



June 24, 2019

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue SW
Washington, DC 20201

Ref: CMS-1716-P: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2020 Rates; Proposed Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Promoting Interoperability Programs Proposed Requirements for Eligible Hospitals and Critical Access Hospitals

Submitted via: Regulations.gov

Dear Administrator Verma:

The California Association of Public Hospitals and Health Systems (CAPH) appreciates the opportunity to submit comments on the proposed guidance referenced above and in particular the policy changes related to Medicare Disproportionate Share Hospital (DSH) payments for the Federal Fiscal Year (FFY) 2020, the changes to the Medicare area wage index, and CMS' proposal to account for housing status as a risk factor when making payment adjustments.

CAPH represents California's 21 county-owned and -operated or county-affiliated public health care systems and the University of California medical centers who deliver care to all who need it, regardless of ability to pay or circumstance. As core safety-net providers to California's low-income population, each year public health care systems serve 2.85 million Californians and provide over 10 million outpatient care visits. All CAPH members provide a significant amount of care to low-income populations, where medical problems can be caused and exacerbated by factors related to poverty, such as poor nutrition, lack of safe and stable housing, incarceration, unemployment, and the chronic anxiety of income insecurity. CAPH is committed to delivering care that recognizes the complex issues that influence our patients' lives, and receiving payment that adequately covers these costs is critical to maintaining public health care systems' mission as safety-net providers. It is in this context that we respectfully offer the comments below.

1. CMS should continue to improve the accuracy and reliability of Worksheet S-10 data.

- a. CMS should continue to review the reliability and accuracy of the worksheet S-10 data elements that are used for the Medicare DSH calculations.*

Beginning with FFY 2014, the Center for Medicare and Medicaid Services (CMS) was required by statute to split Medicare DSH payments into two separate payments: 1) empirically justified payments equal to 25% of the traditional DSH formula; and 2) an aggregate dollar pool of uncompensated care

based on 75% of DSH reduced for decreases in the uninsured population since FY 2013. The uncompensated care pool is allocated based on each hospital's share of national uncompensated care costs.

Worksheet S-10 of the Medicare cost report is used to record charges and costs for uncompensated care. However, because of concerns with how data was reported on the Worksheet S-10, including limited use and a lack of clarity with reporting instructions raised by field staff, CMS previously adopted the use of low-income patient days from before FFY 2014 as a proxy for uncompensated care from FFY 2014 through FFY 2017. Since FFY 2014, CMS has been unwilling to continue using low-income patient days as a proxy because: 1) this could disproportionately benefit Medicaid expansion states; and 2) because uncompensated care costs on the Worksheet S-10 are more highly correlated to audited uncompensated care costs than are Medicaid and SSI days. Therefore, CMS began transitioning from the proxy data to Worksheet S-10 beginning with FFY 2018.

This year's proposed rule for distributing Medicare DSH payments continues on the path to using more uncompensated care data to determine each hospital's pro-rata share of Medicare DSH uncompensated care payments. For FFY 2020, CMS is proposing to rely solely on the Worksheet S-10 data as a measure of uncompensated care, whereas previously it used a blend of proxy utilization data and Worksheet S-10 uncompensated care data. CAPH appreciates the significant work that hospitals and CMS have put into improving this data. Since 2014, when the Worksheet S-10 was first contemplated for payment purposes, stakeholders and CMS have diligently worked to refine reporting instructions to create more clarity and consistency in reporting, including a review of key elements of individual hospital reports through a select review process to ensure reporting accuracy. This trajectory highlights the amount of time needed to introduce new data and the confidence needed to base payments on it. For the portions of the Worksheet S-10 that are relevant for Medicare DSH payments, this trajectory will likely be five to ten years.

Given this work over the past several years, CAPH understands that CMS is ready to move away from using proxy data to determine each hospital's relative share of uncompensated care costs and instead use data from the Worksheet S-10 to measure charity care and non-Medicare bad debt (Line 30 from the Worksheet S-10). In addition, CMS is proposing to use a single year of data to calculate FFY 2020 Medicare DSH payments. **CAPH does not object to this one-year approach for FFY 2020, but urges CMS to revisit the issue in FFY 2021, looking for ways to smooth data over multiple years by taking, for example, a 3-year average.** This "smoothing of the data" is important because not all hospitals have gone through an external review of their data by CMS contractors. In addition, hospitals are also still adjusting to the updated 2017 reporting instructions for the Worksheet S-10. **Because of these ongoing adjustments, CMS should strive to use data from multiple years to calculate Medicare DSH payments. At the same time, we urge CMS to continue to review the reliability and accuracy of the Worksheet S-10 data elements that are used for these calculations, provide updates about those reviews in future rulemaking as it has done under this proposed rule, and expand reviews to all hospitals to ensure all hospitals are subject to the same review and scrutiny of their data.**

b. CAPH remains concerned that the Worksheet S-10 does not fairly account for costs incurred by public safety-net institutions.

