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### **Electronically Submitted**

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1607-P  
Mail Stop C4-26-05  
7500 Security Boulevard  
Baltimore, MD 21244-1850

Re: CMS-1607-P - Comments on the Medicare Hospital Inpatient Prospective Payment System Proposed Rule for FFY 2015

Dear Sir or Madam:

We write to submit comments on behalf of the Jayne Koskinas Ted Giovanis Foundation for Health and Policy regarding various proposals in the Centers for Medicare and Medicaid Services (CMS) Hospital Inpatient Prospective Payment System (IPPS) Proposed Rule for FFY 2015. We appreciate the opportunity to submit these comments to you. Our specific comments are listed below.

#### **I. CMS Should Adopt Socioeconomic Adjustments for Quality and Outcomes Measures**

The Foundation strongly urges CMS to apply risk adjustment factors that will account for patient's socioeconomic status in assessing quality and outcomes measures for hospitals. Several studies have concluded that socioeconomic status is indeed a risk factor that has a real impact on patient outcomes in several measures are beyond the hospitals control, and CMS has not provided data that shows otherwise. Failure to account for these risk factors will skew CMS' data measurements and will produce inaccurate and unreliable outcomes. We respectfully request that CMS reconsider its approach to socioeconomic adjustment factors and that it incorporate such factors where supported by empirical evidence.

- a. Empirical Studies Demonstrate that Patient Socioeconomic Status Impacts Outcomes and Failure to Account for This Impact Disadvantages Hospitals that Provide Care to Those Most in Need, and will Harm the Patients CMS Needs to Protect*

As CMS develops quality and outcome measures, it must ensure that it is using the best empirical evidence to establish metrics that will capture accurate data regarding patient outcomes and quality and that the incentives it puts in place motivate positive changes. An incorrect or

imprecise methodology could create perverse incentives and inadvertently harm providers and patients. .See Atkinson, J. G., Flaws in the Medicare readmission penalty, *The New England Journal of Medicine*, 367(21), 2056–2057 (2012) (“The hospital readmission penalties recently announced by Medicare are an example of a good idea gone wrong. Although providing incentives to reduce the rates of unplanned readmissions seems like a good idea, this program has been implemented in such a way that it penalizes hospitals that treat a large proportion of Medicaid patients . . . .”)

Several recent studies have found that the metrics that CMS currently proposes will not produce the desired result of improving quality, and in fact are weakening the social safety net. See, e.g., Doran, K. M., Ragins, K. T., Iacomacci, A. L., Cunningham, A., & Jubanyik, K. J., The Revolving Hospital Door: Hospital Readmissions Among Patients Who are Homeless, *Medical Care*, 51(9), 767–773, doi:10.1097/MLR.0b013e31829fa-fbb (2013).

In March of this year, National Quality Forum (“NQF”) released a memorandum on a draft NQF report on *Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors*. The memorandum on the draft Report relayed recommendations by a NQF panel of 26 experts on “whether performance measures used in accountability applications, including public reporting and pay-for-performance, should be adjusted for sociodemographic factors in order to improve the accuracy of performance results.” The expert panel concluded that current policy is “unintentionally weakening the network of providers that serve disadvantaged populations, which could end up worsening disparities[.]” due to concerns about:

- Providers avoiding serving disadvantaged populations to ward off being labeled a poor performer, which then worsens access to care for vulnerable patients;
- Funds – based on performance-based incentives – shifting from those that serve the disadvantaged to those that serve the affluent. Safety net providers then have fewer resources to care for vulnerable populations and the array of additional services they need;
- Consumers and payers avoiding providers who serve disadvantaged populations because they are labeled poor performers, even for select quality measures which may not accurately reflect underlying quality of care.

The Foundation urges CMS to review these important studies and to revise its methodology to provide risk adjustment factors for patients’ socioeconomic status. Under the current policy of not adjusting quality and outcome measures for socioeconomic factors, CMS’s quality and outcome measures tend to adversely impact those hospitals that have a high proportion of Medicaid patients. See Ryan, A. M., Will Value-Based Purchasing Increase Disparities in Care? *The New England Journal of Medicine*, 369, 26 (2013).

Hospitals should not be penalized for quality outcomes attributable to patient risk factors beyond the hospitals' control. The better policy is to make an adjustment for socioeconomic factors when those are found to be statistically significant and meaningful. If patient data are stratified by socioeconomic factors and the data show that safety-net hospitals are providing poorer quality care, the reasons for the poorer quality care should be investigated and the hospitals should be held accountable. Either way, empirical analysis should be performed for each particular measure to answer the question whether a particular adjustment should be included for that measure.

*b. CMS' Rationale for Not Providing a Risk Adjustment Factor for Socioeconomic Status is Flawed and Should be Re-Evaluated*

In the proposed rule, CMS proposes to adopt new readmission and inpatient quality reporting measures without risk adjustments for socioeconomic status. *See, e.g.*, 79 Fed. Reg. 27298, 28111, 28229, 28231, 28233, 28235 (May 15, 2014). The proposed rule states, as CMS has argued previously, that "risk adjusting for these characteristics would hold hospitals with a large proportion of patients of . . . low socioeconomic status to a different standard of care than other hospitals," and CMS "seeks to illuminate quality differences, and risk adjustment for socioeconomic status . . . would obscure such quality differences." *See, e.g., id.* at 28111.

This rationale assumes the conclusion to CMS' own argument. More specifically, CMS argues that a risk adjustment for socioeconomic status would hold hospitals that treat low-income patients to a different standard and would obscure true quality differences based upon CMS's assumption that socioeconomic status is not, in fact, a risk factor, beyond a hospital's control, that may contribute to less than optimal outcome. CMS has not shown by any meaningful or reliable statistical analysis that socioeconomic status is not a risk factor. As described above, studies have shown it is a significant risk factor with a very real impact on patient outcomes, and as result, CMS's continuing refusal to account for this risk factor tends to obscure, not illuminate, true quality differences. The current policy inappropriately punishes the very providers that need resources to follow patients post discharge in order to prevent readmission.

CMS' analysis on this point is limited to an observation that some hospitals that treat a large proportion of low-income patients sometimes achieve good quality scores even as compared the scores for hospitals that have a lower proportion of low-income patients. But this is simply an anecdotal observation. It is not a statistically acceptable and reliable analysis.

CMS has attempted to support its current policy of not making adjustments for socioeconomic factors with data provided in the CMS Hospital Quality Chartbook 2013 (Yale New Haven Health Services Corporation Center for Outcomes Research and Evaluation, 2013). Stated in statistical terms, CMS' argument is that no adjustment for socioeconomic factors is needed because the distribution of the results for safety-net and teaching hospitals overlaps substantially with the distribution for other hospitals. But "overlap" is not a generally accepted statistical criterion for evaluating differences. Indeed, even if it were valid, this observation could show that the hospitals treating a large number of low-income patients are treating their patients so well that they should be rewarded under the current methodology, not penalized. A more appropriate inquiry is whether the means of the distributions are statistically significantly

different and whether the differences substantially influence the resulting penalties. If so, the inclusion of socioeconomic adjusters would not reduce hospitals' incentives to improve on the quality measure, but might even improve it. And these adjustments would not obscure differences in quality but could illuminate one or more of the several reasons for differences in outcomes that are beyond a hospital's control and why a given hospital, in fact, provides better or poorer quality care to patients, whether affluent or lower-income.

