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And
FOLEY HOAG LLP

MEMORANDUM

TO: Steve Speil, Federation of American Hospitals **FILE NO:** 27845.953

FROM: John R. Hellow and Alicia W. Macklin, Hooper, Lundy & Bookman, P.C.
 Thomas R. Barker and Andrew M. London, Foley Hoag LLP

DATE: June 7, 2017

RE: Secretary's Authority under 42 USC § 1395ww(r)(2)(C) and Related Provisions to Ensure That the Data It Uses to Allocate UC-DSH Payments to Hospitals is Appropriate Data

I. SUMMARY CONCLUSIONS

As explored in detail below, contrary to CMS's position in the FY 2018 IPPS Proposed Rule, 42 U.S.C. § 1395ww(r)(2)(C) affords the Secretary authority to: (1) continue to use data other than Worksheet S-10 data in the Factor 3 calculation as it has since FY 2014, (2) use a combination of data sources in the Factor 3 calculation as it has since FY 2017, or (3) in parallel with its authority above, exercise authority under 42 U.S.C. 1395ww(d)(5)(I)(i) to provide a longer transition period than currently proposed, as a necessary bridge until appropriate Worksheet S-10 data is available.

II. BACKGROUND REGARDING THE CALCULATION OF FACTOR 3

Factor 3 equals the percent, for each IPPS 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**).

42 U.S.C. § 1395ww(r)(2)(C)(emphasis added).

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For the past four fiscal years, CMS has determined Factor 3 based on the utilization of hospital services by low-income patients defined as inpatient days for Medicaid patients plus inpatient days of Medicare SSI patients. Throughout that time period, CMS declined to use Worksheet S-10 data for purposes of determining Factor 3 for several reasons, including because CMS “believe[d] it is important that data used to determine Factor 3 are data that have been historically publicly available, subject to audit, and used for payment purposes (or that the public understands will be used for payment purposes).” 78 Fed. Reg. 50496, 50635 (August 19, 2013). Also, throughout, CMS noted the many specific deficiencies and drawbacks of relying on the Worksheet S-10 data. *See, e.g.*, 78 Fed. Reg. at 50636; 79 Fed. Reg. 49854, 50015-17 (August 22, 2014); 80 Fed. Reg. 49326, 49522-26 (August 17, 2015); 81 Fed. Reg. 56762, 59963-64 (August 22, 2016). CMS went so far in the FY 2017 IPPS Final Rule as to reject its proposal to start using Worksheet S-10 data for FY 2018, stating:

Instead, we expect to begin to incorporate Worksheet S–10 data into the computation of Factor 3 by FY 2021 once we have taken certain quality control and data improvement measures and also implemented an audit process, as we described above. We believe that postponing our decision regarding when to begin incorporating data from the Worksheet S–10 is necessary to allow us time to consider what changes to the cost report may be necessary and to implement an audit process. When we have determined that it is appropriate to use Worksheet S–10 data, we anticipate proposing to continue to use data from three cost reports, as we are doing for the calculation of Factor 3 for FY 2017, which would have a transitioning effect as we described in the proposed rule. (81 FR 25091).

81 Fed. Reg. at 56965.

Consistent with our view that CMS has ample statutory authority to continue to use its pre-FY 2018 data sources until Worksheet S-10 data becomes “appropriate” either alone or in a hybrid with Worksheet S-10 data to insure robust reporting and auditing of S-10 data before it becomes the sole data source, in a single paragraph CMS in the IPPS FY 2017 Final Rule, explained: (1) why it had the authority to continue to use Medicaid and Medicare with SSI days data, because the data from S-10 was not “appropriate” data and under what conditions it would become “appropriate” to use; (2) that it was apparently appropriate in FY 2017 to use multiple years of data sources to smooth the impact of relative changes in hospital data and, (3) even when Worksheet S-10 data would be appropriate to use that it would continue to use 3 years of

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data, which would necessarily include at first two years of Medicaid and Medicare with SSI days data for a “transitioning effect.”

However, in CMS’s FY 2018 IPPS Proposed Rule, CMS states that it now believes the situation is at a “tipping point” and CMS “can no longer conclude that alternative data are available for FY 2014 that are a better proxy for the costs of subsection (d) hospitals for treating individuals who are uninsured than the data on uncompensated care costs reported on the Worksheet S-10.” 82 Fed. Reg. at 19949. Thus, CMS now proposes to use Worksheet S-10 data in the calculation of the hospital-specific Factor 3 value, beginning in FY 2018. In addition, for FY 2018, CMS proposes to combine such Worksheet S-10 data from FY 2014 with alternative proxy data regarding low-income insured days for FYs 2012 and 2013, and to transition to using Worksheet S-10 data exclusively by FY 2020.

III. LEGAL AUTHORITY OF SECRETARY PURSUANT TO 42 USC § 1395ww(r)(2)(C) AND RELATED AUTHORITY

A. The Secretary Has Authority to Continue to Rely on Proxy Data

Section 1395ww(r)(2)(C) requires the Secretary to determine: (1) the definition of uncompensated care; (2) the data source(s) for the estimated uncompensated care amount; and (3) the timing and manner of computing the amount for each hospital estimated to receive DSH payments. The statute instructs the Secretary to estimate the amounts of uncompensated care for a period “based on appropriate data.” 42 USC § 1395ww(r)(2)(C). And, in addition, the statute expressly permits the Secretary to use proxy data if the Secretary determines that such available data is a better proxy for determining the relative costs of uncompensated care for IPPS hospitals.¹

As mentioned above, CMS, pursuant to that authority, examined the potential data sources for FY 2014 and determined that given the issues and concerns with Worksheet S-10 data, “data on utilization for insured low-income patients can be a reasonable proxy for the treatment costs of uninsured patients,” and that “this alternative data, which is currently reported

¹ While the statute refers to the uncompensated care costs of the uninsured, the Secretary has chosen to define those costs to include charity care costs provided to insured patients, and the bad debt costs, coinsurance and deductible amounts, of insured patients. We express no opinion here on the Secretary’s authority to include such costs in the statutory definition of uncompensated care costs for uninsured patients.

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on the Medicare cost report, would be a better proxy for the amount of uncompensated care provided by hospitals.” 78 Fed. Reg. at 50636. Thus, the FY 2014 Final Rule called for the use of inpatient days of Medicaid patients plus inpatient days of Medicare SSI patients as defined in 42 CFR 412.106(b)(4) and 412.106(b)(2)(i), respectively, to calculate Factor 3.

CMS reiterated its belief that this alternative data would be a better proxy in its Final Rules for FY 2014 to FY 2017. Further, in the FY 2018 Proposed Rule, CMS determined that it is still appropriate to use low-income insured days as a proxy for uncompensated care costs for years prior to FY 2014. 82 Fed. Reg. at 19949.

Notwithstanding CMS’s position that a tipping point has been reached, nothing has changed in the governing statute here to require a sudden shift in CMS’s position. There is no deadline set in § 1395ww(r)(2)(C) that requires the Secretary to settle on “appropriate data,” to estimate uncompensated care. Additionally, the authority to base the Factor 3 calculation on alternative data implies that reevaluation is consistent with Congress’ intent in drafting the statute and that there is no final deadline contemplated. Given concerns with the Worksheet S-10 data that have not been resolved, as well as CMS’s own guidance that “it is important that data used to determine Factor 3 are data that have been historically publicly available, subject to audit, and used for payment purposes (or that the public understands will be used for payment purposes),” 78 Fed. Reg. at 50635, this strongly suggests that the Secretary exercise such authority to continue to rely on the proxy data regarding low-income insured days.

To achieve the goals that CMS has espoused, it would be equally appropriate to use a hybrid approach to using multiple data sources, but minimizing to the greatest extent possible the use of a data source that has not been either consistently or accurately reported by hospitals, or audited by CMS such as the currently available Worksheet S-10 data.

B. The Secretary Has Authority To Determine What Data Are “Appropriate Data”

The language of § 1395ww(r)(2)(C) describes the Secretary’s authority with regard to implementation, as discussed in detail below. In short, the statute uses the term “appropriate,” in describing the data to be used here, signaling that the Secretary should consider all of the relevant factors. The statute uses the term “include” to provide an inexhaustive list of examples of the types of data that may be appropriate, signaling that the Secretary has expressly been given the authority to consider many types of data, and even hybrid sets of data, in determining what constitutes “appropriate data” here. And finally, the statute uses the phrase “based on” the appropriate data, or such alternative data that is a better proxy, to describe how the Secretary

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should presumably estimate the relationship between each hospital's cost of uncompensated care relative to the pool of available funds for payment. Congress allows here that the Secretary need not rely solely on "appropriate data," but should use such data as a starting point in the calculation.

As context for interpreting the Secretary's authority under the statute, it is essential to note that § 1395ww(r)(2)(C) directs the Secretary to "estimate" the amount of uncompensated care for such hospital. In the context of Factor 3, "amount" must mean each hospital's relative portion of the pool of available funds. Factor 3 does not reimburse actual costs of uncompensated care. The pool of available funds after the calculations from Factors 1 and 2 is entirely based on the traditional DSH calculation in Factor 1, which does not at all consider any hospital's actual cost, and it is then reduced in Factor 2 to account for mandatory statutory reductions under Section 3133 of the Accountable Care Act. The statute does not require that this amount correspond exactly to a data set nor does it "mandate exactitude." *See Atrium Med. Ctr. v. U.S. Dept. Health & Human Services*, 766 F. 3d 560, 569 (2014) ("The statute, however, does not mandate exactitude; the Secretary need only 'estimate[]' the proportion of labor costs and the resulting wage index need only 'reflect' the relative area wage levels."). Instead, the use of the word "estimate" provides the Secretary flexibility to use multiple sources of appropriate data to inform the Factor 3 calculation.

This interpretation of the Secretary's authority is bolstered by the statute's use of the word "including" following "appropriate data," which contemplates any number of data sources being used by the Secretary. Case law interpreting similar statutes has found that "the use of a form of the word 'include' is significant, and generally thought to imply that terms listed immediately afterwards are an inexhaustive list of examples, rather than a bounded set of applicable items." *In re Mark Anthony Const., Inc.*, 886 F.2d 1101, 1106 (1989); *see also Fed. Land Bank of St. Paul v. Bismarck Lumber Co.*, 314 U.S. 95, 100 (1941) (noting that "the term 'including' is not one of all-embracing definition, but connotes simply an illustrative application of the general principle"); *Stansell v. Revolutionary Armed Forces of Colombia*, 704 F.3d 910, 915 (11th Cir. 2013) (noting that the term "'includes' is merely illustrative"); *Argosy Ltd. v. Hennigan*, 404 F.2d 14, 20 (5th Cir. 1968) ("The word 'includes' is usually a term of enlargement, and not of limitation.' It therefore conveys the conclusion that there are other items includable, though not specifically enumerated by the statutes." (citation omitted)).

Moreover, the Secretary is instructed to estimate the amount of uncompensated care "based on" the appropriate data, or such alternative data that is a better proxy. Again, the use of this particular undefined phrase is significant: courts have interpreted the phrase, "based on," as

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referring to a “starting point” or “foundation,” *McDaniel v. Chevron Corp.*, 203 F.3d 1099, 1111 (2000) (collecting cases), and the root of “based” (basis) as “not mean[ing] “entire” or “only.” *Anna Jaques Hosp. v. Sebelius*, 583 F.3d 1, 6 (D.C.Cir. 2009); *see also U.S. ex rel. Kreindler & Kreindler v. United Techs. Corp.*, 985 F.2d 1148, 1158 (2d Cir.1993) (holding that “based upon” in the False Claims Act does not mean based “solely” upon). Thus, while appropriate data may be the starting point for the Factor 3 calculation, it need not be the sole data source that the Secretary reliefs on.

In some statutory contexts, courts have found that the phrase “based on” is ambiguous and thus, an agency is expressly delegated authority by the statute to reasonably fill in the gaps. *See Sierra Club v. Environ. Agency*, 356 F.3d 296, 305 (D.C. Cir. 2004); *see also Catawba Cty., N.C. v. E.P.A.*, 571 F.3d 20, 35 (D.C. Cir. 2009); *see also Nat’l Cable & Telecomms. Ass’n v. Brand X Internet Services*, 545 U.S. 967, 980 (2005). Under either interpretation of “based on,” the use of the phrase reinforces the Secretary’s ability to rely on multiple data sources.

In addition, the statute provides the Secretary broad authority to determine what appropriate data to use. The Act does not define, nor give any guidance, as to what “appropriate data” are in the context of the Factor 3 calculation. However, the Supreme Court has interpreted “appropriate” as “an all-encompassing term that naturally and traditionally includes consideration of all the relevant factors.” *Mich. v. Envtl. Prot. Agency*, 135 S. Ct. 2699, 2707 (2015). With the ability to consider all relevant factors, which would include data previously used in the Factor 3 calculation, the Secretary has clear authority to determine that “appropriate data” are: (1) a hybrid of data on utilization for insured low-income patients (inpatient days of Medicaid patients plus inpatient days of Medicare SSI patients) and Worksheet S-10 data or (2) any combination of other appropriate data sources. The fact that the Secretary has previously determined that data on utilization for low-income patients serve as proxy data does not preclude a finding now that such data continue to be appropriate data when viewed in combination with other data such as Worksheet S-10 data that does not satisfy previously stated CMS benchmarks for its use. Further, CMS’s prior determination regarding data on utilization for low-income patients highlights that this data may continue to be appropriate in the determination of the hospital-specific Factor 3, especially when the other option is the use of inaccurately reported and unaudited data only. While CMS notes in the FY 2018 Proposed Rule that it believes the Worksheet S-10 data are appropriate data, contrary to its previous view that such data could not be used until it was at least correctly reported and audited, neither of which has occurred for the FY 2014 S-10 data, it is not bound to select one set of data here if additional relevant factors should be considered.

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Whether and to what extent a data source is appropriate for use in calculating Factor 3 must therefore be determined in the context of how that data is used. Given that the calculation of Factor 3 benchmarks one hospital against all eligible others, Factor 3 is used in much the same way that CMS constructs the wage survey for the IPPS wage index. Because the data is only intended to measure relative resource use in both instances, just as with the wage index survey, consistency and accuracy of reporting by hospitals and auditing by CMS is of critical importance before the data is used. In this regard for the wage index over multiple years, CMS has stated, for example, as follows:

Finally, only 50 percent of hospitals reported contract services. At least 11 percent of those not reporting contract services indicated they would have reported the expenditure if they had been able (as instructed) to determine accurately the actual hours worked. We believe the above inconsistencies in reporting on the 1988 survey would result in inequitable treatment of those hospitals that appropriately did not report contract CRNAs and part B physician direct patient care services, as well as those that were unable to accurately determine hours for other direct patient care contract services. Therefore, we proposed to exclude contract labor from the FY 1991 wage index and develop more detailed instructions and auditing criteria that may allow its inclusion in future wage index updates. [55 Fed. Reg. 35990, 36036 (Sept. 4, 1990)]

Since the origin of the IPPS, the wage index has been subject to its own annual review process, first by the MACs, and then by CMS. Hospitals are aware that both the MACs (via instructions issued by CMS) and CMS evaluate the accuracy and reasonableness of hospitals' wage index data. Each year, in every IPPS proposed rule, we discuss the process wherein CMS asks the MACs to 'revise or verify data elements that result in specific edit failures[.]'; *id.* at 49967 ("We believe that hospitals have had adequate notice and time to structure their contracts so that the wages and hours of contract employees can be determined and included in the cost reports. We expect hospitals to provide accurate data on their cost reports, and the accuracy of the wages and hours of contract labor will continue to be reviewed by the MACs as part of the annual desk review process. [79 Fed. Reg. 49854, 49964 (Aug. 22, 2014)]

As in past years, we performed an extensive review of the wage data, mostly through the use of edits designed to identify aberrant data. We asked our MACs to

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revise or verify data elements that result in specific edit failures. [79 Fed. Reg. 27978, 28064 (May 15, 2014)]

We believe that annual changes in the wage index reflect real variations in costs of providing care in various geographic locations. The wage index values are based on data submitted on the inpatient hospital cost reports. We utilize efficient means to ensure and review the accuracy of the hospital cost report data and resulting wage index. The hospice wage index is derived from the pre-floor, pre-reclassified wage index, which is calculated based on cost report data from hospitals paid under the Inpatient Prospective Payment System (IPPS). All IPPS hospitals must complete the wage index survey (Worksheet S-3, Parts II and III) as part of their Medicare cost reports. Cost reports will be rejected if Worksheet S-3 is not completed. In addition, our Medicare contractors perform desk reviews on all hospitals' Worksheet S-3 wage data, and we run edits on the wage data to further ensure the accuracy and validity of the wage data. We believe that our review processes result in an accurate reflection of the applicable wages for the areas given. [81 Fed. Reg. 52144, 52153 (Aug. 5, 2016)]

It is our intent to ensure that the wage index is calculated from the best available data, consistent with our wage index policies and development timeline....The annual Wage Index Development Timetable has been established through rulemaking, and plays an important role in maintaining the integrity and fairness of the wage index calculation. [81 Fed. Reg. 56762, 56920 (Aug. 22, 2016)]

Separately, in *Anna Jaques Hosp. v. Sebelius*, 583 F.3d 1, 3 (D.C. Cir. 2009) the D.C. Circuit considered the construction of the wage survey and concluded that:

The Secretary conducts this survey by compiling wage data from cost reports submitted annually by hospitals. The Secretary removes data from this survey that fail to meet certain criteria for reasonableness, including data that are 'incomplete[,] inaccurate ..., or otherwise aberrant.' From this scrubbed survey, the Secretary calculates each area's proposed wage index. Before putting the wage index in final form, she solicits comments from the public." [citations omitted][Id. at 5] She scrubbed from the survey data she determined would not reasonably help calculate a meaningful wage index. Applying her criteria for reasonableness, data that were 'incomplete[,] inaccurate ..., or otherwise aberrant' were not used to calculate the wage index. [Id.]

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Because few if any of these similar precautions has taken place with regard to the Worksheet S-10 data, it likely does not on its own satisfy the appropriate data standard of the statute. But to the extent CMS feels that such data will only be accurately reported if hospitals have payment risk associated with such reporting, after the data is at least cleaned of aberrant reported elements (that have been pointed out to CMS by multiple commenters), it could be used in FY 2019, but certainly should receive very little weight, on the order of no more than 10 percent, so that hospitals are not penalized by the misreporting of data by other hospitals and so that hospitals whose aberrant data is excluded are not severely penalized without warning. Such action would allow payment based on such Worksheet S-10 data, and could increasingly be based on such data over time as processes are put in place, much like to wage index survey, to verify consistent reporting of all data elements and to clean such data so that aberrant data is not used. If a hospital knows that aberrant data will be excluded from Worksheet S-10 as a result of such processes, that hospital will have incentive in the following year to avoid such data exclusion to its payment detriment.

C. The Secretary Has Authority to Phase-In or Transition to the Exclusive Use of Worksheet S-10 Data

In CMS's FY 2017 Final Rule, CMS noted its intent to incorporate Worksheet S-10 data into the computation of Factor 3 once additional measures, including quality control and data improvement measures, as well as implementation of an audit process, were in place, and no later than FY 2021. 81 Fed. Reg. at 56963, 56965. CMS specifically discussed the 4-year lag before prospective changes to Worksheet S-10 would result in data that would be used to calculate Factor 3, because there is typically a 3 to 4-year lag between the ratesetting year and the cost report data that CMS is using to develop rates. CMS recognized that it "would need time to draft and implement cost report revisions, hospitals would need time to file cost reports reflecting those new cost report revisions, and the MACs would need time to review those cost reports." 81 Fed. Reg. at 56963. Thus, CMS "anticipate[d] that the revised Worksheet S-10 data, as first reflected for cost reporting periods starting during FY 2017, would be available for use in determining uncompensated care costs no later than in FY 2021." *Id.* In the FY 2018 Proposed Rule, CMS indicates that they "expect that cost reports beginning in FY 2017 will be the first cost reports for which Worksheet S-10 data will be subject to a desk review." 82 Fed. Reg. at 19955.