The Worksheet S-10 contains data on several important sets of services provided by public health care systems, including costs and payments related to Medicaid, CHIP, other state and local indigent care programs, as well as on charity care and non-Medicare bad debt. CAPH is concerned about the ability

of the Worksheet S-10 to correctly measure the true costs incurred by public health care systems, not only for measuring charity care and non-Medicare bad debt for Medicare DSH payment purposes, but also for other sections of the form which may be used for future payment policies.

Inaccurate Cost-to-Charge Ratio (CCR)

The calculation of costs for all of the payers reported in Worksheet S-10 relies on single cost-to-charge ratio (CCR) that could underreport safety net and teaching hospital costs.

First, the CCR does not reflect the cost of a teaching hospital's graduate medical education (GME) expenses. Although CMS' analysis in the FFY 17 proposed rule showed that including GME, or the cost of training interns and residents, would benefit teaching hospitals, they felt GME training costs should not be used to offset uncompensated pool payments. CAPH appreciates the concerns raised by CMS; however, we respectfully disagree and believe strongly that GME needs to be included in the cost-to-charge calculations for uncompensated care payments. Public health care systems train over 50% of doctors in hospitals across California while also providing a significant amount of care for low-income populations. By excluding GME costs, hospitals are underreporting the true amount of uncompensated care provided to the safety-net population. **We recommend that CMS acknowledge the true costs in providing care at safety-net hospital systems, which includes training and residency costs, in the cost-to-charge ratio calculation.**

In addition, CAPH is concerned that using an average CCR to calculate costs, as opposed to applying ratios by cost center, will lead to risks of over or undercounting actual costs. This could be especially problematic if utilization by any subset of the patients measured in the Worksheet S-10 is skewed towards types of services with higher or lower cost-to-charge ratios. **We recommend that CMS study the impacts of using an average CCR, how it affects different types of hospitals, and evaluate options for more accurately determining a hospital's true cost of providing care.**

Only Portions of the Worksheet S-10 Have Been Validated

For the purposes of the Medicare DSH calculations, CMS proposes that only data on charity care and non-Medicare bad debt from line 30 be used to distribute funds. The considerable time and attention that has been devoted to improving the Worksheet S-10 data has been focused only on these sections of the report – lines 20-30. As the Worksheet S-10 becomes a tool that policy makers increasingly wish to use to evaluate policies and on which to base other payments, it is critical to highlight the lack of review these sections (Medicaid, CHIP, and other state and local programs) on the Worksheet S-10 have received. Today, we believe there are inconsistencies in reporting and potential accuracy concerns regarding these areas of the Worksheet S-10 that merit in-depth review before being used for any policy or payment purposes. For example:

- The worksheet should be consistent in allowing hospitals to reduce their Medicaid revenues by the amount of any Medicaid non-federal share funding they provide, whether through provider taxes, intergovernmental transfers (IGTs), or certified public expenditures (CPEs). Like provider taxes and assessments, provider-funded IGTs and CPEs are contributions to the non-federal share of Medicaid payments and often are critical to a state's ability to make such payments. Allowing offsets for provider taxes, but not CPEs and IGTs, distorts shortfall amounts and might create inequities among hospitals.

- Other than lines 26 and 27 of the Worksheet S-10, which are related to total bad debt and Medicare bad debt, the Worksheet S-10 does not connect to any other worksheets in the Medicare cost report, which would make auditing a challenge since there will be no built in checks on internal inconsistencies that could be used to identify problematic data.

