NAUH
NATIONAL ASSOCIATION OF URBAN HOSPITALS

June 17, 2016

Mr. Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244-1850

Subject: 42 CFR Parts 405, 412, 413, and 485 [CMS–1655–P] , RIN 0938–AS77, 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 2017 Rates; Quality Reporting Requirements for Specific Providers; Graduate Medical Education; Hospital Notification Procedures Applicable to Beneficiaries Receiving Observation Services; and Technical Changes Relating to Costs to Organizations and Medicare Cost Reports

File Code CMS-1655-P

Dear Acting Administrator Slavitt:

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 2017 that was published in the *Federal Register* on April 27, 2016 (vol. 81, No. 81, pp. 24946-25322).

NAUH would like to address six aspects of the proposed regulation: Medicare disproportionate share payments, the hospital readmissions reduction program, inpatient rates, observation status/two-midnight rule, the outlier threshold, and reporting data for the Medicare area wage index. We address each of these matters individually below.

Medicare DSH Payments

Medicare DSH Issue 1: Objections to the Proposed New Methodology for Calculating Medicare DSH Uncompensated Care Payments

In the proposed FY 2017 inpatient prospective payment system regulation, CMS proposes initiating a three-year transition, beginning in FY 2018, from calculating hospitals' Medicare DSH uncompensated care payments based on its current uninsured proxy of Medicaid and SSI days to calculating those payments based on the uncompensated care hospitals report on their Medicare cost report's S-10 form. This means using uncompensated care data from line 30 of the S-10 (charity care and non-Medicare bad debt) to calculate Medicare DSH uncompensated care payments rather than the Medicaid/SSI days proxy.

21351 Gentry Drive, Suite 210, Sterling, VA 20166
Phone: 703-444-0989, Fax: 703-444-3029
www.nauh.org

To adjust for questionable data, CMS proposes trimming hospitals with cost-to-charge ratios more than three standard deviations above the mean and replace such ratios with average cost-to-charge ratios. In making this proposal, CMS cited a belief that the Medicaid/SSI days proxy does not have adequate correlation with hospital uncompensated care. CMS's conclusion was based on a report by a consultant that looked at non-profit hospitals' 990 forms and concluded that the correlation between those reports' uncompensated care figures and what hospitals report on their S-10 has improved over time and that this suggests hospitals are doing a better job of reporting their uncompensated care data.

NAUH respectfully disagrees with both the CMS proposal and the basis of MedPAC's recommendation. NAUH believes the data CMS would derive from the current S-10 form, and that it proposes using to calculate hospitals' Medicare DSH uncompensated care payments is inaccurate, lacks uniformity, and should not be used, under any circumstances, for important public policy-making until steps are taken to improve it and those improvements are verified through rigorous auditing. The study indicates that among hospitals that file a form 990, consistency of reporting uncompensated care has improved. That study does not, however, illustrate or even evaluate whether this data is a reasonable proxy for the costs hospitals incur in providing care to the uninsured. Further, we know that the most notable aberrations in the S-10 data occur among public hospitals, which do not file a form 990 and are therefore missing from the analysis.

At the heart of this problem are the instructions for completing the S-10 and the manner in which hospitals interpret those instructions. Those instructions, NAUH believes, are imprecise, leaving them too subject to interpretation – beginning with the question of what, exactly, is "uncompensated care"? Five years ago, a consultant CMS hired to help it implement Affordable Care Act-mandated changes in Medicare DSH policy concluded that "…we found variations in how existing programs and entities define uncompensated care." Those definitions, the consultant noted, vary among federal programs, the states, rating and research organizations, and provider organizations."

The result, NAUH has found in its continuing analysis of uncompensated care reporting on the S-10 form over the past five years, is wild inconsistency in how hospitals report their uncompensated care.

Some examples illustrate this conclusion.

