NAUH
NATIONAL ASSOCIATION OF
URBAN HOSPITALS

January 13, 2015

Congressman Kevin Brady
Chairman
Health Subcommittee
House Ways and Means Committee
301 Cannon House Office Building
Washington, D.C. 20515

Dear Chairman Brady:

I am writing on behalf of the National Association of Urban Hospitals (NAUH) in response to your kind invitation to interested organizations to offer their comments on the Hospital Improvement for Payment Act of 2014 that you proposed in November. NAUH has perspectives on a number of aspects of your proposal; our comments are organized below according to the specific sections of that proposal.

Section 101: Hospital Prospective Payment System (HPPS)

The creation of a separate hospital prospective payment system to cover short hospital stays is an ambitious undertaking and one that, in NAUH's view, has a good deal of merit, as does employing an interim approach until that new system can be developed and extending the moratorium on enforcement of the controversial two-midnight rule. While NAUH supports the concept in general, we have concerns about some aspects of how it would be implemented under this proposal.

First, NAUH opposes distributing current Medicare disproportionate share hospital (Medicare DSH) and indirect medical education (IME) funds among all hospitals within the HPPS because private, non-profit hospitals care for large numbers of low-income and uninsured patients and many have medical education training programs. Those supplemental Medicare payments were introduced in response to specific needs: because some hospitals suffer unusual financial hardships because of the large numbers of low-income patients they serve and because some hospitals operate programs to train our next generation of medical professionals. These hospitals have done and continue to do something special to qualify for these supplemental payments and NAUH believes it would be inappropriate for hospitals with no medical education programs or those that care for relatively few low-income patients to share in these funds and thereby dilute the impact of this vital source of support for hospitals that play a special role in the American health care system. Consequently, we urge you to reconsider this aspect of the proposal and continue to direct these much-needed funds to the hospitals that qualify for them and need them most.

Second, we disagree with the proposal to create a separate Medicare area wage index solely for the proposed hospital prospective payment system (HPPS) through which to pay for short hospital stays. Aside from being a great deal of work for such a limited purpose, creating a new wage index from whole cloth strikes us as both unnecessary and potentially conducive to problems that could make the HPPS less

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accurate and less effective and even unfair because it lacks an appeals process through which to seek recourse for such shortcomings. We do not see why a proxy for labor costs, which is what Bureau of Labor Statistics (BLS) survey data would be, should be used when actual, complete, audited data for every hospital that participates in Medicare is so readily available. BLS survey data also can be misleading about labor costs because it blends hospital labor costs with those of non-hospital health care providers. For example, BLS survey data includes in its analysis of nurses' wages both nurses who work in hospitals and those who work in private doctors' offices and other settings even though the wage scales for these different settings often can be quite different. Nursing homes and doctors, for example, typically pay nurses less and offer fewer benefits, which would produce a misleading – and inadequate – sense of what hospitals must pay to recruit and retain high-quality nurses. A BLS-based wage index would fail to capture this important distinction; it would be just plain wrong. For these reasons, NAUH believes the current Medicare area wage index is much better suited for this purpose.

Third, we appreciate that the bill calls for short-term hospital stay days to count as inpatient days when determining patients' eligibility for Medicare coverage of post-discharge sub-acute care. Many of the low-income patients private urban safety-net hospitals serve lack the financial and community supports needed to facilitate recovery from illnesses and injuries and post-acute care can be their best chance at recovery. Counting these short-term stays as inpatient days for those purposes would help many of our patients and also help reduce avoidable, costly hospital readmissions.

Fourth, NAUH believes that the interim system requirement that hospitals submit both inpatient and outpatient claims for short-stay patients is unduly burdensome, especially since the intention is to reimburse all such stays as inpatient services.

Fifth, NAUH believes that in the interim methodology for paying for short hospital stays, the factor to be used to reduce inpatient payments to reflect that some formerly outpatient cases would then be reimbursed under Medicare's inpatient prospective payment system should be no greater than what is necessary to offset increases in payments that would otherwise occur from moving those those cases from outpatient to inpatient. This should be a budget-neutral adjustment and not viewed as an opportunity to reduce Medicare spending.

Sixth, NAUH believes the bill should explicitly repeal the two-midnight rule when the HPPS takes effect in FY 2020.

