NAUH
NATIONAL ASSOCIATION OF URBAN HOSPITALS

June 12, 2015

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 42 CFR Part 412 , 45 CFR Part 170 [CMS–1632–P] RIN–0938–AS41
Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long- Term Care Hospital Prospective Payment System Policy Changes and Fiscal Year 2016 Rates; Revisions of Quality Reporting Requirements for Specific Providers, Including Changes Related to the Electronic Health Record Incentive Program

CMS-1632-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 2016 that was published in the *Federal Register* on April 30, 2015 (vol. 80, no. 83, pp. 24324-24689).

NAUH would like to address five specific aspects of the proposed regulation: Medicare disproportionate share payments, inpatient rates, the hospital readmissions reduction program, short hospital stays, and outliers. We address each of these matters individually below.

Medicare DSH

NAUH would like to comment on three aspects of Medicare disproportionate share payments addressed in the proposed regulation: the size of the proposed FY 2016 Medicare DSH pool, the proposed methodology for distributing Medicare DSH funds, and the prospect of a meaningful increase in the number of Medicare DSH-eligible hospitals in the coming years.

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The Size of the Medicare DSH Pool

NAUH is very concerned about the surprisingly large decrease in the Medicare DSH pool proposed for FY 2016. 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 increase 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 also believes this category 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 (an issue we address below under "The Prospect of a Growing Number of Medicare DSH Hospitals"). In the FY 2015 final inpatient prospective payment system rule, this "other" factor for FY 2014 was 1.0355, which meant a 3.5 percent inflation factor attributable to this category for that year.

In the FY 2016 proposed rule, however, CMS has published a projected inflation factor for the "other" category for FY 2014 of 0.993. This significant departure from past practice accounts for a surprising $231 million reduction in available money in the uncompensated care DSH pool for FY 2016.

NAUH does not understand how the "other" factor for the same time period could change so drastically in the nine months between last August, when the final FY 2015 rule was finalized, and this April, when the proposed FY 2016 rule was proposed. For this reason, we ask CMS to provide more detailed and specific information about the various components that constitute this "other" inflation factor so we can understand why such a significant change is proposed that would have such a damaging impact on non-profit urban safety-net hospitals.

Finally, NAUH is concerned about the adequacy of the proposed Medicare DSH pool if the Supreme Court rules against the administration in the *King v. Burwell* case later this month. If it does, hospitals in states that used the federal exchange are likely to experience a surge in the number of uninsured patients coming through their doors – both an immediate problem for the affected hospitals and a future problem for other hospitals as well because it would almost certainly lead to changes in hospital payer mix that will increase the demand for Medicare DSH resources. NAUH hopes CMS will revisit its decision on the size of the proposed FY 2016 Medicare DSH pool if the Supreme Court rules against the administration in this case.

The Methodology for Distributing Medicare DSH Funds

NAUH is pleased that in the proposed rule, CMS acknowledges that it remains premature to propose the use of Medicare cost report worksheet S-10 for determining Factor 3 and therefore proposes continuing to employ a utilization of insured low-income patients proxy (defined as inpatient days of Medicaid patients plus inpatient days of Medicare SSI patients as defined in §412.106(b)(4) and §412.106(b)(2)(i), respectively) to determine Factor 3.

As NAUH has conveyed to you in recent years, the data from the S-10 form of the Medicare cost report that appears to be the natural foundation for such a calculation remains, in NAUH's view, seriously flawed. The S-10 seeks to quantify the uncompensated care hospitals provide, but historically, "uncompensated care" is not a universally agreed-upon concept and hospitals have not reported their uncompensated care uniformly. Experience demonstrates that 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

stays 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 that 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, end up categorizing and reporting uncompensated care in different ways, and hospitals in different regions and different states do the same.

In recent years NAUH's own analysis of S-10 data has uncovered numerous instances of data reporting that raises serious questions, and our review of the most recent data finds that this continues to be the case.

Consequently, NAUH continues to believe that any use of S-10 data in its current form would pose an enormous problem. Improving the S-10 so it can be a useful tool in measuring hospitals' uncompensated care, we believe, will require 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.

NAUH understands that CMS is still working on this, appreciates your efforts, and welcomes the opportunity to assist in any way we can. In the meantime, we thank you for choosing a more reliable proxy for utilization by insured low-income patients instead of S-10 data and urge you to continue using this proxy until you have a better, proven, verifiable method for measuring the uncompensated care hospitals provide.

The Prospect of a Growing Number of Medicare DSH Hospitals

For urban safety-net hospitals and millions of Americans, one of the most welcome aspects of the Affordable Care Act has been its expansion of eligibility for Medicaid. This has already enabled nearly twelve million Americans to secure the access to care they had long lacked, and it appears many more will gain similar access in the coming years as even more states expand their Medicaid programs.

