American Hospital Association

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April 5, 2017

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

Dear Ms. Verma:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA), in anticipation of the Centers for Medicare & Medicaid Services' (CMS) hospital inpatient prospective payment system (PPS) proposed rule for fiscal year (FY) 2018, appreciates the opportunity to comment on upcoming proposals related to the Medicare disproportionate share hospital (DSH) payments and the documentation and coding adjustment.

Based on the work of our Medicare DSH Advisory Committee, and given the critical impact it has on the distribution of Medicare DSH payments among hospitals, the AHA remains concerned about the accuracy and consistency of the Worksheet S-10 data. We urge CMS to take additional steps to ensure the accuracy, consistency and completeness of these data prior to their use. This entails auditing the S-10 data, as well as making other modifications to the S-10 worksheet, including, but not limited to, adopting a broad definition of uncompensated care costs to include all unreimbursed and uncompensated care costs, such as Medicaid shortfalls and discounts for the uninsured. Additionally, we urge CMS to restore excessive documentation and coding payment cuts to the inpatient PPS base in FY 2018.

DSH PAYMENT CHANGES

The Affordable Care Act (ACA) requires that, beginning in FY 2014, hospitals initially receive 25 percent of the Medicare DSH funds they would have received under the pre-FY 2014 formula, known as "empirically justified DSH payments." The remaining 75 percent flows into a separate funding pool for DSH hospitals, known as "uncompensated care DSH payments." This pool is reduced as the percentage of uninsured individuals declines and distributed based on the

proportion of total uncompensated care each Medicare DSH hospital provides relative to the national total.

For several years, CMS has discussed using the cost report's Worksheet S-10 data on hospital charity care and bad debt to determine the amount of uncompensated care each hospital provides, in place of the current formula of Medicaid and Medicare Supplemental Security Income (SSI) days. However, because of concerns regarding variations in and the completeness of these data, CMS has stated that it is premature to propose the use of Worksheet S-10. However, in the FY 2017 inpatient PPS final rule, the agency indicated that it planned to institute certain additional quality control and data improvement measures, including an audit process, to the Worksheet S-10 instructions and data. The agency also stated that it intended to begin incorporating Worksheet S-10 data into the DSH computation once these additional measures were in place (but no later than FY 2021) and that the agency would re-propose a policy related to incorporation of these data prior to that time. In advance of such a proposal, the AHA offers the following thoughts and concerns related to Worksheet S-10.

Concerns Related to the Worksheet S-10

Generally speaking, we continue to believe that, if reported in an accurate and consistent manner, the Worksheet S-10 data have the potential to serve as a more exact measure of the treatment costs of uninsured patients. **However, the AHA also continues to believe these data are not yet sufficiently accurate and consistent.** Specifically, the form and its instructions are unclear in some places and lack specificity in others. While CMS has indicated that it would "trim" the S-10 data to remove certain anomalous data points, such a method does not improve the accuracy or consistency of the actual data itself. Hospitals' attempts to reconcile the instructions for the Worksheet S-10 with their obligation to accurately reflect their financial circumstances often lead to frustration and inconsistencies in reporting of this data nationwide.

For example, our analysis of the Worksheet S-10 data identified examples of reporting inconsistencies. When we analyzed FY 2014 data, we found a number of hospitals that had uncompensated care costs on line 30 of the Worksheet S-10 that totaled more than 50 percent of their total expenses for the facility as a whole. One of these hospitals had uncompensated care costs that were over 800 percent of its total expenses. Another had bad debt expenses (Line 28) that were more than 2000 percent of its total expenses.

In addition, in the FY 2015 data, we found hospitals that reported negative charity care charges (Line 20) and negative bad debt expenses (Line 28). Indeed almost 3 percent of cost reports contained negative bad debt expenses. We also found that almost 8 percent of cost reports reported charity care charges of zero, and more than 1 percent reported bad debt expenses of zero. While incurring no charity care or bad debt is certainly possible, the high number of hospitals reporting such raises a red flag and supports the necessity of an audit.

With regard to inconsistences in the data, one of the simplest examples relates to how patient costs are separated into categories on the Worksheet S-10. Specifically, three categories of data collected on the Worksheet S-10 are based on whether the patients described in the category are covered by a particular health care program (difference between revenue and cost for Medicaid

(Line 8), difference between revenue and cost for the Children's Health Insurance Program (CHIP) (Line 12), and difference between revenue and cost for state or local government programs (Line 16)). Two categories are based on whether the patients described in the category fall under certain accounting policies at the hospital (cost of charity care (Line 23) and cost of bad debt (Line 29)). However, while these categories are intended to be mutually exclusive, they are not: individuals who fall under a hospital's charity care policy or with whom the hospital has associated bad debts also may be covered by Medicaid, CHIP, or a state or local indigent care program. Therefore, when reporting values for these various categories, each provider must make decisions how to report these data in a mutually exclusive way, and there is no indication that they do so consistently around the country.

