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Via Overnight Delivery (Confirmation # 8759 2081 2790)

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1599–P
Mail Stop C4–26–05
7500 Security Boulevard
Baltimore, MD 21244–1850

Re: CMS–1599–P; Comments on DSH Provisions of Federal Fiscal Year 2014 Inpatient Prospective Payment System Proposed Rule

Dear Sir or Madam:

We are writing to comment on the provisions of the Federal Fiscal Year 2014 Inpatient Proposed Rule under "V. E. Payment Adjustment for Medicare Disproportionate Share Hospitals (DSHs) (§ 412.106)," 78 Fed. Reg. 24,786, 27,577-27,592 (May 10, 2013). More specifically, this comment addresses two issues: 1) the proposed calculation of each hospital's percentage share of the payment for uncompensated care costs, Factor Three, of the payment calculation prescribed in section 1886(r)(2)(C) of the Social Security Act ("the Act"); and, 2) the higher standard needed by the agency for rule promulgation given the existence of the preclusion of administrative and judicial review provision.

Executive Summary

With respect to the ***Factor Three proposal***, we note that ***there is very poor statistical correlation between a hospital's uncompensated care cost and the sum of the hospital's Medicaid patient days and its patient days attributable to low-income Medicare part A beneficiaries who are entitled to Supplemental Security Income benefits*** ("Medicare part A/SSI patient days"). Moreover, any issue with the quality of the uncompensated care data reflecting more appropriate cost-to-charge ratios which would provide a better proxy for the cost of uncompensated care in compliance with the statutory direction.

Given the considerable discretion that Congress has delegated to the Centers for Medicare and Medicaid Services (CMS) in the implementation of the new DSH payment method, ***the agency needs to adhere to much higher standard in its rule promulgation than is reflected in the proposed rule in explaining the basis and purpose of its proposed policy choices***. The agency's description of the proposed calculation of Factor Three is a example that the agency has not met its obligation in the regard. The agency has not provided an explanation for the proposed

distribution variable and has not identified any empirical base or rationale for concluding that the sum of Medicaid and low-income Medicare part A patient days is an acceptable proxy for a hospital's provision of uncompensated care to uninsured patients.

It is clear that as Medicaid coverage is expanded, the change in Medicaid days should be inversely related to the change in uncompensated care. If currently uninsured patients are enrolled in a Medicaid program then the number of Medicaid days will increase, but the level of uncompensated care will decrease. This effect simply reemphasizes the fact that Medicaid and SSI days are not a good proxy for uncompensated care cost.

Our detailed comments on each of these areas follow.

Detailed Comments Regarding Factor Three of the DSH Formula

CMS has proposed to calculate Factor Three by dividing the sum of each hospital's Medicaid and Medicare part A/SSI days by the total Medicaid and Medicare part A/SSI days for all hospitals that are expected to qualify for a DSH payment for a fiscal year. Under the statute, Factor Three is meant to represent each hospital's percentage of total uncompensated care costs incurred by all qualifying hospitals. The text of the statute reads:

> (C) Factor three.—A factor equal to the percent, for each subsection (d) hospital, that represents the quotient of
>
> (i) the amount of uncompensated care for such hospital for a period selected by the Secretary (as estimated by the Secretary, based on appropriate data (including, in the case where the Secretary determines that alternative data is available which is a better proxy for the costs of subsection (d) hospitals for treating the uninsured, the use of such alternative data)); and
>
> (ii) the aggregate amount of uncompensated care for all subsection (d) hospitals that receive a payment under this subsection for such period (as so estimated, based on such data).

Based on this language, the following four propositions are clear:

- Factor Three is meant to represent each hospital's percentage of the total "uncompensated care" furnished by all qualifying hospitals;
- Each hospital's uncompensated care and the aggregate uncompensated care for all hospitals may be "estimated by the Secretary;"
- But, the Secretary's estimate must be "based on appropriate data;" and, therefore,

- When the Secretary chooses to use available "alternative data," it must be "a better proxy for the costs . . . for treating the uninsured.