- One hospital with a charity care policy that includes care for Medicaid patients whose stays exceed a day limit may include those days in its charity care line on the S-10 while another hospital may include that shortfall on the Medicaid line of the S-10. In this example, both hospitals are providing the same care for the same reimbursement but only one shows the shortfall as uncompensated care.
- Some public hospitals report all of the care they provide to their low-income and uninsured patients on the charity care line of the S-10 and payments from local or county funds or indigent care pool resources on line 18 while others report a reduced number in the charity care line to account for payments received; still others do not report their government support at all.
- Some hospitals report all charges for their uninsured patients on line 23 of the S-10 while others include some of that data on line 29.
- Some hospitals report full charges for the uncompensated care they provide while others report those charges at a discounted rate.
- In some states, hospitals draw funds from CMS-approved state uncompensated care pools to help with the cost of caring for their uninsured patients. Some of these hospitals subtract the money they draw down from these pools from their uncompensated care costs while others do not. Then, in some places, uncompensated care payments are reflected in the S-10's line 19 and not in lines 18 or 20 while other providers report comparable uncompensated care differently.
- More than 60 hospitals did not include the S-10 in their FY 2014 Medicare cost report and another 23 reported providing negative amounts of uncompensated care.

These examples clearly illustrate the challenges CMS has not yet overcome in addressing the inconsistencies in how hospitals can and do report their uncompensated care data – if, as the final point illustrates, they report such data at all.

In some places with public hospitals, the local or county government places all of its government-funded FQHCs and section 330 clinics under the public hospital. Because the public hospital does not claim any direct payments for the care these clinics provide, they claim all of those services as uncompensated care, entitling them to a larger share of Medicare DSH uncompensated care pool even though the local government is financing the clinics. While public hospitals in places like Dallas, Los Angeles, and Chicago do this and benefit enormously from this practice through larger Medicare DSH payments, cities without public hospitals cannot do this at all. This is either unfair to federal taxpayers or unfair to the residents of cities that do not have the same opportunity, yet the instructions for completing the S-10 have not been revised to clarify what is and is not permitted nor have the S-10 reports of the hospitals and health systems been audited to identify and correct such situations.

Attempting to attribute different types of data reporting problems to specific types of hospitals is extremely difficult. After spending five years reviewing the data of every general acute-care hospital in the country that participates in Medicare's inpatient prospective payment system, NAUH has found that same types of hospitals may report their uncompensated care differently; different types of hospitals may report their uncompensated care differently; there can be differences in reporting practices even within distinct hospital types; and there can be differences in reporting practices within regions, within individual states, and even between neighboring hospitals.

NAUH has been monitoring S-10 data reporting ever since CMS began addressing the Affordable Care Act mandate to adjust the uncompensated care portion of hospitals' Medicare DSH payments to reflect the expected decline in the number of uninsured patients they serve. We have polled our members to learn how they report their uncompensated care; we have polled other private urban safety-net hospitals to learn how they report their uncompensated care; we talk to hospital finance executives continually to learn how they report their uncompensated care; and we talk to hospital association officials almost continually to learn about how their members report their uncompensated care.

The lesson we take from all of these efforts is clear: there is no single, uniform manner in which hospitals report their uncompensated care and very little in the way of any patterns for how different types of hospitals, or hospitals located in different areas, report their uncompensated care. Our experience suggests that if you put 100 hospital finance executives in a room and ask them how they report their uncompensated care on their S-10 you will probably get a dozen different answers – if not more.

NAUH closely monitors the uncompensated care that every general acute-care hospital in the country reports on its S-10 and annually models how the data those hospitals report might alter their Medicare DSH uncompensated care payments if CMS were to shift the basis of those payments from the current Medicaid/SSI days proxy to the S-10. Our latest modeling, based on hospitals' FY 2014 Medicare cost reports, produced the following examples of questionable practices or outcomes.

- A county hospital in Texas reported $655 million in uncompensated care on line 30 on its S-10 yet it receives $574 million in county appropriations and $165 million in Medicaid payments in excess of its Medicaid costs, the latter of which included uncompensated care pool funds from the Texas section 1115 waiver. Reason suggests that the purpose of the county appropriation is to support care for the uninsured and that it therefore should be deducted from the line 30 figure to yield a true uncompensated care figure.
- A public Louisiana hospital reported providing nearly $670,000 worth of uncompensated care *per bed*. It also reported $2.9 million on line 18 of its S-10 that year. Subtracting this government

assistance from its uncompensated care total still leaves $643,000 worth of uncompensated care per bed – *1300 percent* of the average amount of uncompensated care per bed reported by hospitals.

