National Alliance of Safety-Net Hospitals

June 24, 2019

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 412, 413, and 495. [CMS-1716-P] RIN 0938-AT73. 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 2020 Rates; Proposed Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Promoting Interoperability Programs Proposed Requirements for Eligible Hospitals and Critical Access Hospitals

Attention: File Code CMS-1716-P

To Whom it May Concern:

I am writing on behalf of the National Alliance of Safety-Net Hospitals (NASH) to convey to the Centers for Medicare & Medicaid Services (CMS) our views on the proposed FY 2020 Medicare inpatient prospective payment system regulation that was published in the *Federal Register* on May 3, 2019 (Vol. 84, No. 86, pp. 19158-19677).

NASH would like to bring to your attention our views on four aspects of the proposed regulation:

- the calculation of Medicare DSH uncompensated care payments;
- proposed changes in the Medicare area wage classification system;
- rounding off numbers in CMS documents and files; and
- disputing disproportionate patient percentages.

We address each of these issues individually below.

The Calculation of Medicare DSH Uncompensated Care Payments

The Present Challenge

When the Affordable Care Act divided Medicare DSH payments into two components, one of which was a Medicare DSH uncompensated care payment that was to be based entirely on how much uncompensated care hospitals provide, it created a major challenge for policy-makers: how to determine how much uncompensated care hospitals provide. Lacking a clear, credible source of uncompensated care data to use for this purpose, CMS for three years – from 2014 through 2016 – used a proxy for

hospital uncompensated care based on two low-income variables: eligible hospitals' Medicaid patients and their SSI patients.

In 2017, CMS announced that it would move away from this proxy and begin a three-year transition into a different source of data for hospital uncompensated care: line 30 of the S-10 worksheet of the Medicare cost report, where hospitals report their uncompensated care. At that time CMS also announced that it would begin calculating hospitals' Medicare DSH uncompensated care payments based on three years worth of data. The purpose of using three years of data was to reduce undue fluctuations in hospitals' Medicare DSH uncompensated care payments from one year to the next.

For years, NASH (previously the National Association of Urban Hospitals) and others have urged CMS to prepare for future use of S-10 data for this purpose in two ways:

- By improving the instructions for completing the form, which have widely been viewed as confusing and have led to hospitals reporting their uncompensated care in many different ways – including ways it is virtually inconceivable that CMS ever intended. Representatives of NASH met with CMS officials on several occasions in recent years to share examples of hospitals reporting uncompensated care data that totally lacked credibility and to discuss specific aspects of the S-10's instructions that give rise to inconsistent and inaccurate data reporting.
- By auditing hospitals' reported S-10 data to ensure that they are reporting this data accurately and in compliance with the S-10's instructions. NASH has been urging CMS to audit S-10 data for nine years – ever since passage of the Affordable Care Act created the new Medicare DSH uncompensated care payment and it appeared inevitable that the S-10 would eventually be used in the calculation of that payment. Auditing is necessary because NASH's reviews of the uncompensated care data hospitals reported on their S-10 in recent years revealed that some hospitals are reporting enormous amounts of uncompensated care that simply cannot be believed in the context of their size, their operating expenses, and their other patient revenue. NASH has shared these reviews with CMS officials on a number of occasions. If left unaddressed, this inaccurate reporting would greatly skew the distribution of the limited pool of Medicare DSH uncompensated care money, inappropriately rewarding some hospitals for their inaccurate data and unfairly penalizing others.

Now, NASH is concerned that while work on both of these tasks is under way, that work remains incomplete at this time. CMS has made progress in improving the S-10's instructions, as can be seen by what NASH believes are improvements in the quality of the data hospitals are reporting. Despite this, further improvements may still be needed. The auditing is not nearly as far along: as described below, the very limited auditing that has been undertaken so far has been troubled and insufficient.

CMS Proposes Using Flawed Data for FY 2020

In its proposed FY 2020 Medicare inpatient prospective payment system regulation, CMS calls for using uncompensated care data from hospitals' FY 2015 S-10 forms when calculating FY 2020 Medicare DSH uncompensated care and also asks interested parties to share their view on the possibility of using FY 2017 S-10 data instead of the 2015 data. NASH believes that neither FY 2015 data nor FY 2017 data is suitable for this purpose.

