National Association of Public Hospitals and Health Systems

1301 Pennsylvania Avenue, NW
Suite 950
Washington, DC 20004
202 585 0100 tel / 202 585 0101 fax
www.naph.org

March 15, 2010

Charlene Frizzera
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-0033-P
P.O. Box 8013
Baltimore, Maryland 21244-8013

Ref: CMS–0033–P: Medicare and Medicaid Programs; Electronic Health Record Incentive Program; Proposed Rule

Dear Ms. Frizzera:

The National Association of Public Hospitals and Health Systems (NAPH) appreciates the opportunity to submit the attached detailed comments on the above-captioned Proposed Rule. NAPH represents more than 140 metropolitan area safety net hospitals and health systems. NAPH members predominantly serve the uninsured and patients covered by public programs—78 percent of inpatient services and 74 percent of outpatient services by NAPH members are provided to Medicare and Medicaid beneficiaries and uninsured patients. Approximately 70 percent of NAPH members' revenues are derived from treating Medicare, Medicaid, low-income, and uninsured patients.

NAPH members play a vital role in their respective communities, averaging 4.5 times as many outpatient visits and 3 times as many emergency department visits as the hospital industry average. In total, 86 NAPH hospital systems provide over 37 million non-ER visits annually. The ongoing economic recession also serves to highlight our members' public commitment. At a time when many hospitals report that fewer patients are seeking care, NAPH members continue to report increased volumes in both the inpatient and outpatient departments of the hospital. Since the beginning of the recession, NAPH members have treated 23 percent more uninsured patients and provided 10 percent more uncompensated care to low-income populations. Now more than ever, it is critical that stimulus funding is available to providers most in need.

NAPH appreciates and supports Congress' goal to encourage the widespread adoption of interoperable electronic health records (EHR). NAPH understands that the purpose of the EHR incentive payment provisions within the American Recovery and Reinvestment Act (ARRA) was to stimulate the economy, while at the same time improve patient care and reduce cost. Since the passage of the ARRA, the national unemployment rate has increased from 8.2 percent to 9.7 percent, reaching as high as 10.1 percent in October, 2009. States, facing unprecedented budget

gaps, have been forced to limit provider payments, and we anticipate the budgetary challenges to be even greater in the current fiscal year. Already, 29 states have cut their budgets for health care services, and NAPH members have felt the impact. While NAPH members continue to provide quality care to the patients they serve, timely capital improvements have always been a challenge to NAPH members due to their limited access to resources. This challenge is even greater now that many have implemented, or are considering, service curtailments and layoffs in an effort to simply stay afloat. Many safety net hospitals have had to reassess their health information technology (HIT) capital investment plans. Industry analysts note that margins of 2% are necessary to allow for investment in capital and infrastructure needs During 2008, NAPH members' aggregate operating margin was -0.7%, compared with 3.3% for hospitals nationally. At this critical time, EHR incentive payments meant, in part, to stimulate the economy should be readily available to needy Medicaid providers so that they can afford the necessary investments to become meaningful EHR users.

NAPH appreciates CMS' acknowledgement that Medicaid incentive payments may be used as a source of capital for hospitals to meet meaningful use requirements and that payments can begin before the start of the Medicare program in fiscal year ("FY") 2011. However, given CMS' proposal to implement a restrictive meaningful use definition, NAPH is concerned that not enough of the incentive payments will be distributed. In fact, CMS acknowledges in its rule that only 42 to 58 percent of available Medicare incentives and only 35 to 40 percent of available Medicaid incentives will be paid out to eligible hospitals. NAPH urges CMS to consider comments from the hospital community and reassess its proposed meaningful use definition so that as much of the approximately $30 billion of hospital incentive payments can be distributed to the providers that need them. NAPH urges CMS to reconsider a variety of policy decisions related to the definition of meaningful use and the structure of the incentive payment programs that would make it more difficult for providers to receive funding, as described in our attached detailed comments.

In general, NAPH agrees with the concerns raised by the overall hospital industry about the Proposed Rule. In particular, however, we encourage CMS to adopt the following policies of particular importance to safety net hospitals and health systems:

- In defining a hospital-based professional, CMS should narrowly interpret the statutory reference to hospital outpatient setting so that professionals working in non-emergency room outpatient settings can qualify for incentive payments. CMS should further clarify that the evaluation of whether a provider is hospital-based for Medicaid incentive payment purposes will use Medicaid claims and encounter data.
- In defining a hospital for purposes of Medicare and Medicaid incentive payments, CMS should use a multi-pronged approach that allows a "hospital" to be defined in ways that acknowledge the varied organizational structures of multi-hospital systems, including the use of a distinct Medicare provider number, a distinct emergency department, a distinct state hospital license, or a distinct "remote location" under existing Medicare provider-based regulations.
- CMS should specify an alternative source of charity care data for use in calculating hospitals incentive payments prior to the availability of revised Worksheet S-10 data to

ensure that the payments can be determined appropriately and according to Congressional intent.