The proposal to calculate Factor Three based each hospital's number of Medicaid and Medicare part A/SSI days appears to be in tension with these statutory commands. Although the Secretary plainly has authority to estimate each hospital's "uncompensated care," the Secretary's estimate must be based on "appropriate data" to represent levels of uncompensated care. When the Secretary chooses to use available alternative data, like Medicaid and Medicare part A/SSI days, that alternative data must be "a better proxy" for each hospital's uncompensated cost of treating uninsured patients.

On its face, CMS's proposal to calculate Factor Three based on Medicaid and Medicare part A/SSI days appears to be in tension with Congress's command that any alternative data used to estimate each hospital's uncompensated care must be a "better proxy" for the costs of treating *uninsured* patients. Medicaid recipients and Medicare part A beneficiaries are not "uninsured."

Thus, for the proposal to be valid, Medicaid and Medicare part A/SSI days must be a "better" proxy for the costs of treating patients who are uninsured. Based upon our analysis using 2010/2011 data, it appears that there is a very poor correlation between Medicaid and Medicare part A/SSI patient days and the amount of uncompensated care cost incurred by hospitals. This comports with the same conclusion reached by MedPAC, several years ago. *See* Medicare Payment Advisory Commission, *Report to Congress, Medicare Payment Policy* (Mar. 2007) (referred to herein as "*MedPAC 2007 Report*")

In its 2007 Report, MedPAC discussed its finding as to the relationship between the "empirically justified DSH payment," which is calculated based on a hospital's number of Medicaid and Medicare part A/SSI days under section 1886(d)(5)(F) of the Act, and a hospital's "uncompensated care (charity care and bad debts)." *MedPAC 2007 Report* at 78. MedPAC found that the DSH payments, calculated based on Medicaid and Medicare part A/SSI patient days, is "poorly targeted to hospitals' shares of uncompensated care." *Id*. Further, "hospitals most involved in teaching and in treating Medicaid and low-income Medicare patients are not, by and large, the ones that devote the most resources to treating patients who are unable to pay their bills. *Id*. at 79.

Congress undoubtedly was aware of the *MedPAC 2007 Report* when it enacted the new DSH payment method under section 1886(r) of the Act. That Report is the bedrock for Congress' adoption of the new DSH payment prescribed in section 1886(r)(1) of the Act. Section 1886(r)(1) explicitly references the *MedPAC 2007 Report* in addressing the "empirically justified" DSH payment made based on Medicaid and Medicare part A/SSI patient days under section 1886(d)(5)(F) of the Act. In that 2007 Report, MedPAC clearly articulated its finding that DSH payments based on the Medicaid and Medicare part A/SSI patient days do not target hospitals most involved in the provision of uncompensated care. It is not plausible, therefore, that Congress intended for the Secretary to calculate each hospital's percentage of uncompensated care cost based on the same Medicaid and Medicare part A/SSI days.

In addition, we note that MedPAC's finding in its 2007 Report is consistent with our own analysis of the relationship between a hospital's uncompensated care cost and the sum of its

Medicaid and Medicare part A/SSI days. As noted above, our analysis shows that there is a poor correlation between a hospital's uncompensated care cost and the sum of its Medicaid and Medicare part A/SSI days. The setup, design and results of the Foundation's analysis are discussed in the Appendix to this letter.

In its selection of the Medicaid/SSI data proxy for uncompensated care, the agency seems to dismiss the S-10 data but does not explain or analyze why those data are not useful. In fact, our analysis indicates that the major issue with the S-10 data lies in an idiosyncratic problem with the cost-to-charge ratio (CCR) used to derive cost from charges for uncompensated care on worksheet S-10 on cost reports submitted by some, relatively few, hospitals. Our analysis confirms that, in some cases, the CCR used on S-10 is obviously incorrect. But CMS can easily remedy that problem using existing data in the agency's possession. CMS uses CCRs for other purposes, and the agency has CCR data for each hospital in the Impact File. The CCRs reflected in the Impact File or in another agency data can be substituted for apparently erroneous CCRs used on submitted S-10 worksheet. In addition, or in the alternative, the agency could cap each CCR reported on S-10 to 1.0 for purposes of estimating each hospital's uncompensated care cost for the 2010/2012 cost reporting period used. Use of the S-10 data, with this simple edit or correction would produce alternative data that is a "better" proxy for uncompensated care cost, in compliance with the statutory directive in section186(r)(2)(C) and consistent with the *MedPAC 2007 Report* to Congress.

