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Francis J. Crosson, M.D.
Chairman
Medicare Payment Advisory Commission
425 I St, NW
Suite 701
Washington, DC 20001

Mark E. Miller, Ph.D.
Executive Director
Medicare Payment Advisory Commission
425 I St, NW
Suite 701
Washington, DC 20001

Dear Dr. Crosson and Dr. Miller:

During the December 13, 2015 public meeting of the Medicare Payment Advisory Commission in Washington, D.C., commissioners and staff discussed a proposal to recommend to Congress that the Centers for Medicare & Medicaid Services (CMS) be directed to use the Medicare cost report's S-10 form to calculate the uncompensated care portion of Medicare disproportionate share hospital payments, with the use of the S-10 for this purpose to be phased in over three years. The National Association of Urban Hospitals, which represents the interests of the nation's private, non-profit urban safety-net hospitals, has serious concerns about such a proposal and would like to share those concerns with you.

The Affordable Care Act and Reduced Medicare DSH Payments

NAUH acknowledges that at least some reduction of hospitals' Medicare DSH payments is appropriate. After all, more than 17 million previously uninsured and underinsured Americans have obtained health insurance under Affordable Care Act provisions, many of them individuals living in communities private urban safety-net hospitals serve.

Even so, the 2010 reform law's long arm, we have seen, continues to leave many people without access to the care they need. Urban safety-net hospitals continue to fill this gap and meet this need and the Medicare DSH payments they receive continue to constitute a vital part of the foundation of resources these hospitals need to serve in this role. In addition, in states that have expanded their Medicaid programs, these hospitals continue to struggle with major Medicaid shortfalls – the sometimes-great difference between what state Medicaid programs pay for care and how much that care actually costs – especially for new Medicaid beneficiaries who have had little or no contact with the health care system in recent years. Together, these two challenges – some people remaining uninsured and others remaining underinsured, through Medicaid – mean that private urban safety-net hospitals will continue to need Medicare DSH to help them serve their communities.

For hospitals that see especially large numbers of Medicaid patients, especially high proportions of publicly insured patients, and relatively few commercial patients, Medicare DSH is absolutely essential

21351 Gentry Drive, Suite 210, Sterling VA 20166
Phone: 703.444.4091 | Fax: 703.444.3029
www.nauh.org

to their ability to serve their communities and even to keep their doors open in some cases. The question, then, is how best to calculate and distribute Medicare DSH uncompensated care payments in a way that is responsible both to the taxpayers who provide that funding and to the safety-net hospitals that continue to provide meaningful amounts of health care for which they are not compensated and depend on this funding for their very existence.

The Shortcomings of the S-10

In theory, the S-10 should be the ideal tool for measuring hospitals' uncompensated care, and therefore their declining need for Medicare DSH money, because it specifically asks hospitals how much uncompensated care they provide. In reality, however, the S-10 asks a question about a concept about which people disagree, it asks the question poorly, and the results it produces in at least some cases seem to defy reason or explanation. We address this matter first by looking at what, exactly, is uncompensated care; second, by examining the instructions hospitals are given for reporting their uncompensated care on the S-10; and third, by looking at the actual data hospitals report.

What is "Uncompensated Care"?

This is an excellent question: if you ask 100 people in and around the hospital industry and health care policy-making they will give you at least a half-dozen different definitions, if not more. The simple reality, though, is that we have never reached any kind of definitive consensus on what exactly constitutes "uncompensated care" and have never successfully collected uniform, nation-wide uncompensated care data from hospitals that can be viewed as credible, accurate, and reliable.

We begin with this understanding: that "uncompensated care" is not a universally agreed-upon concept. In 2012, CMS hired a consultant, Dobson DaVanzo & Associates, to help it consider exactly what constitutes uncompensated care (for purposes of adjusting future Medicare DSH payments) and that consultant's presentation stated that "…we found variation in how existing programs and entities define uncompensated care." Those definitions, the consultants noted, vary among federal programs, the states, rating and research organizations, and provider organizations. While charity care and bad debt are always included in such definitions, the consultant noted that "Some entities also include payment shortfalls from government-funded plans, or third party payers." The CMS consultants also noted in their written presentation that "Uncompensated care is most often defined as charity care plus bad debt but may include governmental and/or commercial payer payment shortfalls."

