PEACH Inc.
Private Essential Access Community Hospitals

June 2019
Congressional Action Program

Key Issues

- **CMS's proposed FY 2020 Medicare DSH uncompensated care (UCC) calculation would rely on faulty, unaudited data, to the detriment of the integrity of the program and Congress's mandate to direct funding to hospitals with verified high levels of uncompensated care.**
- **The proposal would be especially harmful to CA's community safety-net hospitals, which would lose significantly more funding than hospitals in any other state.**
- **PEACH proposes an approach built upon CMS's original intent to use more than one year of data and an additional three-year transition to ensure the calculation of Medicare DSH UCC payments are based on accurate, audited data.**
- **PEACH urges members of CA's congressional delegation to support PEACH's alternative approach to calculating Medicare DSH UCC payments in FY 2020 and to convey this position to CMS officials and the Dept. of Health and Human Services.**

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Medicare DSH Uncompensated Care Payments

On April 24, 2019, The Centers for Medicare & Medicaid Services (CMS) published its proposed Medicare Inpatient Prospective Payment System (IPPS) rule containing proposed changes in Medicare payment policies and inpatient rates for fiscal year (FY) 2020.

PEACH opposes the proposed IPPS rule provisions that would create a new method to calculate Medicare disproportionate share uncompensated care (UCC) payments in FY 2020 and asks California's congressional delegation to support an alternative approach that would create greater fairness and less disruption in the distribution of Medicare DSH UCC payments nationwide.

Background

Since its inception in the 1980s, the Medicare disproportionate share hospital program (Medicare DSH) has served as a vital resource for safety-net hospitals that serve communities with large numbers of uninsured and government-insured residents and has become essential to their ability to continue serving their communities with comprehensive high-value, life-saving health care.

The Affordable Care Act implemented two major changes to the Medicare DSH program: (1) It reduced total Medicare DSH payments in anticipation of a significant reduction in the number of uninsured Americans, thus decreasing the amount of uncompensated hospital care; and (2) It divided Medicare DSH payments into two components, one of which is a Medicare DSH uncompensated care pool representing 75 percent of the overall Medicare DSH program. The UCC payments are calculated based on each eligible hospital's portion of the uncompensated care provided by all hospitals in the country that qualify for Medicare DSH payments.

The Data Challenge Underlying Medicare DSH Uncompensated Care Payments

CMS faces an ongoing challenge in adopting a methodology that accurately determines the level of UCC that Medicare DSH-eligible hospitals provide. Lacking a uniform, credible source of uncompensated care data to use in its calculation of Medicare DSH UCC payments, from 2014 to 2016 CMS used a proxy for hospital UCC based on two low-income variables: eligible hospitals' Medicaid and SSI-patient days. In 2017, CMS announced that it would move away from this proxy and begin using the S-10 worksheet of the Medicare cost report to determine hospital UCC payments. At the same time, CMS also announced that it would begin calculating hospitals' Medicare DSH UCC payments based on three years of data instead of a single year. By using three years of data, CMS sought to reduce undue annual fluctuations in hospitals' Medicare DSH UCC payments and provide a transition period for

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better S-10 instructions to be issued, better reporting by hospitals and thorough CMS auditing and correction of the data.

For nine years, PEACH and others have urged CMS to prepare for the use of S-10 data to calculate UCC in two ways:

(1) Improve the S-10 form instructions, which are widely misunderstood by hospitals and have resulted in aberrant and incorrect data reporting; and

(2) Audit hospitals' S-10 data to ensure accurate data reporting and compliance. Review of the UCC data that hospitals have reported in recent years has established that some hospitals are still reporting inconceivable amounts of uncompensated care, and many may be underreporting. Inaccurate reporting greatly skews the distribution of the limited and fixed pool of Medicare DSH uncompensated care funds, inappropriately rewarding some hospitals for inaccurate data and unfairly penalizing others.

To properly implement Congress's mandate on the distribution of Medicare DSH money, CMS needs S-10 data that has been audited and corrected so that payments are directed to DSH-eligible hospitals in accordance with their verified levels of uncompensated care.

CMS's Proposal for FY 2020

For FY 2020 Medicare DSH UCC payments, CMS proposes eliminating the three-year blend of data and using 2015 S-10 data from all Medicare DSH-eligible hospitals. CMS proposes this even though it has audited approximately 20 percent of hospitals' 2015 S-10 data, and no other FY S-10 data has been audited to date. CMS concedes in its proposed rule that the limited auditing that was completed resulted in significant changes in UCC data, stating that **"approximately 10 percent of audited hospitals have more than a $20 million difference between their audited FY 2015 data and their unaudited FY 2016 data."** CMS also observed that some hospitals have suggested that their data reporting for FY 2017 has improved due to improvements in the S-10 instructions.

CMS's FY 2020 Medicare IPPS proposed rule also asks stakeholders to share their view on the possibility of using data from the FY 2017 S-10 data instead of FY 2015 data. In both cases, CMS proposes using a single year of data rather than a three-year average, which PEACH believes would exacerbate data flaws that could be reduced by using a three-year average.

CMS has suggested that mixing audited and unaudited data would have the effect of "diluting" the results of the audits performed for FY 2015. PEACH disagrees with this rationale because it ignores that about 80 percent of eligible hospitals' FY 2015 S-10 data remains unaudited. In light of the considerable discrepancies CMS found between audited 2015 S-10 data and unaudited 2016 S-10 data, using data from several years is essential to ensuring the use of valid and reliable data and reducing the volatility in distribution of this critical funding source.

CMS should continue to use multiple years of data to calculate payments until all data for a fiscal year has been audited.

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PEACH's Alternative Proposal

PEACH proposes an alternative approach built upon CMS's original intention to use more than one year of data and an additional three-year transition to ensure the calculation of Medicare DSH UCC payments are based on more accurate, *audited* data.

The foundation of PEACH's proposed approach for FY 2020 is as follows:

1. **Use hospitals' FY 2019 actual Medicare DSH UCC payments**
2. **Blend that figure with one year of CMS's proposed S-10 data**

This would mark the beginning of a new three-year transition – for FY 2020, FY 2021 and FY 2022 – during which CMS would phase in use of audited uncompensated care data in the second and third years to replace the questionable, unaudited data used in year one.

The use of multiple years of data is essential to the fairness of this proposal. Using more than one year of data would help smooth the overall data and ensure that no single year's aberrant data, whether the result of reporting errors or just an unusual year, inappropriately skews calculations in ways that unfairly benefit or harm any specific hospital or has wide-ranging effects that can be felt throughout the approximately 2,430 hospitals that will be eligible for Medicare DSH UCC payments in FY 2020. This represents a fair solution that recognizes the importance of a stable funding pool based on reliable and verified data and is especially important in the distribution of scarce resources.

PEACH's Request

CMS's proposed FY 2020 Medicare DSH UCC calculation would rely on faulty, unaudited data, to the detriment of the integrity of the program and Congress's mandate to direct funding to hospitals with verified high levels of uncompensated care. The proposal would be especially harmful to California's community safety-net hospitals as a whole, which would lose significantly more funding than hospitals in any other state.

PEACH asks members of California's congressional delegation to support this alternative approach to CMS's plan for calculating Medicare DSH uncompensated care payments in FY 2020 and to convey this position to CMS officials and the Department of Health and Human Services.