Comment on the Critical Role of the Agency's Notice and Comment Process Given the Presence of the Existent Preclusion of Review Provisions

We note that Congress enacted a provision purporting to preclude review of many of the estimates used to calculate the new DSH payment and has delegated CMS considerable discretion in implementation of that statute. Though we question the validity of the preclusion of review, we suggest that, if anything, it should serve to heighten the agency's vigilance to ensure that it has clearly explained and adequately analyzed its policy choices and that it is responsive to comments on those decisions. This is critical if Medicare beneficiaries and providers are to have the ability to make meaningful comments of the proposals consistent with fundamental notions for due process.

In our view, CMS has failed to meet its obligation in its description of the proposed method for distribution on uncompensated care payments under section 1886(r)(2) of the Act, particularly in regard to its proposed use of Medicaid and SSI days. It appears that this proposal potentially was made for other reasons (e.g. to incentivize State to adopt the Medicaid expansions authorized by the ACA) and without adequate analyses or description as to the underlying rationale for this proposal. CMS was aware of the *MedPAC 2007 Report* discussing its finding year ago that Medicaid and low income Medicare part A days are not a good proxy for uncompensated care costs. In addition, it can be logically expected that uncompensated care costs will generally be lower as Medicaid enrollment increases, yet the proposed rule would redirect uncompensated care payments in the opposite direction, to hospitals in States that elect to expand Medicaid

eligibility. And, here we have presented s more current data analysis and reached a finding similar to MedPAC's finding in the 2007 Report to Congress. CMS, in contrast has identified no legitimate evidence showing that the sum of Medicaid and low income Medicare Part a days is a valid proxy for uncompensated care cost of services furnished to uninsured patients. The agency has not described any analysis to test or confirm its hypothesis that Medicaid and Medicare part A SSI days are a "better proxy" for a hospital's uncompensated care costs. In addition, while the agency has notes that there may be some problems with the reported S-10 data, it does not appear that it has undertaken any analysis whether other data in its possession, like the CCRs in the Impact File, could be used to mitigate problems with reported S-10 data that can then be used to establish better proxy for uncompensated care costs.

We appreciate the opportunity to provide these comments to you. We hope that the agency finds this analysis useful particularly with regard to its assessment of the proposal to calculate Factor Three based on Medicaid and Medicare part A/SSI days. If any of these comments need clarification we would welcome the opportunity to provide such (410 531 1969).

Sincerely

Theodore Giovanis
President

Appendix I

Analysis of the Appropriateness of the S-10 Data and the Proxy Capacity of the CMS proposed Method - Medicaid and SSI days

Calculations:

This analysis used data from the CMS 2552 S-10 taking the most recent year available (2010, 2011 or 2012) in which the hospital had reported using the CMS 2552-10 form. These data were merged with the Medicaid and SSI days provided by CMS as data files associated with the Proposed IPPS Regulation and with the Impact File for FFY 2013 for purposes of the analysis described below. While there may be some mismatches between years for particular hospitals these should not influence the overall conclusions.

Comments:

The use of Medicaid and SSI days as an approximation for uncompensated care cost is not reasonable. There is a poor correlation between these two variables, even after excluding outliers.

The major problems with the S-10 data appear to be due to Cost to Charge Ratios (CCRs) that look clearly incorrect. CMS appears to have either obtained more reasonable CCRs or corrected this problem in calculating CCRs for other purposes, for example, the CCRs published in the Impact file do not suffer from extreme outliers and such obviously incorrect data.

