NAUH
NATIONAL ASSOCIATION OF URBAN HOSPITALS

June 23, 2014

Ms. Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
P.O. Box 8011
Baltimore, MD 21244-1850

Subject: 42 CFR Parts 405, 412, 413, et al., Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System and Proposed Fiscal Year 2015 Rates; Quality Reporting Requirements for Specific Providers; Reasonable Compensation Equivalents for Physician Services in Excluded Teaching Hospitals; Provider Administrative Appeals and Judicial Review; Enforcement Provisions for Organ Transplant Centers; and Electronic Health Record (EHR) Incentive Program; Proposed Rule

Subject: File code CMS-1607-P

Dear Administrator Tavenner:

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 2015 that was published in the *Federal Register* on May 15, 2014 (vol. 79, no. 94, pp. 27978-28384).

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

Medicare DSH

NAUH would like to comment on three aspects of Medicare disproportionate share payments (Medicare DSH) addressed in the proposed regulation: the size of the FY 2015 Medicare DSH pool; the continued use of Congressional Budget Office estimates of anticipated declines in the number of uninsured as a result of Affordable Care Act reforms; and the methodology for distributing Medicare DSH funds.

The Size of the Medicare DSH Pool

NAUH appreciates the work that went into CMS's decision regarding the size of the factor 1 portion

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proposed Medicare DSH pool for FY 2015. The work was thoughtful and well-researched, and we thank you for this.

For future reference, and so we can understand the underlying rationale for the decisions that were made, NAUH would like to know more about the underlying calculations that led to those decisions. To begin, NAUH would like to know more about CMS's decisions and calculations in light of the proposed rule's assertion that

> The Office of the Actuary uses the most recently submitted Medicare cost report data to identify current Medicare DSH payments, supplemental cost report data provided by IHS hospitals to CMS, and the most recent DSH payment adjustments provided in the IPPS Impact File, and applies inflation updates and assumptions for future changes in utilization and case-mix to estimate Medicare DSH payments for the upcoming fiscal year.

NAUH asks CMS to provide more information about the inflation updates and assumptions the Office of the Actuary used to estimate what Medicare DSH payments would have been absent section 1886(r) of the Affordable Care Act. Although we do not know what those assumptions were, the FY 2014 final IPPS rule stated that the Office of the Actuary accounted for additional Medicare DSH expenditures associated with Medicaid expansion. NAUH recommends that this estimate, too, should account for that impact. Specifically, NAUH recommends that the estimate of Medicare DSH payments for the upcoming fiscal year take into account increases in Medicare DSH payment percentages that can be expected among hospitals currently projected to receive DSH as well as increased DSH expenditures attributable to hospitals that are likely to become eligible for Medicare DSH as their DSH patient percentages increase. This calculation, NAUH believes, also should reflect the significant numbers of individuals whose applications for Medicaid are still pending – 1.7 million such people, according to published reports in early June. NAUH would like to know whether the calculation includes these individuals and how much Medicare DSH would otherwise have been paid had they been qualified in a more timely manner.

The Manner in Which CMS Uses CBO Estimates of Changes in Insurance Status

NAUH understands that CMS is required to use Congressional Budget Office (CBO) estimates of changes in the number of uninsured as a result of Affordable Care Act reforms to reduce the Medicare DSH pool but is concerned about the manner in which CMS uses those estimates.

The Affordable Care Act envisioned significant expansion of Medicaid in all 50 states. The Supreme Court changed that, however, making Medicaid expansion optional for the states, and consequently, about half of the states have not expanded their Medicaid program. As a result, reductions in the number of uninsured people are not occurring in a more or less across-the-board manner, as both the reform law and CBO anticipated, instead occurring at very different rates depending on whether individual states have or have not expanded their Medicaid programs.

