June 13, 2018

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

Re: File Code CMS-1677-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 2018 Rates; Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Electronic Health Record (EHR) Incentive Program Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Provider-Based Status of Indian Health Service and Tribal Facilities and Organizations; Cost Reporting and Provider Requirements; Agreement Termination Notices

Dear Ms. Verma:

Southwest Consulting Associates (SCA) appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) 2018 IPPS Notice of Proposed Rulemaking. SCA's comments primarily relate to the proposed changes to the payment adjustment for Medicare Disproportionate Share Hospitals including the uncompensated care pool component of the payment. In this letter, we are submitting comments related to the following items:

1. Factor 1
2. Factor 3

Factor 1

- CMS prepares an estimate of Medicare DSH for FY 2018 using 2014 cost reports as the base and applies various factors to trend that data forward to 2018. Included in the trending factors is a category titled "Other". CMS describes "Other" as "The "Other" column shows the increase in other factors that contribute to the Medicare DSH estimates. These factors include the difference between the total inpatient hospital discharges and the IPPS discharges, and various adjustments to the payment rates that have been included over the years but are not reflected in the other columns (such as the change in rates for the 2-midnight policy). In addition, the "Other" column includes a factor for the Medicaid expansion due to the Affordable Care Act."

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Besides the explanation described in the proposed rule, cited above, there is no other transparency as to the specific items that make up the "Other" adjustment or the value of each of the components. In order to fully evaluate this adjustment to the estimated DSH, a breakdown of the items and their respective values should be published so that the public can make meaningful comments, if warranted.

- Included in the "Other" column is a factor for Medicaid expansion due to the Affordable Care Act (ACA), however, no detailed explanation related to that item is described in the proposed rule. CMS does say that the Medicaid expansion factor was derived from "public information and statements for each State regarding its intent to implement the expansion"; however, CMS did not go into any real detail regarding the numbers used in developing the factor.

  CMS further states that "We note that, in developing their estimates of the effect of Medicaid expansion on Medicare DSH expenditures, our actuaries have assumed that the new Medicaid enrollees are healthier than the average Medicaid recipient and, therefore, use fewer hospital services." CMS has provided no details regarding both the actual Medicaid expansion factor or to support its contention that the expanded population is "healthier than the average Medicaid recipient."

  Previous data, specifically CBO reports, have shown an estimated 12 million additional Medicaid enrollees have entered the system. This represents a 32% increase over pre-ACA levels. This increase should have resulted in a substantial and permanent increase in gross estimated DSH for years subsequent to the enactment of Medicaid expansion. However, the numbers don't seem to reflect this expected result. CMS should provide additional explanation, including actual data, to support its assumed increase in gross estimated DSH for public review and comment.

Factor 3

- Extensive comments regarding the use of S-10 have been made in the past not only from SCA but from many other stakeholders and we will not restate those comments here. CMS has those previous year comments on file and has addressed some of those comments in final rules published during the last several years. However, concerns regarding a number of issues that have been raised for years still exist as there have been no meaningful changes made to the underlying systems, processes and instructions used to compile data for worksheet S-10. In summary:

  - There are still anomalies in the data that the proposed trims do not address. For example, there is one hospital in the FY 2014 cost report files that reflects UC costs 4 times total hospital charges. Factor 3 anomalies affect the distribution of the UC pool, and the impact of such anomalies on the distribution for individual hospitals can be significant. The adequacy of payments to any individual hospital is the direct result of the accuracy with which each hospital reports its data. We continue to believe that the data used to distribute the UC pool should be subject to review prior to its use.

- There are still definitional issues that remain open that should be resolved so that CMS' contractors have clear instructions once they begin reviewing submitted data. One specific example relates to the definition of uncompensated care. This definition should include uncompensated care related to all uninsured patients and specifically include discounts given to uninsured individuals. The current instructions regarding the reporting of "charity care" are insufficiently unclear to ensure worksheet S-10 data used to calculate Factor 3 properly captures an accurate measure of a hospital's uncompensated care costs of treating uninsured patients.

