be included on the S-10 and that only after the data is already in use.

For these reasons, NAUH urges CMS to create a stakeholder group to work with agency staff to review the S-10 and its instructions, consider the manner in which hospitals are currently interpreting those instructions, and identify possible improvements and clarification of those instructions that will enable hospitals to report their uncompensated care in a more accurate, uniform, and verifiable manner, thereby turning the results reported on the S-10 into an appropriate tool for Medicare DSH payment decisions that have profound implications for so many of the recipients of these payments.

Conclusion

For these many reasons, NAUH believes CMS made the right decision last year when it concluded that the uncompensated care data generated by hospitals' S-10 reports is simply not up to the task of being used for Medicare payment purposes. CMS's rationale for withdrawing a similar proposal last year remains as valid now as it was then: nothing has changed that suggests hospitals are better at reporting their uncompensated care on the S-10 now than they were a year ago and none of the changes CMS suggested last year that could improve this situation have been implemented.

Under these circumstances, NAUH urges CMS to continue using the current low-income days proxy for calculating Medicare DSH uncompensated care payments in FY 2018, using FY 2013 Medicaid days while continuing to update SSI days. NAUH urges CMS not to use FY 2014 Medicaid days because this would be unfair to states that did not expand their Medicaid programs under the Affordable Care Act; we believe that law explicitly gives the Secretary the discretion to define the period from which data will be used to calculate Factor 3.

In the meantime, NAUH urges CMS to pursue the improvements it suggested in its explanation of last year for why it was not proceeding with this very same proposal: issuing FAQs and hosting educational seminars for hospitals to help them better understand how to complete the S-10 and, more important, revising and improving the S-10's instructions to eliminate the uncertainty and ambiguity that has produced such wildly erratic and unacceptable data reporting. Finally, NAUH again urges CMS to audit

hospitals' S-10 reporting to ensure that all of these improvements have their intended effect and not to use S-10 data in the calculation of Medicare DSH uncompensated care payments until this data is audited.

The time for the kind of approach CMS has proposed has not yet come. The data is not yet ready and the results would be very unfair to many hospitals that provide a great deal of care to uninsured and underinsured patients. The failure of the proposed approach to net compensation from uncompensated care costs also would result in the federal government supplanting with federal funds the state and local funds that many hospitals currently receive to help care for the uninsured and underinsured of their communities, and we know this is certainly not CMS's or Congress's intention. It also could result in Medicare DSH uncompensated care payments supplementing state and/or local uncompensated care funds, such as uncompensated care pools – pools that in some states involve enormous amounts of money – funded with federal funds under waiver programs, essentially leaving the federal government double- or even triple-paying for uncompensated care in such situations.

Thus, NAUH believes that the right decision CMS made for FY 2017 is the right decision for FY 2018 as well.

NAUH would welcome an opportunity to meet with CMS officials to review the results of our analysis of S-10 data. We also would gladly participate in stakeholder groups we urge CMS to create to help review the S-10's instructions and improve those instructions so they can become the high-quality policy-making tool that the Medicare DSH uncompensated care program truly needs and deserves.

The Hospital Readmission Reduction Program

NAUH is pleased that CMS proposes adding risk adjustment to the Medicare hospital readmissions reduction program by assessing future penalties based on a given hospital's performance in comparison to that of similar hospitals rather than in comparison to all hospitals, as the program currently does. NAUH has called for such risk adjustment ever since the program was introduced, maintaining that certain hospitals – in our case, private, non-profit urban safety-net hospitals – face a degree of challenge in serving their patients that most hospitals do not and that judging all hospitals similarly was therefore unfair.

While NAUH supports this change in philosophy for the readmissions reduction program, we would like to know more about how this change would be implemented before commenting specifically on what CMS is proposing. To do so, we request access to the data CMS proposes employing to determine how many dually eligible patients hospitals serve; an opportunity to thoroughly evaluate the different methodologies CMS has advanced for creating the peer groups to which individual hospitals would be assigned; and the specific formula CMS proposes using to adjust payments to hospitals. Once NAUH has sufficient information about this data and the proposed methodologies we will be in a position to model the proposal for ourselves, test its projected impact on private, non-profit urban safety-net hospitals and other hospitals, and offer more detailed and specific comments on the proposal.

Documentation and Coding Adjustment

Last year CMS reduced inpatient payments an additional 1.5 percent for a documentation and coding adjustment to fulfill the American Tax Relief Act of 2013 (ATRA) requirement that CMS recover $11 billion from federal fiscal years 2014 through 2017. This came in addition to cuts of 0.8 percentage points in FY 2014, FY 2015, and FY 2016. Hospitals expected another 0.8 percentage point cut in FY 2017 but CMS reduced the payments 1.5 percentage points because CMS's Office of the Actuary

concluded that an additional 0.7 percentage point reduction was needed to fulfill the ATRA mandate, citing growing decreases in inpatient admissions.