Despite the above, CMS has now proposed to immediately elect to use unaudited, FY 2014 Worksheet S-10 data to calculate FY 2018 uncompensated care payments. Further, given

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the three-year cost report calculation methodology, FY 2019 uncompensated care payments will be based, in part, on two years of unaudited Worksheet S-10 data and one year of low-income patient days, and FY 2020 uncompensated care payments will be based, in part, on three years of unaudited Worksheet S-10 data.

CMS clearly has authority to phase-in the use of audited Worksheet S-10 data to mitigate the potential fiscal impact of prematurely basing funding on unaudited data,. There is no statutory language that prevents the use of a phase-in as a bridge to increasingly “appropriate data.” The “based on” phrase in § 1395ww(r)(2)(C), as noted above, even contemplates CMS using several data sources in their calculation of uncompensated care cost.

In the absence of an express statutory directive to the contrary, CMS has consistently maintained discretion to adopt transitional periods. Congress provided CMS with a “broad grant of authority” to adjust and revise payment amounts under the IPPS. *Adirondack Med. Ctr. v. Sebelius*, 740 F.3d 692, 697 (D.C. Cir. 2014). Section 1395ww(d)(5)(I)(i) provides “The Secretary shall provide by regulation for such other exceptions and adjustments to such payment amounts under this subsection as the Secretary deems appropriate.” This provision is intended to address, through transitional processes, the unique circumstances of inequitable results that stem from the use of highly questionable data sources, such as is the case here.

CMS has previously used the exceptions and adjustments provision in a broad range of applications. For example, between FY 2014 and FY 2017 CMS used such authority twice to adjust total IPPS payments because of changes in its two-midnight policy. A federal district court found this expansive use of the Section 1395ww(d)(5)(I)(i) to provide an across-the-board adjustment in the IPPS to be a reasonable interpretation of the statutory authorization. *Shands Jacksonville Medical Center v. Burwell*, 139 F. Supp. 3d 240, 260 (D.D.C. 2015).

Notably, CMS has also invoked the authority in section 1395ww(d)(5)(I)(i) multiple times over the history of the IPPS in order to provide for a transition when a proposed CMS policy would have provided for fluctuations in payment. As CMS has stated numerous times, and most recently in the current FY 2018 Proposed Rule (82 Fed. Reg. at 19815) it “is often our practice to phase in rate adjustments over more than one year in order to moderate the effect on rates in any one year.” *See also* 81 Fed. Reg. 24946, 24956 (Apr. 27, 2016); 78 Fed. Reg. 27486, 27494 (May 10, 2013).

For example, in the FY 2009 IPPS rule, CMS implemented a 3-year phase in for the transition from national budget neutrality adjustment to state level budget neutrality adjustment

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for rural wage floors. 73 FR 48434, 48574 (Aug. 19, 2008). CMS implemented the transition in “response to the public's concerns and taking into account the potentially drastic payment cuts that may occur to hospitals in some States.” *Id.* Similarly, in the FY 2015 IPPS Final Rule, CMS adopted a transition period for hospitals that would face a decrease in payment rates resulting from changes in OMB labor market delineations. Hospitals located in counties that moved from urban to rural were able to use their prior wage index for an additional three years and all hospitals that experienced a decrease in their wage index value were able to adopt a 1-year blended wage index. CMS adopted this transitional period to “alleviate” the burden of the changes in payment on providers. 79 Fed. Reg. 49854, 50372 (Aug. 22, 2014); *see also* 69 Fed. Reg. 66922, 66965 (Nov. 15, 2004) (retaining 3-year transition period in the final IPF PPS noting “[w]e proposed this transition period so existing IPFs would have time to adjust their cost structures and integrate the effects of changing to the IPF PPS payment system.”); 70 Fed. Reg. 45026, 45041 (Aug. 4, 2005) (“based in part upon the comments, [] agree[ing] that a transition period for SNFs would be appropriate and beneficial” to minimize fiscal impact of transition to OMB designations); 69 Fed. Reg. 48916, 49206 (August 11, 2004) (“Transitions are a frequently incorporated feature of new Medicare payment policies. Examples are the 4-year phase-in of the IPPS, the 5-year phase-in of the LTCH PPS, and the 3-year phase-in of the IRF PPS”).

One of the only situations in which CMS declines to use a transition period (when the statute is silent regarding transition) is when Congress expressly directs CMS to implement a particular provision by a specific date. *See* 78 Fed. Reg. 50496, 50622 (Aug. 19, 2013) (declining to delay or phase-in the transition from Medicare DSH payments calculated prior to the enactment of section 3133 and Medicare DSH payments calculated under the new payment methodology mandated by section 3133 to mitigate decreases in payments to eligible hospitals because they did not believe that the statute provides authority for any transitional methodology given that the statute designates an effective date of October 1, 2013 for implementing the new payment methodology and provides that provision will be effective “for each fiscal year 2014 and each subsequent fiscal year and, therefore, does not provide [CMS] with the flexibility to delay implementation”). No such implementation deadline exists here.

For all of the foregoing reasons we believe that CMS has ample authority to use the same data sources it has used since FY 2014 for the 2018 Factor 3 calculation, cannot use Worksheet S-10 data until CMS ensures that such data satisfies benchmarks through processes for data integrity, or minimizes the impact of aberrant Worksheet S-10 by ascribing a very low weight to

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it, after excising major aberrations in the data, and phases in the use of Worksheet S-10 data over a longer period than proposed to allow CMS time to Desk Audit reported data using a consistent set of cost reports prepared under current of modified instructions once hospital realize that aberrant data will not be included for payment purposes in the Factor 3 calculation.



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Challenges with the Use of S-10 Data in the Calculation of Medicare DSH Uncompensated Care Payments June 2, 2017

Background

The Centers for Medicare & Medicaid Services (CMS) has proposed using uncompensated care (UC) data from the Medicare cost report's S-10 worksheet to calculate each DSH-eligible hospital's relative share of overall UC among all DSH-eligible hospitals (Factor 3) for the distribution of Medicare DSH UC payments in FY 2018. For years, CMS maintained that S-10 data is not sufficiently accurate to be used this way and wrote the following in the FY 2017 final IPPS rule:

We believe additional time may be needed to make certain modifications and clarifications to the cost report instructions for Worksheet S-10, as well as explore suggestions made by the commenters for ensuring universal submission of Worksheet S-10 by hospitals when filing their cost reports (such as software edits to flag negative, unusual, or missing data or a missing worksheet S-10). As commenters recommended, we will consider issuance of FAQs and hosting of educational seminars for hospitals and MACs as appropriate, coinciding with the issuance of revised cost report instructions. We also intend to explore development of more specific instructions and more uniform review protocols for Worksheet S-10 data.

Despite this, and despite the absence of the additional edits, educational outreach, or significant refinements to the collection instrument that CMS characterized as potentially desirable in last year's final rule, CMS now believes that the S-10 data has reached a "tipping point" and is suitable for use in calculating Medicare DSH UC payments.

CMS based its conclusion on a correlation analysis of charity care reported by not-for-profit hospitals on the S-10 and IRS Form 990 (an analysis that excludes for-profit and government hospitals). While this analysis demonstrates that consistency in charity care reporting across two different collection instruments has increased, it does not examine several of the remaining issues of concern that had caused commenters and CMS to deem the S-10 unsuitable for use as the basis of Medicare DSH UC payment distribution. Specifically, CMS's analysis does not attempt to:

- identify instances of implausible data reporting;
- identify any trends in anomalies, inconsistencies, and instances of implausible reporting; and
- consider the underlying causes of inaccurate reporting.

Why This Matters

Congress has established a finite pool of funds for Medicare DSH UC payments. This pool creates a zero-sum game in which how much UC individual hospitals report affects how much Medicare DSH UC money every other hospital receives. Inaccuracy in S-10 reporting has a direct impact on every hospital eligible for these payments.

Project Objective

The Federation of American Hospitals, California Hospital Association, Healthcare Association of New York State, and Greater New York Hospital Association engaged DeBrunner & Associates to perform additional analysis of the S-10 data reported by all U.S. hospitals and to examine the areas of concern surrounding the S-10 not considered in CMS's analysis. Additionally, we were asked to estimate the impact CMS's proposal could have on payments to hospitals with Medicare Advantage contracts based on their Medicare fee-for-service reimbursement.

Key Findings

Based on a review and analysis of publicly available 2014 and 2015 Medicare cost report data extracted from the March 2017 HCRIS update, DeBrunner & Associates has reached several key findings:

- Clear inconsistencies remained in the data in the 2014 and 2015 reporting periods, indicating that confusion regarding what could or should be reported on the S-10 has not yet been resolved.
- It is not clear that the charity care and bad debt costs reported on the S-10 can accurately be described as "uncompensated care" in all cases.
- To a significant degree, FY 2014 S-10 data reported by hospitals is questionable in far too many cases for it to be a credible tool for use in determining Medicare reimbursement.
- Because S-10 data has never been audited and is collected in a manner that leaves no outside sources against which it can be benchmarked, validation of this data is extremely difficult.
- Using UC data reported by hospitals on their S-10 for computing Medicare DSH UC payments would be highly redistributive, with many hospitals experiencing significant swings in their payments. In this zero-sum redistribution, winners would gain \$2.3 billion and losers would lose \$2.3 billion. The ten percent of hospitals that would see the greatest gains from a shift to basing Medicare DSH UC payments entirely on the S-10 would find their share of the overall Medicare DSH pool rise from 18.8 percent to 44.5 percent of the pool – an increase of \$1.8 billion. This means that 10% of hospitals would experience 77% of the total gains among all hospitals. Others would suffer significant losses, with no assurance that the underlying data is accurate enough to support such changes for either the winners or the losers.
- Although gains and losses net to zero within the fee-for-service program, many hospitals' contracts with Medicare Advantage plans are based on their fee-for-service Medicare reimbursement. We estimate that this multiplier effect would not only increase the magnitude of the redistribution, but also result in an overall lowering in payments to hospitals as payment reductions under Medicare Advantage contracts related to this change would likely be greater than payment increases.

What the Data Shows

The lack of an outside data source against which S-10 data can be compared limited much of this analysis to identifying instances of obvious data reporting implausibility. We found several of these in our analysis of overall reporting trends and suspect that a critical examination of individual hospital data would reveal many more.

Our analysis shows significant variations in data between FY 2014 and FY 2015 – variations that appear improbable over the course of just one year. Among them:

- 210 hospitals reported providing at least 50 percent less UC in FY 2015 than in FY 2014.
- From FY 2014 to FY 2015, 150 hospitals reported providing at least 50 percent more UC. Seventy reported that their UC more than doubled.
- Titus Regional Medical Center, in Texas, reported \$534 million in UC in FY 2014 but only \$9.8 million in FY 2015.
- The University of Virginia Medical Center reported \$17.5 million in UC in FY 2014 and \$141 million in 2015.
- Martin Medical Center, in Florida, reported \$6.9 million in UC in FY 2014 and \$44.1 million in FY 2015.
- Swedish Covenant Hospital reported \$8.7 million in UC in FY 2014 and \$31.4 million in FY 2015 even though Illinois, where it is located, expanded its Medicaid program.

In addition, our analysis shows levels of charity care and bad debt (the value that CMS has defined as uncompensated care) that are clearly higher than what hospitals can sustain without additional compensation.

- Eight hospitals reported providing more than \$500,000 in UC per bed in FY 2014.
- One hospital reported charity care and bad debt costs that were greater than eight times its total operating expenses for the year in 2014.
- The average percentage of total operating expenses represented by charity care and bad debt ranges from four to five percent depending on how it is calculated, yet 18 hospitals reported ratios greater than 25 percent and three reported ratios greater than 50 percent in 2014.
- In 2015, nine hospitals reported ratios of charity care and bad debt costs to total operating expenses greater than 25 percent.

At least part of this issue appears to be systemic: of the 18 hospitals reporting that their charity care and bad debt costs exceeded 25 percent of their operating expenses in 2014, 10 are located in just two states (Texas and Louisiana) and two-thirds are public hospitals. Because these hospitals share similar characteristics and continue to operate despite the especially high proportions of cost attributable to UC, this suggests that the S-10 itself is not adequately directing hospitals to report a significant source of compensation that offsets the charity care and bad debt costs these hospitals incur.

Although these are stark examples, it is very likely that this issue affects the reported UC elsewhere. We are unable at this time to identify how widespread this systemic issue might be without performing detailed reviews of individual hospital data – the kind of detailed review that might be undertaken through auditing.

Such questionable data reporting and the apparent limitations of the collection instrument – and there are many more examples – could lead to an inappropriate distribution of Medicare DSH UC funds if the S-10 methodology were to be introduced.

Causes of Inconsistent Data Reporting

The primary cause of the questionable data reporting may be the instructions for completing the S-10, but the structure of the form itself also leads to inconsistencies across hospitals. Hospitals find the instructions unclear and imprecise, making them subject to interpretation on a hospital-by-hospital basis. DeBrunner has spoken to numerous hospital financial executives who are responsible for completing the S-10 and found that they interpret the form, and how to report data on it, in many different ways.

Areas of Confusion and Individual Interpretation

- Hospitals have difficulty identifying where they are supposed to report non-patient-specific payments they receive to offset their charity care and bad debt costs. These payments generally come from the federal government, state and local programs, or private funds. Some hospitals interpret the form and its proposed use to mean that they should subtract the value of these payments from their charity care and bad debt on Worksheet S-10. It appears that at least some hospitals, however, receive such funds, mostly from government sources, to offset the cost of the charity care they provide but do not report that money on their S-10 as offsets to their charity care costs.
- The instructions for the S-10 define categories for reporting charges that overlap (such as charity care for Medicaid cost-sharing) – that is, they are not mutually exclusive. Hospitals must decide for themselves how (if at all) to avoid reporting charges in multiple categories.
- The UC costs identified on Line 30 of the S-10 are driven largely by charity care, the definition of which is unique to each hospital and alterable at the hospital's discretion.

Limitations of the Form Itself

- Applying a whole hospital cost-to-charge ratio to the combined inpatient and outpatient charges collected on the S-10 does not account for the broad disparities between hospitals' cost-to-charge ratios in these settings.
- All-inclusive rate hospitals do not use charges to track patients' relative resource consumption, so their estimated charity care costs may be less accurate than other hospitals' estimates. CMS's proposed methodology for addressing this problem brings the cost-to-charge ratios for these hospitals into line statistically with other hospitals' without ensuring that their charges are also in line with other hospitals'. Thus, the methodology does not necessarily result in more accurate UC cost estimates for these hospitals.
- The instructions for the S-10 do not define the reported data elements in a format that allows them to be compared to any other reported data. This makes S-10 data extremely difficult to report, audit, and validate.

These are not our observations alone. A 2016 report prepared by the consulting firm Health Management Associates and submitted by the state of Texas to CMS as part of a report on the Texas uncompensated care and delivery system reform incentive payment programs explained why it dismissed the possibility of using the S-10 as a tool for identifying how much UC the state's hospitals provide. Among the reasons cited were that "HHSC [Texas's Health and Human Services Commission] data is carefully reviewed by the Department and is subject to an intensive audit as required under Medicaid DSH regulations. In contrast, the S-10 has typically received little or no attention in the Medicare cost report audits" and "...the S-10 data is more prone to inconsistent and inaccurate reporting because of misunderstandings."

Conclusion

The year-to-year inconsistencies in data reporting identified in our analysis indicate that significant confusion still remained within the hospital industry in 2014 and 2015 regarding what could or should be reported as charity care and bad debt costs on the S-10. In addition, the extremely high levels of charity care and bad debt costs reported by some hospitals – even when given a chance to revise their reporting – calls into question whether the data collected on line 30 of the S-10 can accurately be described as uncompensated care.

We believe CMS's proposal in the FY 2017 final IPPS rule to create software edits to flag negative, unusual, or missing data, to revise cost report instructions, to issue FAQs and host educational seminars explaining those revisions, and develop uniform review protocols of the data is essential to improving the quality of the data reported – but only if the cost report revisions are thoughtfully developed and are designed to address the systemic issues that lead the current version of the S-10 to disregard significant sources of compensation when identifying uncompensated care.

In the absence of these or similar efforts to improve the information collected, serious potential remains for significant redistribution of Medicare DSH UC payments that may not be supported by accurate underlying data.

If CMS were to implement its proposal for 2018, the S-10 would be the only unaudited data reported by hospitals to be used to distribute Medicare payments – payments that represent a significant amount of Medicare reimbursement. The Medicare DSH UC pool represents nearly \$7 billion in fee-for-service payments, and likely another nearly \$3 billion in related payments through hospital contracts with Medicare Advantage plans.

Between these continuing challenges and the questionable UC data many hospitals reported in FY 2014, we believe S-10 data should not be used as the basis for calculating hospitals' FY 2018 Medicare DSH UC payments.



**CALIFORNIA
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*Providing Leadership in
Health Policy and Advocacy*

**The Worksheet S-10:
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California Hospital Association

February 2017

Executive Summary

The Centers for Medicare & Medicaid Services (CMS) has committed to using the Medicare cost report's Worksheet S-10 and its reporting of hospital uncompensated care as the basis for calculating Medicare DSH uncompensated care payments (Factor 3) not later than FY 2021. Because the pool of money from which such payments are made is finite, the manner in which every DSH-eligible hospital reports its uncompensated care on Worksheet S-10 matters to every other hospital eligible for these payments, and in recent years serious questions have been raised about the accuracy and reliability of that uncompensated care data report.

In a zero-sum game such as this, it is imperative that there be consistency in reporting through clarity in the reporting instructions. It also is imperative that the methods for identifying uncompensated care account for the differences in how hospitals establish and bill their charges.

Ambiguity on the S-10 Worksheet

The current format and instructions for Worksheet S-10 do not provide sufficient clarity to ensure consistency in reporting. Without this needed clarity, hospitals are forced to interpret these instructions based on their perceived understanding of what they are to report. These interpretations affect the amount of apparent uncompensated care that an individual hospital provides and therefore the amount of payment it receives as well as the amount of payment every other hospital receives.

This ambiguity leads to unfairness because hospital payments will not be based simply on the amount of uncompensated care they provide but also on their interpretations of how to report that care.

The instructions for Worksheet S-10 are at odds with the structure of the form itself. The structure of the form sums uncompensated care and government payer shortfalls, which mathematically implies that the values are to be mutually exclusive. An individual patient stay, however, may result in both government payer shortfalls and uncompensated care. For instance, a patient may be covered by a government insurance program (Medicare, Medicaid or CHIP) but also have unpaid deductibles and coinsurance which count as bad debt and go into the cost of uncompensated care. The Worksheet S-10's instructions do not dictate a methodology to separate government payer shortfalls from uncompensated care for these patients and do not even acknowledge the issue. CMS has responded to individual inquiries by confirming that the values are meant to be mutually exclusive but has not, to our knowledge, proposed a methodology for accomplishing this or amended the instructions to even bring the issue to hospitals' attention. Hospitals must use their discretion to address this issue and the exercise of this discretion has resulted in variability in reported uncompensated care based solely on the allocation methodology each individual hospital adopts – if it adopts a methodology at all. A hospital simply following the instructions

without scrutinizing the form might not even recognize that the categories are meant to be mutually exclusive.

