June 22, 2018

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, 424, and 495 [CMS-1694-P], RIN 0938-AT27, 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 2019 Rates; Proposed Quality Reporting Requirements for Specific Providers; Proposed Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs (Promoting Interoperability Programs) Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Medicare Cost Reporting Requirements; and Physician Certification and Recertification of Claims

Attention: File Code CMS-1694-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 2019 that was published in the *Federal Register* on May 7, 2018 (Vol. 83, No. 88, pp. 20164-20643).

NAUH would like to address five aspects of the proposed regulation:

- Medicare DSH, uncompensated care, and the S-10
- the Medicare Hospital Readmissions Reduction Program
- quality reporting
- multi-campus hospitals
- submitting documentation as part of a complete cost report

NAUH also suggests an alternative to the methodology CMS proposes employing to calculate hospitals' Medicare DSH uncompensated care payments and responds to the proposed regulation's request for comments about the Medicare area wage index system.

We address each of these matters individually below.

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## Medicare DSH, Uncompensated Care, and the S-10

### *The Medicare DSH Uncompensated Care Pool*

With the number of uninsured Americans increasing in the past year, CMS proposes increasing the Medicare DSH uncompensated care pool for FY 2019. NAUH supports this proposal. NAUH also appreciates CMS's continued use of the data source that revealed this increase in the number of uninsured people, from the U.S. Department of Health and Human Services Office of the Actuary's National Health Expenditures Accounts, rather than the sources Congress required the agency to use in the past. The increase in the Medicare DSH uncompensated care pool that CMS proposes in response to the increase in the number of uninsured people will help urban safety-net hospitals care for the increased numbers of uninsured residents in the low-income communities they serve.

### *Problems Remain With S-10 Uncompensated Care Data*

In the past year CMS has taken steps it hopes will improve the accuracy of the uncompensated care data hospitals report on their S-10: by issuing Transmittal 11; by offering hospitals an opportunity to revise their S-10 uncompensated care data reporting in light of the changes brought about through Transmittal 11; and by directing the Medicare Administrative Contractors (MACs) to identify questionable data on individual hospitals' S-10 and ask them to reconsider that data. As a result, we recognize the possibility that FY 2015 uncompensated care data might now be more accurate than it was at this time a year ago; we look forward to the time when this revised data is publicly available so we can subject it to our own analysis.

In the meantime, however, we remain concerned that a number of specific, recurring data reporting problems that we found in the past remain a problem for many hospitals, including:

- Hospitals that reported providing more Medicare bad debt than total hospital bad debt.
- Hospitals that reported insured charity care charges but no uninsured charity care charges.
- Hospitals that reported negative insured charity care charges after subtracting charges for days that exceeded a Medicaid or indigent care program length of stay limit.
- Hospitals that reported enormous increases in uncompensated care from FY 2014 to FY 2015.
- Hospitals that reported providing unsustainable proportions of uncompensated care.
- Hospitals with a charity care policy that includes care for Medicaid patients whose stays exceed a day limit reporting those days on their charity care line on the S-10 while others reported that shortfall on the Medicaid line of the S-10.

We have encountered such problems again, as we have in the past, in the mostly recently available FY 2014 and FY 2015 data, from the March 2018 HCRIS update that was released in April. This suggests that while CMS may, we hope, be making progress toward addressing S-10 reporting problems, challenges remain and some hospitals still may have flawed data.

NAUH also is concerned that the emphasis of most of this recent activity has been on improving hospitals' FY 2015 data and not on addressing their FY 2014 data problems as well. Even assuming meaningful improvement in hospitals' FY 2015 data, the lack of attention to improving FY 2014 data is of great concern to NAUH because CMS proposes using that still-flawed FY 2014 data in the calculation of eligible hospitals' FY 2019 Medicare DSH uncompensated care payments.