As more people enroll in Medicaid, hospitals are serving higher proportions of Medicaid patients and many of those hospitals will become eligible to participate in the Medicare DSH program; many, in fact, already have. As this process continues, we face the prospect of a shrinking Medicare DSH pool serving a growing number of Medicare DSH-eligible hospitals.

This prospect troubles NAUH a great deal. 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 beginning in 2017. 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.

To address this problem, NAUH urges CMS to consider how it might expand the Medicare DSH pool to ensure that in the coming years it reflects the addition of newly eligible hospitals. The impact of this crisis may not be great now but it soon will be, so the time to plan for it is now rather than waiting until the already-precipitous decline in Medicare DSH resources accelerates and harms vital safety-net hospitals.

Hospital Inpatient Rates

NAUH recognizes that some of the proposed adjustments of the annual Medicare inpatient rate update are statutory requirements. Nevertheless, we are disappointed by the small increase proposed: a net of only 0.3 percent after the various adjustments.

From the perspective of providers, Medicare is continually asking us to do more: report more data, provide care in different ways, invest in more health care information technology, and more, yet continually small increases like this one suggest that Medicare is not interested in helping to pay for any of these improvements. Urban safety-net hospitals are continually stepping up to meet these challenges and urge CMS to join us in stepping up by showing a greater willingness to share the cost of doing so.

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 four 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; and legislation currently before Congress contemplates imposing changes in the program for this very reason.

Showing concern and sensitivity about this problem, last year 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 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, 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 2016 inpatient prospective payment system regulation and urge it to act on this important matter in time for reforms to be introduced when FY 2016 begins on October 1.

Short Hospital Stays

NAUH appreciates the recent actions both CMS and Congress have taken to protect hospitals from punitive actions by Recovery Audit Contractors. We also appreciate that CMS's actions were taken in part in response to the views providers submitted last year after CMS solicited comments and suggestions in the proposed FY 2015 inpatient prospective payment system regulation. We recognize that this has been a controversial area and appreciate the agency's willingness to audit hospitals' performance and educate them while it works to develop a satisfactory policy for reimbursing hospitals for such care.

A revised policy governing Medicare reimbursement for short hospital stays, the proposed FY 2016 suggests, will be included in the proposed FY 2016 hospital outpatient prospective payment system rule,

to be published in draft form in the near future, and will presumably reflect the considerable input offered by providers, MedPAC, and others. For this reason, NAUH wishes to take this opportunity to reiterate our perspective on the basic concepts we believe a short hospital stay policy should embrace.

In NAUH's view, a Medicare hospital stay begins with a physician's initial diagnosis that a patient needs to be admitted to the hospital as an inpatient and is expected to remain at least two midnights or more. Then, when the patient's stay is ultimately shorter, NAUH believes that stay should be classified as a short stay for Medicare payment purposes. A short stay should be reimbursed by Medicare based on Medicare transfer reimbursement policy – that is, for this day, Medicare should pay the hospital twice the per diem rate for the applicable DRG's average length of stay. This perspective is based on the generally accepted view that the greatest investment of resources for patient care occurs during the very beginning of a patient's stay in the hospital and that even in a short stay, a hospital is expending comparable resources on patient care during that first day or two as it does when a patient stays longer. This is the basis for current Medicare transfer payment policy and NAUH believes it should be the basis for Medicare short hospital stay payment policy as well. Further, hospitals that serve large numbers of low-income patients and have medical education programs should not be put at a disadvantage when patients just have short stays, so NAUH believes they should receive Medicare DSH and medical education payments for these short stays as well.

NAUH urges CMS to consider this perspective in developing its short stay policy. It also urges CMS to protect hospitals from arbitrary rulings by RAC auditors; to limit how far back RAC auditors can go in evaluating past hospital efforts; to ensure that RAC audits are completed in a timely manner and that appeals are addressed swiftly; and to ensure that future short stay policy, first and foremost, reflects the best interests of the patients hospitals serve and does not impose needless penalties on the hospitals that serve them.

Outliers

The proposed rule calls for reducing the Medicare outlier threshold from the current $24,626 to $24,485 in FY 2016. While NAUH appreciates the proposal to reduce the outlier threshold, we believe it should be reduced even further because Medicare's spending for outlier cases this year is on target to fall below five percent – the minimum level established by Congress. For this reason, NAUH suggests that CMS consider recalculating the proposed threshold with a target of 5.5 percent of inpatient spending to ensure that the final total does not fall short and instead falls within the statutory range of five to six percent in FY 2016.

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 to CMS and invites questions about the concerns we have raised.

Sincerely,

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Executive Director