Additional scrutiny of the form suggests that the values used to identify the hospital's uncompensated care are meant to be arrived at in a manner comparable to that of the values identified as government payer shortfalls. This is evidenced first because the value is called "uncompensated care," indicating that it is meant to represent care that was provided but for which the hospital did not receive compensation, and second because that uncompensated care is summed with government payer shortfalls to generate the bottom-line result for the entire worksheet. A hospital simply following the instructions might not recognize that the form adds together a figure that represents a hospital's losses (costs minus compensation) associated with government payers to a figure that represents only hospital costs associated with charity care and bad debt without regard to compensation. Just as summing uncompensated care and government payer shortfalls mathematically implies that they are meant to be mutually exclusive, it also implies that they are supposed to both represent the same thing (costs minus compensation). Unlike the issue of mutual exclusivity, however, CMS has generally responded to inquiries about how to report compensation associated with charity care and bad debt by stating that it should not be considered when calculating uncompensated care.

By simply following the instructions, a hospital will double count shortfalls that CMS intends to keep separate because the hospital will not have addressed the mutual-exclusivity issue. By simply following the mathematical implications of the form, a hospital will under-report its uncompensated care because it will subtract its compensation from its costs. By individually inquiring of CMS what it is meant to report, a hospital will learn that it must develop its own methodology to separate uncompensated care from government payer shortfalls and should not regard compensation when calculating uncompensated care.

There is further ambiguity regarding the reporting of charity care charges for patients who meet the hospital's charity care policy but also receive a discount for being uninsured. CMS recently revised this language in the instructions but it remains unclear whether charges discounted under the uninsured discount should be reported for patients who meet the charity care policy or whether they should be disregarded prior to identifying the charges that count as charity care. It may even be that whether these charges should be reported varies depending on the hospital's specific policies or local standards for reporting charity care that have been determined by the courts.

Limitations of the Whole Hospital Cost-to-Charge Ratio in Cost Finding

In addition to ambiguity in what should be reported, Worksheet S-10 in its current form has technical limitations associated with the method used on the form to identify hospital costs. Worksheet S-10 identifies uncompensated care costs by applying a whole hospital cost-to-charge ratio to hospitals' charity care and bad debt charges. Some hospitals, called all-inclusive rate hospitals, do not vary their charges according to the services provided to individual patients. Instead, these all-inclusive rate hospitals charge a uniform rate per day, so charges at these hospitals do not represent the relative resource consumption (costs) of providing care to their patients. Other hospitals charge different amounts depending on whether a service is provided in an inpatient or outpatient setting. The cost-to-charge ratio used on Worksheet S-10 is calculated as if all services at the hospital were billed at the inpatient charge rate, but the charges collected to identify charity care and bad debt include charges billed at the outpatient rate, so the ratio used to find costs is explicitly different from the ratio of costs and charges for services delivered in an outpatient setting at these hospitals. Finally, even if hospitals use a uniform charge for a service regardless of where the service is provided, some services are more frequently provided in some parts of the hospital than others and hospitals may have different cost-to-charge ratios in these different departments. Worksheet S-10 is the only portion of the Medicare cost report that obscures this variation

by using a whole-hospital cost-to-charge ratio instead of different cost-to-charge ratios specific to the types of services provided to the patient.

Why This Matters

Ensuring the accuracy of Worksheet S-10 reporting is so important for two reasons.

First, when policy-makers changed the manner in which Medicare calculates part of Medicare DSH payments (Medicare DSH uncompensated care payments), they specifically set aside a significant pool of money with the intention of directing that money to the hospitals that provide the most uncompensated care. If Worksheet S-10 is the tool to be used to determine how much uncompensated care hospitals provide and how that finite pool of money is to be divided, it needs to produce accurate, reliable results – and it needs to be filled out in a uniform manner by every hospital in the country.

And second, because the pool of Medicare DSH uncompensated care payment money is finite and its distribution is therefore a zero-sum game, every hospital eligible to receive funding from that pool is affected by the data reporting of every other hospital eligible for that funding. Any misinterpretation of Worksheet S-10's instructions in a manner that overstates an individual hospital's uncompensated care, no matter how unintentional, affects every other hospital eligible for Medicare DSH uncompensated care payments: it increases some hospitals' payments – inaccurately and unfairly – at the expense of others.

Questions regarding this paper should be directed to Alyssa Keefe, Vice President Federal Regulatory Affairs at akeefe@calhospital.org or 202-488-4688

**The Worksheet S-10:
Issues and Challenges as a Tool for Calculating
Hospital Uncompensated Care**

California Hospital Association

February 2017

Background

Effective in FY 2014, Section 3133 of the Affordable Care Act (ACA) required hospitals eligible for Medicare disproportionate share hospital payments (Medicare DSH) to be paid 25 percent of the Medicare DSH payments they would have received under previous law. The ACA refers to these payments as “empirically justified Medicare DSH payments.” The remaining 75 percent of payments was reduced as the percentage of uninsured individuals declined from the base year of 2013, with those funds then to be redistributed based on the uncompensated care provided by each hospital eligible for Medicare DSH. CMS refers to these payments as “uncompensated care payments” as the statute refers to this additional payment as being based on each hospital’s share of national uncompensated care costs or another proxy for estimating the costs hospitals incur providing care to the uninsured. Through rulemaking, CMS has established a formula for distributing these uncompensated care payments. For FY 2014 through FY 2017 CMS is using Medicaid and SSI days for the distribution of these funds.

In its FY 2017 rulemaking, CMS presented its timeline and transition plan for introducing Worksheet S-10 data into the calculation of each hospital’s relative share of overall uncompensated care among all DSH hospitals (Factor 3) for the redistribution of uncompensated care funds. CMS first began discussing the use of Worksheet S-10 to allocate hospitals’ share of uncompensated care costs in its FY 2014 hospital inpatient prospective payment system final rule. At that time, it stated that it did not believe these data were reliable enough to use for determining FY 2014 hospital uncompensated care and concluded that hospital utilization by insured low-income patients would be a better proxy for hospitals’ costs for treating the uninsured. It also stated that it believed that by FY 2018, many of these concerns would no longer be relevant. It noted that hospitals were on notice that as of FY 2014, Worksheet S-10 data could be used as the data source to calculate uncompensated care payments. In addition, CMS noted that it had undertaken extensive analysis of Worksheet S-10 data, the purpose of which was to determine the extent to which uncompensated care costs reported on Worksheet S-10 correlated with other sources and were stable over time.

CMS had proposed phasing in data reported on Line 30 (charity care and Non-Medicare bad debt expense) of Worksheet S-10 of the Medicare cost report to determine the uncompensated care payment factor (Factor 3) starting with FY 2014 cost reports for DSH payments in FY 2018. This Worksheet S-10 data would have been phased in as part of a three-year averaging process for Factor 3: an average of two years of proxy data (2012 and 2013) and one year of S-10 data (2014) for FY 2018 DSH payments; one year of proxy data (2013) and two years of S-10 data (2014, 2015) for FY 2019 DSH payments; and three years of S-10 data for FY 2020 DSH payments and thereafter.

Based on comments submitted by stakeholders in response to this proposal, CMS decided not adopt these proposals and noted that it would further evaluate and proceed with revisions of the Medicare cost report

to make it suitable for the task of calculating hospital uncompensated care. In the FY 2017 IPPS final rule, CMS indicated that it intends to use data from a revised Worksheet S-10 in calculating Medicare DSH uncompensated care payments no later than FY 2021 and will again consider proposing a transition to using data from Worksheet S-10 in future rulemaking. CMS also plans to use future rulemaking to continue exploring a different proxy that better reflects the uncompensated care provided by hospitals for hospital uncompensated care payments for FY 2018 and future years.

To account for hospitals that consistently report very high uncompensated care values on Worksheet S-10, CMS proposed a “double trim” methodology targeting hospitals’ cost-to-charge ratio. This proposed methodology can be found on pages 56,971-56,972 of the final rule.

Finally, CMS has updated the instructions for Line 20 of Worksheet S-10 (total initial obligation of patients approved for charity care) so charity care will be reported based on the write-off date rather than the date of service among other changes.

This still leaves important data collection issues unaddressed. If Worksheet S-10 is to be used, it is critical that these issues be addressed because the specific lines on which hospitals report both revenue and costs has a significant impact on their ultimate uncompensated care calculation and the instructions for that reporting are not clear to those reporting their hospital’s uncompensated care at this time. These ambiguities can alter the distribution of Medicare DSH uncompensated care payments for all hospitals eligible for these payments.

In the following pages we explore Worksheet S-10 itself; challenges in identifying the costs of serving patients; the challenge of separating patients into categories; the challenge of separating hospital payments into categories; and the distinct challenges Worksheet S-10 poses for auditors.

Worksheet S-10

CMS annually collects the data used to calculate hospital uncompensated care on Worksheet S-10 of the Medicare cost report. Prior to the Affordable Care Act, Worksheet S-10 was used only to calculate an adjustment to incentive payments to hospitals for implementing and making meaningful use of electronic health record technology. The form itself predates both the electronic health record and Medicare DSH payment formulas. On its face, the current Worksheet S-10 strives to achieve the following goals:

- identify the costs of serving patients
- separate patient costs into categories
- separate hospital payments into categories
- identify the extent to which costs exceed payments for each category and in total

As described below, completing Worksheet S-10 is complicated by variations throughout the country in how both public and private insurers reimburse hospitals for the care they provide. In addition, hospitals have found the form’s instructions to be unclear in some places and lacking in specificity in others. In the FY 2017 proposed inpatient prospective payment system rule, CMS proposed using lines 1, 20, 21, 22, 23, 26, 27, and 29; it does not use the Medicaid lines (2-8), the SCHIP lines (9-12), the other state and local government indigent care program lines (13-16), and certain uncompensated care lines (17-19) for factor 3. Each line is defined in Attachment A.

While it is relatively simple for hospitals to apportion costs based on patients’ relative resource use, it is considerably more difficult to sort those patients into discrete categories in a manner that is applied uniformly nation-wide by every hospital and more complex still to appropriately attribute

payments to those patients. This is complicated because hospitals find the intent of Worksheet S-10 to be ambiguous: does it seek to measure the difference between cost and payments for certain populations or to measure the amount of charity care and bad debt write-off? The following is a discussion of those challenges.

Identifying the Costs of Serving Patients

Patient resource use (cost) is measured based on the mix of items and services provided to them. All of the cost figures reported on Worksheet S-10 start as charges identified at the patient level that are then converted to costs. To reduce those total charges to an estimated cost figure, Worksheet S-10 uses a ratio of a hospital's overall costs to its overall charges: the cost-to-charge ratio.

By comparing overall costs at a facility to overall charges at the same facility, a hospital can identify a ratio of costs to charges that can be applied to a patient's individual charges to determine that individual's contribution to overall costs. For example,

- A hospital has \$90,000 in total costs and \$100,000 in total charges.
- The ratio of costs to charges is .9 ($90,000/100,000$)
- A patient at the hospital received a mix of items and services valued on that hospital's charge master (a list unique to each hospital of charges for items and services) at \$1000.
- By multiplying the ratio of costs to charges by the patient's charges, the cost of the patient's hospital stay was \$900 ($\$1000 * .9$).

Although the notion of using a ratio of a hospital's costs and charges to derive costs from charges is generally agreed upon throughout the hospital industry, the use of hospitals' overall cost-to-charge ratio on Worksheet S-10 raises a number of challenges.

Accounting for Variation in the Ratios Between Costs and Charges Across Cost Centers

The whole-hospital cost-to-charge ratio lacks sufficient specificity to accurately identify the costs of services provided to patients who qualify for charity care or with whom the hospital has a related bad debt expense.

Hospital charge masters vary tremendously in the amount of markup each hospital applies to a particular item or service. The wider an array of services a hospital provides, the more opportunities there will be for such variation. It is reasonable to expect that the patient population receiving charity care at a hospital will not consume the same mix of services as the overall patient population because many of those receiving charity care have no insurance and are likely to seek care less frequently and in different settings than the insured population. Because charity-care utilization patterns are unlikely to match whole-hospital utilization patterns, charity care costs calculated from a whole-hospital cost-to-charge ratio are likely either to over- or under-represent the actual costs incurred by the hospital for providing care. Whether the calculation over- or under-represents costs and by how much depends on the hospital's charge master and the extent to which utilizations patterns vary between the populations.

In addition, different hospital services have different ratios of costs to charges. Recognizing this, the Medicare cost report divides hospital costs and charges for these different services into separate "cost centers." Each of those cost centers is presumed to have a generally consistent relationship between costs and charges within the cost center.

Worksheet S-10, on the other hand, does not assign different cost-to-charge ratios to different services. Instead, it applies a single, whole-hospital cost-to-charge ratio to the charges attributed to each category on the worksheet, assuming that the patients in each category have a mix in the utilization of their various cost centers roughly comparable to that of the hospital population on the whole.

Under circumstances in which the charity care and bad debt patients of a given hospital use, in disproportionate numbers, some hospital services that have especially high cost-to-charge ratios, this results in the lower cost-to-charge ratio used on Worksheet S-10 understating that hospital's actual costs for serving this population. This also can work the other way: some hospitals may have charity care and bad debt patients who utilize more services in lower cost-to-charge ratio cost centers, and in such cases, Worksheet S-10 might overstate such hospitals' costs for serving their charity care and bad debt patients.

Issues in Identifying the Unreimbursed Costs of Charity Care and Bad Debt

Because Worksheet S-10 sums uncompensated charity care and bad debt costs with government payer shortfalls, this implies that these cost figures are meant to represent hospital losses, but the calculation described on Worksheet S-10 does not identify hospital losses. For bad debt, it identifies a portion of the costs attributable to bad debt, but not the portion of associated payments. For periods beginning on or after October 1, 2016, the charity care identified on Worksheet S-10 is the portion of the hospital's costs attributable to charity care write-offs less payments associated with care that was not included in the write-off. The meaning of the resulting figure is not immediately apparent. The explanation of the issue below is not a recommendation of what we believe Worksheet S-10 or its instructions should be but an explanation of the confusion caused by what it is not.

Worksheet S-10 includes the following definition of uncompensated care:

Uncompensated care – Consists of charity care, non-Medicare bad debt, and non-reimbursable Medicare bad debt. Uncompensated care does not include courtesy allowances, discounts given to patients, or bad debt reimbursed by Medicare.

Tellingly, this definition describes concepts (charity care, bad debt, courtesy allowances, and discounts) but does not describe a unit in which those concepts are measured (e.g., charges, costs, losses, or foregone revenues). The definitions of charity care and non-Medicare bad debt do include a unit:

Charity care – Health services for which a hospital demonstrates that the patient is unable to pay. Charity care results from a hospital's policy to provide all or a portion of services free of charge to patients who meet certain financial criteria. For Medicare purposes, charity care is not reimbursable and unpaid amounts associated with charity care are not considered as an allowable Medicare bad debt. A hospital cannot claim amounts of unpaid deductibles and co-insurance for which it has received reimbursement from Medicare (reimbursed Medicare bad debt) as charity care amounts. (Additional guidance provided in the instruction for line 20.)

Non-Medicare bad debt – Health services for which a hospital determines the non-Medicare patient has the financial capacity to pay, but the non-Medicare patient is unwilling to settle the claim. (Additional guidance provided in the instruction for line 28.)

These values are to be measured in "services." Hospitals track the services they provide by assigning a dollar value to each item or services provided to patients. These individual dollar values are compiled on the hospital's charge master. The total charges associated with a patient stay represent the amount of care provided to the patient. Charges for individual items and services vary considerably among hospitals so, for instance, one hospital might assign an MRI a value of \$3000 while another might assign it a value of

\$5000. These charge values on the charge master do not reflect the absolute cost of the item or service: instead, they are a means of tracking the relative value of an item or service when compared to hospital charges overall. These charges also do not represent a hospital's expected payment for providing the item or service because hospitals negotiate contracted discounts with insurers, accept prescribed payment amounts from public payers, and offer discounts and charity care to individuals without insurance. Again, charges represent the relative value of an item or service, or group of items and services, compared to the total items and services provided by the hospital.

Worksheet S-10's definitions of charity care and non-reimbursable bad debt are limited to only a portion of the services hospitals provide to individuals who qualify for charity care or with whom the hospital has a related bad debt expense. For charity care, the portion of services the patient cannot pay for (as identified by the hospital's charity care policy) is charity care while the remaining portion of the services is not. The portion of services attributable to any other discounts the patient might receive, separate from those offered under the hospital's charity care policy (by virtue of the individual being uninsured, for example), also are not charity care. For non-reimbursable bad debt, only the portion of the claim that the patient does not pay is bad debt. The portion the patient does pay is not bad debt.

Worksheet S-10 also provides the following definition of non-reimbursable Medicare bad debt (the third and final component of uncompensated care as defined on the form):

Non-reimbursable Medicare bad debt – The amount of allowable Medicare coinsurance and deductibles considered to be uncollectible but are not reimbursed by Medicare under the requirements of 42 CFR 413.89(h) and CMS Pub. 15-1, chapter 3. (Additional guidance provided in the instruction for line 28.)

This definition is similar to the definition for non-Medicare bad debt but is not expressed in terms of services. Instead, it is expressed as a portion of uncollected Medicare coinsurance and deductibles. Coinsurance and deductibles are, like services, also measured in charges.

The challenge of Worksheet S-10 is trying to convert these charge values into a single number that reflects "uncompensated care" and is reported and calculated in the exact same manner by all hospitals. For the purposes of this endeavor, the smallest meaningful unit of costs or payments at a hospital is the patient stay or visit. If a hospital waives a charge or a patient refuses to pay a portion of his bill, the hospital does not determine that the patient paid for the plaster used to make a cast for his broken arm but not for the ibuprofen he received for the pain. Instead, any discounts (or the unpaid portion of the bill) for the stay or visit are applied as a percentage of the total charges for the stay or visit and any payments received are attributed to the total stay or visit.

Others have considered how best to identify the unreimbursed costs of charity care. The standard developed by the Healthcare Financial Management Association (HFMA) for valuing charity care states that "Once a patient is determined to be eligible for a discount under the facility's charity care policy, the whole account is classified as charity care." As payments are received, revenue is recognized as receipts related to charity care.ⁱⁱ This guidance calls for hospitals to report:

- their total charity care costs (full charges reduced to costs)
- the volume of care they provide (days and discharges or another standard)
- receipts related to charity care (payments they have received associated with these accounts).

This produces a generally reasonable estimate of a hospital's unreimbursed costs for providing charity care (assuming the receipts accurately reflect payments received for providing this care, described further below).

While this is very similar, in theory, to the approach Worksheet S-10 takes to identify unreimbursed costs associated with Medicaid, CHIP, and individuals covered by a state or local indigent care program, it is not, in practice, the method Worksheet S-10 uses to collect information on charity care and bad debt.

Rather than starting with full charges for a patient account and applying a cost-to-charge ratio to estimate costs and then reducing those costs by revenue received, Worksheet S-10 asks hospitals to report only charges that were waived for uninsured individuals eligible for financial assistance under the hospital's charity care policy and only co-pay and deductible amounts for insured individuals eligible for financial assistance under the hospital's charity care policy. Unlike HFMA's standard, which identifies all costs and payments associated with charity care, CMS's methodology identifies only a portion of costs and a portion of payments. This causes problems in reporting charity care provided to insured and uninsured patients alike. While this explanation refers only to charity care, the points apply equally to bad debt.

In the many cases where the charges used to calculate uncompensated care do not represent 100 percent of the charges associated with the patient's stay or visit and the hospital receives some payment associated with the stay or visit, it is very difficult to ascertain the extent to which these charity care and bad debt charges represent uncompensated care in a manner that is comparable across hospitals. The following exercise illustrates this point.