  Confusion about the current instructions for completion of Worksheet S-10, particularly as they relate to costs of services furnished to uninsured patients who receive discounts under a hospital's financial assistance policy, may result in inaccurate and uneven reporting of costs of treating those uninsured patients. The current instructions contain contradictory and confusing language that leaves key terms undefined and therefore fosters uneven and inconsistent reporting of the uncompensated care cost of services furnished to these uninsured patients.

  To ensure consistency and an appropriate representation of the uncompensated care costs of treating uninsured patients who qualify for a full or partial discount under a hospital's financial assistance policy, CMS should: 1) revise and clarify the current definition of "Uncompensated care" in the general instructions for completion of Worksheet S-10; and 2) define the term "charity care criteria" as used in the current instructions for completion of line 20 on Worksheet S-10, to include all patients who receive a full or partial discount under the hospital's financial assistance policy, including those whose incomes are not low enough to qualify for charity.

  The current instructions for Worksheet S-10 define the term "Uncompensated care" as follows: "Defined as charity care and bad debt which includes non-Medicare bad debt and non-reimbursable Medicare bad debt. Uncompensated care does not include courtesy allowance or discounts given to patients." Provider Reimbursement Manual, Part II, § 4012 (Definitions). The text excluding "discounts given to patients" obviously is not intended to mean what it literally says. As indicated in the first sentence, uncompensated care includes discounts given to "charity care" patients. To avoid confusion, especially among Medicare Administrative Contractors, CMS should revise the second sentence of the definition to read: "Uncompensated care does not include courtesy allowances or discounts given to patients who do not qualify for full or partial discounts under the hospital's financial assistance policy."

  This proposed revision to the definition of "Uncompensated care" should reference a hospital's "financial assistance policy," as opposed to a hospital's "charity care policy" or "charity care criteria," for consistency with the terminology used in the regulations implementing the charity care requirements imposed upon tax-exempt hospitals under section 501(r) of the Internal Revenue Code. *See* 79 Fed. Reg. 78954, 79004-79010

(Dec. 31, 2014) (adopting regulations codified at 26 C.F.R. §§ 1.501(r)(4) and 1.501(r)(5)).

In our view, full charges for all uninsured patients who receive full or partial discounts under a hospital's financial assistance policy should be included on line 20 of Worksheet S-10, without limitation based on the patient's income, resources or other factors. The existing instructions for completion of this line of the cost report may result in inconsistent reporting due to a lack of clarity. The existing instructions state that this line should include full charges for patients who are given a discount "based on the hospital's charity care criteria," but the instructions do not define the key term, "charity care criteria." In our view, the applicable criteria are those specified under a hospital's financial assistance policy and there is no limitation under federal law on the criteria that a hospital is required or permitted to apply under its policy. Rather, federal policy is that hospitals should be free to set their own criteria under their financial assistance policies to best meet the needs of the communities they serve. CMS should revise the instructions for line 20 to make these points clear.

- Pursuant to instruction from CMS, providers were afforded an opportunity to submit original or revised S-10 data for cost reporting periods beginning in FY 2014 no later than September 30, 2016. At the time, CMS seemed to indicate in its final 2017 IPPS rule that S-10 would not in fact be used for a number of years and until instructions were revised, etc. However, CMS has again proposed the use of S-10 data and for 2018, specifically S-10 data from the FY 2014 cost reports.

  Some hospitals may not have taken the opportunity to update their S-10 data as allowed in 2016. Since that data may be used for more than one year during the transition period, if finalized as proposed, we think hospitals should be afforded another opportunity to submit revised data that the MACs would then be required to accept and that revised data would then be reflected in the HCRIS database for use in Factor 3 compilation. In addition, if CMS is in fact going to then continue forward with a transition that uses FY 2015 S-10 data that hospitals also be afforded an opportunity to revise that data.

We appreciate the opportunity to submit these comments for your consideration.

Sincerely,

Michael G. Newell
President