In NAUH's view, the analysis that led to last year's larger-than-expected document and coding adjustment failed to account for the increase in Medicare beneficiaries' utilization of outpatient services while inpatient admissions declined and resulted in a much larger documentation and coding adjustment than circumstances warranted. For this reason, NAUH urges CMS to return these payments to hospitals, minus adjustments mandated by the Medicare Access and CHIP Reauthorization Act of 2015 and the 21st Century Cures Act.

Area Wage Index

NAUH opposes CMS's proposal to reduce the labor-related share of hospital payments that are adjusted by the Medicare area wage index from the current 69.6 percent to 68.3 percent. Inasmuch as the wage index system already holds harmless from such a change hospitals with wage index adjustments lower than 1.0, we believe reducing the labor-related shared further undervalues the very real differences in hospital-specific costs. In so doing, in NAUH's view, such a change would specifically harm hospitals in higher-cost urban areas that already experience some of the highest labor costs in the country. NAUH opposes reducing the sensitivity of the prospective payment system to the different circumstances of individual hospitals through the introduction of an approach that would foster the development of a reimbursement system that trends toward the mean despite unquestionable differences in hospital costs.

Those differences are a very real and legitimate concern, and for this reason NAUH urges CMS to withdraw its proposal to reduced the labor-related share of wage index adjustments of Medicare payments for FY 2018.

Quality Reporting

In the draft rule, CMS proposes revising the current pain management questions in the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey to focus on hospitals' communication with patients about patients' pain during their hospital stay. Last year NAUH expressed concern about the pain question in the current survey and urged CMS to consider revising it and we wish to thank CMS for doing so and express our support for this proposed change.

Response to CMS Request for Information: Preserve Medicaid Supplemental Payments Made Through Managed Care

The Medicaid supplemental payment rule finalized on January 17, 2017 imposes new limits on states' ability to increase or create new pass-through payments for hospitals, physicians, and nursing homes through Medicaid managed care contracts. The rule calls for a ten-year phase-out of such pass-through payments.

NAUH urges CMS to withdraw the portion of the regulation that would prohibit states' use of pass-through payments to hospitals through Medicaid managed care contracts. At a time when federal policy-makers are looking to give states greater flexibility, not less, in how they operate their Medicaid programs, such a policy reduces that flexibility and creates a burdensome environment. There are already a number of federal limits on state Medicaid programs, including state upper payment limits, statewide hospital DSH caps, and hospital-specific DSH caps, and another limit is unnecessary and will hinder the

ability of states to operate their Medicaid programs effectively. More important, from NAUH's perspective, is that the harm of eliminating the ability of states to make pass-through payments through Medicaid managed care contracts will be felt most heavily by private, non-profit urban safety-net hospitals. For these reasons, NAUH urges CMS to withdraw its regulation phasing out the ability of states to make these pass-through payments.

In addition, when the rule was proposed last year, that ten-year phase-out period was to begin in 2017 and end in 2027, but the final rule moved that phase-out period back a year, from 2016 through 2026. Most states, including those in which many urban safety-net hospitals are located, employ such pass-through payments and the resources these payments provide are essential to the effective operation of these urban safety-net hospitals. It was because of the clear importance of these payments to their recipients that CMS conceived of the ten-year phase-out period, so NAUH was disappointed to learn that in the final rule CMS effectively turned that ten-year phase-out-period into a nine-year phase-out period by moving the start date of that period to a time before the final rule was published. NAUH urges CMS to reconsider this aspect of the proposed rule and – if it does not withdraw the rule – to restore the originally proposed start date to the ten-year phase out.

Finally, NAUH urges CMS to delay implementation of all aspects of the rule until it provides appropriate guidance to the states. Currently, neither states nor hospitals understand what is expected of them and how they should proceed under the new requirements, and until they receive such guidance, they are not in a position to initiate the steps needed to come into compliance. This poses a special burden for private, non-profit urban safety-net hospitals because in many states they are highly dependent on these pass-through payments.

About the National Association of Urban Hospitals

The National Association of Urban Hospitals advocates for adequate recognition and financing of private, non- profit, urban safety-net hospitals that serve America's needy urban communities. These urban safety-net hospitals differ from other hospitals in a number of key ways: they serve communities whose residents are much older and poorer; they are far more reliant on Medicare and Medicaid for revenue; they provide far more uncompensated care; and unlike public safety-net hospitals, they have no statutory entitlement to local or state funds to underwrite their costs. NAUH's role is to ensure that when federal officials make policy decisions, they understand the implications of those decisions for these distinctive urban safety-net hospitals. NAUH pursues its mission through a combination of vigorous, informed advocacy, data-driven positions, and an energetic membership with a clear stake in the outcome of public policy debates.

* * *

NAUH appreciates the opportunity to present these comments to CMS and invites questions about the concerns we have raised. We especially welcome an opportunity to work with you on the stakeholder groups we have recommended creating to address specific issues.

Sincerely,

Ellen J. Kugler, Esq.
Executive Director