***CMS's Efforts to Improve S-10 Uncompensated Care Data Reporting***

In the past year, as noted, CMS took three major steps to attempt to improve hospitals' S-10 data:

- It issued Transmittal 11.
- It gave hospitals an opportunity to revise their FY 2014 and FY 2015 S-10 reports based on the new directions provided in Transmittal 11.
- It instructed the MACs to flag S-10 uncompensated care data that appears aberrant and ask those hospitals to reconsider their S-10s and file revised reports.

While these steps offer potential for improving the quality of S-10 uncompensated care reporting, there is reason to believe that hospitals continue to struggle with the instructions – specifically, that after hospitals filed revised cost reports in response to CMS's invitation to do so, in many cases the agency felt a need to direct the MACs to review those newly filed cost reports and ask hospitals with aberrant data to reconsider and revise their data yet again. In addition, stakeholders have yet to see the actual data these new processes yield and that data has not yet been audited. As a result, the introduction of these changes, on its own, is not enough, in NAUH's view, to justify relying so heavily on this data for something as important as calculating hospitals' Medicare DSH uncompensated care payments in the coming fiscal year.

Transmittal 11 marks what we hope will be an improvement in helping hospitals complete their S-10 in a more precise, accurate manner. Many of the improvements are changes NAUH has recommended in the past, including clarifying that uninsured discounts should be included; discontinuing the practice of reducing co-pays and deductibles by a cost-to-charge ratio; ending the reduction of unreimbursed Medicare bad debt by a cost-to-charge ratio; and more. The result is that in the future, S-10 uncompensated care data reporting should be better. We use the qualifier "should be" for two reasons: first, because we have not yet been given an opportunity to see this revised data nor to learn how many hospitals have revised their data; and second, because the data has not been audited, at this point there is no assurance that it is better than the data it replaced.

At the same time that CMS issued Transmittal 11 it also invited hospitals to revise their FY 2014 and FY 2015 S-10 reports. As NAUH understands it, many hospitals took advantage of this opportunity but many did not. NAUH is aware of at least one hospital that attempted to revise its FY 2014 S-10 but was unable to do so because it was informed its FY 2014 cost report was closed; this happened even though it attempted to submit its revision within the time frame established by CMS for this purpose.

In the past year, as noted, CMS also called upon the MACs to initiate an informal process of identifying hospitals whose S-10 uncompensated care data appeared aberrant and suggest that these hospitals review the S-10 data they reported and consider amending their uncompensated care report. NAUH understands that this review focused on the most troubling FY 2015 data and paid less attention to equally troubling FY 2014 data. This was a worthwhile undertaking, although far short of the rigorous auditing NAUH recommends (discussed below), leaving as-yet unanswered questions about the quality and accuracy of the revised data.

The release of Transmittal 11, moreover, though welcome, was troubled by a number of problems.

First, upon the release of Transmittal 11, hospitals were given an opportunity, if they wished, to revisit their S-10 and make changes based upon the revised form and its revised instructions. When the MACs identified data that they flagged as possibly aberrant, they asked the hospitals in question to review that data and consider submitting revisions. Both of these efforts focused largely on improving the accuracy of FY 2015 data reporting but neither included auditing of hospitals' revised data. This was a laudable

objective, to be sure, but FY 2014 data, currently proposed for use in the calculation of hospitals' FY 2019 Medicare DSH uncompensated care payments, received far less attention and remains the greater problem today. This leaves the potential for significant, inexplicable differences in uncompensated care reporting from FY 2014 to FY 2015. For example, prior to Transmittal 11, whether a hospital had accurately distinguished between insured and uninsured charity care made no difference in the resulting uncompensated care amount calculated on line 30 of the S-10. After Transmittal 11, however, not reducing co-pays and deductibles reported as uninsured charity care brought to light that some hospitals were likely not accurately distinguishing between insured and uninsured charity care. Further, a MAC letter prompting hospitals to revise their 2015 data often did nothing to address the likelihood that the very same misallocation probably occurred in 2014 as well. Again, this inconsistent data could result in significant changes in how much Medicare DSH uncompensated care money such hospitals receive based on nothing to do with how much uncompensated care they actually provided.