- CMS should clarify that the Medicaid EHR incentive payments to hospitals should not be treated as hospital payments for other purposes, such as inclusion in hospital-specific disproportionate share hospital payment limitations.
- CMS should acknowledge the flexibility afforded by the ARRA and not require Medicaid incentive payments to hospitals to be bound by the Medicare meaningful use phase-in periods.
- CMS should include inpatient bed days and discharges for patients in psychiatric units of eligible acute care hospitals and for newborns in the calculation of the Medicare and Medicaid hospital incentive payment formulas.
- CMS should confirm that populations covered by Medicaid Section 1115 demonstrations should be included in the calculation of Medicaid patient volume for purposes of determining eligibility for professionals and hospitals under the Medicaid incentive program.

NAPH appreciates CMS' consideration of the attached comments and particular attention to the issues noted above. If you have any questions about these comments, please contact Lynne Fagnani or Claudine Swartz at (202) 585-0100.

Sincerely,

Larry S. Gage
President

National Association of Public Hospitals and Health Systems

1301 Pennsylvania Avenue, NW
Suite 950
Washington, DC 20004
202 585 0100 tel / 202 585 0101 fax
www.naph.org

DETAILED COMMENTS BY THE NATIONAL ASSOCIATION OF PUBLIC HOSPITALS AND HEALTH SYSTEMS ON PROPOSED RULE: CMS–0033–P: Medicare and Medicaid Programs; Electronic Health Record Incentive Program

March 15, 2010

The following comments reflect the National Association of Public Hospitals and Health Systems' specific concerns and suggestions regarding the Proposed Rule as it relates to safety net health systems.

1. Meaningful Use Definition

CMS proposes a phased-in, 3-stage approach for achieving meaningful use. CMS' stated goals in defining meaningful use are to: (1) improve quality, safety, and efficiency, and reduce health disparities; (2) engage patients and families in their health care; (3) improve care coordination; (4) improve population and public health; and, (5) ensure adequate privacy and security protections for personal health information. CMS proposes that stage 1 hospital requirements include 23 objectives and be in effect for FYs 2011 and 2012. For FY 2013 and beyond, CMS proposes to expand the list of hospital requirements via future rulemaking. Hospitals that become meaningful users early in the program have two years to transition to the next meaningful use stage; however, hospitals that first become meaningful EHR users after FY 2012 have less time to transition to the next stage. By FY 2015, which is when Medicare penalties begin for hospitals that fail to meet the meaningful use requirements, CMS proposes that all hospitals would have to meet stage 3 meaningful use requirements. **NAPH is concerned that CMS' definition and timing for the phase-in unnecessarily restricts the number of hospitals that can qualify for the incentive payments and urges CMS to reassess its proposed meaningful use definition so that as much of the approximately $30 billion of the hospital incentive payments can be distributed to providers that need them.** Doing so meets the statutory intent of the ARRA—the swift distribution of funds in order to encourage widespread adoption of EHRs, improve patient care, and reduce cost. Below is a discussion of key issues in the regulation that inhibit the distribution of available EHR incentive payments.

a. The all-or-nothing approach for determining meaningful use is overly burdensome and is not a good measure of whether providers are meaningful EHR users.

CMS proposes an all-or-nothing approach for determining whether hospitals are meaningful EHR users. Under the proposed rule, hospitals seeking incentive payments must achieve all 23 objectives to meet stage 1 meaningful use requirements. Many of the 23 proposed

objectives are advanced clinical functions, such as computerized provider order entry and clinical decision support, that generally occur at the end of a multi-year transition to EHRs. NAPH appreciates that meaningful EHR users need to be able to complete advanced clinical functions; however, CMS' all-or-nothing approach to meaningful use asks for too much, too soon. According to a 2008 American Hospital Association (AHA) survey, only 1 percent of the nation's hospitals can meet 10 of the 23 objectives in CMS' stage 1 meaningful use requirement.