The use of "may" in that last sentence is significant: it acknowledges that different entities interpret uncompensated care in different ways. Different hospitals have different, and sometimes significantly different, charity care policies, and that, in turn, affects where they report their costs on the S-10. One hospital with a charity care policy that includes care for Medicaid patients whose stay exceeds a day limit may include that Medicaid shortfall in its charity care line on the S-10, for example, while another hospital, with a different policy, may include the shortfall in 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 if payer shortfalls are not considered. This is only one of a number of ways, including care involving Medicaid waiver populations and non-patient-specific funding streams, that NAUH believes different hospitals, even neighboring hospitals, can end up classifying uncompensated care in different ways, and hospitals in different regions and different states can do the same. The result, NAUH believes, is data that is not suited for policy-making and public reimbursement purposes at this time.

Flawed Instructions for Completing the S-10

As noted, NAUH believes flaws in the S-10 form's instructions lead to data that is inconsistent, incorrect, misleading, and consequently damaging to many hospitals. For example:

- The S-10 asks hospitals to identify, separately, costs and revenue associated with Medicaid, SCHIP, charity care, bad debt, other government payers, and others. Hospitals are sometimes unsure whether and where to include costs and payments associated with certain patients or for certain services, as noted above. If some of those categories are excluded from the calculation, the interpretations of where to include some costs and expenses by different hospitals, and different Medicare administrative contractors, could lead to financial consequences not only for the hospital that encountered this challenge but also for the many other hospitals with which they now must share a limited pool of Medicare DSH uncompensated care funds.
- The S-10 includes two lines for which hospitals are instructed to include private grants, donations, and endowment income restricted to funding charity care along with government grants, government appropriations, and government transfers for support of hospital operations. The numbers to be reported on these lines can be hard to define, yet accurate, consistent reporting from hospital to hospital is essential because hospitals ultimately will be compared based on how much uncompensated care they provide. As it is currently employed, moreover, the revenue reported on these lines is not included in the calculation of uncompensated care.
- The S-10 understates teaching hospitals' costs because it uses a cost-to-charge ratio that includes medical education revenues but does not include medical education costs.

Differences Between Different Types of Hospitals That Pose Policy Challenges

While the S-10 captures costs associated with hospitals' delivery of uncompensated care – however they choose to define that care – it also seeks to capture revenue associated with that care. Some hospital revenue, however, as noted above, is not subtracted from those costs: specifically, public hospitals that receive grants, appropriations, or transfers from local, county, or state governments for support of hospital operations and uncompensated care do not necessarily subtract such funds from their uncompensated care cost total. This can create the appearance that no one is paying for this care when, in fact, these hospitals are receiving funds for this very purpose. This is neither good nor bad, right nor wrong: it only reflects how different kinds of institutions account differently for their income and expenses. Using this different kind of data to calculate Medicare DSH payments, however, would only facilitate the replacement of existing streams of public hospital revenue with Medicare DSH funds – something for which Medicare DSH was never intended. This is a difference that the S-10, in its current form, does not adequately account for, and this suggests a need to improve the instructions that accompany the form before it is used for something as important as determining hospitals' Medicare DSH payments; it is essential that the S-10 accurately acknowledge and account for these differences. If the form cannot be sufficiently improved to do so, this may even speak to the possible desirability of establishing separate Medicare DSH uncompensated care pools for public and private hospitals.

When Hospitals Decide for Themselves What Constitutes Uncompensated Care

When the Affordable Care Act passed and it seemed reasonable that the S-10 might be used for the very purpose MedPAC discussed during its December 13 meeting, NAUH decided to use existing S-10 data to model the potential impact of using the form for this purpose. We have been performing such analyses

ever since and just finished running fresh numbers based on FY 2013 data, supplemented by some of the limited FY 2014 data currently available, so we could share them with you in this letter.

What we found is that hospitals continue to report their uncompensated care in different ways and that the numbers they report, at the very least, intuitively lacks credibility in many cases. The following are a few of the more extreme examples:

- In FY 2013, the Rancho Los Amigos National Rehabilitation Center, a small, 169-bed public facility in California, reported providing more than $737 million in uncompensated care – more than three times its overall patient revenue.
- That same year, the Harris Health System, a public hospital in Texas, reported providing $692 million in uncompensated care – nearly twice its overall net patient revenue.
- Titus Regional Medical Center, another public hospital in Texas, reported providing $6.1 million in uncompensated care in FY 2013 but nearly $535 million in uncompensated care in FY 2014 – an increase of more than 9000 percent.
- Mary Washington Hospital, a non-profit provider in Virginia, reported that its uncompensated care rose from $9.3 million in FY 2012 to $34.1 million in FY 2013 and $51.1 million in FY 2014 – a 447 percent increase in just two years.
- Lake Charles Memorial Hospital, a non-profit hospital in Louisiana, reported that while Medicaid covered only 12 percent of its inpatient days, its uncompensated care rose from $4.8 million in FY 2012 to $12.9 million in FY 2013 to $33.7 million in FY 2014.
- The Texas Regional Medical Center at Sunnyvale, a for-profit hospital in Texas, reported that its uncompensated care rose from $2.5 million in FY 2012 to $28.4 million in FY 2014 – more than a ten-fold increase.
- Carepoint Health-Christ Hospital, of New Jersey, reported an even greater increase in its uncompensated care: more than 1700 percent, from $1 million in FY 2012 to $20.4 million in FY 2014.
- The non-profit Methodist Hospital in Texas reported that Medicaid covered only 7.6 percent of its patient days in FY 2013 but that it provided $35.4 million in uncompensated care that year.