Second, the piecemeal approach of having the MACs identify clearly flawed data left unaddressed questionable reporting by many hospitals because it focused on the most obvious problems, leaving less-obvious but still serious reporting failures unaddressed. In addition, stakeholders still have not been informed about how widespread this data revision process actually was.

Third, as noted, the MACs focused primarily on FY 2015 data, to the general neglect of FY 2014 data, even though the latter is very much a part of FY 2019 Medicare DSH uncompensated care payment calculations.

Fourth, it probably will not be possible to expect all hospitals to be able to revise their S-10s based on Transmittal 11 because of the limits of the software some hospitals use to manage their revenue and cost data. In some cases, the new distinctions mandated by Transmittal 11 may be distinctions that some hospitals' information systems were not capable of making at the time the new directive was released. Those systems will require updated software, making it unlikely that any data collected before Transmittal 11's release by at least some hospitals will ever be useful in revising FY 2014 and FY 2015 S-10 reports and the best that can be hoped for, expected, and required is that this data will be reported beginning in the first fiscal year after Transmittal 11's release (that is, FY 2018).

Fifth, this process has focused on identifying questionable data but has only partially addressed the underlying problem: the S-10's instructions. As NAUH has conveyed to CMS in the past and does so again in this letter, many of the current data reporting problems can be traced to uncertainty about what the S-10's instructions say and where they direct hospitals to report certain kinds of data. Without question, Transmittal 11 improved the S-10 and improved the S-10's instructions, but NAUH believes some ambiguities about the instructions remain. This is a work in progress and not a final product, so NAUH believes CMS should continue the process of improving the instructions and confirming that hospitals understand those improvements through careful auditing.

Finally, the release of Transmittal 11 was accompanied by only limited CMS provider education: a single CMS national provider call and an FAQ. There were no other major hospital education efforts: no open door forums or webinars through which to inform the provider community of the changes and how to incorporate them into their data reporting.

In all, CMS took several important steps toward attempting to improve S-10 data in the past year, and NAUH appreciates these steps. Transmittal 11, in particular, represents a potentially major improvement, but it will only help produce the degree of improvement needed when all of the S-10 reports for FY 2014 and FY 2015 are corrected and audited for accuracy or when future Medicare DSH payments are made based on S-10 data from fiscal years in which all hospitals did their reporting based on Transmittal 11 instructions and the quality of their reporting was verified by auditing.

More needs to be done, NAUH believes, before S-10 data should be used in the calculation of eligible hospitals' Medicare DSH uncompensated care payments. With this in mind, NAUH recommends three steps we believe CMS should take in the coming year:

- In light of the continuing problems with FY 2014 and FY 2015 S-10 data for a significant number of hospitals, use an alternative methodology for calculating hospitals' FY 2019 Medicare DSH uncompensated care payments.
- Improve the S-10 and its instructions.
- Establish a formal process for auditing hospitals' S-10 reports.

We present each of these recommendations individually below.

***Recommendation #1: Use an Alternative Methodology for Calculating Hospitals FY 2019 Medicare DSH Uncompensated Care Payments***

NAUH opposes CMS's proposal to base Medicare DSH uncompensated care payment payments for FY 2019 one-third on the FY 2013 low-income variable, one-third on hospitals' FY 2014 S-10 reported uncompensated care, and one-third on hospitals' FY 2015 S-10 uncompensated care. We do so because of continuing, legitimate questions about the accuracy of hospitals' uncompensated care data reporting on the S-10, and especially because of a possible disparity in the accuracy of that reporting between FY 2014 and FY 2015 and CMS's proposal that data from both of those years be used in the calculation of hospitals' FY 2019 Medicare DSH uncompensated care payments. For this reason, NAUH recommends that CMS use an alternative methodology to calculate those FY 2019 payments – an alternative that does not use FY 2014 data that the past year's efforts has left largely untouched.