Section 103: Repeal of the Two-Midnight Payment Reduction

NAUH appreciates the proposal's call to repeal the 0.2 percent reduction in Medicare inpatient payments in FY 2014 based on implementation of the two-midnight rule and the prospective adjustments that would accomplish this in FY 2016. We urge you to adjust the bill to make a similar adjustment to restore the payment reduction implemented as part of this policy for FY 2015 as well.

Section 104: Monitoring Performance of the RAC Program
Section 105: Improvements to the RAC Program

NAUH appreciates the proposal's call for more oversight and stricter regulation of the RAC audit program. The proposed public reporting of various metrics should enable interested parties (and policy-makers) to compare rates of appeals and denials across auditors; requiring RAC auditors to create a 30-day discussion period prior to issuing full or partial payment denials could reduce both the number of denials and the frequency of appeals; and limiting the number of documentation requests auditors may make would reduce the considerable administrative burden (and costs) RAC audits often impose on hospitals, as would reducing audits' look-back period from four to three years.

One of the overarching problems with the RAC audit program is the significant financial incentives the auditors receive. This seems to be encouraging auditors to overreach, as suggested by a U.S. Department of Health and Human Services' Office of the Inspector General report that found that more than 70 percent of the time – *70 percent* – hospitals win their appeals at the administrative law judge level. This suggests overreach bordering on abuse in search of financial rewards by RAC auditors. NAUH urges Congress to take steps to temper what the facts suggest is overzealousness on the part of auditors, perhaps by imposing financial penalties on overturned claims denials, thereby reducing auditors' financial incentive to deny claims based on inadequate evidence. Other steps that could be taken to ameliorate auditors' apparent pre-disposition to abuse the program in search of profits are to limit auditors to the medical documentation available at the time disputed claims were made, thereby eliminating their ability to second-guess medical authorities well after the fact and with the benefit of 20-20 hindsight, and to permit hospitals to re-bill Medicare Part B claims when Part A claims for admissions have been rejected past the current one-year limit for such re-billings because the frequency of RAC audit rejections is forcing so many cases to remain unadjudicated beyond that current one-year limit.

Section 106: Retrospective Hospital Solutions to Address Problems in the Medicare Appeals Process
Section 107: Retrospective Non-Hospital Solutions to Address Problems in the Medicare Appeals Process
Section 108: Prospective Solutions to Address Problems in the Medicare Appeals Process

NAUH supports all three of these proposals. Specifically, we support the bill's call for establishing an alternative voluntary settlement process of RAC audit appeals in exchange for waiving future appeal rights. We also appreciate the opportunity this proposal offers for hospitals to select the specific claims they feel most strongly about continuing to pursue through the appeal process;

In addition, NAUH welcomes the opportunity to reach an expeditious settlement of other appeals and to do so at a rate to be determined empirically rather than an arbitrary rate. NAUH also hopes the prospect of requiring the federal government to pay interest on successful appeals that take too long to adjudicate will provide a powerful incentive for the agencies involved to improve their processes and address these issues in a more timely manner

NAUH appreciates the proposal to enable hospitals to re-bill surgical DRGs denied as not reasonable and necessary between July 1, 2007 and September 30, 2013 if they are still pending at the administrative law judge level. In addition, NAUH supports the proposal to enable hospitals to point to similar claims of their own that were adjudicated in the past and request adjudication on that basis. This approach, we believe, would greatly improve the entire adjudication process by no longer making it necessary for hospitals to launch an independent fight for each and every claim.

Section 109: Hospital Patient Assessments

The purpose of the data collection proposed in this section is not explicitly stated, and NAUH believes it should be for our feedback to be complete and well-informed.

In the absence of such information, NAUH interprets the data collection requirements in this section as the precursor to a more focused attempt to employ bundled payments for post-acute-care services and we generally support the concept of such an undertaking. The proposed requirements are onerous, however, and in some cases overlap with the meaningful use program and perhaps other Medicare data-reporting requirements as well. For these reasons, NAUH believes the bill should be more forthcoming about the purpose of this data collection and should mandate a specific process to identify and eliminate unnecessary duplication in data collection that would be burdensome and costly for hospitals to collect.