## **II. Medicare Must Assure a Meaningful Opportunity to Appeal Cost Report Claims Without Undue Restrictions and Appeal Requirements and Provide Clarification that Select Appeals or Payments are Not Precluded by the New Proposed Rule.**

Appeals rights generally are provided as a basic right for all citizens and entities. This right to appeal also extends to all Medicare beneficiaries and providers. Any changes in rules or statutes that restrict such rights undermine the fairness of the system. The agency's proposal needs to be constructed and implemented in the context of assuring this basic right. Therefore, there are serious concerns about the provisions of proposed rule concerning the "*Proposed Changes Regarding the Claims Required in Provider Cost Reports, and for Provider Administrative Appeals.*" 79 Fed. Reg. 27,978, 28,209. In short, the proposed rule would preclude payment for an item in a notice of program reimbursement ("NPR") or pursuant to any decision or order by a "reviewing entity" in an administrative appeal unless the provider included an affirmative claim for reimbursement for that item or protest with respect to that item in the cost report submitted to the Medicare Administrative Contractor. *See, e.g., id.* at 28,211-12. For the reasons discussed more fully below, we request that CMS address the following concerns in the final rule.

First, CMS should clarify that none of the proposed new requirements apply to, or would preclude payment pursuant to any order or decision issued in, a direct appeal from a final determination of the Secretary as to the amount payment under the inpatient hospital prospective payment system ("IPPS") established under section 1886(d) of the Social Security Act ("the Act"), 42 U.S.C. § 1395ww(d). Second, the proposed new requirements should not apply to, and should not preclude payment pursuant to any order or decision issued in, an appeal based on a contractor's failure to issue a timely NPR determination for a cost reporting period. Third, even as applied to provider appeals from an NPR, which specifically require dissatisfaction, the proposed new requirements are invalid because they conflict with the statute and are otherwise arbitrary and capricious. Fourth, and relatedly, the proposed new requirements are inconsistent with expedited judicial review ("EJR") provisions in section 1878(f) of the Act, 42 U.S.C. § 1395oo(f), which empowers the Provider Reimbursement Review Board ("PRRB" or the "Board") to grant EJR regarding questions of law governing payment for an item that the Board lacks authority to decide irrespective of any arbitrarily established condition precedent that would always be futile to meet. *See* 42 U.S.C. § 1395oo(f)(1). Fifth, the proposed new requirements are not rationally supported by CMS' purported policy justification for them. Sixth, even if CMS ultimately decides to adopt the proposed new requirements with respect to some types of appeals, CMS should establish clear exceptions to the new requirements where the provider does not or cannot have the necessary information at cost report filing to meet the requirement.

For the above reasons, we therefore request that the proposed rule be amended, if adopted at all, to include an exception to the new cost reporting requirements that would allow for an appeal and payment pursuant to an order or decision in an appeal where, through no fault of the provider, necessary information was not available to the provider or a payment error was unknown to the provider at the time when the cost report was filed.

A more detailed discussion of these issues is included as Exhibit I.

### **III. Proposed Recalibration of MS–DRG Relative Weight Budget Neutrality Adjustment**

The proposed rule indicates that CMS would apply a budget neutrality adjustment factor of 0.992938 for changes to the MS-DRG weights for federal fiscal year 2015. 79 Fed. Reg. at 28317. We have two fundamental concerns about this proposal. First, the adjustment is inexplicably more than three times greater than the same adjustment for the immediately preceding years. Second, CMS appears to have used a different yet unexplained methodology for calculating the adjustment this year. We request that CMS address and explain these departures from prior years and provide an opportunity for interested parties to comment on those details in advance of implementing any changes on October 1, 2014.

#### **a. Unexplained, Significant Increase in MS-DRG Weight Budget Neutrality Adjustment**

The payment rate reduction (0.7 percent) stemming from the proposed budget neutrality adjustment factor of 0.992938 is several orders of magnitude greater than the payment rate reductions associated with prior years' budget neutrality adjustment factors for MS-DRG recalibration. The MS-DRG budget neutrality adjustment factors for federal fiscal years 2012-2014 were 0.997903 for 2012, 0.998431 for 2013, and 0.997989 for 2014. *See* 76 Fed. Reg. at 51787 (final rule for 2012); 77 Fed. Reg. at 53688 (final rule for 2013); 78 Fed. Reg. at 50975 (final rule for 2014). The average payment rate reduction associated those adjustment factors is 0.19 percent. Thus, the payment rate reduction proposed for 2015, 0.7 percent, is more than 3.5 times greater than the average payment rate reduction associated with the MS-DRG budget neutrality adjustment factors for the prior three years.

In view of that anomaly, we are very concerned that nothing in the notice of proposed rule-making indicates that CMS has performed any meaningful analysis to confirm that that proposed budget neutrality adjustment factor for 2015 is correct. The notice gives no indication that CMS has compared the proposed budget neutrality adjustment factor for 2015 with the prior years' factors, that CMS has attempted to identify the reasons why the proposed payment rate reduction for 2015 is so much greater than the reductions associated with prior years' budget neutrality adjustment factors, or that CMS has attempted to confirm whether the substantially greater payment rate reduction proposed for 2015 is appropriate and correct. CMS should perform these analyses, discuss the results of those analyses in the final rule, and afford interested parties a further opportunity to review and comment on the final budget neutrality adjustment factor, and CMS' analysis of that factor, before it becomes effective on October 1, 2014.

b. Inadequate Explanation for Apparent Change in MS-DRG Weight Budget Neutrality Adjustment Methodology

CMS's description of its calculation of the proposed MS-DRG budget neutrality adjustment factor differs, for reasons that are neither addressed nor explained in the notice of proposed rulemaking, from the agency's prior descriptions of its calculation of the same budget neutrality adjustment factor for prior years, and the description of the calculation in the notice of proposed rule-making for 2015 is insufficient to permit meaningful review and opportunity for comment. The proposed rule, 79 Fed. Reg at 28317, describes the following calculation of the MS-DRG budget neutrality adjustment factor for 2015:

[W]e used FY 2013 discharge data to simulate payments and compared the following:

- Aggregate payments using the new OMB labor market area delineations proposed for FY 2015, the FY 2014 relative weights, and the FY 2014 pre-reclassified wage data, and applied the proposed FY 2015 hospital readmissions payment adjustments and estimated FY 2015 hospital VBP payment adjustments; and
- Aggregate payments using the new OMB labor market area delineations proposed for FY 2015, the proposed FY 2015 relative weights, and the FY 2014 pre-reclassified wage data, and applied the same hospital readmissions payment adjustments and estimated hospital VBP payment adjustments applied above.

Based on this comparison, we computed a proposed budget neutrality adjustment factor equal to 0.992938.

This description of the proposed MS-DRG budget neutrality adjustment factor for 2015 differs, in two significant respects, from CMS's above description of the agency's calculation of the same adjustment factor for prior years. *See* 78 Fed. Reg. at 50975 (describing the calculation of the adjustment factor for federal fiscal year 2014); 77 Fed. Reg. at 53688 (describing the calculation of the adjustment factor for federal fiscal year 2013); 76 Fed. Reg. at 51787 (describing the calculation of the adjustment factor for federal fiscal year 2012). The first difference is that the calculation for 2015 applies "OMB labor market area delineations proposed for FY 2015" in the payment simulation model. 79 Fed. Reg at 28317. Second, unlike in past years, this year's description of the calculation of the proposed adjustment factor for 2015 does not address what labor percentages were applied in the payment simulation model. For each the last three fiscal years, CMS has expressly stated that its calculation of MS-DRG budget neutrality adjustment factor used the *prior year's* "labor-related share percentages." *See* 78 Fed. Reg. at 50975 (stating that the calculation of the adjustment factor for 2014 used the "FY 2013 labor-related share percentages"); 77 Fed. Reg. at 53688 (stating that the calculation of the adjustment factor for 2013 used the "FY 2012 labor-related share percentages"); 76 Fed. Reg. at

51787 (FFY [year] proposed rule stating that the calculation of the adjustment factor for 2012 used the “FY 2011 labor-related share percentages”).