For the current 2018 fiscal year, Medicare DSH uncompensated care payments are based in part on its low-income variable for 2012 and 2013 and in part on uncompensated care as reported on eligible hospitals' FY 2014 S-10 reports.

For FY 2019, as noted, CMS proposes weighting Medicare DSH uncompensated care payment calculations one-third on the FY 2013 low-income variable, one-third on hospitals' FY 2014 S-10 reported uncompensated care, and one-third on hospitals' FY 2015 S-10 uncompensated care.

*NAUH, however, recommends that CMS base hospitals' FY 2019 Medicare DSH uncompensated care payments two-thirds on hospitals' 2013 low-income variable and one-third on their FY 2015 S-10 reported uncompensated care.*

This approach eliminates the use of FY 2014 uncompensated care data that is, in NAUH's view, an unquestionably weak and unsuited data component. It also relies on FY 2015 data, which has been the subject of a great deal of attention by CMS and appears to be moving the reporting of hospital uncompensated care data in the right direction, and continues use of the low-income variable, which is an adequate temporary surrogate for the measure of uninsured and low-income patients hospitals serve.

Most important, NAUH's suggested alternative slows the transition of this calculation at a time when it appears that recent developments offer potential for moving that calculation in the right direction in the future because at this time, that potential is only theoretical: it has not been verified by auditing of data reported based on the recent changes in the S-10 and its instructions. Slowing the transition to the newly proposed methodology for calculating Medicare DSH uncompensated care payments would give this process much-needed time: time for hospitals, which have been on the receiving end of a great deal of change in the past year, to absorb the lessons they have learned and do a better job of completing their

next S-10 report and going back and revising their recent S-10s; and time for CMS, too, to absorb the lessons it has learned from the hospital community's response to the changes it has introduced in the past year and build on those changes to improve the S-10 even more and cultivate the further development of an S-10 that does an even better job of quantifying the uncompensated care hospitals report.

In support of these changes, NAUH also recommends that:

- CMS use the coming year to audit any past S-10 data that it contemplates using in future calculations of Medicare DSH uncompensated care payments;
- CMS make its audit protocols public, uniform, and not subject to interpretation by the individual MACs; and
- CMS proceed carefully and deliberately because its decisions are not subject to administrative review and cannot be litigated, thereby greatly increasing the stakes in the coming decisions for the very hospitals, including urban safety-net hospitals, that care for so many low-income and low-income Medicare patients.

***Recommendation #2: Improve the S-10 and its Instructions***

NAUH believes a number of changes are needed in the S-10 itself to ensure its effectiveness as a tool for gathering the quality of data about hospitals' uncompensated care needed to ensure that Medicare DSH uncompensated care payments reach the hospitals that most need them. These changes include:

- *Refining the definition of uncompensated care*. In our view, the S-10 continues to disregard some of the compensation some hospitals receive for serving some of their uninsured patients. In particular, public hospitals often fail to report as revenue appropriations or other payments they receive from their local, county, or state government specifically to care for uninsured patients. When they fail to report this revenue they are, in essence, being paid twice for this care: first by their local, county, or state government and second by the federal government, through Medicare DSH payments. Depending on how those local, county, or state governments structure their payment plans to public hospitals, moreover, those payments could even include some federal Medicaid matching funds, leaving these hospitals to be paid twice by the federal government for the care they provide to some of their patients.
- *Adding utilization measures to the S-10*. NAUH believes the S-10 would benefit from some utilization measures. Today, it is difficult to look at a hospital's S-10, read that it reported providing $12 million worth of uncompensated care, and place that figure in any meaningful context. Introducing utilization measures such as days of care, inpatient admissions, and outpatient visits for all patients and also just for uninsured patients would be a valuable addition to the form.