NASH opposes the use of hospitals' FY 2015 data as the single source of data in the calculation of FY 2020 Medicare DSH uncompensated care reports because while this was the first such uncompensated care data CMS audited, that auditing so far has been not sufficient to give hospitals – and taxpayers – confidence that federal Medicare DSH uncompensated care funds will find their way to the hospitals

providing the greatest *verified* amount of uncompensated care. Among the problems that arose during the first round of auditing were inadequate time frames for hospitals to submit data to auditors; rushed auditing; the use of different auditing methodologies in different parts of the country, between the different Medicare Administrative Contractors (MACs), and even within individual MAC regions; and the lack of comprehensive auditing, with only about 20 percent of affected hospitals actually audited. In its proposed FY 2020 Medicare inpatient prospective payment system regulation, CMS revealed that "approximately 10 percent of audited hospitals have more than a $20 million difference between their audited FY 2015 data and their unaudited FY 2016 data." CMS also observed that some hospitals have suggested that had the S-10 instructions developed for FY 2017 – instructions that clearly represented an improvement over past instructions – been in place when they completed their FY 2015 S-10 reports, those 2015 reports would have had fewer errors and been more accurate. Together, these problems lead NASH to oppose the use of S-10 data from hospitals' FY 2015 Medicare cost reports in calculating hospitals' FY 2020 Medicare DSH payments, even when that data has been audited, because auditing was only undertaken for a relatively small proportion of hospitals.

NASH also opposes CMS's suggested alternative to using FY 2015: using FY 2017 data as the single source of data in the calculation of Medicare DSH uncompensated care payments. That data remains entirely unaudited, and while the instructions that guided hospitals during completion of their S-10 forms for FY 2017 are generally thought to be clearer and better than those used in FY 2015, there is, at least at this time, little reason to believe this unaudited data as a whole is any more accurate and any more credible than FY 2015 data. Upon reviewing this data, NASH found evidence of some improved data but also numerous examples of reported uncompensated care data that simply lack credibility – generally, hospitals reporting so much uncompensated care that it seems inconceivable that their doors could remain open. In addition, while hospitals that did undergo auditing of their FY 2015 data undoubtedly learned lessons that will improve their ability to complete future S-10 reports, 80 percent of DSH-eligible hospitals have not yet undergone those audits and therefore are not better prepared to complete future S-10s worksheets.

One Year of Data is Insufficient

The proposed FY 2020 regulation also calls for another change: calculating FY 2020 payments based on one year of data instead of three, as has been the case in recent years. NASH opposes this shift in approach. With so little auditing completed and the auditing that has been done of questionable value, NASH opposes any methodology for calculating hospitals' Medicare DSH uncompensated care payments that relies on data from just a single year. In addition to the problems specific to 2015 and 2017 data, outlined above, ***NASH objects to using data from just one year because the possibility of aberrant data from any one year skewing the distribution of Medicare DSH uncompensated care payments is too great.***

CMS is on record expressing this same view, writing in the final FY 2017 regulation that

> …because the data used to make uncompensated care payment determinations are not subject to reconciliation after the end of the fiscal year, we believe that it would be appropriate to expand the time period for the data used to calculate Factor 3 from one cost reporting period to three cost reporting periods. We stated that using data from more than one cost reporting period would mitigate undue fluctuations in the amount of uncompensated care payments to hospitals from year to year and smooth over anomalies between cost reporting periods.

Also,

> We stated that we believe that computing Factor 3 using data from three cost reporting periods would best stabilize hospitals' uncompensated care payments while maintaining the recency of the

> data used in the Factor 3 calculation. We indicated that we believe using data from two cost reporting periods would not be as stable while using data from more than three cost reporting periods could result in using overly dated information.