Section 110: Cost Information on Hospital Payments

NAUH believes there are problems with the provision in the bill that calls for hospitals to report how much money they collect from uninsured and insured patients for the 50 most common DRGs. Such information would tell more about the quality of the insurance those patients have, and the fees hospitals have negotiated with their insurers, than provide anything useful for consumers about hospitals' costs or uncompensated costs or what consumers might experience if hospitalized.

This provision also would require MedPAC to report annually on charity care as a proportion of total care furnished by acute-care hospitals. This requirement is fraught with problems and challenges, beginning with defining what constitutes "charity care" and "uncompensated care" and then ensuring that all hospitals report their charity care and uncompensated care in a uniform manner and that those numbers are accurate, as verified by audits. To our knowledge, this has never been done successfully.

Different hospitals have different charity care policies and different hospitals define uncompensated care differently: there is no single hospital industry or federal standard. Thus, what one hospital might report as charity care or uncompensated care might not be viewed or reported in the same manner as another, making hospital-to-hospital comparisons not only inappropriate but also misleading and leaving such data of little value for policy-making purposes.

The Centers for Medicare & Medicaid Services (CMS) has been struggling with this challenge for years as it seeks to implement an Affordable Care Act requirement that it reduce Medicare disproportionate share hospital payments (Medicare DSH) to reflect the growing number of people with health insurance and distribute a portion of the remaining money based on how much uncompensated care individual DSH-eligible hospitals provide. CMS is required to base this calculation on how much uncompensated care hospitals provide – or, more precisely, how much uncompensated care hospitals provide relative to other DSH-eligible hospitals – but the lack of reliable, credible data to answer this question has posed a real challenge for the agency.

The natural tool for CMS to make this calculation is the S-10 form, which is part of the Medicare cost report that every hospital that participates in Medicare files regularly with the federal government and seeks to quantify the uncompensated care hospitals provide. This form was revamped several years ago to enhance its ability to serve in this manner, but an NAUH analysis of the form and the data it produces found that the lack of a clear, specific, uniform definition of what constitutes uncompensated care, inadequate directions on how to complete the form, and the lack of comprehensive auditing of the figures hospitals provide to determine their accuracy has rendered the S-10 useless for this purpose so far. Consultants hired by CMS reached a similar conclusion, noting 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.

CMS clearly agrees and has not used data from the S-10 for its intended purpose in implementing the Affordable Care Act's mandated reduction of Medicare DSH payments, suggesting that the agency, like NAUH, views the data as insufficiently accurate and credible for policy-making purposes. NAUH agrees and urges Congress not to require hospitals to report on their charity care until CMS has developed a means to ensure that such data is uniform, accurate, credible, verifiable.

Section 201: Repeal of Moratorium on Physician-Owned Hospitals

NAUH opposes ending the moratorium on building new physician-owned hospitals. It also opposes permitting the completion of physician-owned hospitals that were under construction at the time the moratorium was imposed and allowing for the addition of new beds at grandfathered facilities. The existing procedures for considering the addition of new beds are, in our view, sufficient for this purpose.

Section 212: Documentation by Non-Physician Providers

NAUH supports the bill's provision to authorize nurse practitioners, physician assistants, clinical nurse specialists, and midwives to meet the documentation requirements for ordering a hospital stay. In our view, making greater use of such professionals in hospitals is an excellent way to improve the quality of care and reduce hospital costs. Professionals in these positions either are qualified to make such decisions or can easily be prepared to fulfill this role.

Section 217: Readmissions Equity

NAUH strongly supports the bill's requirement to direct the Secretary of Health and Human Services to make adjustments to Medicare's hospital readmissions reduction program to take into account socio-economic factors. NAUH has been an enthusiastic proponent of such a measure virtually since the day it was included in the Affordable Care Act.

NAUH supports Medicare's effort to find ways to reduce avoidable hospital readmissions, but as we have conveyed to CMS in recent years, we believe the Medicare hospital readmissions reduction program, as currently constituted, continues to lack adequate risk adjustment and therefore is unfair to private urban safety-net hospitals and is harming them. 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 outside of the primary diagnosis for their cases. In addition, these patients frequently pose challenges to providers that go well beyond their immediate medical condition. Often, urban safety-net hospitals serve low-income patients who lack the resources needed to follow their discharge instructions. Together, these factors – the medical problems and the social challenges – require both additional treatment and additional outreach; in many cases, they also require fundamental behavioral change by the patient. They cannot all be addressed overnight, and yes, at times they require further hospitalization.