NAUH also believes it is essential that CMS continue working to improve the S-10's instructions. Over the years NAUH has spoken to countless hospital finance officials and asked them about how they interpret the current instructions and we seldom hear the same answer twice. We have found that in addition to specific challenges like those noted above, some hospitals interpret the current instructions very literally while others see flaws in the instructions and instead report data where they think it should be reported rather where the instructions say to report it. Greater clarity can overcome the different ways individual hospitals respond to the current ambiguity and uncertainty: improve the instructions and provide training on the instructions and hospitals will no longer feel a need to make decisions about matters no one wants hospitals deciding on their own. Transmittal 11 represents a potentially promising step forward toward producing reliable uncompensated care data upon which to base Medicare DSH

uncompensated care payments, and NAUH urges CMS to continue with this improvement process.

In its pursuit of ways to improve the S-10 and its instructions, CMS now has at its disposal a fresh trove of insight into the form's shortcomings: the lessons learned when it issued Transmittal 11 and fielded questions about it from hospitals and the work of the MACs in identifying and addressing questionable data reporting. This offers real opportunity to identify problems and propose solutions that will improve the S-10, improve the S-10's instructions, and improve the quality and accuracy of the data hospitals report. In addition, CMS no doubt will be able to identify data reporting problems that persist despite the improvements introduced with Transmittal 11, and these problems offer natural and obvious targets for future improvement efforts. NAUH urges CMS to work cooperatively with the hospital industry to understand more completely the current problems and ambiguities and then to improve the form, and its instructions, so the S-10 can be a worthy tool for use in the implementation of important public policy.

***Recommendations #3: Establish a Formal Process for Auditing Hospitals' S-10 Reports***

It is essential, NAUH believes, for S-10 data reporting to undergo rigorous auditing to ensure the quality of the data hospitals report – and to ensure that hospitals are reporting their uncompensated care accurately.

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 described above, as well as the many more that can be found, illustrate what can happen when unclear instructions are combined with lack of accountability.

The needed auditing 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. 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.

NAUH believes S-10 data needs auditing – real auditing, thorough auditing, professional auditing, and not the mere desk auditing that CMS previously said will introduce in 2020. While NAUH appreciates the effort CMS has made in recent months, through the MACs, to take a closer look at selected hospitals' S-10 data on a case-by-case basis, such an approach does not and cannot take the place of comprehensive, systematic auditing.

***Why This Matters***

With a finite pool of money 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 has little basis in reality or merit because of the manner in

which the S-10 is now used. 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. Improving the S-10, improving its instructions, and auditing the uncompensated care data hospitals report is the best way to ensure that these scarce federal resources find their way to the hospitals that are providing the most uncompensated care – as Congress intended.

### *Conclusion*

NAUH believes CMS has taken potentially important strides in the past year toward transforming the S-10 into a credible source of data to be used in the calculation of Medicare DSH uncompensated care payments. As we detail in this letter, however, problems remain – problems that can be overcome, to be sure, but serious problems nonetheless. We have described those problems and outlined some of the things we believe CMS should do to address them. Specifically, the three steps NAUH recommends are:

1. Use an alternative approach to calculating hospitals' FY 2019 Medicare DSH uncompensated care payments.
2. Improve the S-10 and its instructions.
3. Establish a formal process for auditing hospitals' S-10 reports.

Some of those things involve specific steps CMS can take while others involve pausing and taking time. Hospitals need time to absorb the lessons they have learned so they can do a better job of reporting their uncompensated care on their S-10 reports. CMS, on the other hand, needs time to analyze how hospitals have responded to the changes it has introduced, identify problems that remain, and craft new ways of addressing those problems by developing improvements in the S-10 and its instructions and introducing an auditing program that ensures that hospitals understand what CMS seeks through the S-10 so that report can become a credible tool for calculating fair, appropriate Medicare DSH uncompensated care payments in the future.