These inaccuracies and inconsistencies have a critical impact on the distribution of Medicare DSH payments. That is, because the 75-percent pool is a fixed amount, inaccurately reported data by one hospital will affect the DSH payments of all other hospitals. In addition, because Congress has generally foreclosed subsequent administrative and judicial review of DSH payment calculations, hospitals have no recourse to correct data after it is used. It is critical for CMS to ensure this data is accurate and consistent before its use.

Suggested Improvements to the S-10

CMS has indicated that tying the S-10 to payment and requiring its regular use will inherently improve its accuracy. However, given the inaccuracies and inconsistencies discussed above, we do not believe that simply tying these together will improve the S-10 data. **Therefore, we urge CMS to audit the S-10 data prior to their use to verify that they are correct and complete, and also to incorporate changes the AHA has previously communicated to CMS, outlined below.**

Audit the S-10 Data Prior to Their Use. **We urge CMS to audit the S-10 data prior to their use to verify that they are correct and complete.** For example, the agency could conduct a side audit to expedite the process, similar to audits for the occupational mix survey data. We note that hospitals are eager to learn how auditors will interpret the Worksheet S-10, and greater clarity of CMS's expectations would ensure hospitals are in a much better position when they fill out the Worksheet S-10.

In addition, once CMS ensures the accuracy and consistency of the Worksheet S-10 data, we believe that transitioning to its use, either through a phase-in approach and/or a stop-loss policy, is appropriate. We also believe that if a phase-in approach is used, a longer time period than that proposed in the FY 2017 inpatient PPS proposed rule may be warranted, such as CMS has implemented in the past with, for example, the capital PPS. These types of policies would help mitigate large payment fluctuations and promote stability in DSH payments to hospitals.

Additional Changes to Improve S-10 Data. We have communicated our major concerns and suggestions regarding the Worksheet S-10 to CMS on multiple occasions, including in a stakeholder discussion group lead by Dobson DaVanzo & Associates, LLC, in January 2014 and

in our comments on the FYs 2015, 2016 and 2017 inpatient PPS proposed rules. Many of those comments are still relevant and are reiterated below.

1. **Uncompensated Care Costs**. The AHA continues to recommend that the definition of uncompensated care be broad based and include all unreimbursed and uncompensated care costs, including the unreimbursed costs of Medicaid and other state and local government indigent care programs reported on Line 19 of Worksheet S-10. In addition, we recommend that this definition also include any discounts to uninsured individuals who are unable or unwilling to provide income information to the hospital, since those are also costs incurred by hospitals in providing treatment to the uninsured. This broad definition of uncompensated care costs will be important in accurately measuring a hospital's unreimbursed costs, and it will ensure the most appropriate basis for calculating future uncompensated care payments.

2. **Revisions to the CCR for Worksheet S-10**. The ratio of cost to charges (CCR) calculation on line 1 of Worksheet S-10 flows from Worksheet C, column 3 (costs) and column 8 (charges). Column 3 costs do not include the cost of training residents (direct graduate medical education (GME) costs), but column 8 charges do inherently include the cost of training residents. Therefore, the numerator and denominator of the CCR are not consistent. As a result, the AHA continues to recommend that the formula calculating the CCR for Worksheet S-10 be modified to include GME costs.

3. **Medicaid Reporting**. The AHA has made three recommendations related to the reporting of Medicaid DSH data on lines 2-6 of the Worksheet S-10. Specifically, we have indicated that hospitals should be required to report Medicaid DSH on a separate line, rather than having the option of including DSH in total Medicaid revenues (Line 2) without breaking it out separately. In addition, non-DSH supplemental payments (e.g., upper payment limit) should be reported on a separate line from Medicaid revenue and Medicaid DSH and the instructions for Medicaid lines should be revised to indicate that stand-alone CHIP should not be included in Medicaid line items. CHIP is difficult to interpret from a DSH perspective given the various forms of implementation across states. To date, CMS has taken no action related to these recommendations; therefore, the AHA renews its request for CMS to address these issues related to Medicaid reporting on Worksheet S-10.

4. **Private Grants, Donations, Endowments and Government Grants, Appropriations and Transfers**. The AHA has requested that CMS clarify the purpose of Lines 17 and 18 on the Worksheet S-10, both in the near term and for the future. Line 17 requires the reporting of grants, gifts and investment income that are related to uncompensated care. Line 18 requires reporting of a very broad scope of data related to the general operation of the hospital, whether or not they relate to uncompensated care. Both lines appear to be informational only, since they are not included in any of the totals elsewhere on Worksheet S-10. The AHA requests, again, that CMS offer clarification related to Lines 17 and 18 and, in the absence of such clarification, recommends that these lines be deleted.