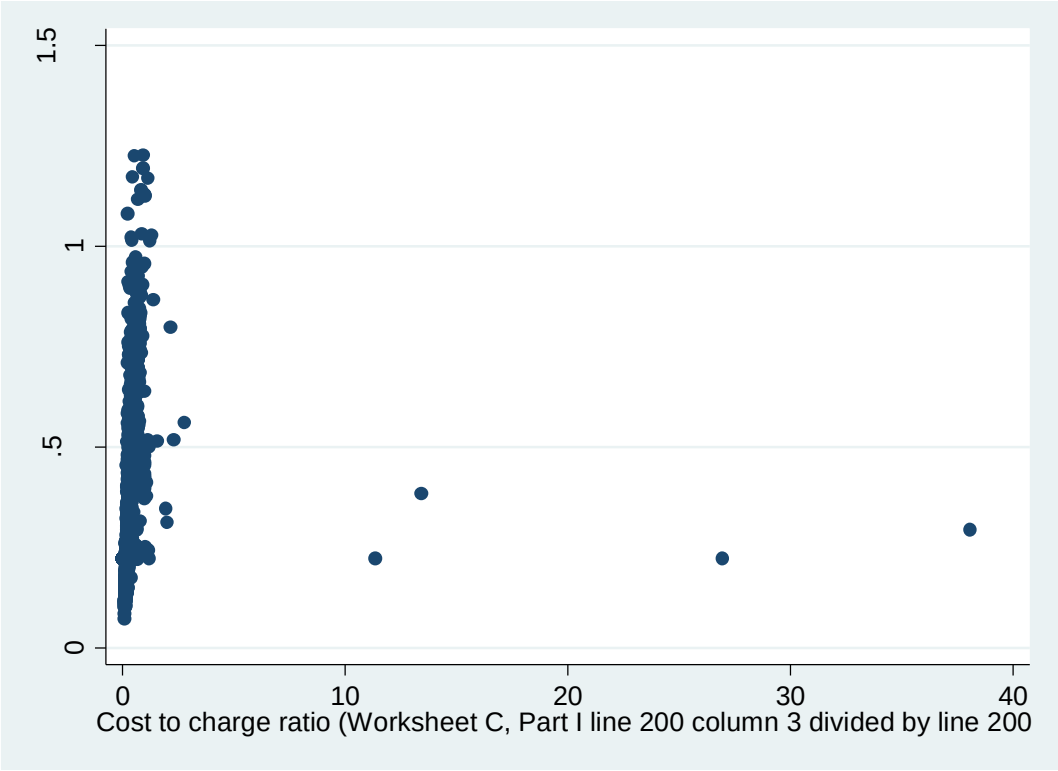
One way to deal with the obviously incorrect CCRs in the S-10 would be to cap the CCR at 1.0, in keeping with the former policy of paying the lesser of costs or charges. In addition, the CCRs used in the S-10 should be checked against the data reported elsewhere in the Cost Report. The cost of uncompensated care should then be calculated using an edited CCR.

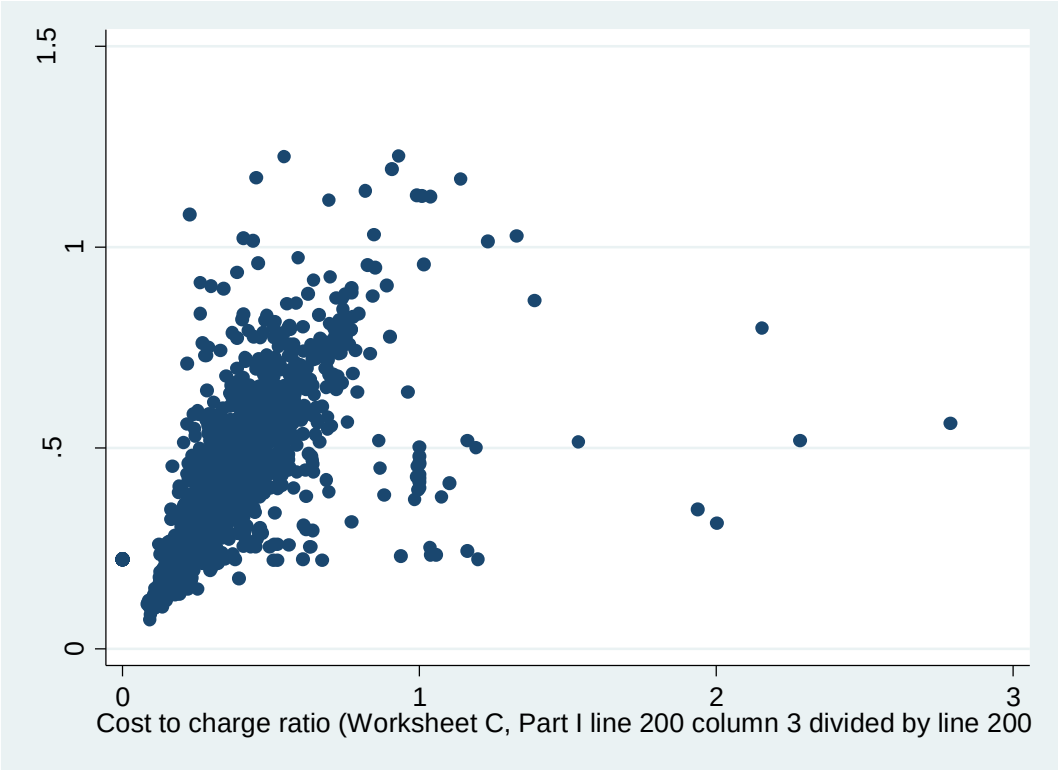
Summary:

The problems with the S-10 UCC seem to be largely due to CCRs that are unreasonable. The CCRs in the Impact file look more reasonable, and for the majority of hospitals the CCRs in the Impact file and the S-10 match fairly well.

The use of Medicaid and SSI days is not a good proxy for the UCC cost.

Comparison of CCR from the Impact File and the CCR from the S-10

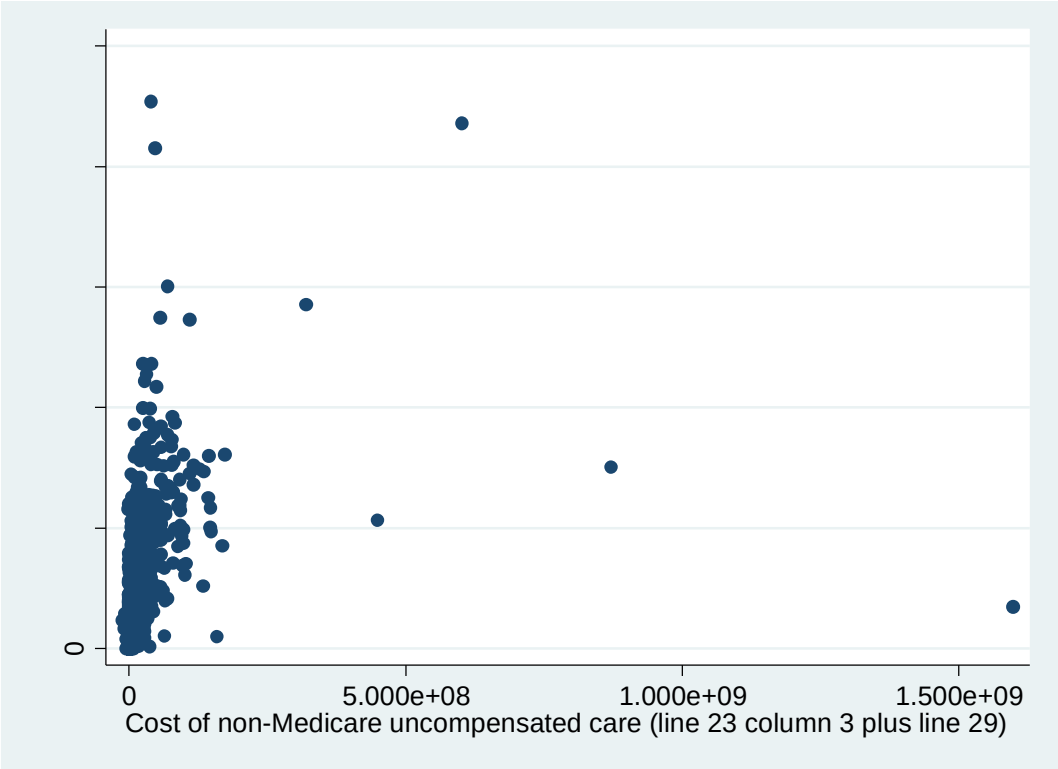




This graph was developed using the same data as the previous graph but after having dropped a few hospitals with CCRs over 10 in the S-10 data. This analysis used the S-10 data mostly from Cost Reporting years 2010 and 2011, and the Impact file for FFY 2013, which should be using close to these years.