As noted above, the path to improving just lines 20-30 will likely be a five to ten year process. Any expanded use of the Worksheet S-10 to include other lines of data would need to go through a similar review, including: 1) an analysis of the accuracy of the data compared to other available sources; 2), the updating of instructions to ensure consistent and comparable data is reported within and among hospitals; and 3) the potential revamping of the form to address any issues identified and to ensure that the intended purpose for which the Worksheet S-10 is being used can actually be achieved with the available data. **Should the Worksheet S-10 be used for other purposes in the future, we would urge CMS to go through this validation process.**

2. CMS should reject the harmful proposal on wage index disparities.

CMS is proposing to make a budget neutral adjustment to hospitals' wage indices to reduce disparities among high- and low-wage index areas. CMS would do this by increasing the wage index values for certain hospitals with low-wage index values and decreasing the wage index values for certain hospitals with high-wage index values, and would implement this policy for at least four years. CMS also proposes to exclude from the area wage index calculation data from seven California hospitals that they believe have aberrantly high wages, though CMS has also confirmed that the data are accurate.

The existing wage index adjustment is designed to reflect the fact that certain places have a higher cost of living than others by making a payment adjustment that accounts for local price inputs. The resulting payment is meant to ensure that Medicare appropriately reimburses providers based on their local operating costs, reflecting very real and not easily altered geographic discrepancies in costs. In California, the cost of goods and services in 2017 were 14.8% above the national average,¹ requiring higher wages to ensure hospitals can attract a workforce that can also live in the community. Upwards of 57% of hospital spending statewide is on labor-related costs. While we appreciate that CMS wishes to address the financial challenges of our nation's rural hospitals, such help should not come at the expense of other hospitals.

In addition to the immediate financial harm the 2020 wage index proposal would inflict on our hospitals, the proposal violates the provision of the Social Security Act requiring CMS to adjust payments to reflect area differences in wages,² and is not supported by the exceptions provision on which CMS purports to rely.³ The wage index proposal would result simply in a shift of Medicare funds from high-wage states to low-wage states, with accounting for local labor costs faced by hospitals.

¹ Bureau of Economic Analysis, US Department of Commerce. <https://www.bea.gov/news/2019/real-personal-income-states-and-metropolitan-areas-2017>, last accessed June 17, 2019.

² 42 USC Section 1395ww(d)(3)(E).

³ 42 USC Section 1395 ww(d)(5)(I).

Because CMS' wage index proposal does not meet the intent or the legal requirements of the Social Security Act, we urge you to reconsider and withdraw this proposal. If CMS wishes to adjust wage index values for certain low-wage index areas, the agency should allocate additional funds to ensure parity in these values. CMS should also include all accurate data in its area wage index calculations.

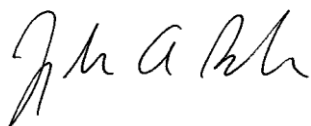
3. CAPH supports factoring into reimbursement whether a person is experiencing homelessness.

CAPH affirms the comments made by America's Essential Hospitals in support of CMS' proposal to recognize homelessness as a comorbid condition in Medicare. CAPH's members have extensive experience serving low-income communities, where medical problems can be caused and exacerbated by factors related to poverty, such as poor nutrition, lack of safe and stable housing, incarceration, unemployment, and the chronic anxiety of income insecurity. Through an innovative program in California's 1115 Medicaid waiver, public health care systems have been working to build more integrated support systems that specifically provide social supports to populations that are experiencing homelessness; such systems are often more resource intensive. This waiver also permits the use of Medicaid funds to provide a range of supportive housing services, including housing navigators, financial assistance for security deposits and move-in fees, and other support to help patients maintain relationships with landlords. With one exception in North Carolina,⁴ CMS does not permit Medicaid funds to be used to provide direct rental assistance.

We applaud CMS' willingness to increase reimbursement for health care services in recognition of the more complex needs of patients experiencing homelessness. As with any new coding or payment policy, we anticipate that such coding changes will take time to be widely adopted and reflected in data. We look forward to continuing to partner with CMS to support the health and welfare needs of our patient population by implementing such policies. We would also urge the agency to consider even more ambitious policies, like the ones approved in North Carolina's Medicaid 1115 waiver for short-term post-hospitalization housing, which supports improving housing stability, and in turn overall health, for our most vulnerable patients.

Thank you for the opportunity to submit comments.

Sincerely,



Jackie Bender
Vice President of Policy

⁴ North Carolina's Medicaid 1115 waiver permits Medicaid funds to be used for "Short Term Post Hospitalization," whereby Medicaid will pay for temporary housing, not to exceed 6 months, for people who would otherwise be homeless upon discharge. See Attachment G: Enhanced Case Management and Other Services Pilot Program Eligibility and Services, available at <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nc/nc-medicaid-reform-ca.pdf>, accessed June 20, 2019.