5. **Trims to Apply to CCRs on Line 1 of Worksheet S-10**. In the past, CMS proposed trimming data to control for data anomalies. In the inpatient PPS proposed rule for FY 2017, the agency proposed a policy whereby all hospitals with a Worksheet S-10 CCR that is above a CCR "ceiling" or that is greater than 3.0 standard deviations above the geometric mean would receive the statewide average CCR.[1] The AHA has raised concerns about the soundness of this trimming methodology. Specifically, we are concerned that, under that proposal, CMS would trim hospitals that had CCRs that appeared to be anomalous, but were actually the result of their use of alternative methods of cost accounting that had previously been approved by Medicare audit contractors. We continue to urge CMS to revise its trim methodology so that it does not penalize these providers.

Additional Comments Related to DSH Payments

In the inpatient PPS final rule for FY 2017, CMS made a change to the DSH payment methodology to address concerns from the hospital field that using only one year of data to determine a hospital's uncompensated care may result in unpredictable swings and anomalies. Specifically, the agency expanded the time period for the data used to calculate hospitals' Medicaid and Medicare SSI inpatient days from one year to three years. Therefore, beginning in FY 2017, and until CMS proposes a transition to the Worksheet S-10, the agency will use three years of cost-report data to calculate the distribution of the uncompensated care portion of DSH payments to hospitals.

The AHA has a concern related to this methodology, which we urge CMS to consider with regard to its upcoming inpatient PPS proposed rule for FY 2018. Specifically, CMS does not annualize cost report data to account for those hospitals that may have had cost reports that are more or less than 365 days in any given year. If a provider has a short cost-reporting period, this inappropriately reduces the number of Medicaid and Medicare SSI days included in the uncompensated care calculation and negatively impacts the DSH payment received by that hospital. If a provider has a long cost-reporting period, that result is reversed. **Therefore, we urge CMS to annualize the amounts reported on the cost reports when calculating its proxy for uncompensated care costs to account for such cost reporting periods.** Doing so would also more fairly account for hospitals with multiple cost reports in a single FY that together total more than 365 days.

Finally, we continue to urge CMS and the Office of the Actuary (OACT) to provide all information possible related to its methodology for calculating DSH payments. It is especially important that the agency improve transparency related to this complex methodology given that Congress has generally foreclosed subsequent review, making the adequacy and completeness of notice-and-comment rulemaking that much more important from a constitutional due process perspective.

[1] The CCR "ceiling" is the one that was published in the final rule of the fiscal year that is contemporaneous to the particular worksheet S-10 data being used.

MEDICARE SEVERITY DIAGNOSIS-RELATED GROUP (MS-DRG) DOCUMENTATION AND CODING ADJUSTMENT

The American Taxpayer Relief Act of 2012 (ATRA) required CMS to make adjustments to the standardized amount to recoup $11 billion that the agency claims is the effect of documentation and coding changes from FYs 2010 – 2012 that CMS says do not reflect real changes in case mix. To complete this recoupment, for FY 2017, CMS finalized a coding cut of 1.5 percentage points to inpatient PPS payments. **The AHA remains extremely troubled by the size of this cut, which is almost double the cut of 0.8 percentage points anticipated by hospitals. We continue to believe that this cut should have been reduced to what the agency originally estimated and planned – 0.8 percentage points for FY 2017.**

However, since CMS imposed this cut of 1.5 percentage points in FY 2017, the AHA strongly urges CMS to ensure that the amount in excess of 0.8 percentage points is returned to the standardized amount in FY 2018, in accordance with Congress' intent in both the ATRA and the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Specifically, the ATRA cuts were recoupment cuts; as such, Congress intended that the cumulative 3.2 percentage point cut (0.8 percentage points for each of FYs 2014 – 2016, plus 0.8 percentage points in FY 2017) be restored in FY 2018 through a one-time increase in inpatient PPS payments. Congress altered the timing and amount of this restoration in MACRA, but still intended that 3.0 percentage points of the 3.2 percentage point ATRA cut be restored.

More specifically, because CMS implemented a cut of 1.5 percentage points in FY 2017, the agency, in total, removed 3.9 percentage points from the standardized amount. Yet, MACRA allows for only 3.0 percentage points to be returned to hospitals by FY 2023. Consequently, CMS's proposed cut would leave hospitals with a permanent cut of 0.9 percentage points after the MACRA adjustments have been made, instead of the 0.2 percentage point cut that Congress intended. This additional 0.7 percentage point cut is inconsistent with Congress's intent in the ATRA and MACRA, which, together, required almost total restoration of the documentation and coding cuts.

We appreciate your consideration of these issues. Please contact me if you have questions or feel free to have a member of your team contact Priya Bathija, AHA senior associate director for policy, at (202) 626-2678 or pbathija@aha.org.

Sincerely,

/s/

Thomas P. Nickels
Executive Vice President
Government Relations and Public Policy