- A 96-bed public hospital in Texas reported $534 million in line 30 uncompensated care. This amounts to more than $5.5 million worth of uncompensated care per bed, or *11,700 percent of the average uncompensated care per bed* among all hospitals that report providing charity care. On line 18 of this public hospital's S-10 form it reports no government financial support at all.
- A new, 10-bed non-profit hospital in Ohio reported providing nearly $6.5 million in uncompensated care – more than 30 percent of its net patient revenue.
- A non-profit hospital in Connecticut reported a *nearly 2000 percent increase in its uncompensated care* from FY 2013 to FY 2014.
- A hospital in Massachusetts, a state in which 97 percent of the residents are currently insured, reported providing more than $100 million in line 30 charity care – even though Massachusetts has a CMS-approved uncompensated care pool.
- A for-profit hospital in Florida reported an increase in its uncompensated care from *negative* $5.5 million in FY 2013 to $33.6 million in FY 2014, leaving uncompensated care to account for more than 16 percent of its net patient revenue.

These aberrant numbers, and the lack of such aberrant numbers for so many other hospitals, illustrate some combination of misinterpretation of the S-10's instructions, the lack of clarity of those instructions, and the possible lengths to which some providers appear to be going to report their costs and expenses in a manner that will maximize their Medicare DSH money – and that will maximize that Medicare DSH money in a manner that, in the zero-sum environment that Medicare DSH has become, enable them to benefit at the expense of hospitals throughout the country and, in some cases, their neighboring competitors.

Such difficult-to-accept uncompensated care reporting has serious implications for entire states.

- California hospitals would collectively see their Medicare DSH uncompensated care payments decline more than $400 million if the S-10 were to become the basis for calculating those payments.
- Texas hospitals would gain nearly $600 million in additional Medicare DSH uncompensated care payments if the S-10 were to become the basis for calculating those payments. Together, two Texas hospitals alone would see their Medicare DSH uncompensated care payments rise nearly $300 million at a time when the number of uninsured people in that state is declining.
- While the nation-wide uninsured rate is currently 11.7 percent, Oklahoma has the second-highest uninsured rate in the country: 16.5 percent. Despite this, the proposal to base Medicare DSH uncompensated care payments on S-10 data would result in that state's hospitals losing $11.7 million in such payments.
- Meanwhile, New Jersey's uninsured rate is well below the national average: just 9.7 percent. Despite this, the proposed methodology would result in its state's hospitals receiving $63 million *more* in Medicare DSH uncompensated care payments even though that state also has a CMS-approved uncompensated care pool.

These and countless other examples point to the inadequacy of current S-10 data for the purposes of determining how much uncompensated care hospitals provide and calculating eligible hospitals' Medicare DSH uncompensated care payments. In the current environment, supported by unclear instructions for completing the S-10 and the lack of auditing and enforcement, they have created a system that clearly benefits some states more than others, and at the expense of those others.

Further, while NAUH does not dispute the consultant's observation that hospitals are doing a better job of reporting their uncompensated care data on the S-10 than they did a few years ago, we disagree about the

significance of this observation. Even if is true in the aggregate, the nature of this calculation of Medicare DSH uncompensated care payments is such that the remaining inaccuracy and lack of uniformity in the data reported can have a very large impact on hospitals in the zero-sum environment that Medicare DSH uncompensated care has become: hospitals that, for whatever reason, over-report their uncompensated care benefit financially from doing so while those that do not suffer financial harm. Even a few hospitals with questionable reporting, moreover, can affect a large number of other hospitals. One wonders, for example, how the uncompensated care reported by the two Texas hospitals cited above that would result in them receiving an additional $300 million in Medicare DSH uncompensated care payments under the proposed methodology would affect other DSH-eligible hospitals around the country. For this reason, the possibility that some hospitals are "doing better" is not good enough. They *all* have to do better, and until they do, this data is not good enough for public policy-making purposes. Today, despite any apparent improvements in data reporting, the data generated through the S-10 remains fundamentally flawed: inaccurate, inconsistent from hospital to hospital, based on questionable and varying interpretations of the instructions for completing the form, and in general unreliable.

Finally, NAUH supports CMS's proposal to require hospitals to report charity care data on the S-10 based on the date that charity care is recorded rather than the date on which it is delivered.

In light of all these concerns, considerations, and problems, how can the S-10 instructions be brought up to a standard that reflects CMS's intent and produces the kind of reliable uncompensated care data needed to constitute the basis of fair Medicare DSH uncompensated care payments?