## The Medicare Hospital Readmissions Reduction Program

NAUH appreciates the changes CMS has introduced in the Medicare Hospital Readmissions Reduction Program. Specifically, we support the change to organizing hospitals into peer groups and evaluating their performance in comparison to similar hospitals.

At the same time, however, we are concerned that this program may soon reach a point of diminishing returns where hospitals have done everything they might reasonably be expected to do to prevent avoidable readmissions but still find themselves penalized for their performance compared to that of their peers for circumstances that are simply beyond their control. The introduction of this program appears to have been valuable, but it has raised the bar on avoidable readmissions to a level where, at some point in the near future, it may no longer be possible to improve performance more than very marginally, leaving a few hospitals that fall just slightly below the level of performance of their peers – yet performing at levels far superior to those prior to the readmissions reduction program's introduction – subject to significant financial penalties.

NAUH also urges CMS to assess whether five peer groups is the appropriate number of groups or whether the objective of treating hospitals fairly might better be served by introducing more peer groups that do a better job of distinguishing between different types of hospitals.

In addition, a number of studies have raised legitimate questions about the true value of the readmissions reduction program. NAUH encourages CMS to include the readmissions reduction program in a broader review of all of its quality improvement programs and to consider first, whether the readmissions reduction program is worth retaining, and second, whether these programs as a group have achieved their objectives and perhaps should give way to other approaches to achieving quality-related objectives.

NAUH would welcome an opportunity to work with CMS to address these questions.

## Quality Reporting

NAUH wishes to thank CMS for proposing to reduce the paperwork burden on hospitals through changes in the quality reporting program.

NAUH also appreciates that CMS is taking steps to recognize the impact of social risk factors in quality measurement and wishes to address briefly accounting for those risk factors in Medicare's quality program. In the proposed rule, CMS advances two possible means of accounting for social risk factors: calculating differences in outcome rates among patient groups within a hospital while accounting for their clinical risk factors, which would permit comparison of those differences across hospitals; and assessing outcome rates across hospitals for subgroups of patients, such as dually eligible patients, thereby facilitating comparisons among hospitals on their performance in caring for their patients with social risk factors. As a first step, CMS proposes including stratified data on Pneumonia Readmission measure data for dually eligible patients in hospitals' confidential feedback reports beginning in the fall of 2018 and using both methodologies identified above.

NAUH supports the use of social risk adjustment, including adjustment for sociodemographic status. Research continues to suggest that sociodemographic factors beyond providers' control – the availability of primary care and physical therapy, easy access to medications, appropriate food and other supportive services, and others – influence patient outcomes. For example, a January 2016 report from the National Academy of Medicine found evidence that a wide variety of social risk factors may influence performance on certain health care outcome measures, such as readmissions, costs, and patient experience of care.

In addition, the Improving Medicare Post-Acute Care Transformation (IMPACT) Act required the Department of Health and Human Services' Office of the Assistant Secretary for Planning and Evaluation to perform a study of risk adjustment for sociodemographic status based on quality and resource use measures and to incorporate its findings in future rule-making. Its report found that clinicians, hospitals, and post-acute providers are more likely to score worse in CMS pay-for-performance programs when they care for large numbers of poor patients.

Together, these reports provide evidence of what urban safety-net hospitals and other providers have long known: that patients' sociodemographic and other social risk factors matter greatly when trying to assess the performance of health care providers. NAUH urges CMS to incorporate sociodemographic adjustment into any quality or cost measures it uses to assess hospital performance.

## Multi-Campus Hospitals

NAUH wishes to thank CMS for its proposed rule defining how multi-campus hospitals would be treated by Medicare for special purposes. This is an important acknowledgement of the changing nature of the

hospital industry and we believe this proposed regulation, if implemented, would give hospitals a clearer understanding of the implications of combining with other hospitals as the consolidation of the industry continues.