Until now, CMS had insisted on basing these payments on three years of data even after it shifted from basing payments on the low-income proxy to uncompensated care data as reported on the S-10. Now, however, it proposes changing its approach and basing the payments' calculation on just a single year of data, leaving hospitals potentially vulnerable to precipitous declines in their Medicare DSH uncompensated care payments because of either one unusual year of their own activity or questionable reporting by other hospitals.

Accuracy in S-10 reporting is so important because Medicare DSH payments are made out of a single pool of federal funds, with hospitals drawing from that pool based on the amount of uncompensated care they provide in comparison to other DSH-eligible hospitals. As a result, every hospital's reporting affects how much Medicare DSH uncompensated care money every other DSH-eligible hospital receives. Whether the result of misinterpreting the S-10's instructions, placing the wrong data on the wrong line on the form, an accounting or mathematical error, or an attempt to maximize their potential Medicare DSH uncompensated care revenue, some hospitals could unfairly receive a windfall of Medicare DSH uncompensated care money – and they would do so at the expense of other hospitals, including those that reported their data exactly as CMS intended. Conversely, the same reporting mistakes could result in aberrant data in which some hospitals' uncompensated care is under-reported, resulting in such hospitals not receiving the Medicare DSH uncompensated care payments to which they should reasonably be entitled.

An Alternative Approach: NASH's Proposal

NASH proposes an alternative to CMS's plan for calculating hospitals' FY 2020 Medicare DSH uncompensated care payments: a three-year proposal that would cover FY 2020, FY 2021, and FY 2022. At the heart of this proposal is NASH's belief – a belief CMS in the past made very clear that it shares – that these payments should be made based on more than one year of hospitals' S-10 data. Using more than one year of data would help smooth the overall data and ensure that no single year's aberrant data, whether the result of reporting error or just an unusual year in the life of a hospital, inappropriately skews calculations in ways that unfairly benefit or harm any hospitals or has wide-ranging effects that can be felt throughout the universe of the approximately 2,430 hospitals that will be eligible for Medicare DSH uncompensated care payments in FY 2020.

NASH has concluded that the more recent the data is, the more likely it will be reliable – or at least closer to reliable – for three reasons: first, CMS has improved the S-10's instructions since 2015, suggesting that data reported after 2015 should be more reliable than it was that year or prior to that year; second, future auditing should uncover flaws in hospitals' data reporting practices that hospitals will correct in the future, leading to more accurate reporting as time passes; and third, improved auditing will enable CMS to adjust hospitals' reported uncompensated care totals, which also should make future data more accurate.

With this in mind – using more recent data, including audited data, and the value of using data from more than one year – NASH suggests that instead of adopting its proposed methodology, CMS instead use the following methodology for calculating Medicare DSH uncompensated care payments over the next three years:

For FY 2020 *(year one of three):*

Calculate Medicare DSH uncompensated care payments based on a blend that consists two-thirds of the Medicare DSH uncompensated care payments hospitals receive in FY 2019 and one-third on hospitals' calculated share of the overall Medicare DSH uncompensated care pool for FY 2017.

For FY 2021 (year two of three):

Calculate Medicare DSH uncompensated care payments based on a blend that consists one-third of the Medicare DSH uncompensated care payments hospitals receive in FY 2019 and two-thirds on the average of hospitals' calculated share of the overall Medicare DSH uncompensated care pool for FY 2017 and FY 2018.

For FY 2022 *(year three of three):*

Calculate Medicare DSH uncompensated care payments based on the average of hospitals' calculated share of the overall Medicare DSH uncompensated care pool for FY 2017, FY 2018, and FY 2019.

A more detailed explanation of this methodology is included as an appendix to this letter.