Another complicating factor is the challenges the uninsured faced using health insurance exchanges to enroll in Medicaid and purchase private insurance. The federally facilitated marketplace had a troubled launch and 27 states chose to rely solely on that marketplace; another seven operated marketplaces in partnership with the federal government. These operations were all handicapped to a degree by the problems encountered during the initial launch of the federal marketplace. Another 17 states operated their own exchanges – with varying degrees of success. Some worked well but others encountered problems as great at those experienced by the federal exchange. Whether federal or state-operated, the troubled exchanges had one thing in common: they detracted from the number of people who obtained health insurance during the enrollment period – but they did so unevenly, with people in some states having more trouble than people in others. Yet another complicating factor is that at this time, we cannot completely discern how many of those who enrolled in health insurance through the exchanges are newly insured and how many simply took advantage of the exchanges to obtain new insurance.

Together, these factors suggest that reducing the Medicare DSH pool based on the CBO estimates will be especially advantageous for hospitals in some states and especially harmful for hospitals in others. For this reason, NAUH recommends that CMS reduce its planned cuts in the Medicare DSH pool so it does not needlessly create winners and losers and does not jeopardize access to care in some communities.

The Methodology for Distributing Medicare DSH Funds

NAUH is pleased about the manner in which CMS has decided to measure the uncompensated care portion of hospitals' Medicare DSH payments. As we have conveyed to you over the past three years, the data from the S-10 data form of the Medicare cost report that appeared to be the natural foundation for such a calculation is, in NAUH's view, seriously flawed and has not improved in recent years.

The S-10 seeks to quantify the uncompensated care that hospitals provide, but historically, "uncompensated care" is not a universally agreed-upon concept and hospitals have not reported their uncompensated care uniformly. CMS's own consultants on how to quantify hospital uncompensated care noted 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, they noted that "Some entities also include payment shortfalls from government-funded plans, or third party payers." CMS's consultants also wrote that "Uncompensated care is most often defined as charity care plus bad debt but may include government and/or commercial payer shortfalls."

The use of "may" in that observation 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 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.

Challenges such as these lead to data reporting that raises serious questions, such as:

- A public hospital in California, which reported providing $3.3 billion worth of uncompensated care on the S-10's line 30 in FY 2012 – an amount that strains all credibility and also represents an increase of nearly 50 percent over what the hospital reported for FY 2011 (with only 2266 discharges).
- A private, non-profit hospital in Florida reported that its uncompensated care more than doubled in FY 2012, from $85.3 million in FY 2011 to $197.9 million in FY 2012.
- A public hospital in Alabama reported that its uncompensated care more than doubled, from $39.5 million to $104 million, from FY 2011 to FY 2012.
- A private, non-profit health system in Wisconsin reported a 38-fold increase in its uncompensated care, from $4 million in FY 2012 to $152 million in FY 2013.
- A non-profit hospital Indiana reported that its uncompensated care more than doubled in just a year, from $56.7 million in FY 2012 to $125.7 million in FY 2013.

These examples – and there are many, many more – demonstrate the weakness of S-10 data and its

continued unsuitability for use in the implementation of important public policy. NAUH appreciates that CMS appears to agree through its decision to use instead what we believe to be a more tested and reliable proxy for this vital calculation: hospitals' Medicaid and Medicare SSI days. On behalf of private, non-profit urban safety-net hospitals, we thank you for this decision.

While NAUH appreciates the complexity of the challenge of how best to calculate hospitals' FY 2015 Medicare DSH payments, we also recognize that this methodology, now in its second year of use, may very well be temporary, leaving us concerned about CMS's future intentions. NAUH is especially interested in how S-10 data may be part of those future plans. We continue to believe that any use of S-10 data in its current form would pose an enormous problem. Improving the S-10, 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. Uniformity of uncompensated care reporting, so lacking today, is absolutely essential to this process because of the manner in which the Medicare DSH pool is divided: proportional to eligible hospitals' uncompensated care costs. If some hospitals report selected costs as uncompensated that other hospitals categorize differently, this could result in an unfair distribution of Medicare DSH payments. The objective of this endeavor should be fairness in the distribution of Medicare DSH resources, and NAUH supports CMS's decision to use a proxy for uncompensated care until it finds a way to produce the uniformity of reporting that leads to such fairness.