Because CMS has not addressed why it is appropriate to use the OMB labor market area delineations proposed for FY 2015 in the calculation of the MS-DRG budget neutrality adjustment and has not identified the labor-related share percentages used to estimate either part of the payment simulation model (before and after the changes to the MS-DRG weights for 2015), interested parties are unable to meaningfully review and comment on potential errors in the calculation. Depending on what labor-related share percentages were used, and how they were used, in each part of the payment simulation model, CMS’s calculation may be inappropriately duplicating other budget neutrality adjustments for 2015 or incorrectly adjusting the payments to account directly or indirectly for labor-related share percentages which would be in violation of section 1886(d)(3)(E)(i) of the Social Security Act.

Accordingly, we request that in the final rule, CMS address why it is appropriate to apply the OMB labor market area delineations proposed for FY 2015 in the MS-DRG budget neutrality calculation for 2015 and how and whether the use of those proposed new labor market delineations impacts the resulting MS-DRG budget neutrality adjustment factor. In addition, we request that CMS expressly identify and address the labor-related share percentages used in each component of the payment simulation model used to calculate the final MS-DRG budget neutrality adjustment factor for 2015. Finally, CMS should afford interested parties a further opportunity to review and comment on the final budget neutrality adjustment factor, and CMS’s analysis of that factor, before it becomes effective on October 1, 2014.

#### **IV. Disproportionate Share Provisions of the FFY 2015 Proposed Rule**

The FFY 2015 proposed rule includes numerous proposals relating to disproportionate share hospital (“DSH”) payments and our general comments thereon follow and are elaborated upon in greater detail in Exhibit II.

First, CMS should satisfy the requirements of the Administrative Procedure Act and the Medicare Act by providing meaningful explanations for the calculations and figures contained in the proposed rule relating to the new DSH payment for uncompensated care costs. Second, we request that CMS account for the effects of the recent D.C. Circuit decision on DSH Part C days in *Allina* when determining DSH payments for uncompensated care costs for FFY 2015. Third, CMS should satisfy its legal obligation to furnish interested parties with advance opportunity to comment on new calculations based on the more recent data that CMS intends ultimately to use for its final rule. In addition, we request that CMS reconsider its decision not to reconcile final DSH payments for uncompensated care with actual data for cost reporting periods covering FY 2015.

Detailed discussion of these specific areas is provided in Exhibit II.

#### **V. CMS should use the CMS 2552 S-10 data for the new Disproportionate Share Uncompensated Care Distribution as the current method is inconsistent with the statutory**

**requirements and continues to emphasize the inverse relationship between low income coverage and reduced uncompensated care.**

CMS invited comments on the approach and timetable for transitioning to the CMS 2552 S-10 based uncompensated care data. It is widely known that the best way to improve the quality of any rate related data is to “use it” for payment purposes. To do otherwise, offers no incentive what so ever for the provider community to improve the quality of their reported data. CMS has done this itself in regard to increase the quality of reported quality measures. In actuality, the S-10 data that providers have already reported could be assumed to be correct as these providers have certified to this fact by signing the cost report upon submission. There may be an alternative argument that there were issues with the description or definitions of the amounts that should be included on the applicable lines in the cost report instructions. However, the major underlying cause of issues with the S-10 data lies in the cost-to-charge (CCR) reported on the S-10 forms. Our FFY 2014 comments were based upon our analysis which demonstrated that replacing the S-10 reported CCRs with the CCRs in the CMS IPPS Impact File remedied the variation in the data. Therefore, a readily available solution existed and continues to exist today for the agency to use its own data. Accordingly, the S-10 data and definitions per se is unlikely to be the reason those data should be rejected.

The agency should begin using the S-10 data at the earliest possible time perhaps for FFY 2015 (In FFY 2014, we commented that with minor adjustments using data in CMS’s possession, the S-10 data were useable in their current state and such continues to be the case.). If the agency believes that these data may be somehow deficient (which is doubtful given our analysis but for the CCR issue) the agency could utilize a transition adjustment, as it has it has for many other adjustments. The agency could base the Factor 3 distribution adjustment on a blend of: 50% of the S-10 data based adjustment and 50% of its current data or another proxy based adjustment - just as the agency has proposed for the FFY 2015 AWL. This would provide the incentive for the provider community to increase its vigilance on proper reporting of the data and simultaneously allow the agency to comply with the statutory charge that Factor 3 be based upon uncompensated care which the current adjustment clearly fails to accomplish. By using the S-10 data, even for a transitional period, the agency could achieve the dual purposes of inducing better reporting and compliance with its statutory responsibility.

**VI. CMS Should Adjust the Core Based Statistical Areas (CBSAs or Metropolitan Statistical Areas - MSAs) to Make them More Suitable for use as Labor Markets for Calculating the Wage Index**

We strongly urge CMS to reconsider the continued use of CBSAs, as determined by the Office of Management and Budget (OMB), to define hospital labor markets for purposes of calculating the wage index. To account for variances in hospital wage costs in local labor markets relative to the national average, CMS assigns each IPPS hospital an area wage index that adjusts a portion of the IPPS payment per case upward or downward to reflect average wage levels in the hospital’s local labor market relative to the national average. In the proposed rule, 79 Fed. Reg. at 28054-63, CMS proposes to incorporate new labor market delineations based on CBSAs that have been reconfigured by OMB to reflect 2010 census data.



The use of CBSAs for this purpose has in the past and, under CMS's proposal will continue to lead to anomalous results that do not accurately reflect actual hospital labor markets. For example, because of the regions that CMS is using to calculate the wage index, hospitals that are directly across the street from one another, compete in the same labor market and have similar wage costs may be assigned radically different wage indexes, resulting in substantially different payment rates for the same case, depending on whether the hospitals are in a CBSA or not, and if so, which one. *See Acumen, LLC, Revision of Medicare Wage Index: Final Report, Part II* (March 2010) at 18 (noting that the use of CBSAs has "create[d] boundary conditions in which two hospitals that are very close together but in different sides of ... [a] boundary can be assigned different wage index values which result in different payments")

As a further example of the flaws in the current system, because of the expansion of CBSAs to include outlying areas, the wage indexes for hospitals located in urban core areas are arbitrarily reduced. For example, the proposed rule would expand one large CBSA that includes a major city to include three outlying counties of an adjacent state which have comparatively low wage costs. Because those hospitals' comparatively low labor costs will now be averaged with the comparatively higher wage costs of hospitals located in the urban core and due to the relative size of the wage base in those lower paying counties, the wage index for the entire larger CBSA would be arbitrarily reduced by 3 percentage points under the proposed rule when fully implemented.

As demonstrated in the example above, the arbitrary lines drawn by CMS through its application of a census-based proxy for actual labor markets (the CBSAs) result in wage indexes, and thus Medicare payment rates, that do not accurately reflect actual differences or similarities in labor costs. Nevertheless, in the proposed rule, CMS has not demonstrated that it has conducted any study nor provided any analysis regarding whether and to what extent there is any homogeneity in the labor costs of hospitals within the newly-delineated CBSAs.