To illustrate the complexities associated with deriving uncompensated care from charity care and bad debt charges, the table below presents information associated with five archetypical patients. Each patient presents a scenario resulting in a hospital writing off charges to charity care. While this is presented as charity care, it applies equally to charges written off as bad debt. Simply replace the charity care discount in each scenario with an equal amount that the patient was billed but did not pay – the result is exactly the same.

For illustrative purposes, the example shows that in each scenario the charges are \$1,000 and the hospital's costs are 50 percent of its charges.

Scenarios Resulting in Charity Care Write-Offs (Equally Applicable to Bad Debt)

	Patient A	Patient B	Patient C	Patient D	Patient E
Total Charges (Services Provided)	\$ 1,000	\$ 1,000	\$ 1,000	\$ 1,000	\$ 1,000
Insured (Y/N)?	N	N	N	Y	Y
Uninsured Discount (Y/N)?	N	N	Y	N	N
Uninsured Discount	N/A	N/A	45%	N/A	N/A
Charity Care Discount	100%	80%	55%	\$ 20	\$ 500
Payer Discount	N/A	N/A	N/A	45%	45%
Deductible Amount	N/A	N/A	N/A	N/A	\$ 500
Co-Pay Amount	N/A	N/A	N/A	\$ 20	N/A
Total Costs	\$ 500	\$ 500	\$ 500	\$ 500	\$ 500
Patient Pay Obligation	\$ -	\$ 200	\$ -	\$ -	\$0
Insurer Pay Obligation (discounted charges less co-pay or deductible)	\$ -	\$ -	\$ -	\$ 530	\$50
Total Payments	\$ -	\$ 200	\$ -	\$ 530	\$ 50
Costs Minus Payments (Loss/Gain)	\$ 500	\$ 300	\$ 500	\$ (30)	\$ 450
Hospital Charity Care Charges	\$ 1,000	\$ 800	\$ 550	\$ 20	\$ 500

- Patient A - Patient A is low-income, has no insurance, and qualifies for free care under the hospital's charity care policy. The hospital does not have a separate uninsured discount for patients who are also eligible for charity care.
- Patient B - Patient B is low-income, has no insurance, and qualifies for an 80 percent discount under the hospital's charity care policy. The hospital does not have a separate uninsured discount for patients who are also eligible for charity care.
- Patient C – Patient C is low-income, has no insurance, and qualifies for free care under the hospital's charity care policy. The hospital offers a 45 percent discount to all patients without insurance regardless of whether the patient meets the hospital's charity care policy.
- Patient D – Patient D is low-income, has insurance, and qualifies for a waiver of a \$20 co-pay under the hospital's charity care policy.
- Patient E – Patient E is low-income, has insurance, and qualifies for a waiver of a \$500 deductible under the hospital's charity care policy.

As you can see, charity care and bad debt result from many different circumstances. If we hold constant a hospital's charges and costs, we see that charity care and bad debt will vary as a function of the hospital's own discount policies, the extent to which its patients have insurance coverage, and the extent to which that coverage is sufficient to cover the costs of providing care to that patient. Keeping in mind that the smallest meaningful unit for matching costs and payments in a hospital is the stay or visit, you can see from these examples that there is not necessarily a relationship between charity care or bad debt charges

and the costs and payments associated with those charges. Perhaps the starkest example of this is Patient D, where the hospital made \$30 providing care and wrote off \$20 to charity care, but you can see that it varies with each example.

The following table shows costs and payments as a percent of charity care or bad debt charges for each patient archetype. It is clear that there is no consistency in the relationship between written-off charges and costs or between written-off charges and payments. Because there is no consistency in the relationship between written-off charges and costs, a single variable (such as a cost-to-charge ratio) cannot be applied to these charges to identify costs. Because there is no consistency in the relationship between written-off charges and payments, a single variable (such as a cost-to-charge ratio) cannot be applied to these charges to identify payments. Because there is no relationship between written-off charges and either of these amounts, a single variable (such as a cost-to-charge ratio) cannot be applied to written-off charges to identify the difference between costs and payments.

	Patient A	Patient B	Patient C	Patient D	Patient E
Costs	50%	63%	91%	2500%	100%
Payments	0%	25%	0%	2650%	10%

Because the goal of Worksheet S-10's reporting of charity care and bad debt charges is to identify uncompensated care, it is important to remember that these charges alone (or even the portion of costs that they represent) are insufficient to identify the compensation associated with the portion of services for which a hospital either does not charge or cannot collect. Although a hospital may not charge for a portion of the services provided or be able to collect the full amount billed for a particular patient stay or visit, it does not follow that the hospital received no compensation for that portion of the services. To identify the extent to which the services were compensated, costs *and* payments must be identified at the patient stay or visit level and both must be allocated along with the charity care and bad debt charges.

In addition to the implication that the charity care and bad debt figures on Worksheet S-10 are meant to be net of associated compensation because they are summed to identify a value called "uncompensated care," there is an additional indicator that hospitals are meant to report these figures net of compensation. Specifically, the uncompensated care figured is added to another figure called "unreimbursed care," which represents the hospital's losses (costs minus compensation) associated with providing care to individuals with certain forms of public insurance. If these numbers are to be summed, it is more than reasonable for a hospital to expect that they are intended to represent comparable values; that is, the values reported for charity care and bad debt should also represent hospital losses.

As you can see in the table below, the total losses associated with the care provided to the archetypical patients in this example was \$1,720 (\$2,500 in costs minus \$780 in payments). This remains true whether the written-off care is charity care or bad debt. If we assume that the goal of Worksheet S-10 is not to identify the total loss associated with the care but only the portion associated with charity care or bad debt write-offs, we could note that written off charges were 57.4 percent of the total charges (\$2870/\$5000) and allocate 57.4 percent of the hospital's losses to write-offs, giving us an uncompensated cost of write-offs of \$987.28 (\$1435 in costs attributable to write-offs minus \$447.72 in payments attributable to write-offs).

	Patient A	Patient B	Patient C	Patient D	Patient E	TOTAL
Total Charges	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$5,000
Written-Off Charges	\$1,000	\$800	\$550	\$20	\$500	\$2,870
Total Costs	\$500	\$500	\$500	\$500	\$500	\$2,500
Total Payments	\$ -	\$200	\$ -	\$530	\$50	\$780
Costs Minus Payments (Loss/Gain)	\$500	\$300	\$500	(\$30)	\$450	\$1,720

Instead of identifying either of these loss values, however, Worksheet S-10 calculates something different. To calculate a hospital's bad debt costs, Worksheet S-10 looks at the write-off amount and applies the hospital's cost-to-charge ratio. If we assume that the values in the archetype example are bad debt instead of charity care, this would be the totals in the line called "charity care charges" (\$2870) multiplied by the hospital's cost-to-charge ratio of .5. The result is \$1435 in bad debt costs, which is then characterized as uncompensated care. Note that this is the same as the written-off portion of costs (57.4 percent of total costs) identified in the loss calculation above without regard to the written-off portion of payments.

		Patient A	Patient B	Patient C	Patient D	Patient E	Total
A	Total Charges (Services Provided)	\$ 1,000	\$ 1,000	\$ 1,000	\$ 1,000	\$ 1,000	\$ 5,000
B	Bad Debt Charges	\$ 1,000	\$ 800	\$ 550	\$ 20	\$ 500	\$ 2,870
B/A	Bad Debt Charges As Percent of Total Charges	100.0%	80.0%	55.0%	2.0%	50.0%	57.4%
C	Total Costs	\$ 500	\$ 500	\$ 500	\$ 500	\$ 500	\$ 2,500
D	Total Payments	\$ -	\$ 200	\$ -	\$ 530	\$ 50	\$ 780
C-D	Total Costs Minus Total Payments (Loss/Gain)	\$ 500	\$ 300	\$ 500	\$ (30)	\$ 450	\$ 1,720

C*B/A	Bad Debt Costs	\$ 500	\$ 400	\$ 275	\$ 10	\$ 250	\$ 1,435
D*B/A	Bad Debt Payments	\$ -	\$ 160.0	\$ -	\$ 10.6	\$ 25.0	\$ 447.7
(C*B/A) - (D*B/A)	Uncompensated Cost of Bad Debt	\$ 500.0	\$ 240.0	\$ 275.0	\$ (0.6)	\$ 225.0	\$ 987.3
B*C/A	S-10 Uncompensated Cost of Bad Debt	\$ 500	\$ 400	\$ 275	\$ 10	\$ 250	\$ 1,435

For cost reporting periods beginning prior to October 1, 2016, Worksheet S-10 instructed hospitals to report information that resulted in a similar calculation to identify the uncompensated cost of charity care. One difference is that this calculation identified total charges for charity care patients minus actual patient payments for uninsured individuals, which achieves the same result if the patient pays for a portion of the bill but a different result if the patient does not pay. For cost reporting periods beginning after October 1, 2016, however, Worksheet S-10 employs a different method to identify uncompensated charity care. Now, hospitals are to report only the written-off charges (i.e., the same amount used in the bad debt example above) but are to subtract patient payments from those charges before reducing the result by a cost-to-charge ratio. The result is that Worksheet S-10's calculation of uncompensated charity care costs no longer matches the portion of costs attributable to charity care. It is unclear what the result of this calculation represents.

		Patient A	Patient B	Patient C	Patient D	Patient E	Total
A	Total Charges (Services Provided)	\$ 1,000	\$ 1,000	\$ 1,000	\$ 1,000	\$ 1,000	\$ 5,000
B	Charity Care Charges	\$ 1,000	\$ 800	\$ 550	\$ 20	\$ 500	\$ 2,870
C	Total Costs	\$ 500	\$ 500	\$ 500	\$ 500	\$ 500	\$ 2,500
D	Patient Payments	\$ -	\$ 200	\$ -	\$ -	\$ -	\$ 200
C*B/A	Charity Care Costs	\$ 500	\$ 400	\$ 275	\$ 10	\$ 250	\$ 1,435
(B-D)*C/A	S-10 Uncompensated Cost of Charity Care	\$ 500	\$ 300	\$ 275	\$ 10	\$ 250	\$ 1,335

Issues in Identifying Outpatient Costs

Some hospitals bill their patients different charges based on whether care is delivered in an inpatient or an outpatient setting. This is called tiered pricing. The cost-to-charge ratio used on Worksheet S-10 is calculated according to the inpatient level of charges and therefore lowers these hospitals' apparent costs for services delivered in an outpatient setting.

Hospital cost reports are generally used to calculate inpatient hospital payment rates, so the charges used to calculate the cost-to-charge ratios on the Medicare cost report are reported as if every service were provided in an inpatient setting. Worksheet C of the cost report (from which the S-10 derives its cost-to-charge ratio) instructs hospitals that the charges reported there must comply with specific guidance in CMS's provider reimbursement manual, which states "Charges should be...uniformly applied to all patients whether inpatient or outpatient." So hospitals that use tiered pricing must report their outpatient charges on worksheet C as if they were billed at the inpatient rate. Worksheet S-10, however, requires both inpatient and outpatient charges to be reported together according to the amounts written off, which for hospitals that utilize tiered pricing, are based on the lower charges billed in the outpatient setting. This practice dampens such hospitals' cost figures on Worksheet S-10 because although the outpatient services are provided at a discounted charge, the cost-to-charge ratio is calculated as if they were not.

For example, a hospital that charges \$2,000 for an MRI in an inpatient setting but \$1,000 for an MRI in an outpatient setting will incur the same cost for the MRI in each setting. Assume, in this situation, that this cost is \$500. If we use an inpatient-standardized cost to charge ratio (as Worksheet S-10 does) we will see that the hospital's costs are .25 times the hospital's charges. If that hospital waives its \$1,000 charge for a charity care patient in an outpatient setting, applying the cost-to-charge ratio to the hospital's outpatient charges will only identify \$250 in costs.

Though the hospital incurred the same costs in both settings, the lower outpatient charges have made the hospital's costs appear lower because the ratio of costs to charges was calculated on a different basis than the actual charge to the patient.

Calculating Costs for All-inclusive Rate Hospitals

All-inclusive rate hospitals do not use charges to track patients' relative resource consumption. Instead, they charge a flat fee for all patient stays. For these hospitals, charges do not represent the amount of services provided to patients and are therefore not suited for use as the basis for identifying the portion of services attributable to charity care and bad debt.

As noted in comments from a number of stakeholders during the rulemaking process, there is a type of hospital for which the cost-to-charge ratio calculation simply does not work: so-called all-inclusive rate hospitals. While the number of such hospitals is small, the impact of using a standard cost-to-charge ratio for each is large. These hospitals have simplified charge masters that are not effective at allocating costs for the calculation of charity care. In some cases, the ratio of costs to charges identified by the standard method leads to a situation in which applying it increases the hospital's apparent charity care costs far beyond its charges. Addressing this problem requires developing a completely different methodology to generate cost figures analogous to those reported by non-all-inclusive rate hospitals. In addition, some of these hospitals report a cost-to-charge ratio on Worksheet S-10 that is different from the one described in the instructions for the S-10.

CMS's current proposal for addressing these anomalous charge figures does not attempt to identify these hospitals uncompensated care costs. Instead, it attempts to produce an uncompensated care value for the hospital that is generally in line with the uncompensated care provided at a typical hospital. The so-called "double-trim methodology" would replace these hospital's reported cost-to-charge ratios with an average cost-to-charge ratio. CMS would then apply this generic cost-to-charge ratio to the hospital's charges. The result is a cost-to-charge ratio that is not representative of the hospital's billing practices being applied to a charge value that does not reflect the hospital's costs. This adjustment would only be applied if the hospital's reported data were statistically anomalous. For all-inclusive rate hospitals where the application of a cost-to-charge ratio to the hospital's flat fees results in a value that is within the range of expected values, there would be no adjustment.

Separating Patients into Categories

The instructions for Worksheet S-10 do not state that hospital charges reported as charity care and charges reported associated with government payers should be mutually exclusive. Because the cost values derived from those charges are added together, however, implies that they are meant to be mutually exclusive. CMS has confirmed that these charges are meant to be mutually exclusive in response to individual hospital inquiries but has not updated Worksheet S-10's instructions to clarify this point or provided a uniform methodology for separating charity care and bad debt charges from government payer charges. The result is a lack of uniformity in reported data as hospitals must decide whether and how to separate these charges.

Worksheet S-10 seeks to separate patient costs into the following discrete categories:

- Medicaid costs
- Children's Health Insurance Program (CHIP) costs
- state or local indigent care program costs
- charity care costs
- bad debt costs

CMS uses this separation to distinguish between "unreimbursed care" (line 19) and "uncompensated care" (line 30). Confusingly, Worksheet S-10 lists the "unreimbursed care" total under the heading "uncompensated care," further reinforcing the perception that these values are meant to be comparable, i.e., to represent costs minus payments.

- Unreimbursed care is care that is covered by Medicaid, CHIP, or other state or local government programs but that costs more to deliver than the hospital receives as payment.
- Uncompensated care is care that is delivered to individuals who either fall under the hospital's charity care policy (charity care) or who are determined to be financially able but unwilling to pay hospital bills for which the hospital expected payment (bad debt).

Worksheet S-10 creates confusion because it instructs hospitals to sum the values from categories that are not mutually exclusive. Three of the categories – difference between revenue and cost for Medicaid, difference between revenue and cost for CHIP, and difference between revenue and cost for state or local government programs – are based on whether the patients described in the category are covered by a particular health care program. The sum of these three categories (line 19) are included on line 31 as unreimbursed care along with the other two categories that comprise uncompensated care – cost of charity care (line 23) and cost of bad debt (line 28). The cost of charity care (line 23) and the cost of bad debt (line 28) are based on whether the patients described in the category fall under certain accounting policies at the hospital and are included under the heading of "uncompensated care." Thus, line 31 includes

“unreimbursed care” (Medicaid, CHIP, and state or local government indigent care) and uncompensated care (bad debt and charity care).

But these categories are not always mutually exclusive: individuals who fall under a hospital’s charity care policy or with whom the hospital has associated bad debts (the categories comprising uncompensated care) may also be covered by Medicaid, CHIP, or a state or local indigent care program (the categories comprising unreimbursed care) and vice versa. Thus, following the current instructions on Worksheet S-10 will sort some patients into multiple categories.

Line 31 – total unreimbursed and uncompensated care cost – adds these two subtotals together. .

Complying with the instructions thus leads to “double-counting” of costs for which the hospital received no payment and an illogical total on the bottom line, but at the same time, adjusting the unreimbursed and uncompensated figures to fix the number on the bottom line results in inaccurately reflecting one or both of those measures. Because the formula on the form double-counts patients but cost-reporting practices and CMS’s response to inquiries dictate that the categories should be mutually exclusive, any method a hospital might use will lead to at least one value being “wrong.” Hospitals attempt to reconcile this issue in different ways and this, in turn, affects the amount of uncompensated care that appears on their Worksheet S-10. Without a hospital-by-hospital examination it is impossible to determine the extent to which there is variation in how different hospitals address this issue.

CMS’s responses to individual inquiries regarding the reporting of uncompensated care and unreimbursed cost suggest it may not be aware that there is an overlap in these categories.

If a PATIENT is covered under a State/Local indigent care program (therefore not classified as Charity Care for financial purposes) they should be reported on line 14 and the revenue associated should be reported on line 13.ⁱⁱⁱ

Coverage by an indigent care program does not necessarily preclude an individual from falling under the hospital’s charity care policy.

The amounts [on lines 19 and 20] are separate and should not be duplicated nor reported in both lines 19 and 20. Line 31 is a summary of Unreimbursed Care (basically where the costs for the different state programs exceeds the payments received under these programs) and Uncompensated Care [sic] (which consists of the provider’s charity care as determined by their policy and non-Medicare [sic]and non-reimbursable bad debt). The amounts on line 19 are not included in the Uncompensated Care Amounts on line 30.^{iv}

If hospitals follow the instructions for filling out the individual lines on the cost report, this is not true. Aside from the general fact that individuals may be eligible for charity care and also covered by Medicaid, CHIP, or a state or local indigent care program, the instructions specifically tell hospitals to report certain Medicaid costs in line 20 if they are covered under the hospital’s charity care policy.

With hospitals competing for uncompensated care reimbursement from a finite pool of resources based on how much uncompensated care they provide relative to the uncompensated care provided by all DSH-eligible hospitals, the manner in which one hospital completes Worksheet S-10 has an impact on all other hospitals. That impact can be large: in a zero-sum game, it can result in some hospitals being significantly overpaid and some significantly underpaid from the uncompensated care pool. Recognizing this also can have the effect of encouraging some hospitals to “game” the form, in entirely defensible ways, in search of large payments.

Separating Hospital Payments into Categories

Because Worksheet S-10 sums charity care and bad debt with government payer shortfalls, there is a mathematical implication that the charity care and bad debt values should also represent shortfalls. Some hospitals have chosen to subtract the value of government grants that support the provision of charity care from their charity care and bad debt charges when reporting on Worksheet S-10. Although the mathematical implication is just as logical as the implication that uncompensated care and government payer shortfalls should be mutually exclusive, CMS has responded to individual hospital inquiries stating that non-patient-specific payments to hospitals to compensate them for the provision of charity care should not be factored into the calculation of the hospitals uncompensated care.

As difficult as it is to separate patients (and their associated costs) into the categories identified on Worksheet S-10, it is even more difficult to separate payments, which is another important aspect of calculating hospitals' uncompensated care. As described above in the section addressing identifying costs, hospitals are able to ensure that payments that are directly related to an individual patient's care follow that patient's costs into whatever category or categories the hospital has deemed appropriate for that patient.