CMS should reassess the timeframe necessary to meet its requirements and should take into account Congress' intent to distribute as much of the EHR incentive payments as possible to hospitals that can use this funding source to purchase and implement their EHRs. Based on CMS' own estimates, less than half of available hospital incentives will be paid out to eligible hospitals. NAPH urges CMS to reconsider the all-or-nothing approach to meaningful use so that more of the incentive funds can be made to hospital to help them in their efforts to purchase and upgrade their EHRs. **CMS should instead adopt one set of meaningful use criteria and allow hospitals additional transition time to become meaningful EHR users.**

In addition to requiring hospitals to meet all 23 objectives in order to achieve stage 1 meaningful use requirements, under CMS' proposed rule, hospitals will be required to make investments in their EHRs without knowing the full scope of meaningful use requirements for stages 2 and 3. While NAPH supports Congress' goals of encouraging widespread adoption of EHRs to enhance patient care and reduce cost, NAPH believes that the practical difficulties inherent in such a requirement would hinder the goals of the EHR incentive programs. As recommended above, CMS can address this issue by adopting one set of meaningful use criteria and specifying the full scope of requirements so that they can be knowable at the onset of the program.

Towards this end, NAPH endorses the AHA's proposal for an alternate transition approach to meaningful use, including establishing the full scope of meaningful use objectives up-front, lengthening the timeframe for achieving the ultimate vision of meaningful use, taking a phased, flexible approach to defining meaningful use, and establishing a meaningful use technical expert panel. NAPH also urges CMS to conduct annual assessments to determine the extent to which hospitals are achieving the meaningful use requirements, and to report on whether hospitals with specific characteristics—such as size, payer mix, and other criteria deemed appropriate by CMS—are able to meet the requirements. This would enable CMS to target additional resources to hospitals that still need help to become meaningful EHR users.

b. <u>Late adopters have less time to transition between stages of meaningful use.</u>

CMS' proposed phased-in, 3-stage meaningful use approach along with the adoption schedule creates additional burdens for hospitals that become meaningful EHR users later. As noted earlier, hospitals that first become meaningful EHR users in FY 2011 have 2 years to transition to stage 2 and another 2 years to transition to stage 3. However, hospitals that first become meaningful EHR users after FY 2012 only have 1 year to transition from stage 1 to 2 and then to 3. We understand that this approach is likely due to the ARRA's requirement that penalties start in FY 2015 for hospitals not meeting the meaningful use requirements—at the

stage 3 level, as proposed by CMS. However, while *penalties* must begin in 2015, hospitals trying to become meaningful EHR users should not have to meet overly aggressive requirements in order to qualify for *incentive payments*. CMS should reassess the transition period so that hospitals that need the incentive payments to meet the meaningful use criteria continue to receive the resources towards accomplishing that goal. NAPH acknowledges that this means some hospitals will not have reached the final phase-in by 2015. However, hospitals that do not become meaningful EHR users until later may lack necessary resources to make the needed investments and so may be subject to the penalties anyway. Forcing these hospitals to meet an accelerated schedule will only mean that they will receive fewer payments, which is inconsistent with the incentive program's goal of encouraging all hospitals to adopt interoperable EHRs. **CMS should therefore extend the meaningful use phase-in period so that hospitals have adequate time to qualify for the resources that will help them adopt certified EHR.**

NAPH members have historically operated at lower margins than hospitals nationwide—negative 0.7% in 2008, compared with 3.3% for hospitals nationally—and with less access to resources for capital improvements, such as EHRs. Many NAPH members have nonetheless made significant progress towards use of EHR. However, because incentive payments do not cover the entire cost of adoption and use, hospitals that need more time to accumulate the capital to become meaningful EHR users should not be penalized. CMS noted that EHR system costs can run as high as $20 million to $100 million, yet by its own estimates, CMS acknowledges that Medicare incentives per hospital will only be about $3.6 million, on average.[1] **NAPH urges CMS to ensure that all hospitals have adequate transition time to implement the necessary EHRs to meet meaningful use requirements.**

c. <u>The proposed methods for demonstrating compliance are overly burdensome.</u>

CMS has also proposed to require hospitals to demonstrate compliance with the hospital objectives by meeting specified thresholds that require the reporting of numerator and denominator data. For example, in order to determine if at least 80 percent of all patients admitted to the hospital have at least one entry recorded as structured data in their medication list, hospitals will have to report the number of unique patients that meet this criteria as the numerator and the number of all unique patients as the denominator. Because having the capability to perform a particular function electronically does not necessarily mean it is only performed electronically, numerous thresholds as proposed by CMS would require tremendous effort on the part of the hospitals to merge chart abstracted data along with the electronically captured data. We believe CMS has significantly underestimated the burden of such manual collection activities. To better allocate hospitals' resources, **NAPH urges CMS to reconsider the proposed thresholds and the methods for demonstrating compliance so that hospitals can focus their efforts on implementing EHRs, rather than generating reports.**

d. <u>The proposed clinical quality measures are not ready for electronic reporting.</u>