NAUH believes CMS can improve the accuracy, reliability, and uniformity of S-10 data by taking the following steps:

- Define all the terms – especially "uncompensated care – more thoroughly and more clearly.
- Improve the instructions for each line.
- Be clearer, and much more specific, about what revenue must be reported as offsetting uncompensated care and where on the form that offsetting revenue should be reported.
- Audit hospitals' data reporting to verify both the effectiveness of the improvements and the quality of the data hospitals report.

The value of auditing data 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.

NAUH also would like to offer four suggestions for improving the S-10; we shared two of these with CMS in the past.

- Line 21 reduces the charity care charges reported on line 20 by a cost-to-charge ratio. The charges in column two represent co-pays and deductibles waived under a charity care policy. NAUH does not believe it is appropriate to reduce these amounts by a cost-to-charge ratio because they do not represent full charges. If CMS agrees with this suggestion, NAUH believes it may be necessary to

clarify the instructions for line 20 to make it clearer that any charges associated with Medicaid non-covered services or days exceeding length-of-stay limits should be reported in column one.

- Line 29 reduces the bad debt expense reported on line 28 by a cost-to-charge ratio. Similar to our concern with the charity care cost calculation above, some portion of this bad debt expense is attributable to patient coinsurance and deductibles which are already reported at a net payment amount and should not be further reduced by a cost-to-charge ratio. Unlike charity care, however, this portion is not separately identifiable in bad debt. We believe the S-10 should be revised to avoid reducing amounts that do not represent full charges by a cost-to-charge ratio.
- Line 30, which is a hospital's total unreimbursed and uncompensated care cost, should reflect the impact of revenue associated with government grants and appropriations and transfers for support of hospital operations, private donation and grant funds, hospital-funded uncompensated care pools, intergovernmental transfers and grants, and endowment income restricted to funding charity care. To that end, NAUH believes line 30 should be revised to instruct hospitals to subtract lines 17 and 18 when calculating the value of this field. With this revision, line 30 would represent a more appropriate value to use for calculating future Medicare DSH adjustments. Even if the form is not revised, NAUH suggests that for the purposes of future Medicare DSH adjustments, this same methodology should be used to determine hospitals' uncompensated care costs.
- All charges on the S-10 are reduced by a single cost-to-charge ratio reported on line 1. In our experience, hospitals often have significantly different cost-to-charge ratios for their inpatient and outpatient services and often have a significantly different mix of inpatient and outpatient service utilization among the charity care population and the overall hospital population. For these reasons, we believe it would be more appropriate for the S-10 to distinguish between inpatient and outpatient charges and adjust them by separate cost-to-charge ratios.

NAUH would be pleased to meet with CMS officials to review these proposals and, if you wish, to convene a task force of our own members to develop recommendations for other aspects of the S-10.

Finally, NAUH is aware that there is a perception that S-10 data will not improve until it is actually used for payment purposes and that it is therefore better to start using the data now than it would be to spend time trying to improve it. We disagree with such an approach, for several reasons.

- Using the data in its current form could result in Medicare DSH payment reductions that could cause serious and even potentially irreparable harm to some safety-net hospitals.
- Proceeding with use of this data now is especially a problem because there is a fixed pool of money for Medicare DSH uncompensated care payments. This means that one hospital's "mistake" or "misinterpretation" would directly harm others.
- Hospitals have no appeal or litigation rights if they believe the methodology for making these payments treats them unfairly. This, in our view, makes it inappropriate to begin using the approach with the assumption that it will treat some unfairly and that they will just have to accept that they have no recourse over that unfair treatment.

For these reasons, NAUH opposes using data that is seriously flawed and urges officials to fix the data before using it for payment purposes.

NAUH believes that in its current form, the S-10 is inadequate for public policy-making purposes: inaccurate, unreliable, deeply flawed, and ultimately misleading about the work many hospitals are doing in their communities. Numerous examples illustrate that using the S-10 to calculate hospitals' Medicare DSH uncompensated care payments would use erroneous data to unjustly reward some hospitals and do so at the expense of others. It also would reward hospitals in states that chose not to expand their Medicaid programs while penalizing those in states that did. NAUH recommends that CMS withdraw its proposal to use the S-10 to calculate Medicare DSH uncompensated care payments beginning in FY 2018 and instead begin a process of examining the S-10 and the data reported on it;

clarifying the meaning and intention of each line on the report; improving the instructions for completing the report; and initiating rigorous auditing of hospitals' data reporting on a revised S-10. NAUH further recommends that CMS only use the S-10 to determine hospitals' Medicare DSH uncompensated care payments when it can do so with a high degree of confidence that the data reported on the form is accurate and that distributing the payments in this manner will be fair to all eligible hospitals, the residents of the communities they serve, and American taxpayers.