And there are many more examples of hospitals reporting data that raise questions about the reliability of the figures they have reported.

In the pre-Affordable Care Act era this would be a problem between hospitals and CMS and no one else's concern. Under the reform law, however, one hospital's possible over-reporting of uncompensated care is a problem for every hospital that does not over-report its uncompensated care. Under the new methodology, DSH-qualified hospitals compete for a limited pool of Medicare DSH money and the hospitals that *report* providing the greatest amounts of uncompensated care may see significant sums of money from the Medicare DSH uncompensated care pool while others may see relatively little.

In fact, according to NAUH's modeling of how Medicare DSH uncompensated care payments might be made using FY 2013 S-10 data, while 111 hospitals currently account for 25 percent of that uncompensated care pool, using the S-10 for this purpose would result in fewer than half as many hospitals – just 48 – sharing 25 percent of that pool. The three bigger "winners" under such circumstances would be:

- LAC/RANCHO Los Amigos National Rehabilitation Center (California) – a projected $151.9 million in Medicare DSH uncompensated care payments, an increase of $148 million over the the $3.9 million it will actually receive in FY 2016
- Harris Health System (Texas) – $142.7 million in Medicare DSH uncompensated care payments, an

increase of $125 million over the $17.7 million it will actually receive in FY 2016
- LAC-USC Medical Center (California) – $93.4 million in Medicare DSH uncompensated care payments, an increase of $73 million over the $20.4 million it will actually receive in FY 2016

Such an extraordinary increase in Medicare DSH payments would be both unprecedented and difficult to justify.

This concentration of a shrinking DSH uncompensated care pool, in turn, means that some hospitals stand to lose significant amounts of Medicare DSH revenue – losses that could jeopardize their financial health. The following, for example, is what would happen if FY 2013 S-10 data were to be used to calculate the Medicare DSH uncompensated care payments of the non-profit urban safety-net hospitals that serve the highest proportions of Medicaid patients.

- Montifiore Medical Center (New York) would lose $41.7 million in Medicare DSH uncompensated care payments
- New York Presbyterian Hospital would lose $33.1 million in Medicare DSH uncompensated care payments
- Community Regional Medical Center (California) would lose $16.1 million in Medicare DSH uncompensated care payments, leaving it receiving less than $1 million in such payments

These hospitals care for significant proportion of Medicaid patients: at Montifiore, Medicaid pays for 48.8 percent of the hospital's inpatient days; for New York Presbyterian, 30.3 percent; and for Community Regional, 57.5 percent. The prospective loss of such enormous sums of Medicare DSH money could be disastrous for these hospitals – and many other private urban safety-net hospitals like them.

If this were a matter of just a few hospitals truly providing most of the country's uncompensated care, this would be appropriate – but there is little reason to believe this is the case. Instead, this appears to be about data provided, not actual uncompensated care provided. The result, however, is clear – and troubling: adoption of the S-10 for use in calculating the uncompensated care portion of Medicare DSH payments would cost private urban safety-net hospitals a collective half-billion dollars a year.

This, in turn, speaks to the need to audit this data. In NAUH's view, the value of auditing data cannot be overstated. Several years ago, when Medicaid DSH reporting standards were modified, audits uncovered significant problems in hospitals' initial filings and many hospitals needed to revise their filings in keeping with auditors' findings. In many cases, the data necessary to document what the auditors requested simply did not exist in the beginning, so CMS therefore did not impose any financial consequences for audit results until the sixth year of audited data was available so hospitals could begin collecting and reporting relevant data. This is a natural part of the evolution of data reporting: even though the hospitals were being diligent, their understanding of the new requirements was incomplete and required further guidance. NAUH believes it is reasonable to assume that a similar situation would unfold when new S-10 reporting instructions are developed and that it is therefore appropriate to ensure that those instructions are being followed properly before basing important policy decisions on the data they produce.