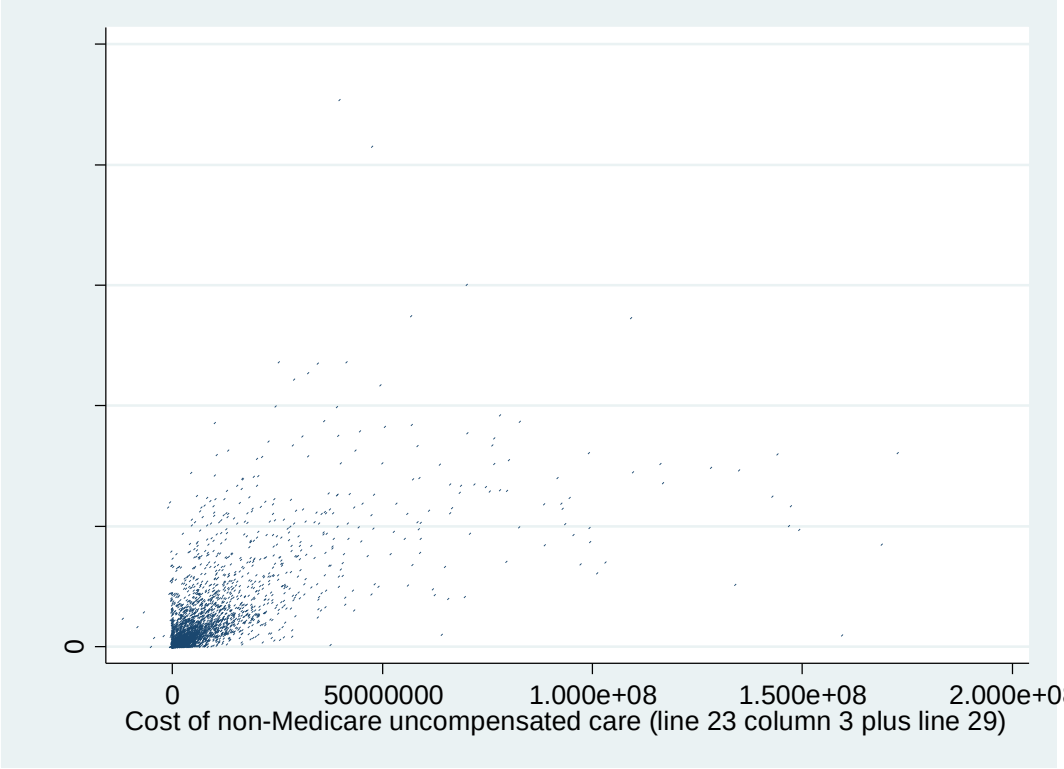
Conclusion: The CCRs in the impact file generally look appropriate, but some of the CCRs in the S-10 are absurdly variance. However, there are a few hospitals with CCRs in the impact file greater than 1.0 and so have more reasonable looking CCRs than in the S-10. A correlation analysis of the untrimmed CCRs provided a correlation of only 0.12, but trimming the CCRs to be under 1.0 gave a correlation coefficient of 0.83.

Low income days versus non-Medicare UC from the S-10



The hospital on the extreme right is reporting $1.5 billion in non-Medicare uncompensated care – a probable error.

Low income days versus non-Medicare UC from the S-10 having dropped hospitals with UC over $200,000,000



Conclusion: There is a poor correlation between the UCC percentage and the DSH percentage (correlation coefficient of 0.36). This is in keeping with MedPAC's conclusions (in its 2007 report). It is clear that Medicaid and SSI days continue to fail as a reasonable proxy for uncompensated care costs, and the whole purpose of the change in the distribution of the 75% of DSH using non-Medicare uncompensated care was to account for this. The proposed formula simply perpetuates the current inequities and usurps the intent of the Congressional change.