There are, however, other, non-patient-specific payments a hospital receives that also must be appropriately accounted for on Worksheet S-10. These latter payments pose a challenge in identifying uncompensated care.

Most state Medicaid programs make some sort of supplemental payments to hospitals that are not directly tied to individual patient care – generally, Medicaid DSH or non-DSH supplemental payments. These payments serve a variety of purposes that vary from state to state, such as:

- supporting the standby costs of high-cost services such as trauma centers and obstetrics units
- offsetting low Medicaid reimbursement rates
- ensuring access to hospital services in otherwise underserved areas
- investing in delivery system reform
- reimbursing hospitals for the costs they incur associated with uncompensated care

Outside of Medicaid, states and local governments also make grant payments to some hospitals to provide care to the uninsured and underinsured or to otherwise support hospital operations. Hospitals also may receive funding for these purposes from endowments or other private sources.

Worksheet S-10 does not allocate any of this non-patient-specific funding to offset uncompensated care costs reported on the form. There are two lines on the form on which hospitals report these sorts of payments that are not used at all in the uncompensated care calculation: lines 17 (private grants, donations, or endowment income restricted to funding charity care) and 18 (government grants, appropriations or transfers for support of hospital operations). In these cases, payments are reported but do not offset any costs. Simply reducing the uncompensated care costs identified on the S-10 by the payments reported in these lines would not fully address the issue, because while these lines do collect information on payments that support the provision of uncompensated care, those payments are comingled with other payment amounts that may not be so specifically targeted.

Although the form does not instruct hospitals to offset uncompensated care costs with these payments, some hospitals do exactly that. For example, some hospitals receive grant funding from a local government to provide care to the uninsured. In a case like this, Worksheet S-10's instructions are unclear: while they state that payments from payers should not be reported on line 22, does that exclusion

apply to a grant from a local government? Some hospitals report the grant money on line 22 while others choose not to record their waived charges on line 20 because the grant funding was intended to offset those costs. Still others report the payment on line 18, where it will have no impact on the calculation of their apparent charity care.

Different hospitals respond to the question of state uncompensated care pool payments in different ways. Some report payments specifically dedicated to supporting the delivery of uncompensated care, such as those made in Texas, New Jersey, Louisiana, and New Mexico, as Medicaid payments; others, however, report such payments in lines that are not used in the calculation of the bottom line, such as lines 17 and 18. Both of these methods could be considered appropriate depending on how each hospital interprets Worksheet S-10's instructions and intent.

The lack of a bright-line distinction identifying an entire patient account as either charity care or not contributes to this problem because hospitals must attempt to identify for themselves an appropriate charge to report on line 20 and an appropriate charge to report on line 22 while attempting to avoid double-counting.

Many payments are subject to this lack of clarity, including grant payments from prison systems, payments made under section 1115 waivers that are distributed based on hospitals' charity care volume, and state-sponsored, health-care-related financial assistance for non-Medicaid-eligible low-income individuals. The costs of delivering care for these patients are clearly uncompensated care, but hospitals are unsure whether to offset these costs with these payments or to record the payments elsewhere on the form. Some hospitals in Ohio, for example, specifically asked CMS how to report payments associated with one such financial assistance program but did not receive definitive guidance.

While costs are identifiable at the patient level (assuming an appropriate use of the cost-to-charge ratio), payments are not always tied to a specific patient account. Non-patient-specific payments made to reimburse hospitals for the costs of providing uncompensated care identified in this section would not be counted against a hospital's uncompensated care using patient-level accounting. To account for these payments, Worksheet S-10 would need a methodology for identifying which supplemental payments are attributable to uncompensated care and which are not. This is a complicated task and, in reviewing CMS responses to hospital inquiries regarding where to report these payments, it seems that the current guidance is to report them in line 18 even when they are specifically designated for indigent care. This is one of the lines that is not used in any of the calculations on Worksheet S-10.

For example, in response to a question from a hospital regarding whether to report a payment from an indigent care trust fund as a charity care payment, CMS responded that "Charity Care is patient specific so if the patient met the providers Charity Care policy and has been written off as Charity Care on their books they would be reported on line 20 accordingly. The lump sum payments are going to be reported on line 18." Because Worksheet S-10 does not collect full charges and payments for charity care and bad debt payments, attempting to identify a basis to allocate non-patient-specific payments to these populations would be difficult, if not impossible. Furthermore, without a clear definition and method for identifying which supplemental payments should be considered compensation for providing uncompensated care and which should not, as well as a means of separately reporting those payments, there is no means of identifying the appropriate payments to allocate.

Limitations on Assessing Accuracy

Together, these challenges suggest that it would be very difficult to audit hospitals' Worksheet S-10. Worksheet S-10 is the only source for the specific data it collects so it is difficult to determine whether that data is accurate. Auditors generally attempt to ensure that the figures reported in one place on the cost report fit together with figures reported elsewhere, but the figures on Worksheet S-10 do not necessarily have counterparts elsewhere on the cost report or with hospitals' accounting systems. The only items on Worksheet S-10 that could be audited in this traditional manner are the cost-to-charge ratio, Medicaid revenues, and possibly bad debt expense, though there are reasons that bad debt reported on Worksheet S-10 might not match the bad debt reported elsewhere on the cost report.

The charity care data collected on Worksheet S-10 will not tie to what was used to construct a hospital's balance sheet (Worksheet G) or what is reported on its financial statement because charity care in those areas is identified at full charges reduced to costs and further reduced as appropriate for any remaining patient payment obligation and payments received. This is generally the same methodology Worksheet S-10 uses to identify Medicare, CHIP, and state or local government programs.

As noted, Worksheet S-10 does not collect full charge information for charity care patients with a source of third-party coverage yet reduces the reported amounts for those patients by a cost-to-charge ratio, which means the numbers will not match. An auditor cannot compare the result of this calculation to the hospital's financial information because the result of the calculation is not related to the financial impact on the hospital of providing care. Additionally, if hospitals do not report charity care associated with a patient to avoid double-counting that patient, this will affect the charity care reported in line 23.

Because of the unique reporting required on Worksheet S-10, the only way for an auditor to verify the information would be to review patient-level data and assess the hospital's process for complying with the instructions. This is far more time-consuming and detailed work than most audits involve.

Auditors also would face the same challenges as hospitals in determining how to comply with Worksheet S-10's formula. The lack of clarity means that auditors, too, will have to answer for themselves the same questions hospitals must answer when completing the form. Just as reports vary among hospitals, the definition of compliance will inevitably vary among auditors as well.

Finally, Worksheet S-10 also collects no patient volume data such as days or discharges that could put the reported uncompensated care figures in even a general context.

Conclusion

CMS recognizes to some extent the complexity of completing Worksheet S-10 and the importance of refining its instructions and continues to do both. For example, Worksheet S-10 will now instruct hospitals to report charity care based on the year in which care was written off rather than the year in which it was delivered. Prior to this change, hospitals had to estimate how much charity care was provided in a particular period (it can take years to accurately identify who qualifies for charity care because of the documentation requirements) and these estimates were sometimes very inaccurate. This has now been addressed, but it will likely be four years until these changes appear in the available Worksheet S-10 data. Data available prior to that will not have this issue addressed.

This long period between revising Worksheet S-10 and the revised data being available highlights the need to expediently address the confusion in the hospital community regarding Worksheet S-10 so the

data reported on it is the best possible estimate of hospital uncompensated care prior to its adoption as the basis for distributing Medicare DSH payments.

Hospitals are confused by Worksheet S-10. Their attempts to reconcile the instructions for the worksheet with their obligation to accurately reflect their financial circumstances lead to frustration and inconsistencies in reporting. Specific questions to CMS have not led to additional clarity.

The charity care and bad debt calculations are where the majority of the confusion lies. Because of this, they are also most likely to be where the greatest variation in reporting lies. At the same time, CMS also has proposed using these very lines to calculate Factor 3 to distribute Medicare DSH payments. It still remains to be seen how auditors will interpret the worksheet and whether there may be financial liability associated with reporting the “wrong” information on the worksheet. Without greater clarity of CMS’s expectations, hospitals are put in an untenable position every time they fill out Worksheet S-10.

With hospitals competing for uncompensated care reimbursement from a finite pool of resources based on how much uncompensated care they provide relative to the uncompensated care provided by all DSH-eligible hospitals, the manner in which one hospital completes Worksheet S-10 has an impact on all other hospitals. That impact can be large: in a zero-sum game, it can result in some hospitals being significantly overpaid and some significantly underpaid from the uncompensated care pool.

We hope CMS will be able to provide this clarity in time for hospitals to begin reporting more standardized information that better represents their actual uncompensated care costs before Worksheet S-10 is used to distribute Medicare uncompensated care DSH payments.

i All-inclusive rate hospitals are an exception to this and issues related to identifying their uncompensated care are described more thoroughly later in this paper.

ii HFMA Principles and Practices Board Statement 15 6.3 (a) - This is guidance for valuing charity care for disclosure on financial statements. It draws on FASB Accounting Standards Update No. 2010-23, which standardized charity care disclosure at the cost level. Both of these documents were published after the creation of Worksheet S-10. The following is a sample footnote from that same guidance for disclosing charity care:

The net cost of charity care provided was approximately \$xx,xxx in 20x1 and \$xx,xxx in 20x2. The total cost estimate is based on (describe the cost estimation method). The net cost of charity care is determined by the total charity care cost less any payments for patient service revenue due to sliding-scale payments or other patient-specific sources, which were \$x,xxx in 20x1 and \$x,xxx in 20x2.

Lump-sum payments associated with this care, according to this guidance, are to be disclosed in a separate footnote that would appear in the hospital’s financial statement.

iii CMS response to question submitted by HFS.

iv *Ibid.*

Attachment A

The following are the categories and lines on Worksheet S-10:

Uncompensated Care and Indigent Care Cost Computation

Line 1 - cost to charge ratio

Medicaid

Line 2 - net revenue from Medicaid

Line 3 - Did you receive DSH or supplemental payments from Medicaid?

Line 4 - If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid?

Line 5 - If line 4 is no, enter DSH or supplemental payments from Medicaid

Line 6 - Medicaid charges

Line 7 - Medicaid cost

Line 8 - Difference between net revenue and costs for Medicaid program

State Children's Health Insurance Program (SCHIP)

Line 9 - net revenue from stand-alone SCHIP

Line 10 - Stand-alone SCHIP charges

Line 11 - Stand-alone SCHIP cost

Line 12 - Difference between net revenue and costs for stand-alone SCHIP

Other state or local government indigent care program

Line 13 - Net revenue from state or local indigent care program

Line 14 - Charges for patients covered under state or local indigent care program

Line 15 - State or local indigent care program cost

Line 16 - Difference between net revenue and costs for state or local indigent care program

Uncompensated care

Line 17 - Private grants, donations, or endowment income restricted to funding charity care

Line 18 - Government grants, appropriations or transfers for support of hospital operations

Line 19 - Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care program

Line 20 - Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility

Line 21 - Cost of initial obligation of patients approved for charity care

Line 22 - Partial payment by patients approved for charity care

Line 23 - Cost of charity care

Line 24 - Does the amount in line 20, column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?

Line 25 - If line 24 is yes, enter charges for patient days beyond an indigent care program's length of stay limit

Line 26 - Total bad debt expense for the entire facility

Line 27 - Medicare bad debts for section 1886 hospitals

Line 28 - Non-Medicare and non-reimbursable bad debt expense

Line 29 - Cost of non-Medicare bad debt expense

Line 30 - Cost of non-Medicare uncompensated care

Line 31 - Total unreimbursed and uncompensated care cost

Select Financial and Operating Characteristics of Physician Owned Hospitals and Non-Physician Owned Hospitals

Dobson | DaVanzo

Dobson | DaVanzo

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March 30, 2016

Fact Sheet

Dobson | DaVanzo recently examined select operating and financial characteristics of hospitals in categories defined by hospital ownership¹. This fact sheet provides descriptive statistics for physician owned hospitals (POH) and non-physician owned hospitals, as shown in Exhibit 1 and Figures 1 through 7. Exhibit 1 provides these statistics in tabular form, while Figures 1 through 7 present the data graphically.

In this fact sheet, POH are defined as hospitals on the Physician Hospitals of America member hospital list as of March 30, 2016. Non-POH are defined as acute care hospitals that fall under the inpatient hospital prospective payment system (IPPS) defined under Section 1886(d) of the Social Security Act. We identified 68 POH and

3,116 non-POH to be included in the table using the FY 2016 Hospital IPPS Final Rule and Correction Notice Impact Public Use File and FY 2014 Medicare Cost Reports.

The data were drawn from the FY 2014 Medicare Cost Reports, FY 2016 Hospital IPPS Final Rule and Correction Notice Impact Public Use File, and 2014 CMS 100% Standard Analytic File Limited Data Set (LDS) for inpatient and outpatient services. Specific data sources for each variable are provided in the Appendix.

The statistics included in Exhibit 1 and Figures 1 through 7 represent select hospital financial and operating characteristics. They illustrate the differences between POH and non-POH on multiple dimensions.

Exhibit 1: Summary Statistics for Physician Owned Hospitals (POH) and All Other Medicare IPPS Hospitals (Non-POH)² from the 2014 Medicare Cost Reports, 2014 CMS 100% Standard Analytic File Limited Data Set, and 2016 Hospital IPPS Final Rule and Correction Notice Public Use File

	POH	Non-POH
Number of Hospitals	68	3,116
Hospital Operating Characteristics		
Medicaid Discharges as a Percent of Total	2.2%	12.4%
Percentage of Hospitals in Hospital Group with Medicare Maximum Readmission Penalty of 3%	10.3%	0.9%
Percentage of Medicare Inpatient Claims with Emergency Department Services	21.1%	72.4%
Percentage of Medicare Inpatient Claims for Patients with Dual Eligibility	12.2%	27.6%
Mean Number of CC/MCCs ³ per Medicare Claim	1.3	2.4
Hospital Financial Characteristics		
Total All-Payer Margin (Average)	21.0%	8.0%
Uncompensated Care Costs as Percent of Total Hospital Expense	1.6%	3.9%

¹ This study was commissioned by the Federation of American Hospitals and the American Hospital Association.

² Physician owned hospitals were identified using the Physician Hospital of America member hospital list as of March 30, 2016. We note that four hospitals on this list were not included in the analysis because Medicare provider numbers could not be found. Non-physician owned hospitals were identified using the FY 2016 Hospital IPPS Final Rule and Correction Notice Impact Public Use File and FY 2014 Medicare Cost Reports.

³ CC is defined as complicating or comorbid condition. MCC is defined as a major complicating or comorbid condition.

Charts

Figure 1. Medicaid Discharges as Percent of Total Discharges for Physician Owned and Non-Physician Owned Medicare IPPS Hospitals

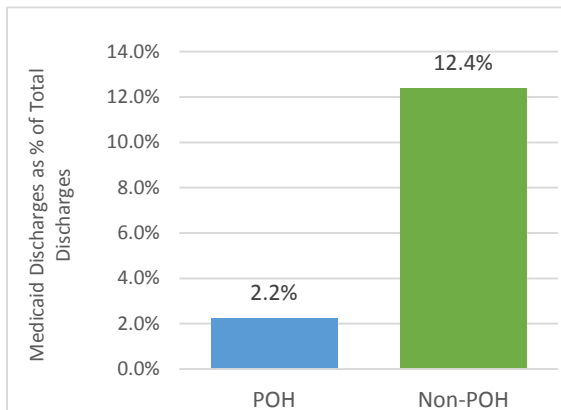


Figure 2. Percentage of Hospitals with Medicare Maximum Readmission Penalty of 3% for Physician Owned and Non-Physician Owned Medicare IPPS Hospitals

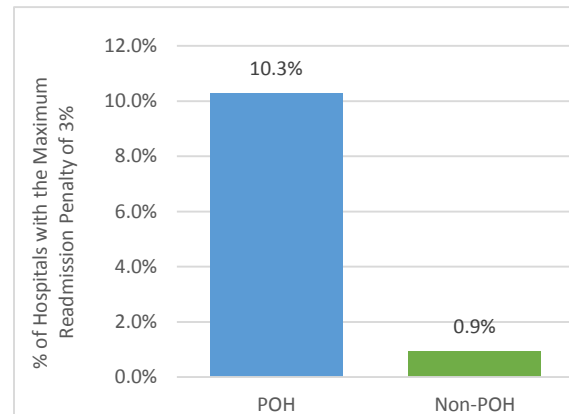


Figure 3. Percentage of Medicare Inpatient Claims with Emergency Department Services for Physician Owned and Non-Physician Owned Medicare IPPS Hospitals

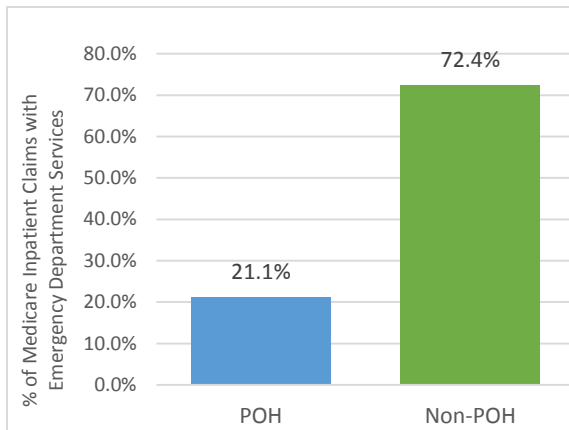
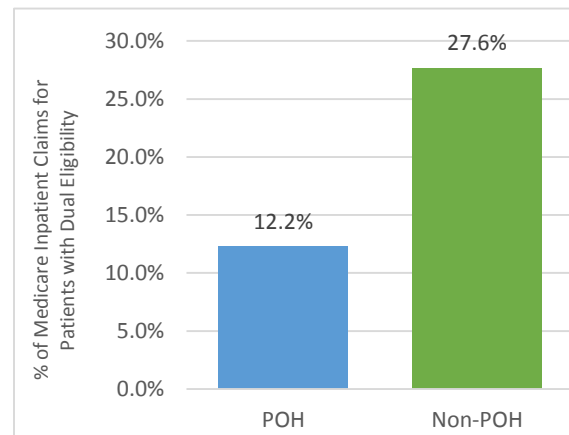


Figure 4. Percentage of Medicare Inpatient Claims for Patients with Dual Eligibility for Physician Owned and Non-Physician Owned Medicare IPPS Hospitals



Note: Data were drawn from the FY 2014 Medicare Cost Reports, 2014 CMS 100% Standard Analytic File Limited Data Set for inpatient and outpatient services, and FY 2016 Hospital IPPS Final Rule and Correction Notice Impact Public Use File. Physician owned hospitals were identified using the Physician Hospitals of America member hospital list as of March 30, 2016. Non-physician owned hospitals were identified using the FY2016 IPPS Final Rule and Correction Notice Impact Public Use File and FY2014 Medicare Cost Reports.