By using this approach, ***CMS would reduce the importance of unreliable 2015 data in the calculation of Medicare DSH uncompensated care payments and instead use the most credible data available at the time of the calculation for each of the three years. Most important, adopting NASH's alternative proposal would buy CMS time: time to improve its auditing, time to do more auditing, time to engage in additional provider education to ensure that hospitals understand how to comply with Medicare's uncompensated care data reporting requirements, and time to refine the S-10's instructions still further if the outcome of future auditing suggests that improvements are still needed.*** NASH's proposed alternative also would eliminate the need for any auditing of hospitals' FY 2016 S-10 data, which is not needed to implement this alternative approach. NASH's proposed approach also takes advantage of the two major advances CMS has implemented in recent years: better S-10 instructions and a commitment to auditing. Together, these steps can help ensure that future uncompensated care data reporting is more accurate and can constitute an appropriate foundation for the calculation of Medicare DSH uncompensated care payments during the next three years and do so without the volatility inherent in potentially significant swings in hospitals' annual Medicare DSH uncompensated care payments – swings that CMS made a point of expressing its concern about in the past. Until then, NASH believes our alternative approach to that calculation for the next three years would produce more appropriate payments to hospitals.

NASH would welcome an opportunity to meet with CMS officials to explain this proposed alternative methodology and its benefits in greater detail and includes a more detailed explanation of this approach as an appendix to this letter.

Proposed Changes in the Medicare Area Wage Classification System

The "Compression Proposal"

The Medicare area wage classification system adjusts Medicare payments to hospitals based on hospitals' labor costs relative to the average labor costs of hospitals across the country. Parts of the country where labor costs are greater than average are assigned a higher wage index, more than 1.0, which is applied to

Medicare's standard payments; areas with lower wage costs, on the other hand, are assigned a lower wage index, less than 1.0, which is applied to the same standard Medicare payments. The wage index assigned to each hospital is based on an objective formula that reflects hospitals' actual incurred labor costs in different parts of the country.

CMS has proposed what is being referred to as a "compression proposal" that would inflate the wage indexes of hospitals with indexes below the 25th percentile so Medicare can direct more money to those hospitals. To pay for this increase and make this proposal budget-neutral, CMS calls for arbitrarily cutting the wage indexes of hospitals currently above the 75th percentile for wage index values.

This wage index proposal seeks to address what CMS describes as "growing disparities between low and high wage index hospitals, including rural hospitals that may be in financial distress and facing potential closure" by providing "certain low wage index hospitals with an opportunity to increase employee compensation without the usual lag in those increases being reflected in the calculation of the wage index."

NASH does not dispute CMS's conclusion that some distressed hospitals may need additional financial assistance from Medicare and urges CMS to identify such hospitals. At the same time, however, NASH believes CMS should explore means other than the proposed wage index changes for providing this additional assistance.

This wage index compression proposal raises a number of concerns. There is, to be sure, a growing disparity in the wage indexes of hospitals because there is a growing disparity in wages in different parts of the country. The wage index itself, however, has neither caused nor contributed to this disparity; it is, instead, a reflection of this disparity. Previous commenters have suggested that it is possible that the lag in wage data could suppress a hospital's ability to increase wages, but the existence of such wage suppression is undocumented and its potential impact is limited by several factors, including the presence of other hospitals in a labor market area; Medicare fee for service representing only a portion of hospital reimbursement; and probably most significantly, the FY 2005 modification of the wage index that artificially reduces the labor-related share for labor market areas with a wage index adjustment less than 1.0 that was expressly created by Congress to address this perceived issue.

The assertion that this proposal would help rural hospitals facing financial struggles is undermined by NASH's analysis that only 26 percent of the redistributed money would even reach rural hospitals while 74 percent of the redistributed money would go to urban hospitals. In fact, there are more than 60 rural hospitals in 20 different states that lose money under the proposal.

Finally, it is not clear from the explanation provided in the proposed rule that the Secretary has the authority to implement this change. The rule states that the adjustment would be made under

> …section 1886(d)(3)(E) of the Act, which gives the Secretary broad authority to adjust for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level, and requires those adjustments to be budget neutral, and our exceptions and adjustments authority under section 1886(d)(5)(I) of the Act.

Between CMS's proposed inflation of the lowest quartile and its proposed reduction to the highest quartile, it is not reasonable to conclude that the proposed policy change would continue to reflect "…the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level…" CMS cannot, as the rule seems to argue, arbitrarily alter wage adjustments as long as it ensures that those above the national average are greater than 1.0 while those below the national

average are below 1.0. Inherent in the concept of an area's relative wage is the proportionality of that relativity, which is lost under this proposal.