OMB openly acknowledges these limitations on the use of the census-based CBSAs and has warned government agencies including CMS that the CBSAs may not be appropriate for government funding purposes:

Program designs that treat all parts of a CBSA as if they were as urban as the densely settled core ignore the rural conditions that may exist in some parts of the area . . . OMB urges agencies, organizations, and policy makers to review carefully the goals of the nonstatistical programs and policies to ensure that appropriate geographic entities are used to determine eligibility for and the allocation of Federal funds.

[*See* 65 Fed. Reg. 82228, 82229 (Dec. 27, 2000). Although CMS itself recognizes that "MSAs are not designed specifically to define labor market areas," 79 Fed. Reg. at 28055 (May 15, 2014), CMS has not heeded OMB's warning and has proposed no revisions in the proposed rule to fix the broken system for 2015, as it has been repeatedly urged by Congress to do, see, e.g., Patient Protect and Affordable Care Act § 3137 (directing the Secretary to submit to Congress a plan for reforming the wage index system). CMS instead has punted, complaining that "no consensus has been achieved regarding how best to implement a replacement system." 79 Fed. Reg. at 28055.]

We urge CMS to reconsider the use of the unadjusted CBSAs as the basis for defining hospital labor markets for purposes of the wage index. The use of CBSAs results in anomalous effects and does not accurately reflect the true wage costs of hospitals within a given area.

As we have suggested in the past one approach the agency could undertake is to examine the CBSAs/MSAs and modify them to be Medicare hospital labor markets. Changes in the CBSAs/MSAs and criteria which lead to their inappropriateness have been more pronounced since 1990. During the 1990 cycle, the CBSA/MSA definitions were changed dramatically. As an example, incongruously these definitions caused some large CBSAs/MSAs to become huge and other large CBSAs/MSAs to be split into several component CBSAs/MSAs. These changes did not pattern the labor markets of hospitals; nevertheless, they were used as such and such use caused major fluctuations in the AWIs. With the current 2010 census based CBSAs/MSAs, this phenomena continues to emphasize the failure of the CBSAs/MSAs as labor markets. The agency could develop labor markets using the 1990 based CBSAs/MSAs and reverse engineer the additions and subtractions to each CBSA/MSA since that time evaluating the appropriateness and applicability as labor markets of each change; making an appropriate adjustment - reassigning counties, to each area as necessary. This process should include analyses of the resultant within area wage variability and how that changes. This process will result in a more rational set of labor markets – ones with lower wage variability which is an agency objective. Simultaneously, CMS could evaluate the current geographic reclassification criteria and effect of those reclassifications to assure they are appropriate for the newly developed areas as there will always be effects to be mitigated. However, the basic system will be more fair and reasonable.

We appreciate the opportunity to provide these comments to you. If any of these comments need clarification we would welcome the opportunity to provide such (410 531 1969).

Sincerely

Theodore Giovanis  
President  
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Highland, MD 20777

## **EXHIBIT I**

### **Medicare Must Assure a Meaningful Opportunity to Appeal Cost Report Claims Without Undue Restrictions and Appeal Requirements and Provide Clarification that Select Appeals or Payments are Not Precluded by the New Proposed Rule.**

#### **A. CMS Should Clarify That the Proposed New Requirements Are Not Applicable To an Appeal from Notice of a Determination of the Secretary As To an Inpatient Prospective Payment System (IPPS) Payment Amount Under Section 1886(d) of the Act.**

We ask that CMS clarify in the final rule that the proposed new cost report requirements are categorically inapplicable to, and would not preclude payment pursuant to any order in, appeals from notice of a final determination of the Secretary as to the IPPS payment amounts established under section 1878(d) of the Act. The notice of proposed rulemaking does not mention these types of appeals and does not address the application of the proposed new cost report requirements in this context. We therefore presume, and request that CMS clarify in the final rule, that the proposed new cost report requirements do not apply to appeals from notice of an IPPS rate determination by Secretary in a IPPS rulemaking for a federal fiscal year.

As CMS is aware, Congress amended section 1878 when the IPPS was first enacted to establish providers' right to appeal directly from a determination of the Secretary as to the amount of payment under the IPPS. And, as the agency is also aware, the D.C. Circuit long ago rejected the agency's original view that a hospital must first file a cost report with its contractor, and then receive an NPR from the contractor for that cost reporting period, before the provider can appeal an IPPS rate determination of the Secretary. *See Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 145 (1986) ("the effect of the new language [added to section 1878 when IPPS was enacted] . . . is to eliminate the requirement that PPS recipients file a cost report prior to appeal.") Insofar as hospitals cannot be required to file a cost report as a predicate to an appeal from an IPPS rate determination by the Secretary, it follows that hospitals also cannot be required to file a cost report claim or protest with respect to an item as condition precedent or predicate to their statutory right to appeal and receive payment on an item pursuant to any order or decision issued in an appeal from an IPPS payment rate determination by the Secretary for a federal fiscal year. This is a separate avenue of appeal that is distinct from the cost report requirements and the requirements for appeals from cost report determinations. *See id.*

Moreover, because appeals from IPPS rate determinations are distinctly different from appeals from cost report determinations, the policy rationales articulated in the proposed rule for the new requirements are inapposite in this context. The notice of proposed rulemaking states that the new requirements to include an affirmative claim for reimbursement or protest for an item, in a cost report, are intended to promote the agency's ability "to accurately estimate the program's potential liabilities," to promote contractor's ability to gauge their own future appeals workloads and to help providers by enlisting contractor's assistance in clearing misunderstandings about Medicare reimbursement requirements. 79 Fed. Reg. at 28,211.

None of these objectives would be promoted by requiring a hospital to protest an IPPS rate determinations in a cost report filed long after the hospital has already appealed from its earlier notice of the Secretary's IPPS rate determination. When a hospital has already appealed an IPPS rate determination for a federal fiscal year, it would be entirely unnecessary, burdensome and duplicative to require the hospital to protest the issue again in a later-filed cost report for a cost reporting period overlapping some portion or all of the federal fiscal year. The filing of an appeal from notice of a final determination of the Secretary in an annual IPPS rulemaking provides CMS with more direct, more timely, and more complete notice of potential liabilities in question than the Secretary would receive through a later cost report protest. Further, the notice given to CMS and the contractors upon the filing of an appeal from an IPPS rate determination is provided long before hospitals file cost reports for hospital fiscal years encompassing some portion of the federal fiscal year covered by the IPPS rule. IPPS rate determinations are published by the Secretary in the annual IPPS rules in August each year, 60 days before the start of the new federal fiscal year. Appeals from the notice of these determinations are due 180 days later, typically in mid-February of the next calendar year. This appeal window expires long before the later times when cost reports are filed for any cost reporting periods encompassing some or all of the federal fiscal year covered by the IPPS rule. The *earliest* such cost reporting period would end on December 31, three months after the start of the federal fiscal year, and those cost reports would not be due until 8 months after the start of the federal fiscal year, and 3-4 months after the appeal deadline for direct appeals from publication of the IPPS rule. Cost reports for hospital cost reporting periods ending on September 30, moreover, would not be filed until a year or so after the deadline for direct appeals for each IPPS rule.

Furthermore, the CMS contractors are bound by the Secretary's IPPS rate setting rules and have no authority to grant relief in such cases even if hospital disputes with those determinations are protested in a cost report. In fact, the contractors play no role whatsoever with respect to payment disputes concerning the IPPS rate determinations in the annual IPPS rules, as these determinations are subject to expedited judicial review (EJR) under section 1878(f) of the Act.