Possible Changes in the 340B Program

NAUH also has misgivings about the proposal discussed at the December 13 MedPAC meeting to reduce section 340B Part B drug payments ten percent of the average sales price (ASP) and direct those savings

to the Medicare DSH uncompensated care pool. Our analysis suggests this would amount to $500 million being removed from the 340B program and added to the Medicare DSH uncompensated care pool.

The criteria for participating in the 340B program are more rigorous than those for Medicare DSH eligibility. Thus, if the change MedPAC commissioners discussed in December were to be adopted, NAUH estimates that this would remove approximately $500 million from the 340B program and that about 30 percent of that amount would be redistributed – that is, taken it away from 340B-qualified safety-net hospitals that serve especially high proportions of Medicaid patients and given instead to hospitals that do not meet the more rigorous 340B participation criteria because they serve fewer Medicaid patients and play much less a role in the health care safety net. Such a change would be especially damaging to urban hospitals: the average private, non-profit urban hospital that participates in the 340B program sees 28.8 percent of its inpatient days paid for by Medicaid, stands to lose an average of $1 million a year in Medicare DSH payments if the S-10 were to be used to calculate Medicare DSH uncompensated care payments, and would, under the 340B proposal MedPAC commissioners discussed at their December meeting, face additional losses of vital 340B resources as well.

NAUH does not understand the policy basis for such a change and looks forward to learning more about what MedPAC hopes to achieve through such a change. Absent such information at this time, however, NAUH strongly opposes this proposal.

NAUH's Perspective

NAUH agrees that in the long run, the S-10 may be the best tool for calculating hospitals' uncompensated care for the purpose of determining Medicare DSH payments. In the short run, however, we believe this data is flawed, inaccurate, and inconsistent and therefore not yet suitable for this purpose. We believe CMS should address these problems through changes in the form, changes in the instructions for completing the form, and a period of auditing data submitted by hospitals to ensure that these changes are achieving their objectives. Under the current circumstances, however, NAUH believes it is premature to use the S-10 in the calculation of Medicare DSH payments and urges MedPAC not to recommend its use to Congress for this purpose at this time.

About the National Association of Urban Hospitals

The National Association of Urban Hospitals (NAUH) advocates for adequate recognition and financing of private, non-profit urban safety-net hospitals that serve America's needy urban communities. Whereas CMS defines "urban hospitals" on a purely geographic basis, we define "urban safety-net hospitals" more narrowly. By definition, urban safety-net hospitals, like hospitals categorized as urban by CMS, are located in urban areas; unlike all urban hospitals, however, what we refer to as urban safety-net hospitals are all private and non-profit; they have at least 200 beds; and at least 15 percent of their patients are insured by Medicaid. Currently, 559 hospitals across the U.S. meet these criteria – 16 percent of the 3401 acute-care hospitals in the country. Most are located in low-income urban communities that are not served by public hospitals while others work alongside their public counterparts in service to such communities.

These urban safety-net hospitals differ from other hospitals in a number of important ways: they serve communities whose residents are much older and poorer; they are far more dependent on Medicare and Medicaid for revenue; they provide more uncompensated care; and unlike public safety-net

hospitals, they have no statutory entitlement to local or state subsidies to help underwrite their costs. Collectively, they also provide an outsized proportion of care to the nation's Medicare, Medicaid, and Supplemental Security Income (SSI) patients: while just 16 percent of the nation's acute-care hospitals, private, non-profit urban safety-net hospitals account for nearly half – 47 percent – of all Medicaid inpatient days, 43 percent of all SSI inpatient days, and 41 percent of all Medicare inpatient days.

Many of the Medicare patients served by urban safety-net hospitals are low-income individuals and have been for much of their adult lives. Often, they have had only periodic and episodic contact with the health care system, and when they turn to us for care, they have numerous medical problems that need to be addressed that fall beyond the reason they turned to us in the first place. In addition, these patients frequently pose challenges that go well beyond their immediate medical condition. Many lack the resources and family supports to maintain their health in good times and to recover from injuries and illnesses and stay out of the hospital in bad times. Together, these factors – the medical problems and social challenges – require additional outreach, additional treatment, and additional resources to address, and current reimbursement systems, both public and private, neither contemplate nor reflect the additional costs such hospitals incur addressing these challenges.

NAUH's role is to ensure that when federal officials make policy recommendations and decisions they understand the implications of their actions for these distinctive private 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.

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We appreciate this opportunity to share our views on this most important matter and share your interest in ensuring that future adjustments in Medicare DSH payments are made in the best, most effective, and fairest manner possible. We welcome any questions you may have about the assertions offered above and would be pleased to share more data with you or even the complete data set we developed for our recent analysis.

Sincerely,

Ellen Kugler, Esq.
Executive Director