In the meantime, we again wish to express our thanks for CMS's decision to use the proxy you have chosen 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.

Hospital Readmissions Reduction Program

The Need for Appropriate Risk Adjustment

NAUH supports CMS's effort to find ways to reduce avoidable hospital readmissions, but as we have written to CMS for the past three 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. Increasing the hospital readmissions reduction program's maximum penalty from two to three percent while also adding new medical conditions to the program, as proposed in this regulation, will only increase that harm.

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 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 recent months, 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, and "Socioeconomic Status and Readmissions: Evidence From An Urban Teaching Hospital," also May 2014, and the Agency for Healthcare Research and Quality, "Conditions With the Largest Number of Adult Hospital Readmissions by Payer," April 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, the vast majority of those who have submitted comments on the issue – 143 out of 148 parties – have expressed support for additional risk adjustment for socio-economic factors, as have the majority of NQF members (56 out of 68).

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 urges CMS to incorporate this, or some other form of socio-economic risk adjustment, into the readmissions reduction program.

A Much-Needed Adjustment to the Methodology

NAUH objects to the practice of calculating a three-year average when scoring hospitals' performance on avoidable Medicare readmissions. Such an approach, we believe, fails to reward improvement and even continues to punish hospitals that have improved their performance.

Consider, for example, the possibility that in the earliest year of any three-year period, a hospital performs poorly in attempting to prevent avoidable Medicare readmissions and is penalized the maximum amount, or close to the maximum amount, under the readmissions reduction program. If this hospital takes its poor performance to heart and, stung by the financial penalties, implements new practices that lead to a significant improvement the following year, its poor performance the previous year is still held against it by the current scoring methodology and it may suffer financial penalties again even if it has raised its performance to an acceptable level. Under the current program, one year of poor performance hurts a hospital for three years, not just for one. This problem is further exacerbated by the lag in the data being used. For FY 2015, for example, the applicable period is July 1, 2010 through June 30, 2013. This means that three-quarters of the period represents readmissions from before this program was implemented.

NAUH believes this is wrong and urges CMS to stop using a three-year rolling score for grading hospitals and judge them only on their most recent performance.

Hospital Inpatient Rates

NAUH recognizes that some of the proposed adjustments of the annual Medicare inpatient rate update are statutory requirements. Last year, however, CMS applied a budget neutrality factor in anticipation of increased inpatient spending associated with the implementation of Medicare's two-midnight rule. In light of the challenges the agency encountered in implementing this rule, NAUH urges CMS to evaluate whether experience in the current fiscal year demonstrates that this adjustment was justified. If, as we suspect, it is not, we urge CMS to reverse this adjustment in FY 2015.

Outliers

The proposed rule calls for raising the Medicare outlier threshold from the current $21,748 to $25,799, an increase of nearly 19 percent. This is an unusually large increase, and unlike in the past, much of the data underlying this calculation is not available to the public.

NAUH would like to know more about the underlying rationale for this significant increase and asks CMS for the data it used to develop this proposal and for further information about how and why it is proposing such a major increase.

Area Wage Index Classification System

NAUH wishes to thank CMS for the thoughtful, quality work that went into this year's revisions of the area wage index classification system. We believe private, non-profit urban safety-net hospitals are generally treated fairly by this system. We also appreciate that CMS has created transition periods for

hospitals that will be experiencing significant losses of Medicare revenue as a result of changes in the wage index of the community in which they are classified.

Short Hospital Stays

NAUH appreciates CMS's solicitation of provider views on short hospital stay payment policy. We recognize that this has been a controversial area and also 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.

In NAUH's view, a Medicare short 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 proposal 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 further proposes that they receive Medicare DSH and medical education payments for these short stays as well.

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