In any event, to our knowledge, CMS has never monitored protested items on as-filed cost reports. We are aware of no process or procedure by which contractors aggregate or transmit this information to CMS or by which CMS tracks protest issues and potential liabilities.

For these reasons, the imposition of a cost report protest requirement with respect to an issue or item that has been appealed from notice of an IPPS rate determination of the Secretary fails to "strike a balance between, on the one hand, having providers present enough information so as to put intermediaries on notice as to actual or potential reimbursement disputes, and, on the other hand, not making it unduly burdensome for providers to file cost reports." 73 Fed. Reg. 30,190, 30,195 (May 23, 2008). This new requirement, as applied to issue or items in dispute in IPPS rate appeals, would amount to a burdensome paperwork requirement that is both unnecessary and duplicative. Accordingly, we request that CMS clarify in the final rule that the proposed new cost report requirements do not apply to, and would not preclude payment pursuant to an order in, any appeal from notice of a final determination of the Secretary as to the amount of payment under the IPPS statute.

## **B. The Proposed New Requirements Should Not Apply To an Issue or Item In an Appeal Based On a Contractor's Failure To Issue a Timely NPR**

The proposed new cost report requirements should not apply to, and should not preclude payment pursuant to any order or decision issued in, an appeal based on a contractor's failure to issue a timely NPR for a cost reporting period. The application of the proposed new requirements in this context violates the plain language and intent of section 1878(a)(1)(B) of the Act. That section of the appeals statute does not require dissatisfaction for an appeal based on the untimely issuance of an NPR. *See* 42 U.S.C. § 1395oo(a)(1)(B). The Secretary has specifically admitted that the protest requirement adopted in 2008 is inconsistent with section 1878(a)(1)(B) and therefore should not be applied to appeals based on a contractor's failure to timely issue an NPR. *See Charleston Area Med. Ctr. v. Burwell*, No. 1:13-cv-00643 (D.D.C. 2013) (Defendant's Response to Order to Show Cause and Proposed Order, June 17, 2014).

Insofar as the Secretary has conceded that the statute does not permit the imposition of a protest requirement as a condition precedent to an appeal based on a contractor's untimely issuance of an NPR, the agency cannot impose the same requirement to achieve the same end merely by re-labeling the condition a "cost report requirement." Congress made a decision that no showing of dissatisfaction is required for an appeal based on an untimely NPR. 42 U.S.C. § 1395oo(a)(1)(B). And, it is well-established that "[t]he most reliable guide to congressional intent is the legislation that Congress enacted." *See Friends of the Earth v. Env'tl. Prot. Agency*, 446 F.3d 140, 146 (D.C. Cir. 2006) (quoting *Sierra Club v. Env'tl. Prot. Agency*, 294 F.3d 155, 161 (D.C. Cir. 2002)). Moreover, CMS may not, "avoid the Congressional intent clearly expressed in the text simply by asserting that its preferred approach would be a better policy." *Id.* at 145 (quoting *Engine Mfrs. Ass'n v. Env'tl. Prot. Agency*, 88 F.3d 1075, 1089 (D.C. Cir. 1996)). In short, the Secretary cannot undermine the intent of Congress by imposing the same requirement to the same end under a different label.

Furthermore, the statutory right to appeal the lack of a timely NPR would be rendered meaningless if CMS can preclude payment and relief through such an appeal via the imposition of new cost reporting requirements, especially given the statutory power of the Provider reimbursement Review Board (PRRB or Board) under section 1878(d) of the Act to revise matters "covered by such cost report. . . even though such matters were not considered by the intermediary." The intent of the statutory provision permitting appeal based on the untimely issuance of an NPR is to preclude indefinite delay in the provider's right to appeal and payment, not to offer up a right to appeal in form only with no substantive right to relief.

Finally, it appears arbitrary and capricious to deny relief pursuant to a decision or order in an appeal based on contractor's untimely issuance of a final cost report determination in an NPR on the ground that the hospital failed to timely "protest" an issue or otherwise include claim for reimbursement in the same cost report. When the contractor has failed to issue a timely final payment determination in an NPR, it makes no difference whether the provider protested an issue or filed a claim in the cost report. Regardless of whether a claim or protest was included or not included in the cost report, the contractor necessarily would not have reviewed the issue or item that would be the subject of a cost report claim or protest and necessary would not have made a

determination on the item or issue before the appeal is commenced, as the statutory trigger for the appeal is the contractor's very failure to make its determination in a timely manner.

### **C. Even as Applied To Appeals From an NPR, the Proposed New Requirements Are Invalid Because They Otherwise Conflict With Section 1878 and Are Arbitrary and Capricious**

While application of the proposed new cost report requirements to appeals from IPPS rate determinations and the untimely issuance of an NPR is otherwise problematic for the specific reasons discussed above, these proposed new requirements also should not be applied to items or issues in dispute in appeals from an NPR (or based on an untimely NPR, as described above) because the proposed new requirements precluding payment on an item that is not claimed or protested in the cost report is inconsistent with the plain text of section 1878 overall and Supreme Court precedent construing the statute.

Section 1878(d), specifically grants the Board the power to:

[A]ffirm, modify, or reverse a final determination of the fiscal intermediary with respect to the cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination (emphasis added).

This statutory provision advances Congress' clear intent to invest the Board with legal authority to address the full range of reimbursement matters that are "covered by" a provider's cost report, regardless of whether the CMS contractor considered a particular matter in making its final determination. The proposed rule does the opposite, limiting the Board's authority only to matters that are "appropriately claim[ed]," and purportedly considered by the contractor, with respect to the cost report. CMS not only defies Congressional intent as reflected in the plain language of the statute, but also ignores binding Supreme Court precedent.

In *Bethesda Hospital Association v. Bowen*, the Supreme Court interpreted the limits of the Board's review authority under section 1878(d) and concluded: "The only limitation prescribed by Congress is that the matter must have been "covered by such cost report," that is, a cost or expense that was incurred within the period for which the cost report was filed, even if such cost or expense was not expressly claimed." 485 U.S. 399, 406 (1988) (emphasis added). By structuring the cost reporting requirements to make the claim of a specific item a "substantive prerequisite" to reimbursement pursuant to administrative review authorized by statute, the proposed rule imposes a new limit on the Board's authority that Congress did not intend or authorize, and limits the rights of providers appeal their reimbursement determinations.

The proposed new requirements would also impermissibly encroach upon the Board's statutory authority in another respect. Everyone agrees that the Board has the power to decide if an appeal is timely filed (*e.g.*, within 180 days of notice of an NPR) and whether the appeal meets the applicable amount in controversy requirement, and the proposed rule would not change that. Given that the Board unquestionably has statutory authority to make those determinations, CMS must provide (and has not provided) some rational explanation why the Board should not also

have authority to decide what constitutes “dissatisfaction” in context of a particular provider appeal from a specific NPR determination for a cost reporting period. The proposed rule would deprive the Board of its statutory power to decide what constitutes dissatisfaction, and CMS has provided no rational explanation for why this statutory role should be removed from the Board and turned over to CMS and its contractors. This is both contrary to the plain language of the statute and otherwise arbitrary and capricious. Congress enacted a system in which the Board decides whether a provider is dissatisfied with a final payment determination in NPR and has the power to adjudicate, resolve and order appropriate relief in appeals from NPRs, even as to matters that were considered by the contractor in its review of the cost report submitted by the provider.