CMS proposes to require hospitals to attest to the electronic reporting of 35 clinical quality measures in FY 2011 and report these measures electronically by FY 2012. Most of the 35 measures proposed by CMS are not ready for electronic reporting. For example, only 8 of the

[1] 75 Fed. Reg. 1844, 1980 (Jan. 13, 2010).

measures are endorsed by the National Qualify Forum and approved by the Hospital Quality Alliance; however, not even these measures have the electronic specifications necessary for electronic reporting. While automated quality reporting is critically important to the meaningful use of electronic health records, no EHR system in use today is able to automatically report the full set of proposed measures. While NAPH appreciates CMS' effort to coordinate with existing CMS quality initiatives, NAPH believes that CMS should allow for more time for measures to be developed and tested for automated reporting.

NAPH recommends that CMS require the reporting of quality measures directly from the EHRs only if those measures have been tested and only after CMS successfully completes its ongoing pilot program. Moreover, NAPH urges CMS to require only the electronic reporting of measures that have been chosen for use in the Medicare pay-for-reporting program.

e. Uncertainty and delay in the certification process hinders timely adoption of EHR.

The HIT marketplace does not have the capacity to support the timeframe imposed by the proposed rule. Uncertainty and delays in finalizing the process by which EHR systems will be certified as capable of achieving meaningful use delays product development by vendors. This, in turn, pushes back implementation dates for providers.

CMS should extend the time frame during which stage 1 meaningful use objectives will be used for determining incentives by one more year to allow for the completion of product certification. CMS should also adopt a "grandfathering provision" under which existing hospital EHR systems that meet meaningful use objectives could be accepted as certified for two years; upgrades to existing systems or new systems would need to be certified.

2. Concerns Related to Both Medicare and Medicaid Incentive Payment Programs

a. The CMS certification number is not a good proxy for fairly distributing hospital incentive payments.

EHR incentives contained in the ARRA are available to each hospital deemed to be a "meaningful user" of a certified EHR. The ARRA defines "hospital" as "a subsection (d) hospital," which merely means a general, acute care, short-term hospital that receives payments under the Medicare prospective payment system. Yet, CMS has chosen in the proposed rule to limit the definition to a "hospital" as defined solely by the CMS certification number ("CCN") used for the Medicare cost report.[2]

[2] Related to the Medicare incentive payments, CMS states in the preamble to the regulations that "for purposes of this provision, we will provide incentive payments to hospitals as they are distinguished by CCN in hospital cost reports. Incentive payments for eligible hospitals will be calculated based on the provider number used for cost reporting purposes, which is the CCN of the main provider (also referred to as OSCAR number)." 75 Fed. Reg. 1844, 1911 (Jan. 13, 2010). CMS also clearly states in the proposed regulations for the Medicaid incentives that "A multi-site hospital with one CMS Certification Number is considered one hospital for purposes of calculating payments." *Id.* at 2002 (proposed 42 C.F.R. § 495.310(f)(6)).

Defining hospitals solely by the CCN could, contrary to the intent of the ARRA, create a barrier to widespread EHR adoption and use. There is no standard policy that defines the specific types of hospital facilities to which the CCN applies. For example, CCNs may conceivably encompass small portions of hospitals, such as a single department, which clearly make them inappropriate to use in defining a hospital. In contrast, multiple hospitals often operate under one CCN, with Medicare treating one hospital campus as the main hospital and the others as provider-based hospital campuses. For many other purposes, however, these separate campuses are separate hospitals—they often have separate emergency rooms, duplicate departments, separate contracts for other administrative services, etc.

Because the Medicare and Medicaid payment incentives in the ARRA are calculated using a per-hospital base amount ($2,000,000), plus a capped per-discharge amount per hospital, using only the CCN to define a hospital would result in EHR incentives being distributed in a manner that does not foster widespread EHR adoption and use. Specifically, a health care system with multiple hospitals but a single CCN would be disadvantaged because the system would be eligible for only one base amount and would be much more likely to reach the discharge cap, resulting in fewer discharges counting towards their payment amount. For example, one NAPH member hospital estimates a $10 million difference based solely on whether CMS treats two acute care hospitals operating under the same CCN as separate facilities. In addition, such a health care system would be subject to penalties at the system level, even if, for example, only one of the system's multiple hospitals was determined not to be a meaningful user.