NASH asks CMS to withdraw this proposal. There undoubtedly are hospitals in need of additional financial support and many are located in low-wage areas, but we do not believe the wage index is either the cause of their troubles or an appropriate means of addressing them. NASH believes CMS should identify the true root causes of these financial challenges and then work with Congress to secure the funding needed to address this problem.

The Proposed Exclusion of the Wage Data of Some Hospitals

NASH also objects to CMS's decision to exclude wage data from eight hospitals located in the "northern" region of a single state because the wages these providers pay are noticeably higher than the wages paid by other hospitals in the area. In this case, one entity owns multiple hospitals and negotiates common wages with its workforce throughout the region in which its hospitals are located. CMS has expressed concern that these common wages are not representative of the wages hospitals need to pay in the areas in question.

CMS asserts that it does not believe these wages "accurately reflect the economic conditions in their respective labor market areas during the FY 2016 cost reporting period." NASH believes this conclusion misses the point: *The actual wages paid in a region are not a proxy meant to reflect economic conditions. They* ***are*** *the economic conditions that the wage index is meant to reflect***.** In this situation, a hospital or hospitals in a region paying higher wages forces other hospitals in that region to increase their wages to compete for staff. It is these local market conditions, and not Medicare fee-for-service payments, that dictate the wages paid to hospital staff.

NASH objects to CMS's proposal to eliminate wage data that it acknowledges to be legitimate. Doing so for these particular hospitals for the reasons articulated in the proposed rule would set a dangerous precedent for the future elimination of other unquestionably legitimate wage data. We believe this is a step CMS should not take and urge the agency to restore the wage data of the excluded hospitals to the calculation of the average wages in the wage index areas in which they are being paid.

Rounding Off Numbers in CMS Documents and Files

In the draft regulation, CMS proposes a new policy addressing when and how it would round off numbers in various documents and files related to wage index calculations: rounding to two decimal places for dollar amounts, to whole numbers for hours, and to five decimal places for any numbers within the wage index calculations not expressed as hours or dollars, such as ratios, inflation factors, and other amounts.

NASH is grateful to CMS for its proposal to provide transparency and consistency in the calculation of the wage index and supports the use of a standard policy. We suggest, however, that average hourly wages, including the national average hourly wage, be treated as a ratio rather than a dollar figure. These values are, in fact, imputed ratios and not actual dollar figures. Rounding them to two decimal places rather than five and then rounding the final wage indexes to four decimal places results in final wage indexes where precision exceeds accuracy.

The example below compares wage indexes for two hypothetical CBSAs and two hypothetical national averages when average hourly wages (AHWs) are rounded to five or two digits. As this comparison illustrates, rounding AHWs with five-digit precision results in an identical wage index of 1.1277 for all combinations while using two-digit precision results in wage indexes ranging from as low as 1.1275 to as

high as 1.1280. Rounding to fewer digits in an interim step amplified apparent variation in wages because a difference as small as 1/1000 of a cent could count the same as a difference of one cent.

	Current	Rounded
National AHW A	43.21499	43.21
National AHW B	43.21500	43.22
CBSA A	48.73499	48.73
CBSA B	48.73500	48.74
CBSA A Wage Index using NAHW A	1.1277	1.1277
CBSA B Wage Index using NAHW A	1.1277	1.1280
CBSA A Wage Index using NAHW B	1.1277	1.1275
CBSA B Wage Index using NAHW B	1.1277	1.1277

Although the distortion is small, these calculations are generally performed by computers rather than by hand so there is no trade-off in cost for the improved accuracy of using five digits for AHWs. As long as there is a published standard, CMS does the public a service by publishing it and consistently applying it. We believe this slight modification of that standard would result in a more accurate measure of a labor market area's wages relative to the national average at no additional cost.

Disputing Disproportionate Patient Percentages

NASH supports any policy that would enhance hospitals' abilities to provide updated and accurate information with minimal administrative burden for hospitals, the Provider Reimbursement Review Board, and the Medicare Administrative Contractors for use in calculating hospitals' DSH patient percentages.