#### **D. The Proposed New Cost Report Requirements Also are Inconsistent With the EJR Provisions of Section 1878**

Likewise, the proposed new cost report requirements are impermissibly inconsistent with the statute and otherwise unreasonable as applied to items or issues in appeals made subject to EJR under section 1878(f) of the Act. Section 1878(f) empowers the Board to grant EJR with respect to questions of law governing payment for an item that the Board lacks authority to decide. *See* 42 U.S.C. § 1395oo(f)(1). The proposed rule would interject a further condition precedent to adjudication of these payment disputes by federal courts in violation of the statute’s plain language and intent.

Section 1878(f) provides for expedited federal court review over items or issues that the Board lacks power to address. *See* 42 U.S.C. § 1395oo(f)(1). Period. Nothing more is required. The point of this provision for expedited court review is to avoid unnecessary delay in adjudicating payment disputes that the Board, and the contractors, lack the power to decide. Thus, the requirement that all claims must first be considered by the contractor undermines the very purpose of the EJR statute and the role Congress chose to confer upon the PRRB in connection with EJR cases by adding an additional, unnecessary, and futile layer of administrative review as condition precedent to the Board’s statutory role. To the extent that the Board and the CMS contractor lack the power to decide a legal question with respect to payment for an item or issue in dispute, it is arbitrary and capricious to require a provider to first “protest” the item in a cost report filing with the contractor in order to preserve its statutory right obtain “expedited” review of the underlying payment dispute in federal court.

Furthermore, to the extent that the proposed rule encapsulates CMS’ position that the Administrator has any role to play in reviewing any aspect of a Board decision granting EJR, CMS should revoke that position in the final rule because it is clearly contrary to the plain language and intent of the section 1878(f). As the Secretary admits, the statute does not authorize the Administrator to review a Board decision granting EJR. 79 Fed. Reg. at 28,214. In granting EJR, the Board must necessarily determine that it has jurisdiction. CMS’ attempt to parse a jurisdiction decision from a decision granting EJR and its stance that the Administrator may review the jurisdiction part of the decision is unsupportable under the statute. We therefore request that the agency address this disconnect.

## **E. CMS' Policy Justifications Do Not Constitute a Rational Basis For the Proposed New Cost Report Requirements**

In addition to foregoing problems, the proposed new cost report requirements are unsupported by any rational basis. CMS has proffered a host of ostensible policy justifications for the proposed new requirements, but they do not amount to a rational basis for the new requirements.

As justification for the new requirements, CMS offers that the proposed rule would allow providers to avail themselves of the “contractor’s deep expertise and experience and . . . resources” in resolving reimbursement disputes. 79 Fed. Reg. at 28,211. CMS says that the new requirements would promote “the interests of administrative finality and efficiency” and help to conserve the Board’s “scarce resources” by preventing providers from bringing appeals that could be addressed by the contractors if a “timely cost report claim for full payment” is made. 79 Fed. Reg. at 28,211. CMS also says that the new requirements as to findings that the Board may or may not include in its decisions would help preclude piecemeal litigation. *Id.* at 28,214.

But these asserted policy rationales do not hold water. First, providers do not need this “assistance” from CMS’ contractors in identifying payment issues that the providers dispute, and especially at the price of forfeiting their right to receive any payment at all upon appeal with respect to an item that was not claimed or protested in the cost report. This form of “assistance” is no “help” to providers. Moreover, while CMS paints a pretty picture of contractors working together with hospitals to identify situations in which a hospital may have mistakenly claimed an item under protest, instead of affirmatively claiming payment for that item through the cost report itself, and then helping the hospital identify and fix that problem, that picture is illusory, not reality. In reality, when a contractor determines that a hospital has mistakenly protested an item it should have claimed, no CMS requirement would direct the contractor to add that item to the allowable claims in the hospital’s cost report. Instead, the contractor is free to use that error against the hospital to (1) not reimburse the hospital for the item in question in the NPR and (2) oppose any subsequent appeal on the ground that the protest was not proper. Notably, CMS has never adopted any requirement that would direct a contractor proceed differently.

Second, if CMS were truly concerned about managing the workload of the contractors and the Board, and the scarce resources made available to them to perform their statutory review functions, then an allocation of more realistic budget resources to the contractors and the Board would be a far more productive method to address those concerns. CMS’ chronic failure to allocate sufficient budget resources to permit timely processing of provider appeals through the PRRB should not be put on the backs of providers at the expense of their statutory rights to review. In reality, the ever-increasing backlog of appeals before the Board, which has reached into the tens of thousands of cases, is not attributable to providers failing to claim reimbursements amounts to which they are entitled, as the proposed rule might suggest, but to the continue failure to allocate sufficient budget resources to the Board and the contractors to handle appeals in a timely fashion.

Finally, the provisions of the proposed rule prescribing Board findings that are required or foreclosed seems to be tailored to promote, and not preclude, piecemeal litigation. *See* 79 Fed. Reg. at 28,213. In short, the proposed rule would preclude the Board from including certain



findings in a decision denying jurisdiction but would require the same findings in a decision granting jurisdiction, granting EJR or deciding the merits of a case. This is at odds with the goal of avoiding piecemeal proceedings, *id.* at 28,214, and seems designed merely to work against providers faced with a Board decision denying jurisdiction. Further it is irrational and inefficient for CMS to conclude that the Board must make findings as to whether an appeal from a revised NPR is proper but not include in that decision factual findings as to whether a claim was properly reflected in the cost report. *Id.* at 28,214-215.

**F. In Any Event, the Proposed New Cost Report Requirements Should Not Apply When a Provider Did Not Have Access To Necessary Information Or Was Not Aware of a Payment Error When It Filed the Cost Report**

Even if CMS ultimately decides to adopt the proposed new requirements with respect to some types of appeals, CMS should establish clear exceptions to the new requirements. In particular, the proposed new requirements should not apply to, and should not preclude payment pursuant to any order or decision issued in, an appeal when the provider did not have the information it would have needed to claim or protest an item, or was unaware of a payment error, through no fault of its own, at the time the provider was required to make its initial cost report filing for a cost reporting period. These circumstances would include calculation errors and omissions made by CMS, the contractor and the state agencies that were unknown to the provider or beyond its control when the cost report was filed and claims that were not included in the cost report due to the unavailability of information to the provider through no fault of the provider.

The proposed rule assumes a cost reporting and appeal structure that does not reflect the reality of the hospital reimbursement process. The proposed rule states that, in order to receive the full and proper amount of reimbursement a provider is owed for a particular cost reporting item, “the provider should either claim full payment for, or properly self-disallow, the item in the cost report that the provider submits originally to the contractor.” *Id.* at 28,209. But the proposed rule ignores the fact (otherwise acknowledged) that providers often lack access to the information necessary to complete their cost reports in a timely fashion or otherwise may be unaware of a payment error, through no fault of their own, at the time when the cost report is filed.

The 2008 rule reflected the fact that necessary information is not always available to providers at the time they file their cost reports. In 2008, CMS revised the PRRB appeal regulations to reflect this problem, stating: “We acknowledge what there may be instances in which a provider may be uncertain as to whether Medicare payment is incorrect because it does not have access to underlying data (for example, data from a State agency).” 73 Fed. Reg. at 30,194. This admission from the 2008 rulemaking is incompatible with the new cost report requirements that CMS proposes now, which would limit reimbursement to only those items for which an “appropriate claim” or “protest” is included on the cost report. *See, e.g.*, 79 Fed. Reg. at 27,988.