## Submitting Documentation as Part of a Complete Cost Report

In the proposed regulation, CMS calls for requiring hospitals to submit detailed documentation underlying various components of their Medicare cost reports: bad debt, Medicaid days associated with their DSH adjustment, and charity care and uninsured discounts. NAUH does not object to this new requirement.

We are, however, concerned about the timing of these requirements and urban safety-net hospitals' future ability to revise their cost reports based on more recent data. Currently, hospitals have six months to file their cost reports with their MACs and up to 12 months thereafter to revise them. In some cases, however – retroactive determinations of Medicaid eligibility are an excellent example – the final disposition of some of the data elements to be required of hospitals may change well after even this extended deadline for filing and revising Medicare cost reports. For this reason, NAUH asks CMS to explicitly confirm in the final regulation that hospitals will have ample opportunity to update and revise their Medicare cost reports as those reports move closer to final settlement – time even beyond the current parameters for filing and revising the reports.

## Medicare Area Wage Index: Response to Request for Comment

While acknowledging the challenges that the current Medicare area wage index poses at times, in general NAUH supports the current Medicare area wage index system and believes it superior to any alternative that has been proposed in recent years. We believe wage adjustments based on the cost of labor in different parts of this country are absolutely essential for Medicare because those costs vary so greatly in different geographic areas. The concerns periodically expressed by some that certain parts of the country are ill-served by the current wage index system are, in our view, based on sentiment and emotion rather than on fact; the data does not support their assertions, and when circumstances change, the current system gives those who feel ill-served by that system ample and fair opportunities to address what they perceive to be inappropriate treatment.

We are especially concerned about a proposal that appears to resurface every few years: that the wage data upon which wage adjustments are made should come from the Bureau of Labor Statistics (BLS) rather than from actual, real-time hospital wage data. NAUH believes this is a bad idea. We do not see the value of using broad categories of data that fail to reflect real employment markets and conditions when actual hospital wage data that does reflect actual hospital wage costs is available and verifiable.

One of the most important factors in wage index calculations, for example, is wages paid to nurses. BLS data, however, does not capture important differences within the nursing profession, inappropriately lumping nurses who work in different settings into a single category. In so doing, BLS data ignores the sometimes considerable differences in skill and education levels required of nurses in different settings – hospitals, nursing homes, doctors' offices, public health facilities, and others – and the considerable differences in wages required to recruit nurses to these different settings and then retain them. Hospital nurses, for example, require a different, higher level of skill and education than nurses in other settings. They also work in a more stressful environment and work less desirable hours, including evening and overnight shifts. As a result, hospitals must offer nurses more money than nursing homes, doctors' offices, and others. Some states, moreover, have legal nurse staffing requirements that increase the demand for hospital nurses, which in turn increases how much money hospitals must pay to ensure that

they can meet their nurse staffing requirements. BLS data reflects none of these distinctions and therefore would offer a poor foundation upon which to make broad policy decisions that would have a major impact on hospitals and, no less important, on the communities hospitals serve. In addition, reporting wage data to BLS is voluntary, and in any geographic areas where BLS concludes that it did not receive enough responses to calculate average wage costs, it infers such data. NAUH disapproves of this approach and again believes it is better to use actual hospital wage data than incomplete and possibly even inferred data.

NAUH strongly encourages CMS to reject any shift to the use of BLS data in the calculation of Medicare wage adjustments and instead urges CMS to continue to base hospital wage adjustments on real hospital wage costs as reported by hospitals and as audited periodically by CMS. In addition, if CMS wishes to pursue possible changes in the wage index system, NAUH urges it subject the process to fresh analysis – many of the reviews that call attention to the system's challenges are outdated – and to convene a broad-based group of providers and other stakeholders to evaluate the challenges and explore potential improvements or alternatives.

## 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.

Sincerely,

Ellen J. Kugler, Esq.
Executive Director