Charts

Figure 5. Mean Number of CC/MCCs per Medicare Claim for Physician Owned and Non-Physician Owned Medicare IPPS Hospitals

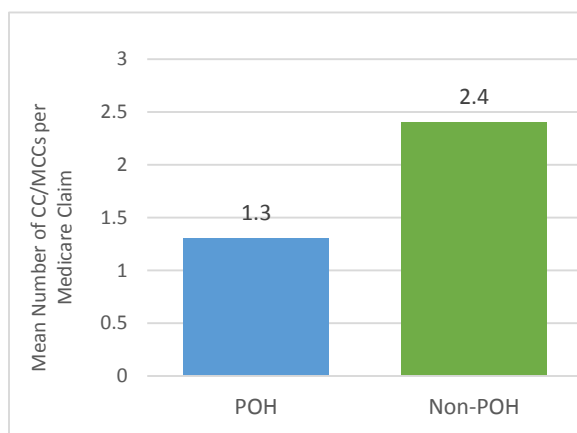


Figure 6. Average All-Payer Margin for Physician Owned and Non-Physician Owned Medicare IPPS Hospitals

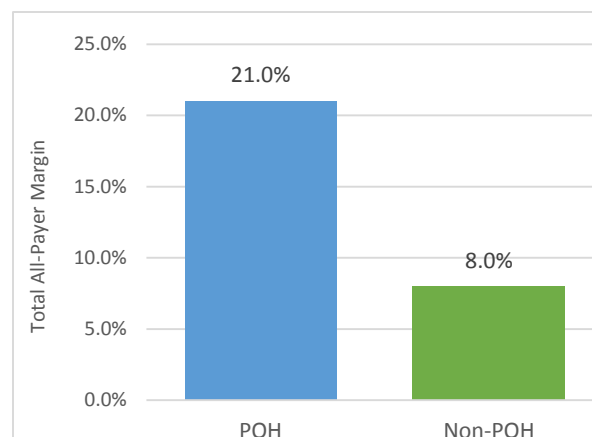
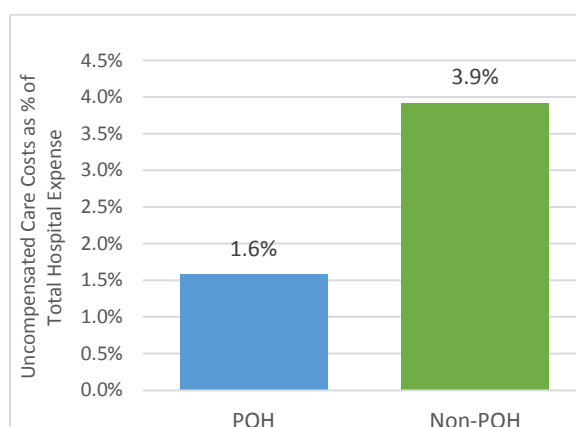


Figure 7. Uncompensated Care Costs⁴ as Percent of Total Hospital Expense for Physician Owned and Non-Physician Owned Medicare IPPS Hospitals



Note: Data were drawn from the FY 2014 Medicare Cost Reports, 2014 CMS 100% Standard Analytic File Limited Data Set for inpatient and outpatient services, and FY 2016 Hospital IPPS Final Rule and Correction Notice Impact Public Use File. Physician owned hospitals were identified using the Physician Hospitals of America member hospital list as of March 30, 2016. Non-physician owned hospitals were identified using the FY2016 IPPS Final Rule and Correction Notice Impact Public Use File and FY2014 Medicare Cost Reports.

⁴ Uncompensated care costs are defined as Line 30 from the S-10, which includes the cost of charity care plus the cost of non-Medicare and non-reimbursable Medicare bad debt expense.

Appendix

Appendix: Data Sources Used to Calculate Summary Statistics

Source: FY 2014 Medicare Cost Reports			
Data Point	Worksheet	Line	Column
Medicaid Discharges as a Percent of Total	S-3, part I	14	14
Total discharges	S-3, part I	14	15
Net patient revenue	G-3	3	1
Other revenue	G-3	25	1
Total revenue	Sum of Net patient and Other revenue		
Operating expense	G-3	4	1
Other expense	G-3	28	1
Total expense	Sum of Operating and Other expense		
Uncompensated care	S-10	30	1

Source: 2014 CMS 100% Standard Analytic File Limited Data Set		
Data Point	File	Variable(s)
Percentage of Medicare Inpatient Claims with Emergency Department Services	FY2014 Inpatient Claims File, FY2014 Inpatient Revenue File. ER claims were defined as having charges in revenue centers (0450-0459 or 0981).	REV_CNTR, REV_CNTR_TOT_CHRG_AMT
Mean Number of CC/MCCs per Medicare Claim	FY2014 Inpatient Claims File, FY2014 CC File, FY2014 MCC File	ICD_DGNS_CD1 - ICD_DGNS_CD25

Source: 2016 Hospital IPPS Final Rule and Correction Notice Impact Public Use File	
Data Point	Variable(s)
Medicare readmission penalty	Readmission Adjustment Factor



Charles N. Kahn III
President & CEO

May 17, 2017

The Honorable Dr. Tom Price
Secretary
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

Dear Secretary Price:

The Federation of American Hospitals (FAH) appreciates your commitment to undertake regulatory reform and reduce the regulatory burden on health care providers, as directed by the February 24, 2017 Executive Order. The FAH is the national representative of more than 1,000 investor-owned or managed community hospitals and health systems throughout the United States. Our diverse membership includes teaching and non-teaching, short-stay, rehabilitation, long-term acute care, psychiatric, and cancer hospitals in urban and rural America, and they provide a wide range of acute, post-acute, and ambulatory services.

Our members are committed to ensuring patients receive high-quality care and believe a comprehensive review and repeal or revision of regulations that are outdated, ineffective, or otherwise overly burdensome will further our shared goals of improving health outcomes and efficiencies in care delivery. The attached document recommends actions the Department of Health and Human Services (HHS) could take to implement regulatory reform across a variety of areas, such as alternative payment models, Medicaid, hospital and post-acute payment policies, and quality measurement and reporting. For example, HHS should ensure that the Center for Medicare & Medicaid Innovation (CMMI) acts only within its designated authority to voluntarily *test* alternative payment models, not make permanent or mandatory changes to the Medicare program. HHS also should indefinitely suspend the troubled Hospital Star Ratings system while the Agency collaborates with stakeholders on appropriate risk adjustment. Additionally, HHS should provide hospitals with flexibility to relocate their provider-based departments to meet community needs and still retain hospital outpatient payments.

Thank you again for your attention to these critically important policies. We look forward to working with you as you continue these efforts and would be happy to meet with you and your staff to discuss any of the recommendations.

Sincerely,

A handwritten signature in black ink, appearing to read "Andrew Bremberg". The signature is fluid and cursive, with a large initial "A" and a stylized "B".

cc:

Seema Verma

Jared Kushner

Andrew Bremberg

Gary Cohn

Mick Mulvaney

REGULATORY REFORM

Alternative Payment Models / MACRA Implementation

- **Halt Mandatory CMMI Models** – *The FAH does not believe that section 1115A authorizes the Centers for Medicare & Medicaid Services (CMS) to mandate provider participation in Center for Medicare & Medicaid Innovation (CMMI) models such as the Episode Payment Model (EPM) or the Comprehensive Care for Joint Replacement (CJR) models. As such, CMS should make them voluntary.* CMMI authority is designed to test models and make recommendations to Congress for permanent or mandatory changes to the Medicare program. Specifically, CMMI’s general authority is to test innovative payment and services delivery models to reduce program expenditures while preserving or enhancing quality of care. The law further directs CMS to evaluate CMMI models and, if appropriate, allows CMS to expand “the scope and duration” of an existing model to a “Phase II,” provided certain requirements are met. CMS is required to report periodically to Congress on CMMI models and make proposals for legislative action on models it deems appropriate. Notably, nowhere does the law expressly state that CMS can make models mandatory.
- **Ensure Meaningful MIPS Measurement and Maximize Advanced APM Participation** – *CMS should set a path for the Quality Payment Program (QPP) for 2018 and beyond that ensures meaningful measurement in the Merit-Based Incentive Payment System (MIPS) reporting and that maximizes participation in Advanced Alternative Payment Models (APMs).* As CMS transitions to the QPP, so far the Agency has chosen a large set of potentially reportable measures from which clinicians can choose. Instead, FAH encourages CMS to rapidly move to a streamlined set of standardized high-priority measures that would align incentives and actions across the health care system. The move to streamlined measures should include allowing hospital-based clinicians to utilize hospital quality measures for measurement under MIPS, as envisioned in the *Medicare Access and CHIP Reauthorization Act (MACRA)*.

In last year’s final QPP rule, CMS projected that the vast majority of physicians would not reach Advanced APM Qualifying Participant (QP) status and thus would not be eligible for the five percent bonus. CMS should allow more APMs to be designated as Advanced APMs, particularly the Bundled Payments for Care Improvement (BPCI) and Medicare Shared Savings Program (MSSP) Track 1. Additionally, as the CJR model is currently underway, CMS should implement the finalized changes to the model on July 1, 2017 in order for CJR to qualify as an Advanced APM. Post-acute care (PAC) providers should also be included in the development of APMs, such as through a “shared accountability” payment methodology that features price flexibility for inpatient rehabilitation facilities (IRFs). Adopting additional options – other than payment amount and patient count – for use in determining the Advanced APM Threshold Score will also increase Advanced APM participation by not disadvantaging multispecialty practices. Finally, CMS should revise the financial risk definitions: to provide Advanced APM status to APMs transitioning from one-sided to two-sided risk; and begin at lower levels of financial risk that gradually increase over time.

- **Recalibrate Bundling Programs – CMS – with robust stakeholder input – should reexamine the bundling programs, such as the BPCI to ensure they are successful in achieving program goals.** Existing health care bundling programs have been rolled out in a manner that is “too much too soon” without the opportunity to evaluate ongoing programs to determine best practices and implement mid-course program adjustments. There is a need to reexamine and recalibrate numerous program requirements to ensure they are operationally feasible and actually improve value-based, coordinated care, such as providing timely data to providers; length of episodes; stop-loss and stop-gain limits; areas used to establish regional prices; downside risk; target price discount factors; payment flexibility for PAC providers to better achieve efficiencies; appropriate waivers under fraud and abuse laws for gainsharing purposes; gainsharing caps; development of preferred provider networks; and duplicative beneficiary notice requirements.
- **Implement Prospective Beneficiary Assignment to Medicare ACOs – CMS should prospectively assign beneficiaries to an Accountable Care Organization (ACO) in Track 1 and Track 2 of the MSSP.** CMS performs a preliminary prospective assignment that provides ACOs with information about the fee-for-service population that is likely to be assigned to it for the performance year. However, the final list of beneficiaries assigned to the ACO is determined based on a retrospective reconciliation completed after the end of the performance year, which drives the calculations of average per capita expenditures for the performance year.

The current retrospective methodology creates significant uncertainty for ACOs, as they are unable to clearly identify the patient population they are responsible for until after the performance year has ended. ACOs are undertaking significant investments to redesign care delivery to better serve patients, and they must have clear information regarding their assigned patient population in order to proactively and effectively serve the patients for whom they are responsible.

- **Increase Flexibility in Developing Preferred Provider Networks for APMs – CMS should waive statutory and regulatory requirements for alternative payment models (APMs), or adopt a more flexible interpretation of current law, that would permit hospitals to offer beneficiaries a “preferred provider list” to promote better care and patient experience. At a minimum, hospitals should be permitted to exclude from the list certain post-acute providers with objectively poor quality scores.** In recent years, the value of preferred provider networks has emerged as a critical factor in facilitating care coordination and optimization of care in APMs. Yet, hospital APM participants are required to provide Medicare beneficiaries with a full list of area home health and skilled nursing facilities in the discharge planning process. This is confusing for patients, has little value, and prevents hospitals from highlighting high quality providers that can best coordinate care under an APM arrangement.
- **Create Single Bundled Payment Program Stark and Medicare Anti-Kickback Waiver – CMS should replace its current piecemeal approach to bundled payment program fraud and abuse waivers and develop a single, overarching “Bundled Payment Waiver” of the Stark physician self-referral law (Stark Law) and Medicare**

anti-kickback statute (AKS), applicable to all gainsharing arrangements under a CMS-led bundled payment program. Alternatively, CMS should consider a new “Bundled Payment Program Exception” to the Stark law, or revisit and modify current Stark law exceptions (e.g., risk-sharing exception) to permit gainsharing under CMS-led bundled payment programs. Outdated laws and regulations, such as the Stark Law and AKS, undermine hospital efforts to achieve successful coordinated care arrangements and participate in new APMs. Gainsharing is a critical component of APMs, such as CJR or the EPM bundled payment programs, and serves to align participating providers’ otherwise disparate financial interests. Yet, to facilitate such gainsharing arrangements, hospitals need legal certainty that such efforts will not run afoul of federal fraud and abuse laws, and an overarching waiver from these laws would provide that certainty and in a timely manner. Gainsharing programs take careful deliberation on the part of numerous stakeholders, involve painstaking drafting of sharing arrangements, and further entail drawn out negotiations with potential gainsharing partners. An overarching waiver, rather than issuance of waivers with a final rule, would allow participants the time needed to enter into effective gainsharing arrangements.

- **Provide Payment and Regulatory Flexibility for IRFs in CMMI Bundling Programs** – *CMS should provide IRFs an optional, voluntary discount to the standard payment amount, or otherwise enable them to assume more risk, for relevant IRF cases discharged from an acute care hospital participating in a CMMI bundling program.* At the same time, regulatory relief under the 60 Percent Rule and Three-hour Rule would be granted to provide IRFs treating these patients at payments below the current IRF prospective payment system (PPS) rates with the flexibility needed to participate in the program without jeopardizing their Medicare status. This shared accountability payment model would strengthen the relationship between acute care hospitals and IRFs and reduce costs by enabling IRFs to pass along savings from accepting payments lower than the IRF discharge-based PPS.

Medicaid

- **Preserve Medicaid Supplemental Payments in Managed Care** – *CMS should revisit its recently implemented rule restricting the use of pass-through payments in Medicaid managed care arrangements and restore the ability of states to use this financing mechanism.* Medicaid provider payment rates already fall far short of the cost of care, and by restricting the use of and phasing out supplemental pass-through payments as a permissible financing mechanism, CMS has imposed unreasonable pressure on providers with adverse consequences for patients, especially since approximately 70 percent of Medicaid beneficiaries are enrolled in managed care plans.
- **Withdraw Regulation and FAQs Regarding Treatment of Third Party Payers in Calculating Medicaid DSH Uncompensated Care Costs** – *CMS should rescind its recently finalized regulation, which defined uncompensated care costs for Medicaid disproportionate share hospital (DSH) purposes in a manner not supported by the statute.* In determining a hospital’s specific-DSH limit, CMS has sought to define the cost as the costs of providing care to Medicaid eligible individuals minus payments made

by third-party payers. Such a definition is in direct conflict with the Medicaid statute. CMS's interpretation has resulted in many hospitals facing significantly reduced or eliminated Medicaid DSH payments, which could well limit access to care.

PAMA Implementation

- **Delay PAMA Implementation and Ensure Beneficiaries Receive Timely Services** – *CMS should delay the January 1, 2018 implementation date for ordering providers to consult appropriate use criteria (AUC) and for furnishing providers to submit claims-based documentation.* Specifically, CMS should allow a 12 to 18 month implementation timeframe after CMS approval of the clinical decision support mechanisms (CDSMs) providers can use to consult AUCs. The list of approved CDSMs is not expected until this summer, leaving very little time for providers to work with their health information technology vendors to implement these new requirements under the *Protecting Access to Medicare Act of 2014* (PAMA). Additionally, in order to enable beneficiaries to receive necessary, timely services, CMS should develop a pathway for a furnishing provider to perform and receive reimbursement for advanced imaging when the ordering physician does not consult CDSM.

PAC Payment Policies

- **Retire the LTCH 25 Percent Rule** – *CMS should completely retire the 25 percent Rule as it is no longer necessary in light of the new two-tiered payment system.* The new long-term care hospital (LTCH) patient criteria and two-tiered payment system address the same policy concern that the 25 Percent Rule was initially developed to address: that patients may have been transferred to the LTCH setting to maximize reimbursement and not because the LTCH was the most appropriate care setting. Now that payment at the LTCH PPS standard Federal payment rate is only available for a subset of historic LTCH patients with LTCH approved, very specific conditions, the FAH does not think the 25 Percent Rule is necessary.

Further, the FAH believes it is arbitrary for CMS to pay for care rendered to LTCH-appropriate patients at different rates (e.g., LTCH rate or IPPS equivalent rate) solely based on the number of patients discharged to the LTCH from the discharging hospital. If the patient is appropriately treated and classified such that the LTCH is eligible for reimbursement at the LTCH PPS standard Federal payment rate, the patient's care should be paid as such, regardless of the percentage of discharges to the LTCH from the discharging or transferring hospital.

- **Clarify IRF 60 Percent Rule ICD-10 Compliant Codes** – *For purposes of presumptive testing, CMS should clarify that it will not exclude IRF ICD-10 codes used for a case that would have been included under ICD-9 as a result of the effects of its prior coding modifications.* The FAH is very concerned that the transition to ICD-10 has limited the extent to which IRFs can use the “presumptive testing” methodology to demonstrate compliance with the 60 Percent Rule. Patient cases in impairment group codes for traumatic brain injury, hip fracture, and major multiple trauma are especially vulnerable

to exclusion. These cases were previously eligible and counted, but are now not eligible due solely to the way in which the General Equivalence Mappings translates, which alters the clinical definitions from ICD-9 to ICD-10 in ways IRFs do not recognize. The FAH believes that this is an unintended oversight with negative consequences for IRFs and patients, which CMS could and should seek to correct through rulemaking. This is a straightforward fix that would help ensure the 60 Percent Rule is functioning properly, and as CMS intends – to reduce reliance on the costly and burdensome “medical review” process in favor of its “preferred” method, “presumptive testing.”

More broadly, CMS should consider supporting efforts to eliminate the 60 percent rule, introduced some 30 years ago. It is arguably an anachronism today and impediment to the ongoing transformation of health care delivery into a system of seamless, patient-centered care. The rule imposes significant burden and cost both on government agencies to administer, and on providers to comply, with diminishing and questionable benefit.

- **Expand 60 Percent Rule Data Transparency** – *CMS should provide IRFs with access to their patient-level data submitted for presumptive testing under the 60 Percent Rule.* Currently, IRFs do not know which cases satisfied the rule and which cases did not and have been unable to access this patient-level data from CMS. This information would enable IRFs to reconcile their internal 60 Percent Rule testing procedures against CMS’ presumptive testing procedures and thus reduce the burden and cost of compliance.
- **Publish Clear, Consistent IRF Coverage and Patient Admission Criteria Through a Transparent Public Process** – *CMS should remove the current sub-regulatory restrictions and clarification documents in favor of clear, formal policy implemented through notice and comment rulemaking with stakeholder input.* In 2010, CMS implemented a series of patient admission criteria governing Medicare’s coverage of IRF benefits that have since been the subject of inconsistent interpretation and enforcement by Medicare contractors. For example, the so-called “Three-Hour Rule” has resulted in a series of sub-regulatory restrictions, “regulation by conference call” via Q&A documents, and “clarification” documents pertaining to the extent to which rehab and therapy delivered in individual, group, and concurrent modes satisfy this rule. CMS declares in Proposed and Final Rule preambles and policy manuals that the “preponderance” of therapy provided to IRF patients must be via the individual modality. Yet, Medicare contractors routinely claim their denials of IRF claims involving 50 percent or more of individual therapy is consistent with CMS policy and requirements.
- **Harmonize IRF Appeal Rights Under the PRRB** – *The Department of Health and Human Services (HHS) should grant IRFs access to the Provider Reimbursement Review Board (PRRB) process for Low-Income Patient (LIP) appeals.* While acute care hospitals can appeal DSH payment determinations by their contractors to the PRRB, IRFs’ cannot appeal parallel LIP payment adjustment determinations by their contractors. Instead, IRFs are forced to seek such appeals through the federal court system, which is more burdensome, costly, and time-consuming.