The proposed rule uses the computation of Medicaid eligible days in the disproportionate share hospital (“DSH”) payment calculation as an example of the application of the “appropriate claim” standard. We note, however, that the resolution of the example given in the proposed rule, in which a provider is credited with the appropriate number of Medicaid eligible days, is

reached solely through the discretion and administrative largesse of the contractor. *See* 79 Fed. Reg. at 28,209-10.

As CMS likely understands, however, providers commonly lack necessary information at the time when a cost report is filed, and the cost report payment calculations submitted in as-filed cost reports often are tentative, and not final, at that time. The DSH payment calculation used as an example in the proposed rule is a case in point. One of the two primary variables that go into the DSH payment calculation, the Medicare Part A/SSI fraction, invariably is not available when the initial cost report is filed for a given cost reporting period. The Medicare Part A/SSI fraction is calculated by CMS, not the hospital or the Medicare Administrative Contractor. CMS calculates the SSI fractions for discharges in the federal fiscal year in which the hospital cost reporting period begins, and CMS' calculation of the SSI fractions for a federal fiscal year often are not performed or released until after initial cost reports are filed. CMS delays the calculation of the SSI fractions, in part, to ensure that the fractions include SSI entitlement determinations that are made after the end of a federal fiscal year and may be applied retroactively to periods occurring within the federal fiscal year. *See* 75 Fed. Reg. 50,042, 50,281-83 (Aug. 16, 2010). Thus, the SSI fractions for federal fiscal year 2009, for example, were not published by CMS until 2012.

Just as the SSI fraction cannot be calculated by CMS until long after the end of a federal fiscal year, in order to account for retroactive eligibility determinations, a hospital likewise cannot determine a final and complete count of Medicaid-eligible patient days, which make up the second variable in the DSH payment calculation, until long after the end of the cost reporting period and after the initial cost report filing must be submitted to the contractor. Medicaid eligibility determinations often are made long after the end of a cost reporting period and are made effective retroactively to periods occurring within the cost reporting period. In addition, there are sometimes delays between the time when a Medicaid eligibility determination is made by or on behalf of a Medicaid State agency and the time when that eligibility determination is uploaded and made available to hospitals seeking to verify patients' Medicaid eligibility status for purposes of supporting the Medicare DSH payment calculation. Though statutorily required to do so under section 951 of the Medicare Modernization Act of 2003, CMS has not promulgated any standards affirmatively requiring States to make this information available to hospitals for this purpose, or requiring them to make this information within any specific timeframe. *See* 70 Fed. Reg. 47,427, 47,441-43 (Aug. 12, 2005).

Moreover, there can be considerable time lags between the determination of Medicaid eligibility and the time when that eligibility data is made available to hospitals for purposes of substantiating the Medicare DSH payment calculation. Even when a State agency has systems in place to permit a hospital to obtain Medicaid eligibility verification for Medicare DSH purposes, hospitals cannot obtain accurate and complete eligibility information by the time when the initial cost report filing is due. Therefore, imposing a specific "appropriate claim" requirement for payment in these circumstances, which are beyond hospitals' control, severely curtails the providers' rights to receive the appropriate amount of reimbursement for DSH and to appeal DSH payment determinations that inappropriately omit some Medicaid-eligible patient days for a cost reporting period. This violates due process principles and is arbitrary and capricious.

As CMS knows, there also are cases when hospitals may be unaware of other payment errors, through no fault of theirs, at the time when the cost report must be filed for a fiscal year. This typically occurs with respect to payment errors committed by CMS which are unknown to hospitals and were not disclosed by hospitals when they were required to file their cost reports. *See, e.g., Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) (agency refused to release data for years and did not inform providers fully about how it calculated the Medicare Part A/SSI fraction); *see also Cape Cod Hosp. v. Sebelius*, 630 F.3d 203 (D.C. Cir. 2011) (agency performed payment rate calculation one way and described it a different way in the Federal Register). Thus, the application of the new cost report requirements without an express exception, at a minimum, for situations when a hospital was unaware of a payment error at the time it filed its cost report would appear to be an unreasonable and capricious attempt to block statutory review and appeal rights with respect agency payment errors.

## Exhibit II

### Detailed Discussion of the Medicare DSH Provisions of the Proposed FFY 2015 Rule

Below are detailed description and discussion of the Medicare DSH Provisions of the FFY 2015 Proposed Rule.

#### A. Adequate Explanation of Calculations in Proposed Rule

The proposed rule explains that the process for determining the uncompensated care pool (Factor 1) for FFY (Federal fiscal year) 2015 will be the same process as it was for FFY 2014. 79 Fed. Reg. 27,978, 28,098 (May 15, 2014). Namely, according to the proposed rule Factor 1 will again be based on a recent estimate by the Office of the Actuary that Medicare DSH payments would be \$14.205 billion in 2015 if it were not for the changes to DSH methodology made by the ACA. *Id.* As in 2014, the 2015 proposed rule provides an inadequate explanation for how the Actuary's Office came to this number. According to that supplemental data file<sup>1</sup> and the proposed rule, 79 Fed. Reg. at 28,098, the agency extrapolated from these 2011 DSH data by applying certain unexplained update factors to derive an estimated payment for 2015.

The agency has unlawfully provided too little detail for hospitals to be able to comment meaningfully on this calculation in proposed rule. *See American Radio Relay League, Inc. v. FCC*, 524 F.3d 227, 237 (D.C. Cir. 2008) (agencies must make available the “technical studies and data” relied upon in a rulemaking); *Appalachian Power Co. v. EPA*, 251 F.3d 1026, 1035 (D.C. Cir. 2001) (agencies must explain the assumptions and methods used in predictive computer models); *Connecticut Light & Power, Co. v. Nuclear Regulatory Comm’n*, 673 F.2d 525, 530 (D.C. Cir. 1982) (“To allow an agency to play hunt the peanut with technical information, hiding or disguising the information that it employs, is to condone a practice in which the agency treats what should be a genuine interchange as mere bureaucratic sport.”).

Without further details about the calculations and the data underlying them, hospitals do not have the legally required opportunity to comment on whether the starting point for extrapolation is correct, whether all adjustments made to that starting point are proper, or whether the adjustments have been made consistently throughout the proposed rule. For example, it is unclear based on the information furnished what Medicaid expansion level(s) are presumed by CMS in calculating Factor 1 and Factor 2, including whether the agency has consistently accounted for the level of Medicaid coverage in Factor 1 and Factor 2, what adjustment CMS made to Factor 1 to account for the presumed Medicaid expansion level for FFY 2015, and how CMS calculated the DSH payment impact that would result from the estimated expansion in FFY 2015 in the absence of the ACA changes to the DSH payment calculation. One particular figure highlights this problem with the lack of adequate explanation. In the data file accompanying the FFY 2015 proposed rule, the agency provides for an “Other” adjustment for FY 2014 of 1.0328, but the same adjustment used for 2014 in the FFY 2014 final rule was 1.049, but CMS has

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<sup>1</sup> A link to the supplemental data file for the proposed rule is available at:  
<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FY2015-NPRM-DSH-Supplemental-File.zip>

provide no explanation at all for the change to that update factor. CMS needs to explain this adjustment and the change.