Medicare DSH Issue 2:
An Alternative Proposal for a New Methodology for Calculating Medicare DSH Uncompensated Care Payments

(As an alternative to using the S-10 in its current form, NAUH respectfully proposes another approach to calculating hospitals' uncompensated care and determining their Medicare DSH uncompensated care payments.)

In addition to the technical challenges posed by using the S-10 to determine hospitals' uncompensated care for the purpose of calculating Medicare DSH uncompensated care payments, NAUH believes that even accurate, verifiable uncompensated care data would not achieve what Congress intended when it passed the Affordable Care Act. That law called for this calculation, which is currently "Factor 3" in the Medicare DSH uncompensated care payment calculation, to be

> …the amount of uncompensated care for such hospital for a period selected by the Secretary (as estimated by the Secretary, based on appropriate data (including, in the case where the Secretary determines that alternative data is available which is a better proxy for the costs of subsection (d) hospitals for treating the uninsured, the use of such alternative data))...

CMS' proposed methodology uses estimated charity care and bad debt costs as a proxy for the costs that subsection (d) hospitals (that is, hospitals covered by Medicare's inpatient prospective payments system (IPPS)) incur when treating the uninsured as the basis for distributing Medicare DSH uncompensated care payments to eligible hospitals. NAUH believes this is not a good proxy because using an estimate of hospitals' actual incurred costs runs counter to the philosophical foundation of the IPPS, which was created specifically to avoid cost-based reimbursement. Instead, that system aspires and works to reimburse providers for the cost of providing services at an efficiently run hospital. The current IPPS establishes average costs per case through DRGs and then adjusts payments to reflect factors that affect different aspects of hospitals' costs – factors such as labor costs, teaching programs, percentage of low-income patient served, and severity of patient illness. Additional adjustments offer incentives for improving hospital performance, such as adjustments for readmissions, hospital-acquired infections, and specific aspects of value in the care hospitals provide. The resulting rate is based in part on hospitals' costs but also on their efficiency and quality.

The proposed methodology for calculating Medicare DSH uncompensated care payments does not do this. Instead, basing such payments in part on hospitals' uncompensated care costs as reported on the S-10 bases those payments strictly on hospital costs without regard to efficiency or quality. In fact, distributing Medicare DSH uncompensated care payments based strictly on hospital costs incurred caring for individuals without third-party coverage has the potential to reward inefficiency.

A better approach, NAUH believes, is to create a proxy for cost-adjusted discharges attributable to uninsured patients. The process for doing so would begin by revising the S-10 to require hospitals to report the number of discharges and outpatient visits attributable to individuals with no third-party health care coverage – that is, the uninsured. The form would require hospitals to report four values associated with services delivered to this population: 1) number of discharges, 2) number of outpatient claims, 3) charges, and 4) payments, doing so separately for patients who are and who are not covered by state or

local indigent care programs. In addition, hospitals would need to report total outpatient claims. Reporting this data on the S-10 would give CMS a reasonable data source for identifying uncompensated care for use in distributing Medicare DSH uncompensated care payments. If nothing else, it would provide CMS with a standard unit to compare the reasonableness of reported uncompensated care costs across hospitals.

Under NAUH's proposed approach, the new Factor 3 would be equal to the quotient of a hospital's cost-adjusted discharges for a base year divided by the average cost-adjusted discharges in the base year for all hospitals eligible for Medicare DSH uncompensated care payments in the payment year. This would create a single, auditable data source for determining hospitals' uncompensated care for use in calculating hospitals' Medicare DSH uncompensated care payments. Our ten-step process for arriving at this figure would apply to all hospitals covered by Medicare's IPPS (except hospitals in Maryland and those participating in Medicare's bundled payment initiative). Those ten steps are:

1. Identify the total number of inpatient discharges attributable to uninsured individuals in the base year. For the purposes of this calculation, the term "uninsured individuals" includes all individuals to whom a hospital can attribute a claim for which there is no associated third-party payment. The term "third-party payment" includes payments from state and local government programs.
2. Identify the total number of outpatient claims attributable to uninsured individuals in the base year.
3. Identify the total inpatient revenue per inpatient discharge.
4. Identify total outpatient revenue per outpatient claim.
5. Multiply outpatient visits attributable to uninsured individuals by the ratio of outpatient revenue per claim to inpatient revenue per discharge.
6. Add the number identified in step 1 to the number identified in step 5 to calculate adjusted discharges attributable to uninsured individuals.
7. Identify the average per-discharge IPPS payment amount by applying the same logic used in the IPPS PC Pricer (the tool CMS offers hospitals to enable them to estimate what Medicare might pay for a given discharge) but substituting the hospital's case-mix index in the base year for the relative value of the DRG and excluding the portion of payments attributable to uncompensated care DSH. This would be the numerator to determine the hospital's cost adjustment factor. The denominator for the cost-adjustment factor would be equal to the weighted average numerator value identified in this step for all subsection (d) hospitals projected to receive DSH in the payment year.
8. Identify the hospital's cost-adjustment factor by dividing the numerator calculated in step 7 by the denominator calculated in step 7.
9. Multiply the adjusted discharges calculated in step 6 by the cost-adjustment factor calculated in step 8 to determine the hospital's cost-adjusted discharges attributable to the uninsured.
10. Calculate the hospital's Factor 3 by dividing the hospital's cost-adjusted discharges calculated in step 9 by the average cost-adjusted discharges for all hospitals projected to receive DSH in the payment year.

This methodology offers a number of advantages over the approach presented in the proposed regulation:

1. *It would maintain the IPPS's incentives for the efficient and high-quality delivery of health care services*.
2. *It would avoid the use of cost-to-charge ratios*. The data currently used by CMS to identify uncompensated care requires the agency to employ a statistical trim methodology to alter reported cost-to-charge ratios for certain hospitals. This trim removes some of the clearly aberrant results in the calculation of Factor 3 but leaves others intact because it is limited as a bright-line trim that affects only those above a certain threshold, replacing them with an average, while leaving

similarly but not as egregiously troubling ratios untouched. While such trims are reasonable for normalizing aberrations in the aggregate, the nature of the Factor 3 calculation means that every cost-to-charge ratio that is not accurately reflected either through a potentially inappropriate trim, or the lack of an appropriate trim, affects the amount of Medicare DSH uncompensated care payments to all eligible hospitals and not just to those with questionable ratios. NAUH's proposal eliminates the need to use cost-to-charge ratios by employing a methodology that compares inpatient and outpatient revenues within a hospital without comparing revenue across hospitals.

3. *It better aligns Medicare and Medicaid DSH*. While NAUH recognizes that the Medicare DSH and Medicaid DSH programs are distinct and were created to address different concerns, they both now require CMS to contemplate a measure of the amount of care that hospitals provide to individuals without third-party health coverage. In the Medicare DSH program this measure affects the distribution of Medicare DSH uncompensated care funds while in the Medicaid DSH program it affects limits on federal financial participation for hospitals' unreimbursed costs attributable to serving uninsured patients. While CMS specifically rejected the use of unreimbursed charity care and bad debt costs as a proxy for the cost of treating the uninsured in the Medicaid program, it is proposing that very same measure as a proxy for the costs of treating the uninsured in the Medicare program. NAUH's proposed methodology would more closely align the Medicare definition of cost for treating the uninsured with the Medicaid definition of costs attributable to uninsured patients while still recognizing the distinct purposes of the two programs.
4. *It better reflects the costs for which the Factor 3 data is intended to be a proxy as defined by Congress*.

In summary, NAUH believes our proposed methodology, based on cost-adjusted discharges attributable to uninsured individuals, offers several important advantages: it would enable CMS to maintain the incentives built into the current IPPS; it would be based on data that would be easier to report, verify, and audit; it would avoid the arbitrariness of statistical trims; it would more closely align the Medicare and Medicaid definitions of "uninsured"; and it would more closely reflect what we believe to be Congress's intention as articulated in the Affordable Care Act.