Other Payment and Compliance Issues

- **Reform the RAC Program** – *The Administration should reform the Recovery Audit Contractor (RAC) program by holding RACs accountable for their performance.* The current RAC program design, in which RACs receive payment based on their claim denials, has resulted in overzealous denials, delayed payments to health care providers for appropriate services, and a years-long backlog of appeals. CMS should improve the RAC program by: recouping payments from hospitals (and paying RACs) only after a final Administrative Law Judge (ALJ) decision upholding the denial; creating one reasonable, balanced standard in the manual provisions for patient status determinations; requiring RAC physicians to review and approve denials before issuing them to a provider; automatically overturning RAC denials deemed inappropriate by a RAC Validation Contractor (RVC) and informing providers of RVC determinations; and applying a financial penalty to RACs for poor performance, as measured by appeal overturn rate at the ALJ level.
- **Withdraw Home-Health Pre-Claim Demonstration** – *CMS should withdraw the Pre-Claim Review Demonstration for Home Health Services.* Last year, CMS implemented a three-year Pre-Claim Review Demonstration for Home Health Services initially intended for staggered implementation in five states (Illinois, Florida, Texas, Michigan, and Massachusetts). In March, CMS paused the demonstration for at least 30 days in Illinois, and announced it will not expand the program to Florida in April, as previously scheduled. The demonstration has been fraught with problems, such as delaying claims due to simple paperwork errors rather than potential fraud, as well as excessive and unanticipated wait times in submitting the pre-claims for approval, including issues with using an online portal. These delays significantly affect workflow, negatively affect outcomes for beneficiaries, and interfere with quality improvement and care coordination, rather than achieving the demonstration program's goal of reducing fraud and abuse.
- **Streamline Medicare Advantage Compliance Training Requirements** – *CMS should streamline the Medicare Advantage compliance training requirements for first tier, downstream, and related entities (FDRs), including hospitals, and exempt FDRs from using the CMS compliance training programs if the FDR has an internal, comprehensive compliance training program that includes training similar to the CMS training.* CMS recently implemented new Medicare Advantage compliance training requirements for hospitals and other FDRs based on use of standardized and more generic training modules developed by CMS. Hospitals take compliance training very seriously, and over many years have developed sophisticated compliance programs designed to meet federal compliance training requirements, while using their own internal comprehensive and personalized compliance training programs that are very specific to the compliance protocols in a specific hospital. While CMS has taken steps to provide hospitals with some flexibility in being able to integrate their own compliance training materials with the CMS modules, these modules continue to cause unnecessary burden and confusion for hospital employees. For example, CMS modules often impose training requirements that are not relevant to a particular hospital, and results in training being offered out of context or in a disjointed manner that is not clear and concise. Further,

CMS has been issuing new compliance training requirements for a coming year after the year has started, while many hospital systems that provide thousands of employees with compliance training, have developed and rolled out their compliance training programs well before the start of the year.

- **Withdraw/Simplify “Program Integrity Enhancements to Provider Enrollment Process” Proposed Rule** – *CMS should withdraw the “Program Integrity Enhancements to the Provider Enrollment Process” proposed rule and reconsider a more narrow, tailored approach.* CMS issued this proposed rule in 2016 to implement statutory requirements to help ensure that entities and individuals who pose risks to the Medicare program and beneficiaries are kept out of or removed from Medicare for extended periods. Under the proposal, a provider or supplier that submits a Medicare, Medicaid, or CHIP enrollment or revalidation application must disclose any current or previous “affiliation,” whether direct or indirect, with a provider or supplier that has had one of four specifically enumerated adverse “disclosable events.” In implementing this statutory provision, the proposed rule is much too broad, unworkable, and unduly burdensome. For example, under the proposed rule, in addition to reporting information about its indirect owners (as currently required), providers and suppliers internally would need to identify all affiliation relationships held by the applicant’s indirect owners, which could include large mutual or pension funds or retirement vehicles that have extremely large and diverse investment holdings, and then determine whether any of these “affiliations” are with a provider or supplier that has had a disclosable event. As ownership in health care providers and suppliers has become more complex and indirect, and increasingly non-health care entities are investing in health care solely as passive investment vehicles, compliance with this requirement will be extremely challenging, if not impossible. It also is highly questionable whether the provisions in the proposed rule would achieve the desired result of reducing fraud, waste, or abuse in federal health care programs.
- **Simplify Public Company Reporting Requirements for Medicare Enrollment** – *CMS should simplify Medicare enrollment reporting requirements for publicly-traded companies.* Specifically, publicly-traded companies should not be required to report any direct or indirect ownership interests held by mutual funds or other large investment or stock-holding vehicles on CMS Form 855. Since the ownership percentage of mutual funds or other large investment vehicles in publicly-traded companies may fluctuate daily, thereby rising above or below the five percent reporting threshold, it is unreasonable and burdensome for publicly-traded providers or suppliers to track and report such changes. In addition, the ability of publicly-traded providers or suppliers to gather necessary information to report these mutual fund or other large investment vehicles is oftentimes unreasonably difficult, if not impossible.
- **Broaden and Increase Flexibility in Anti-Kickback Safe Harbor for Free or Discounted Local Transportation Services** – *CMS should broaden and increase the flexibility in the Medicare anti-kickback safe harbor for free or discounted local transportation services.* We appreciate that the HHS Office of Inspector General (OIG) has finalized safe harbor protection under the Medicare anti-kickback statute for free or

discounted local transportation services. This is a step in the right direction, however, providing more flexibility in the safe harbor would increase patient access to quality and integrative care. For example, the safe harbor should: (i) permit transportation services for any patient who has financial or other need, or to whom such transportation would encourage patient compliance or promote preventive care, rather than limiting the safe harbor to established patients only; and (ii) broaden the existing 25-mile threshold (50 miles for patients in a rural area), as these restrictions undermine the purpose of the safe harbor, especially for “special patient populations” such as patients undergoing cancer treatment or who need special behavioral treatment. Often, the quality medical care needed to best treat their condition is available only at facilities over a much greater distance (than 25 miles).

- **Increase Flexibility in Beneficiary Inducement CMP Exception** – *HHS OIG should provide additional flexibility in the newly-created exception to the Civil Monetary Penalty (CMP) rules regarding beneficiary inducement and whether certain payments to beneficiaries are considered “remuneration” under the CMP rules.* We appreciate that the HHS OIG has finalized an exception to the CMP rules regarding beneficiary inducement so that certain payments to beneficiaries are not considered “remuneration,” including, for example: (i) copayment reductions for certain hospital outpatient department services; (ii) certain remuneration that poses a low risk of harm and promotes access to care; or (iii) certain remuneration to financially needy individuals. This exception is a step in the right direction, and we encourage CMS to provide additional flexibility when interpreting “remuneration” so that hospitals can help patients realize the benefits of their discharge plan and maintain themselves in the community. For example, remuneration that “promotes access to care” should be defined to include nonclinical services that are related to a patient’s health, such as social services or dietary counseling.
- **Create Guidance and Refinements to 60-Day Overpayment Rule** – *CMS should work with stakeholders to refine and provide further guidance regarding certain aspects of the Returning and Reporting Medicare Program Overpayments final rule.* The rule became effective in March 2016 and contains certain broad-based standards that should be further clarified. For example, the regulation requires providers to use “reasonable diligence” to determine whether an overpayment may have occurred. The rule discusses that “reasonable diligence” includes both “proactive compliance activities to monitor claims and reactive investigative activities undertaken in response to receiving credible information about a potential overpayment.” Currently, providers have no guidance about the steps necessary to meet these standards. This is problematic because CMS has been asserting that if a provider does not have a sufficiently “proactive compliance” program or does not sufficiently undertake “reactive investigative activities,” the provider is not protected against penalties even if the provider discovers an overpayment. This subjects the provider to liability under the False Claims Act, which is inequitable given that the threshold requirements in the final regulation are ambiguous and lack adequate guidance for compliance.

- **Suspend Hospital Star Ratings** – *The Administration should suspend indefinitely the Hospital Star Ratings system and work with the industry and quality experts to ensure that any future star rating system includes appropriate risk adjustment and accurately distinguishes among providers.* The Star Ratings system is deeply flawed and does a disservice to patients, their families, and providers by not providing accurate risk-adjusted information on which to make decisions.
- **Adjust Outcome Measures for Socio-Demographic Status (SDS)** – *The Administration should immediately adjust readmission and other outcome measures used in any federal payment program to accurately account for and capture socio-demographic status differences among hospitals.* Hospitals have been required to report several readmission and outcome measures since 2010. These measures also are used in consequential payment programs such as the Hospital Readmission Reduction program, the Hospital Acquired Condition Program, and the Hospital Value-Based Payment Program. Over time, it increasingly has become clear that the readmission and outcome measures do not reflect accurately the care hospitals provide, and the measures should be adjusted to capture differences among hospitals in the socio-demographic characteristics of the patients they treat.
- **Suspend and Refine Electronic Clinical Quality Measure Reporting Requirements for eQCMs** – *The Administration should delay the Stage 3 Meaningful Use Program in order to gather input from stakeholders prior to further implementation and, at a minimum, allow a 90-day reporting period in each year in which Stage 3 is first implemented.* Hospitals currently are required to report electronic clinical quality measures (eQCMs) for purposes of Meaningful Use Stage 3 and also for the Inpatient Quality Reporting (IQR) program. However, the value of these measures for improving patient care is not clear. The requirements around reporting of eQCMs are extensive and require hospitals to expend significant resources re-tooling their EHR systems to capture and report the eQCMs solely for the purpose of meeting arbitrary standards and not for the purpose of improving patient care.
- **Streamline Hospital Quality Measures** – *HHS should step back and focus on measures that really matter and can drive care improvement aligned across care settings.* CMS requires an increasing number of quality measures be reported each year. While improvements in quality in hospitals and other health care facilities continue at a faster pace, the proliferation of measures results increasingly in conflict and overlap across programs. CMS should reassess current measures and review any new measures to focus on the most pressing clinical areas in need of improvement and ensure measures align across programs and care settings. In addition, CMS should consider expanding the programs for which quality data vendors are able to submit data on behalf of hospitals. In particular, it would be extremely helpful for vendors to submit data on the Perinatal Care and Behavioral Health measures just as they do for all other core measures. Allowing vendors to electronically submit the data would alleviate data entry burden for hospitals and improve the quality of the data submitted.

- **Postpone Implementation of PAC Quality Measures to Ensure Appropriate Alignment Across Care Settings** – *CMS should postpone all Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT) Act quality measure implementation until the new cross-cutting measures have been tested and refined in the specific setting where they are being used.* The passage of the IMPACT Act reforming PAC payment and subsequent implementing regulations have placed significant burden on post-acute providers and the government quality reporting systems. Implementation time has been inadequate and requirements to report functional status data two different ways, such as for Inpatient Rehabilitation Facilities, causes enormous confusion in the field and does little to improve patient care. Harmonizing quality measures across settings requires significant testing in the actual setting to minimize or eliminate unintended consequences of measures not adequately capturing the patient care provided in the setting. The varying complexity of patients and their care needs across post-acute settings challenges measure developers to effectively capture the differences. Robust setting-specific testing and revision is needed prior to full deployment of the measures in consequential payment programs.
- **Expand PAC Provider Access to Patient-Level Information for Use in Analysis of Quality Reporting Programs for Inpatient Rehabilitation Facilities (IRFs)** – *The Administration should permit post-acute providers access to pre- and post-acute patient-level claims data beyond three days.* Under the current system, post-acute providers receive aggregated claims data, which does not fully inform the facility of the patient’s clinical condition and nuances that may be important for better understanding the facility’s performance on outcomes measures. Permitting access to more robust patient-level data, similar to what acute care providers receive, would better inform the understanding of the patient’s recovery and provide more specific information for the quality improvement work of the IRF. For example, CMS recently began publishing IRFs’ 30-day readmission rates on the “IRF Compare” website. IRFs should be provided with relevant data and information about the patients comprising these rates to facilitate improvement and better outcomes on this measure.
- **Ensure Appropriate Pre-Deployment Testing of all Federal Systems for Collecting and Reporting Hospital Quality Data Both at CMS and CDC** – *The Administration should ensure full testing of any changes to quality measures and the reporting structures to which the data is reported before the new/updated systems are deployed.* Hospitals are required to report a series of quality measures to CMS and Centers for Disease Control and Prevention (CDC). FAH members welcome the opportunity to improve patient care and value the feedback received from reporting data. However, inordinate resources are expended in reporting data to and retrieving data from faulty federal reporting systems. This year alone, CMS has had to recall preview reports, suspend reporting for several weeks, or change reporting deadlines three times in the first quarter due to problems with QualityNet reporting. Deploying systems that cannot either accurately receive the data or report data back to hospitals costs both the government and hospitals hundreds of thousands of dollars each year. Additionally, more robust testing of CDC National Healthcare Safety Network (NHSN) quality reporting systems prior to deployment of any new upgrade would avoid the challenges, downtime, and inability of

hospitals to effectively and efficiently retrieve their data to either check that it was recorded appropriately or inform improved patient care. Each time an upgrade is issued, hospitals experience significant challenges and down time in submitting and retrieving data at CDC.

- **Reform the Data Reporting Mechanisms for the NHSN at the CDC** – *The FAH recommends that CDC develop a vendor submission system similar to the CMS system of certified vendor reporting on behalf of multiple hospitals.* The NHSN was designed to facilitate public health reporting between local and federal health departments, but has been expanded to accept direct reporting of infection measures from 5,000 hospitals. The system is neither designed nor funded to efficiently handle the reporting load, nor can it efficiently generate reports that are needed for care improvement. By implementing a system whereby vendors could collect and report data on behalf of hospitals, the reporting of CDC data could be streamlined and more readily facilitate hospital quality improvement with the timely feedback of quality data to hospitals.

Health Information Technology

- **Delay Stage 3 Meaningful Use and Increase Flexibility** – *The Administration should delay the Stage 3 Meaningful Use Program and, at a minimum, allow a 90-day reporting period in any year in which Stage 3 is first implemented.* The current Meaningful Use Program is costly and burdensome for providers and has not resulted in the desired efficiencies and patient care improvements. Delaying Stage 3 would allow for a meaningful evaluation of whether the Program is meeting its goals and to further align the hospital Program with the Advancing Care Information (ACI) category of the MIPS for physicians, including eliminating the “all-or-nothing” standard. At a minimum, a 90-day reporting period in 2018 – and in any year in which Stage 3 is first implemented – with appropriate and timely notice to affected stakeholders is necessary to enable providers to implement system updates and train staff.
- **Modify MACRA Information Blocking Attestations** – *The Administration should modify the MACRA data-blocking attestations or provide clear guidance on how these requirements will be enforced so that providers understand what actions they need to take and/or avoid in order to be found in compliance.* Effective April 16, 2016, MACRA requires that EHR “meaningful users” demonstrate that they have not “knowingly and willfully taken action (such as to disable functionality) to limit or restrict the compatibility or interoperability of certified EHR technology.” CMS requires this be met through a three-part attestation that is so broad that providers could inadvertently be labeled as “data blockers” for taking reasonable actions regarding EHR functionality in response to requests for medical records.
- **Expand Coverage of and Establish Payment Parity for Telehealth Services** – *The CMS should take steps to remove Medicare’s restrictions and expand reimbursement of telehealth services. Medical and behavioral health services that can be appropriately delivered via telehealth technology should be reimbursed by Medicare, Medicaid, private insurance, and other payers at the same level as when those services are*

delivered in person. CMS currently engages in an outdated process for determining which services provided via telehealth are eligible for Medicare reimbursement. The process has resulted in Medicare beneficiaries not having access to appropriate telehealth services.

Hospital Payment Policies

- **Permit Hospital Provider-Based Departments to Relocate to Meet Community Health Needs** – *CMS should provide hospitals with broad flexibility to relocate provider-based departments, whether on- or off-campus, and retain hospital outpatient payments. At minimum, a number of exceptions, such as lease expiration and organic growth and community needs, are necessary for hospitals to deliver efficient, high quality care in a safe location.* In addition, this flexibility would enable hospitals to successfully renegotiate favorable lease terms, comply with local building codes, and preserve access to care in the aftermath of a natural disaster. Rural hospitals, for example, serve communities spread across larger geographic areas, making off-campus outpatient departments an important avenue to providing services needed by the community. As new employers arrive, expand, and contract or new housing developments are constructed, a rural community's needs can shift dramatically, and hospitals ought to be in a position to adapt to meet those needs. CMS regulations, however, unreasonably restrict a hospital's ability to do so by stipulating that under most circumstances an existing provider-based department that relocates would forfeit its ability to be paid as a hospital outpatient department.
- **Refrain from Enforcing CAH 96-Hour Rule** – *CMS should not enforce a condition of payment for Critical Access Hospitals (CAHs) requiring certification that a patient is likely to be discharged or transferred within 96 hours of inpatient admission.* As a Condition of Participation, CAHs are required to have an average length of stay of 96 hours or less per patient for acute care. There is also a separate condition of payment for CAHs that requires physician certification that a patient is expected to be discharged or transferred within 96 hours of admission. Some medical services offered by CAHs have standard lengths of stay greater than 96 hours and thus a physician would be unable to make the certification, which would result in non-payment to the CAH for those services. Enforcing this provision would prevent CAHs from offering necessary services that could extend beyond 96 hours.
- **Increase Flexibility and Simplify the MOON** – *CMS should simplify the Medicare Outpatient Observation Notice (MOON) form by making it an easy-to-understand, one-page form and removing open "free text" fields that are burdensome and unnecessary for patient understanding of their patient status.* The Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act), requires hospitals to provide notice to Medicare and Medicare Advantage patients informing them of their outpatient status. CMS has developed the MOON form that hospitals provide to patients informing them of their status. This form is needlessly complex and confusing for patients.

- **Clarify Flexible Timing of a Physician’s Admission Order** – *CMS should clarify that a physician’s order to admit a patient to a hospital need not be finalized (i.e., authenticated by a signature) prior to patient discharge for billing purposes.* CMS adopted a new admission order authentication timing standard (i.e., that the physician’s order must be finalized prior to patient discharge) when the Agency proposed a new physician order and certification scheme as part of its Two Midnight policy. While the Two Midnight policy was largely later modified, effective January 1, 2015, informal CMS policy suggests the new authentication standard for admission orders remains in effect. This is a completely different and unwarranted authentication standard for admission orders than applies to all other types of physician orders that support Medicare inpatient hospital services and also differs from the approach taken by every other payer. Physicians often authenticate (i.e., sign) all relevant orders (including admission orders) during regularly scheduled intervals, but that may occur after a patient’s discharge.

Accreditation

- **Retain Flexibility for Private Sector Accreditation Standards** – *The Administration should retain flexibility for private sector accreditors to innovate while still “meeting or exceeding” CMS survey standards.* HHS has historically deemed that providers meeting certain private sector accrediting body standards (e.g., the Joint Commission) meet or exceed the Medicare Conditions of Participation (COPs). Recently, the Agency has begun requiring these private sector bodies to use the same survey processes used by CMS. Such restrictions limit variation and innovation in the private sector.
- **Promptly Issue Flexible Guidance for Hospital Co-Location Arrangements** – *CMS should promptly issue flexible guidelines regarding co-location arrangements to allow greater access to care and enhance coordinated care for patients.* Hospitals often share medical space with other providers, which is called “co-location.” This allows them to furnish a broader range of services tailored toward the health needs of their patients, which is especially important for providing patients with greater access to care, including in rural areas where specialists can travel to a rural hospital to treat patients. Also, for PAC providers, the ability to co-locate with a hospital is becoming increasingly important as payment and care delivery models continue to be developed throughout the country. Recently, CMS has taken a more restrictive approach to shared medical space, which has caused confusion and infeasible surveyor requirements, such as imposing requirements that a shared space be separate from the hospital and provide, for example, independent entrance and waiting areas. This presents significant obstacles for patient access and quality of care, as well as moving toward more value-based care.