Further, the update factors that CMS apparently applied to extrapolate an estimate of DSH payments that otherwise would be made for 2015 from cost report payment data for 2011 appear to conflict with the Actuary's prior, historic estimates of annual increases in the aggregate DSH payment. As discussed at the March 2013 AHLA conference, the Actuary's prior estimates as to aggregate DSH payments made to hospitals for federal fiscal years 2000 through 2012 indicated that aggregate DSH payments increased from \$5.18 billion for fiscal year 2000 to \$11.93 billion for fiscal year 2012. Those estimates reflect an average increase of more 7 percent per year from 2000 through 2012. Yet, the agency's supplemental data file for the proposed rule indicates that in estimating what the Medicare DSH expenditure would be for 2015, in the absence of the ACA amendment to the DSH payment method, CMS has assumed that aggregate DSH payments would have increased by less than 5 percent per year from 2011 to 2015. On its face, this internal inconsistency strongly suggests that the update factors used to establish the Factor 1 estimate in the proposed rule may be substantially understated.

## **B. Need to Implement *Allina* Ruling in Factor 1**

Another significant concern, which comments also raised in response to the FFY 2014 proposed rule, 78 Fed. Reg. 50,496, 50,629 (Aug. 19, 2013), is that the Secretary's Factor 1 determination seems to reflect the agency's invalidated 2004 rule on the counting of patient days for individuals who receive Medicare benefits through enrollment in a Medicare Advantage plan under Part C of the Medicare program. A number of commenters objected to this same aspect of the agency's FFY 2014 rule because the United States District Court for the District Columbia had vacated the 2004 rule several months before the Secretary published the proposed and final IPPS rule for FFY 2014. *See id.*; *Allina Health Services v. Sebelius*, 904 F. Supp. 2d 75 (D.D.C. 2012). In the FFY 2014 final rule, the Secretary decided not to change this aspect of its methodology based, in part, on the fact that the agency has appealed the district court decision to the Court of Appeals for the District of Columbia. 78 Fed. Reg. at 50,629.

On April 1, 2014, however, the Court of Appeals for the District of Columbia affirmed the district court's vacatur of the the agency's 2004 rule on the counting of Medicare Advantage days. *Allina Health Servs. v. Sebelius*, 746 F.3d 1102 (D.C. Cir. 2014). Further, the Secretary has decided not to avail itself of any opportunity to appeal that decision, so the decision is now final. The agency's incorporation into the Factor 1 calculations of the invalidated DSH rule on Medicare Advantage Part C days must be rectified in the final rule. CMS cannot use prior year (*i.e.*, 2011/2012) data for its calculations without adjusting that data to reflect what it should have been under binding D.C. Circuit precedent.

## **C. Opportunity for Comment on Calculations in Final Rule**

Aside from failing to explain the numbers actually contained in the proposed rule, CMS's rulemaking is also faulty because it will use different data and calculations for the final rule without any opportunity for the hospitals to comment. According to the proposed rule, CMS bases its Factor 1 calculations on the December 2013 update of the Medicare Hospital Cost Report Information System (HCRIS), and supplemental data furnished by Indian Health Service

(IHS) hospitals as of December 2013. 79 Fed. Reg. at 28,098. With respect to Factor 3, CMS uses the December 2013 update of the 2011/2012 Medicare cost reports for the Medicaid days, and the FY 2011 SSI fractions for the Medicare SSI days. *Id.* at 28,102. CMS makes clear that it will use different data to determine DSH payments for uncompensated care in the final rule; CMS will use the March 2014 data for Factor 1 and for Factor 3 Medicaid days, and the FFY 2012 SSI fractions for Factor 3 Medicare SSI days. *Id.* at 28,098, 28,102. And, once again, the Secretary's proposed rule fixes payment amount determinations at the time when the agency will promulgate the final IPPS rule for 2015. *Id.* at 28098.

The proposal to determine the amount of hospitals' new DSH payment based on data first released with the final rule, and on which hospitals will have no meaningful opportunity to comment, violates the notice and comment rulemaking requirements prescribed by the Administrative Procedure Act, 5 U.S.C. § 553, and the Medicare statute, 42 U.S.C. § 1395hh. *See Allina Health Servs.*, 746 F.3d at 1110 (“[A]n agency's failure to disclose *critical* material, on which it relies, deprives commenters of a right under § 553 to participate in rulemaking.”) (internal quotation marks omitted).

#### **D. Use of Best Data Available**

The above described problems would be avoided if the amount of the DSH uncompensated care payments were finally determined, as traditional DSH payments are determined, when final payment determinations are issued in NPRs for hospitals' cost reporting periods covering FFY 2015. *See Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20, 41 (D.D.C. 2008) (explaining the repeated recognition in case law that in order for CMS to produce sufficiently accurate figures, it must use the most reliable data available).

In fact, CMS has taken an arbitrarily inconsistent approach as to finality of the DSH payments for uncompensated care costs that reflects CMS's own recognition of the need to use the best available data. As noted above, CMS indicated in the proposed rule that the payment amounts published in the Supplemental Data File along with the final rule will not change. 78 Fed. Reg. at 28,098. But continuing the approach CMS took for FFY 2014, eligibility for the new DSH payment is not determined at that time. *Id.* at 28,096. Rather, the DSH payment amount reflected in the supplemental file will not be paid to a hospital that does not ultimately qualify for a traditional DSH payment based on its actual number of low-income patient days for 2015. *See id.*; 42 C.F.R. § 412.106(g)(1). Thus, if a hospital does not end up with a sufficient number of low-income patient days to produce a disproportionate patient percentage that is great enough to qualify for the traditional (or “empirically justified”) DSH payment, then the hospital will not be paid any DSH amount for uncompensated care costs, and any DSH uncompensated care payments made to the hospital on an interim basis during the course of the year will have to be refunded to the Secretary when the NPR is issued, years after the end of the hospital cost reporting periods. Final should not sometimes mean final and sometimes mean non-final.

To achieve the most accurate payments and avoid this inconsistency, CMS should use the traditional payment reconciliation process to calculate final payments for uncompensated care costs pursuant to section 1886(r)(2) of the Act. We do not object to CMS using prospective estimates, derived from the best data available, to calculate interim payments for uncompensated care costs in a federal fiscal year after 2013. Interim payments should be subject to later

reconciliation, however, based on estimates derived from actual data for the Federal fiscal year. This is the traditional process that the program has used to calculate Medicare payments for inpatient hospital services including Medicare DSH payments made to hospitals over the past three decades.

Section 1886(r)(2) of the Act contemplates just such an approach. The statute provides for the use of several estimated “factors” to calculate the uncompensated care cost payment under section 1886(r)(2) of the Act. The statute requires the Secretary to determine the aggregate amount of DSH payments that would be made absent the new uncompensated care payment (Factor 1), the change in the uninsured rate (Factor 2), and the level of uncompensated care furnished by each hospital and all hospitals in the aggregate (Factor 3). But the statute only requires that part of Factor 2 be finally determined in advance and not based on actual data for a given fiscal year. Specifically, section 1886(r)(2)(B)(i)(I) of the Act directs the Secretary to calculate the change in the uninsured percentage for a fiscal year from 2014 to 2017 compared to a baseline uninsured percentage in fiscal year 2013 that is determined “based on the most recent estimates available from the Director of the Congressional Budget Office” before a House vote in 2010. By not imposing other similar restrictions on the data used for the factors, Section 1886(r)(2) of the Act calls for the Secretary to determine the other factors and the other parts of Factor 2 used in the calculation of the payment for uncompensated care costs based on actual data for the specific fiscal year in which those costs are incurred. Using this approach, the factors would still be “estimates,” but the estimates would be more accurate to the extent they would be derived from actual data for the fiscal year and not mere extrapolations from prior-period figures.