* * *

The National Alliance of Safety-Net Hospitals appreciates the opportunity to share our views on the proposed Medicare inpatient prospective payment system regulation with CMS and welcomes any questions you may have about the ideas we have presented in this letter. In particular, we would be pleased to meet with CMS officials to discuss our alternative approach to calculating Medicare DSH uncompensated care payments for FY 2020, FY 2021, and FY 2022.

Sincerely,

Ellen Kugler
Executive Director

Enclosure (Appendix: "Calculation of Factor 3 for FY 2020")

About the National Alliance of Safety-Net Hospitals

The National Alliance of Safety-Net Hospitals advocates for adequate recognition and financing of private safety-net hospitals that serve America's neediest communities. These private safety-net hospitals differ from other hospitals in a number of key ways: they serve communities whose residents are older and poorer; they are 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 funds to underwrite their costs. NASH's role is to ensure that when federal officials make policy decisions, they understand the implications of those decisions for these distinctive private safety-net hospitals. NASH 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. Until 2019 NASH was known as the National Association of Urban Hospitals, and its evolution into NASH reflects its members' recognition that private safety-net hospitals can be found serving communities not only urban but also rural and suburban across the country.

Appendix: Calculation of Factor 3 for FY 2020

Factor 3 represents a hospital's share (as estimated by the Secretary) of the total uncompensated care provided by all hospitals eligible to receive DSH payments. CMS has, in recent years, calculated UCC DSH payments using an average of three factor 3 calculations subject to a budget neutrality adjustment that modifies the average factor 3 for each hospital to spend the appropriate amount of money (i.e., factor 1 times factor 2) for the fiscal year.

For the reasons stated in the accompanying comment letter, NASH recommends that for FY 2020, CMS implement year one of a three-year transition to using a three-year average of audited post-transmittal 11 data. The schedule for this transition would be as follows:

- Year one (FY 2020) would consist of a blend of 2/3 of a hospital's 2019 UCC DSH payment with 1/3 of the hospital's UCC DSH payment based on unaudited 2017 S-10 data. During FY 2020, CMS could engage in audits of the 2017 data.
- Year two (FY 2021) would consist of a blend of 1/3 of a hospital's 2019 UCC DSH payment with 2/3 of the hospital's UCC DSH payment based on the average factor 3 derived from the hospital's audited 2017 data and unaudited 2018 data. During FY 2021, CMS could engage in audits of the 2018 data.
- Year three (FY 2022) would consist of an equally weighted blend of the hospital's audited 2017 and 2018 data and unaudited 2019 data.

Each year thereafter, CMS could continue to engage in audits while rolling forward the three-year average, adding a new year of data to the calculation and dropping the oldest year of data. The result balances timeliness and accuracy while also maintaining year-over-year stability.

Specifically, for FY 2020, a hospital's final factor 3 would be calculated by:

- Calculating for each hospital a preliminary 2017 factor 3 by dividing the hospital's reported line 30 uncompensated care (subject to any adjustments or trims) by the total reported line 30 uncompensated care (subject to any adjustments or trims) reported by all hospitals expected to receive DSH in FY 2020 on their 2017 cost reports.
- Calculating for each hospital a blended FY 2020 factor 3 by summing the hospital's preliminary 2017 factor 3 plus its FY 2019 final factor 3 plus its FY 2019 final factor 3 and dividing by 3 if the hospital received a payment in 2019 and 1 if the hospital received no payment in 2019.
- Deriving a standardization factor by calculating the average factor 3 for all hospitals projected to receive DSH and dividing the result by 1.0.
- Calculating each hospital's final FY 2020 factor 3 by multiplying its blended FY 2020 factor 3 by the standardization factor.

Puerto Rico hospitals, Indian Health Service and Tribal hospitals would continue receive a factor 3 based on low-income insured days from FY 2013.

For 2021, each hospital's factor three would be based on the three-year average of its 2019 final factor 3, its 2017 factor 3 and its 2018 factor 3.