Local / National Coverage Determinations

- **Increase Transparency in the LCD Process** – *CMS should require a transparent process for Medicare Administrative Contractor (MACs) local coverage decision (LCD) determinations, including open meetings and publishing rationales.* LCDs determine whether millions of beneficiaries have access to new procedures and technological advances, but the current decision-making process lacks transparency. Enabling true

beneficiary and stakeholder input into the LCD process will help ensure beneficiaries have access to medically necessary care.

- **Issue National Coverage Decision and Establish an Appropriate Accreditation Timeline for Sleep Labs** – *CMS should develop and issue a National Coverage Decision (NCD) regarding accreditation of sleep labs to supersede several LCDs recently issued by MACs, and in the meantime, there should be a moratorium on the current LCDs.* While we support accreditation of sleep labs, the recent LCDs are inconsistent with prior CMS rulemaking and guidance and establish significant changes in the sleep lab accreditation process. Further, the LCDs lack notice and did not establish an appropriate timeline for accreditation to occur. The LCDs were finalized January 2017 and became effective in February 2017, despite a seven- to nine-month accreditation backlog and that the Joint Commission has not yet issued accreditation standards. This puts patient access to sleep labs at significant risk and thus a national coverage approach is needed.

HIPAA

- **Establish Cybersecurity Safe Harbors** – *The Administration should develop safe harbors for providers that demonstrate a minimum level of cyberattack readiness and mature information risk management programs.* The Health Information Portability and Accountability Act of 1996 (HIPAA) Security Rule requires “covered entities,” such as health care providers, to address and assess cybersecurity risks, so that they can safeguard the confidentiality and security of electronic protected health information (PHI). Providers also are audited to ensure compliance with these requirements. Failure to comply with HIPAA can result in substantial monetary penalties. The FAH recommends the establishment of safe harbors and positive incentives for providers meeting these safe harbors rather than a punitive approach for providers that are the victims of a cyber-attack despite investing in and practicing good cyber readiness and risk management.
- **Remove HIPAA Regulation Barriers to Sharing Patient Information for Clinically Integrated Care** – *The Administration should update the HIPAA regulations to remove the “patient relationship” requirement and permit the sharing and use of patient medical information among clinically integrated providers.* HIPAA limits the sharing of patient medical information for health care operations purposes, such as quality and improvement activities, only to those providers who have a “patient relationship” with the patient. This restriction, while originally well-intentioned, is outdated in today’s era of integrated, team-based care settings where the patient can benefit from care coordination and quality improvement efforts but may not have a “patient relationship” with all the providers in the group.
- **Allow Treating Providers to Access Their Patients’ Substance Use Disorder Records** – *The Administration should align the 42 CFR Part 2 requirements with the HIPAA requirements to allow the use and disclosure of substance use disorder records from a federally assisted program for “treatment, payment, and health care operations”*

without prior written authorization. Currently, 42 CFR Part 2 requires individual patient consent to share addiction records from federally funded substance use treatment programs. Using the HIPAA requirements would improve patient care by enabling providers with a patient relationship to access their patient's entire medical record.

- **Increase Flexibility and Clarity Regarding OCR Guidelines on Charges for Patient and Third Party Requests for PHI under HIPAA** – *The Office for Civil Rights (OCR) should be required to work with affected stakeholders to develop clear guidelines regarding “covered entity” fees and processes that may be charged for individuals’ PHI, and distinguish third party requests for PHI versus requests from individuals or their personal representative.* HIPAA permits a “covered entity” to impose a reasonable, cost-based fee to provide the individual (or the individual’s personal representative) with a copy of the individual’s PHI, or to direct the copy to a designated third party. There is substantial confusion, however, regarding these fees. While guidelines issued by OCR in February 2016 were intended to clarify matters, much confusion remains, especially regarding fees that may be charged for “third party” requests for this information, such as requests for massive amounts of medical records/PHI requested for litigation purposes.

Medicare Beneficiary Identification Numbers

- **Delay the Transition from SSNs to MBIs** – *The Administration should delay the transition in order to address numerous stakeholder timing, operational, and fraud concerns, with negative consequences for beneficiaries.* The transition from using Social Security Numbers (SSNs) to Medicare Beneficiary Identifiers (MBIs) is an enormous undertaking for the Medicare program, the states, beneficiaries, and the providers who serve them. Congress put forth an aggressive timeline for this transition in MACRA, requiring these changes by April 2019. However, given the current state of implementation planning, it is unlikely CMS can meet this deadline without severe consequences for stakeholders, including interruptions in beneficiary access to care. Thus far, stakeholders have raised concerns regarding state readiness; interactions with Medicare Advantage reporting; beneficiary and provider education; the vulnerability of the cards to fraud, especially as millions of new cards are mailed to beneficiaries; and the need for a longer transition period in which both SSNs and MBIs will be accepted. We commend CMS for setting up a mailbox for stakeholders to submit their questions; however, to date there have been no responses from the Agency to those questions, and stakeholders do not believe they have enough time to complete the necessary system changes and training.

Student Loan Repayment

- **Implement Parity for Student Loan Repayment Programs** – *The Administration should eliminate the distinction between non-profit and investor-owned organizations for determining student loan repayment program eligibility.* Registered nurses and advanced practice registered nurses working in a Health Resources & Services Administration (HRSA) defined Critical Shortage Facility (CSF) can receive relief for 60 percent of their unpaid qualifying nursing education loan balance in exchange for two

years of service through the Nursing Education Loan Repayment Program. However, a CSF is defined as a public or private non-profit health care facility located in, designated as, or serving in an area with shortages of primary care or mental health professionals. There is a similar limitation on loan repayment eligibility under the Public Service Loan Program. Thus, nurses and other clinicians who care for patients in investor-owned organizations are not eligible for either program, even if those organizations provide public health and safety services and/or are located in workforce shortage areas. These limitations exacerbate the already significant barriers in recruiting these important professionals to shortage areas, which adversely affects patient access to care. They also discriminate against health care clinicians at investor-owned institutions that provide the same critical services to patients in those areas as those services provided by clinicians at non-profit organizations. The FAH urges the Administration to eliminate barriers to, and propose funding for, loan repayment parity for the health care workforce.

Access to Medications

- **Maintain Timely Patient Access to Compounded Drugs** – *The Administration should drop the “one-mile” radius provision for hospital pharmaceutical compounding for its own patients.* The April 2016 Food and Drug Administration (FDA) draft guidance for hospitals and health systems compounding pharmaceuticals for use with their own patients included a provision that would limit to a one-mile radius the distribution of such compounded products. The FAH encourages FDA to drop this restriction prior to issuing a final guidance document. The one-mile limit is arbitrary and unworkable and does not consider the physical structure of some facilities. The current proposed restriction would significantly hamper appropriate patient care.

Summary of research modeling

FY 2018 Proposed Inpatient Prospective Payment System

Outlier Payments

Date: June 6, 2017

Introduction

Watson Policy Analysis (WPA) was asked to analyze issues and replicate outlier payments from the Centers for Medicare & Medicaid Services (CMS) Fiscal Year (FY) 2018 Inpatient Prospective Payment System (IPPS) proposed rule. In short, this outlier policy sets forth a set of rules whereby CMS provides payment to inpatient hospitals for a portion of their high cost inpatient cases once particular thresholds are met. CMS describes its methodology and logic starting on page 20172 of the Federal Register.¹ We attempted to replicate the CMS logic and then compared our results and made a variety of adjustments to assess the impact of using different parameters. This report summarizes our findings.

Summary

A summary of findings is as follows:

- WPA was able to come reasonably close to the CMS calculation of the Fixed Loss Threshold (FLT). WPA estimated actual outlier payments for FY2018 at \$26,788 compared to the CMS published \$26,713.
- WPA analyzed CMS' charge inflation calculation and did not identify any issues or concerns in the calculation based on the data presented. However, there is not clear information or data provided to allow the underlying numbers used in the calculation to be able to be replicated and/or tested for accuracy.
- WPA calculated an actual outlier payment proportion of 5.27% versus the 5.37% reported in the rule for FY 2016. As a part of the rate-setting, the target percentage is intended to be 5.1%. However, in some years the target may be met while in other years the target is not met.

Background on outlier payments

In the IPPS program, CMS has established the concept of "outliers" to be high cost cases which are paid an additional amount so that providers' potential losses are limited. When the estimated costs of a case exceed the payment for the case, plus a threshold, CMS will generally

¹ "Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System Policy Changes and Fiscal Year 2018 Rates; Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Electronic Health Records (EHR) Incentive Program Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professions; Provider-Based Status of Indian Health Service and Tribal Facilities and Organizations; Costs Reporting and Provider Requirements; Agreement Termination Notices" *Federal Register* Vol. 82, No. 81, Friday, April 28, 2017

pay 80% of the costs that exceed the payment plus the threshold. CMS pays 90% for discharges assigned to one of the “burn” diagnosis related groups (DRGs).

This threshold is known as the “fixed loss threshold” (FLT) and is set prospectively with each rule based on a target that operating outlier payments will be 5.1% of total operating payments, including outliers. This target is determined by simulations of expected payments.

Background from CMS on outlier payments can be found at:

<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/outlier.html>

Additional detail is provided by CMS each year in the IPPS rule.

Analysis 1: Replication of the CMS estimated FY 2018 outlier payment from the FY 2018 IPPS proposed rule

WPA estimated payments, including outlier payments from the FY 2015 Proposed Medicare Provider Analysis and Review (MedPAR) Proposed File, following the methodology set forth in various IPPS rules. In modeling payments, WPA used information from the following data sources:

- MedPAR FY 2016 proposed file: contains inpatient hospital claims from FY 2016 that were used by CMS to model proposed FY 2018 payments,²
- Table 5 – Weight file: contains the proposed weights for FY 2018,
- Impact file: contains hospital specific characteristics and payment factors,
- DSH Supplemental File: contains uncompensated care per claim payment amounts for providers,
- The FY2018 Proposed IPPS rule in particular information on cost and charge inflation factors, and
- Inpatient Provider of Services File: contains provider specific information.

In addition, other factors such as charge inflation, CCR adjustment factors, and standardized payment amounts from the proposed rule were used.

Complete payments were calculated including operating, capital, disproportionate share hospital (DSH), indirect medical education (IME), uncompensated care, etc. for each case, following the CMS methodology. The CMS methodology excludes sole community hospitals, hospitals that have become Critical Access Hospitals (CAHs), and Maryland hospitals.

WPA calculated a fixed loss threshold of: \$26,788 versus the published number of \$26,713, a difference of \$75 or about 0.28%.

As a part of this replication, there are some methodological notes:

² CMS actually released two versions of the MedPAR, one version immediately after the rule was released which had discharges with substance abuse diagnoses or treatments removed from the data; and a later version with those discharges returned to the data. Analyses reported here are based on the second release of the data.

- Although we have been able to replicate the final calculation for the charge inflation factor with the data presented in the rule, it is not possible to replicate the underlying numbers that are presented in the rule. CMS published numbers without releasing the full underlying data that went into those numbers or detail on their methodology (such as what data was included in the numbers, or the data cleaning that may have taken place.) CMS has released summary data by month and by provider to address this issue.
- CMS appears to provide potentially different descriptions of the charge inflation calculation, but this does not appear to make any material difference.

Please note that the FLT will adjust with the release of the final rule and associated files.

Analysis 2: Comparison of Cost-to-Charge ratios from the FY 2017 proposed rule Impact file and the Inpatient Provider Specific File

As part of the analysis, we compared the CCRs included in the impact file (used in modeling the FLT) with the CCRs from the Provider Specific File (PSF).

Comparing the 3,370 providers listed in the impact file and a simulated December 2016 PSF file, we had a match rate of 94.33% (3,179 providers). When comparing the impact file provider list and the March 2017 PSF, we had a match rate of 68.84%.³

For the December 2016 comparison, the average difference in operating CCRs between the impact file and the PSF file (weighted by the number of discharges) was -0.017% if all providers were used, and -0.679% if just those providers with differences were used.

For the March 2017 comparison, the average difference in operating CCRs between the impact file and the PSF file (weighted by the number of discharges) was -0.342% if all providers were used and -0.516% if just those providers with differences were used.

The table of matching statistics reported two years ago in a report from The Moran Company – “Modeling Fiscal Year 2015 Inpatient Prospective Payment System Outlier Payments” dated June 23, 2014, and then updated with WPA calculated data is as follows:

³ Note: The PSF file for December 2016 was removed before the IPPS rule was released and not downloaded. So as an approximation, we took the March 2017 and restricted it to records in the PSF file prior to 1/1/17, to simulate a December 2016 PSF file. This is consistent with prior years.

IPPS Rule for FY	Matching Rate Between Impact file and Most recent PSF CCRs	Average Percent Difference Between the Impact File and Most Recent PSF Operating CCR of the Same Hospital (weighted By Discharges)
Final 2010*	93.2%	0.4%
Final 2011*	96.4%	0.1%
Final 2012 - Dec 2010 Update	96.9%	0.2%
Final 2012 - March 2011 Update	65.3%	1.6%
Final 2013	92.1%	0.0%
Final 2014	97.2%	-0.1%
Proposed 2015 - Dec 2013 Update	98.8%	-2.7%
Proposed 2015 - March 2014 Update	64.8%	1.0%
Proposed 2016 - Dec 2014 Update	89.6%	-0.02%
Proposed 2016 - March 2015 Update	61.6%	0.19%
Proposed 2017 - Dec 2015 Update	94.16%	-0.014%
Proposed 2017 - March 2017 Update	65.70%	0.236%

* Vaida Health Data Consulting, Modeling FY 2013 IPPS Outlier Payment. June 11, 2012

Note that WPA developed new programs to analyze the data, so there may be differences with the previous analyses by The Moran Company and Vaida Health Consulting. However, the matching percentage calculated by WPA is within a similar matching percentage as that calculated by the Moran Company. In addition, the average difference in operating CCR is much smaller.

Analysis 3: FY 2016 Outlier payment using FY 2016 MedPAR data

In order to examine the actual outlier payments, WPA modeled payments and combined outlier payment information to estimate the actual payments. CMS published an estimate that outlier payments were 5.37%.⁴ The chart below shows operating payments and the outlier payments that we calculated. The operating payments and the total are based on the modeling simulation. The outlier payment amount is from the reported outlier payments from the MedPAR 2016 Proposed File. In the simulation using the CMS FLT we estimate that outlier payments are 5.27%.

⁴ P. 20175 of the Federal Register version of the rule.

Data Source	Operating IPPS Payments Net of IME, DSH and Outlier Amounts (\$) (Does not include Capital)	Outlier Payments (\$)	Outlier Payment Level (%)	Total Medicare Payment (\$)
MedPAR 2016 Actual Outlier Payments, FY 2016 Final Rule Impact File Adjustment Factors.	81,767,595,191	4,552,819,444	5.27%	\$108,795,465,363

Analysis 4: Outlier payments from Medicare cost reports, 2015 update

For the past several years, WPA has calculated estimated outlier payments based on the HCRIS cost report data. This analysis has been conducted each year as a part of the IPPS proposed rule analysis.

Federal Fiscal Year (Month of HCRIS release)	Number of cost reports	IPPS Payments Net of IME, DSH and Outlier amounts	Outlier Payments	Outlier Payment Level (%)	Target Outlier Payments (5.1%)	Shortfall in Outlier Payments
FY 2013 (December)	2,875	\$75,513,803,937	\$3,820,292,807	4.82%	\$ 4,058,170,707	(\$237,877,900)
FY 2013 (March)	3,047	\$80,760,714,604	\$4,270,125,578	5.02%	\$ 4,340,143,777	(\$70,018,199)
FY 2014 (December)	2,388	\$63,505,784,324	\$3,085,415,408	4.63%	\$3,412,850,369	(\$327,434,961)
FY 2014 (March)	3,054	\$82,479,662,313	\$4,343,131,876	5.00%	\$4,432,521,368	(\$89,389,492)
FY 2015 (December)	2,850	\$78,849,610,927	\$3,847,264,205	4.65%	\$4,238,185,938	(\$390,921,733)
FY 2015 (March)	3,036	\$84,552,076,553	\$4,283,484,754	4.82%	\$4,543,853,974	(\$260,369,220)

The FY2013 analysis was conducted in the Spring of 2015 during the proposed rule comment period, and each Fiscal year was done in the successive calendar years following that. The month refers to the data release month of the HCRIS data.

Note that these numbers are subject to change as more hospitals submit cost reports and also cost reports are reviewed and revised.

Analysis 5: Fixed Loss Threshold over time

From examining the fixed loss threshold in proposed rules and final rules, there is a pattern of the fixed loss threshold declining. The following table shows the fixed loss thresholds for recent years.

FY	Final	Proposed	Variance	% of Variance
2009	\$ 20,045	\$ 21,025	\$ (980)	-4.66%
2010	\$ 23,140	\$ 24,240	\$ (1,100)	-4.54%
2011	\$ 23,075	\$ 24,165	\$ (1,090)	-4.51%
2012	\$ 22,385	\$ 23,375	\$ (990)	-4.24%
2013	\$ 21,821	\$ 23,630	\$ (1,809)	-7.66%
2014	\$ 21,748	\$ 24,140	\$ (2,392)	-9.90%
2015	\$ 24,626	\$ 25,799	\$ (1,173)	-4.55%
2016	\$ 22,544	\$ 24,485	\$ (1,941)	-7.93%
2017	\$ 23,573	\$ 23,681	\$ (108)	-0.46%
2018		\$ 26,713		

Analysis 6: Explorations on changes in the Fixed Loss Threshold

As evidenced in Analysis 5, the Fixed Loss Threshold has been adjusting over time, and the FY 2018 Proposed Rule Fixed Loss Threshold is more than \$3,000 higher than the FY 2017 Final Fixed Loss Threshold. In response to this, WPA conducted various examinations and probing of the data and other issues that may relate to the Fixed Loss Threshold.

No single, definitive, cause for the increase was identified. However, one intriguing finding of this research was:

- a) The impact of “extreme” cases on the Fixed Loss Threshold; and
- b) The increase in the rate of “extreme” cases.

In the IPPS rate-setting process, statistical outliers – extreme cases – generally are removed from the calculations during the normal methodology. However, these cases are left in during the calculation of the Fixed Loss Threshold.

To examine this issue, WPA tested trimming out cases with a total charges greater than particular thresholds. This removed the case if the total charges were greater than a threshold. (Note: For the actual calculation of cost for the Fixed Loss Threshold, covered charges are used.)

The following table shows the results at different trim points.

Trim threshold	Number of cases removed	Calculated FLT	Percentage trim removes
None	-	\$ 26,788	0.000%
\$ 2,000,000	738	\$ 25,585	0.008%
\$ 1,750,000	1,076	\$ 25,327	0.011%
\$ 1,500,000	1,733	\$ 24,890	0.018%
\$ 1,250,000	2,942	\$ 24,294	0.031%
\$ 1,000,000	5,679	\$ 23,317	0.060%
\$ 750,000	13,039	\$ 21,595	0.139%
\$ 500,000	38,637	\$ 18,561	0.411%

Removing a relatively small number of cases can have the impact of shifting the Fixed Loss Threshold potentially thousands of dollars.

WPA then examined the trend of high charge cases over time. The following table shows the number of cases with covered charges greater than \$1.5 million over time.

Year	Number of cases over \$1.5 million	Percentage of total cases	Number of unique providers
2011	926	0.0088%	272
2012	994	0.0098%	272
2013	1,092	0.0111%	283
2014	1,329	0.0141%	306
2015	1,539	0.0161%	320
2016	1,733	0.0185%	334

As can be seen, the number and proportion of these extreme cases has been increasing over time. These cases are also distributed at a large number of providers.