NAUH believes its proposed alternative – a proxy for cost-adjusted discharges attributable to uninsured patients – is superior to using the S-10 in its current form: it is more consistent with the spirit, purpose, and objectives of the Medicare inpatient prospective payment system, better reflects how Congress intended for Medicare DSH payments as part of implementation of the Affordable Care Act, avoids the use of highly questionable cost-to-charge ratios, and better aligns Medicare DSH and Medicaid DSH.

Medicare DSH Issue 3:
The Size of the Medicare DSH Uncompensated Care Pool

NAUH is concerned about the large decrease in the Medicare DSH pool proposed for FY 2017. Part of this pool is predicated on a calculation of how much CMS would have paid in Medicare DSH absent the enactment of the Affordable Care Act and is then based on adjusting that figure in a number of areas, including to adjust the standardized amount, the number of Medicare discharges, and changes in case mix. The final category for which an inflation factor is applied is labeled "other" and is a catch-all category for considerations such as capturing changes in Medicare payment policy since 2012, the impact of court decisions, Medicaid expansion, and others.

NAUH believes this last category also is the appropriate place to implement much-needed adjustments in the size of the Medicare DSH pool to reflect the growing number of hospitals becoming eligible for DSH as they serve more Medicaid patients. This year, we understand this will be at least 38 new hospitals.

This is a continuing concern for NAUH. After all, Medicare DSH was created to help non-profit urban safety-net hospitals and others like them that face distinct challenges serving the especially large numbers of low-income residents of their communities. Those challenges may be declining in number but unquestionably remain – including significant reductions of Medicaid DSH payments such hospitals face in the coming year. The dilution of the Medicare DSH pool we can expect in the coming years – the need to divide a shrinking pool of resources among a growing number of hospitals – could detract from the ability of many long-time recipients of Medicare DSH, providers like urban safety-net hospitals for which the program was created, to continue meeting the needs of their communities. We believe it is essential for us to prevent unwarranted erosion of these resources.

Our concern, then, in addition to the technical updates noted above, is whether the proposed FY 2017 pool has been adjusted to reflect the addition of these 38 hospitals. NAUH hopes CMS has included this consideration in determining the size of the FY 2017 pool and that the final rule will reflect appropriate transparency in this matter by presenting the individual assumptions and update factors, including adjustments made to assure adequate funding for the newly eligible DSH hospitals.

NAUH urges CMS to provide more information to stakeholders about how it determined the size of the proposed FY 2017 Medicare DSH uncompensated care pool, including specific information about where and how those calculations included additional resources for hospitals that will be newly eligible these payments in FY 2017.

Medicare DSH Issue 4:
Cost Report Periods for Calculating Medicare DSH Uncompensated Care Payments

CMS has proposed using three years of data to calculate hospitals' uncompensated care DSH payments instead of a single year, as it does now, to reduce fluctuations in DSH uncompensated care payments to hospitals that experience large changes in their data from year to year. Under this proposal, CMS would calculate Factor 3 for each year of data involved and average the results to determine a hospital's effective Factor 3. Hospitals with no data for one of the years would receive a Factor 3 based on the average for the available years within the three-year period.

In deciding to base the calculation on three years of data, CMS concluded that two years of data might not be sufficient to smooth fluctuations while four years might involve data too old to be relevant for this purpose. This is the same balance CMS strikes when demonstrating wage comparability for wage-index reclassifications. NAUH supports this proposal and thanks CMS for addressing large fluctuations in uncompensated care DSH payments from year-to-year due to this issue.

NAUH is concerned, however, about the method CMS has proposed to attribute data to each year when performing this calculation.

From 2014 through 2016, CMS determined hospitals' low-income days using data from a base year, or if a hospital did not file a full year's cost report in the base year, the year prior to the base year. In all instances the data was based on a full year's cost report.

For FY 2017, CMS proposes combining data from all cost reports beginning in a fiscal year to identify a hospitals' low-income days attributable to that period. This methodology could pose a problem for some hospitals.

Hospitals may file multiple cost reports in a single fiscal year for several reasons. For example, a hospital might file a six-month cost report and an 18-month cost report as the result of a merger midway through the cost-reporting period. This keeps the data separate for the individual and merged facilities but also enables them to preserve the surviving hospital's cost-reporting period in the future. In such an instance, the proposed methodology would attribute two years of data to a single year and no data to the following year. In the three-year average methodology, that hospital's data would be overstated because three years of data would be used to calculate two Factor 3s that would then be averaged together. Conversely, if a hospital has only a short cost reporting period beginning in a year, that hospital could be disadvantaged by the calculation. NAUH asks CMS to modify its proposal to appropriately attribute portions of the cost reporting period to the period for which it is calculating a Factor 3.