NAUH is not alone in observing the problems the hospital readmissions reduction program poses in its current form – and the likelihood that it treats safety-net hospitals unfairly.

The article "A Path Forward on Medicare Readmissions," published on March 28, 2013 in the *New England Journal of Medicine*, concluded that

> …there is now convincing evidence that safety-net institutions, as well as large teaching hospitals, which provide a substantial proportion of the care for patients with complex medical problems, are far more likely to be penalized under the HRRP [hospital readmissions reduction program]. Left unchecked, the HRRP has the potential to exacerbate disparities in care and create disincentives to providing care for patients who are particularly ill or who have complex medical needs

The article recommends, among other measures, addressing this problem through more refined risk adjustment, noting that

> …insofar as data on readmission rates primarily capture the socioeconomic and health status of patients rather than hospital quality, adjusting for socioeconomic status would ensure that if a safety-net hospital can achieve similar readmission rates as non-safety-net hospitals for its poor patients, having an additional number of poor patients would not, in and of itself, lead to penalties, as it does now.

MedPAC has expressed similar concern. As reported in a March 7, 2013 *CQ HealthBeat* article,

> …the socioeconomic status of patients served may affect readmission rates, MedPAC staff said. Admission rates may be higher at hospitals that treat many low-income patients who have less access to adequate health care outside the hospital. Such patients arrive sicker and may wind up in the hospital again a short time after discharge.

MedPAC reiterated this concern in its June 2013 report to Congress, writing that

> …there is now convincing evidence that safety-net institutions, as well as large teaching hospitals, are far more likely to be penalized under the HRRP [hospital readmissions reduction program]. Left unchecked, the HRRP has the potential to exacerbate disparities in care and create disincentives to providing care for patients who are particularly ill or who have complex medical needs.

In the past year other respected voices have added theirs to the chorus of those calling for reconsideration of the readmissions reduction program, including the journal *Health Affairs* ("Adding Socioeconomic Data to Hospital Readmissions Calculations May Produce More Useful Results," May 2014, "Socioeconomic Status and Readmissions: Evidence From An Urban Teaching Hospital," also May 2014, and "California Safety-Net Hospitals Likely to be Penalized by ACA Value, Readmission, and Meaningful Use Programs, August 2014); the Agency for Healthcare Research and Quality ("Conditions With the Largest Number of Adult Hospital Readmissions by Payer," April 2014); and the *Annals of Internal Medicine* ("Neighborhood Socioeconomic Disadvantage and 30-Day Rehospitalization," December 2014).

Finally, it is worth noting that the National Quality Forum (NQF), the organization that develops and certifies the measures used in the readmissions reduction program, has convened a panel to address this very issue. While the panel has not issued its final recommendations, its draft report "…recommends that risk adjustment may be appropriate for some performance measures under some conditions, a change to current NQF policy."

In response to this concern, MedPAC has recommended that CMS modify the readmissions reduction program so that hospitals' readmissions are compared only to the readmissions of comparable hospitals. NAUH has long maintained that it is inappropriate to compare dissimilar hospitals, and under the MedPAC recommendation, the readmissions reduction program would compare the readmissions of urban safety-net hospitals to those of other urban safety-net hospitals. In this manner, the program would remain an effective tool in combating avoidable readmissions and would do an even better job of identifying hospitals whose performance does not measure up to their peers. NAUH supports the MedPAC recommendation to compare hospitals' Medicare readmissions only to those of similar hospitals and supports compelling CMS to incorporate this, or some other form of socio-economic risk adjustment, into the readmissions reduction program.

For all of these reasons, NAUH enthusiastically endorsed last session's H.R. 4188, the Establishing Beneficiary Equity in the Hospital Readmissions Program Act, sponsored by House Ways and Means Committee member James Renacci (R-OH). To aid in this effort, NAUH members participated in recruiting their own House members to co-sponsor or at least support the bill, and we expect a similar effort as the 114th Congress begins work this month. Consequently, we support the provision in the

Hospital Improvement for Payment Act of 2014 that calls for adjusting Medicare's hospital readmission reduction program to account for the socio-economic status of hospital patients.

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.

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NAUH appreciates the opportunity to present these comments and invites any questions you may have about the views we have expressed.

Sincerely,

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Executive Director