Hospital Readmissions Reduction Program

NAUH is disappointed that this year's draft regulation does not include a proposal to reform the hospital readmissions reduction program.

For the past five years NAUH has responded to the proposed inpatient prospective payment system regulation by asking CMS to modify the readmissions reduction program to add a risk adjustment component based on our belief that the program, as currently constituted, is unfair to private urban safety-net hospitals and is harming them because it lacks such risk adjustment. While in the beginning NAUH was among the very few expressing such a concern, the passage of time has seen many come to share our view. MedPAC and the National Quality Forum feel the same way; scholarly articles in the *New England Journal of Medicine*, *Health Affairs*, and *Health Services Research* have echoed this view and presented research to support it; the U.S. Department of Health and Human Services' own Agency for Healthcare Research and Quality shares this perspective as well. In March, the journal *Health Affairs* reported on the issue, highlighting a MedPAC proposal to address the challenge by "…grouping hospitals into peer groups based on their share of low-income Medicare patients and then set readmissions targets for each peer group. Put another way, hospitals with similar shares of low-income patients would be compared with each other instead of all hospitals" ("The Challenges Of Rewarding Value Over Volume Without Penalizing Safety-Net Hospitals," March 20, 2016). And just last month, a study published in another important journal, *JAMA Pediatrics*, reached the same conclusion ("Explaining Racial Disparities in Child Asthma Readmission Using a Causal Inference Approach," May 16, 2016).

Two years ago CMS invited public comment and recommendations on the subject. Despite this, despite the growing consensus that the readmissions reduction program is flawed and needs to be reformed, and despite the continual harm this program is causing to many private urban safety-net hospitals, this year's proposed regulation does not call for any changes in the program. Unlike many other aspects of Medicare policy and health care reform, which are directed by Congress, CMS has the authority to address this problem on its own. We are disappointed that it did not do so this year through the proposed FY 2017 inpatient prospective payment system regulation and urge you to act on this important matter in time for reforms to be introduced when FY 2017 begins on October 1.

NAUH urges CMS to introduce socio-economic risk adjustment to the readmissions reduction program beginning in FY 2017. The current program treats private urban safety-net hospitals and other safety-net providers unfairly, a conclusion now supported by numerous quality, credible scholarly studies as well as by MedPAC. Adding socio-economic risk adjustment would correct that unfairness while maintaining the integrity of the program and preserving its valuable and important objectives.

Inpatient Rates

CMS has proposed increasing the final documentation and coding adjustment called for by the American Tax Relief Act of 2013. NAUH believes the rate of growth in inpatient services between 2016 and 2017 will more closely resemble the historic trend than the decreases that were observed in recent years. We ask that the Office of the Actuary re-examine its analysis to ensure that it has not "overcorrected" by not accounting for the return to the historic trend that we expect to see in 2017.

Observation Status/Two-Midnight Rule

NAUH appreciates the care with which CMS has addressed the provider community's concerns about observation status and the two-midnight rule, including the decision to compensate hospitals for FY 2014-2016 payment reductions associated with this program.

Outlier Threshold

The proposed rule calls for raising the Medicare outlier threshold from the current $22,544 to $23,681 in FY 2017. Actual outlier payments in FY 2015 (the last year for which complete data is available) amounted to 4.68 percent of total Medicare DRG payments, which means they fell short of the congressional established minimum target of 5.1 percent. NAUH believes CMS should calculate the outlier threshold by estimating a threshold that would result in expenditures at the midpoint of the target range rather than the bottom of that range, which should reduce rather than raise the outlier threshold for FY 2017.

Reporting Data for the Medicare Area Wage Index

NAUH appreciates and supports CMS's proposal for hospitals redesignated rural to be treated as entirely rural and to permit hospitals currently reclassified as rural to do so without giving up their wage index reclassification. We believe this will create consistency in the application of current wage index guidelines.

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 meet with you to discuss our concerns about the use of the S-10 for calculating Medicare DSH uncompensated care payments and our ideas for improving the instructions for completing the S-10.

Sincerely,

Ellen J. Kugler, Esq.
Executive Director