Linking EHR incentive payments only to the single CCN would not accurately reflect the deployment costs of EHR systems across all hospitals in a system. The total cost of EHR implementation far exceeds the purchase cost of the actual application or software, including additional administrative costs for necessities such as workstation installation, servers, staff training and differences in clinical services among each of the hospitals. Even hospitals that are part of the same system often require significant variations in their EHRs, as local policies and processes must be incorporated in EHR utilization. For example, installations must accommodate the differing network infrastructures of legacy software, physician preferences, clinical protocols, expert rules protocols, workflows and ancillary system integration. In addition, a hospital system may encompass both a children's hospital and an adult acute-care hospital, each of which requires a different interface and clinical system.

For EHR incentive payment purposes, we urge CMS not to use the CCN as the sole criterion to define a hospital. Instead, we ask CMS to use a multi-pronged approach that allows a "hospital" to be defined in one of several ways that acknowledge the varied organizational structures of multi-hospital systems. This should include defining a hospital based on a distinct Medicare provider number as CMS has proposed, as well as a distinct emergency department, a distinct state hospital license, or a distinct "remote location" of a hospital (as defined under Medicare provider-based regulations under 42 C.F.R. § 413.65). Under this multi-pronged definition, each distinct hospital would then be eligible to qualify separately for the EHR incentives. CMS could use the hospital cost report, with certain modifications, to collect the hospital-specific data that will be necessary to determine the EHR

incentive payment for each hospital. CMS' interpretation should not disadvantage or unfairly penalize hospitals that are operating in the kind of coordinated systems that EHR adoption is meant to encourage.

We believe CMS could feasibly implement this recommendation for purposes of calculating both the Medicare and Medicaid incentive payment amounts, and for purposes of implementing the Medicare penalty. **However, even if CMS concludes that this is not feasible for the Medicare incentives, we believe that CMS should amend proposed 42 C.F.R. § 495.310(f)(6) and allow states to define hospital on a different basis for the Medicaid incentives.** States will be charged with calculating the amount of the Medicaid payments. And while CMS has proposed the Medicare cost report as one possible source of data for determining the Medicaid EHR incentive, CMS has also proposed to use Medicaid cost report data, MMIS data, and hospital financial statements and accounting records to determine Medicaid EHR incentives. There is no absence of state-level usable data to implement this definition. For example, in Florida, every geographically separate hospital reports data, including discharge data, to Florida's Agency for Health Care Administration ("AHCA"), regardless of whether or not the hospital shares a Medicare CCN.

While we generally support the idea of consistency between the two incentive programs to limit the burdens on providers and CMS, deviating from that goal in this instance will not impose any further burden. Furthermore, it will permit more Medicaid funding to get to the safety net systems most in need of capital funding to support their EHR adoption efforts. It is clear from the fact that hospitals do not have to meet the meaningful use requirements to get the first year of Medicaid payments and from the proposal to allow Medicaid funds to be distributed in FY 2010 that both Congress and CMS have acknowledged this distinct role for the Medicaid incentives**.**

b. <u>The lack of charity care data from the revised Worksheet S-10 jeopardizes eligible hospitals' ability to access the full amount of the incentive payments.</u>

CMS proposes to use charity care data reported by hospitals on the revised Worksheet S-10 to determine the charity care adjustment portion of the Medicare and Medicaid EHR incentive payments. The fact that CMS has not yet finalized the revised Worksheet S-10, which was supposed to be in effect for hospital cost reporting year 2010, means that charity care data will not be available for at least the first two Medicare payment years. Particularly for early adopters, this could potentially affect the first 2 payment years for hospitals under the Medicare incentive program and payments across the entire span of the Medicaid incentive payment program, because total Medicaid payments are determined prospectively before any payments are made. This charity care adjustment is critical to ensuring that additional incentive payments are made to hospitals like NAPH members who serve low-income patients and as a result have smaller margins for making investments in HIT.

NAPH urges CMS to specify an alternative source of charity care data for use in calculating hospitals incentive payments prior to the availability of revised Worksheet S-10 data to ensure that the payments can be determined appropriately and according to congressional intent. These alternative sources of charity care data should include hospitals'

reports to state Medicaid agencies, or hospitals' current Worksheet S-10's, among others. Alternatively, CMS should explicitly permit the calculation of total Medicaid incentive payments to be adjusted when S-10 data using the revised Worksheet are available.

With respect to the charity care data on the revised Worksheet S-10, CMS must ensure that line 19 of the revised worksheet captures the most complete and accurate value of charity care provided in a manner that is most consistent with the statute. Specifically, for patients approved for partial charity care, CMS should clarify that the draft instructions for line 19 require hospitals to report the entire value of all services provided to the partial charity care patients (at full charges) on line 19. In order to appropriately determine the costs associated with charity care patients, CMS should further clarify that full charges associated with a charity care patient are to be included on line 19 and not on line 26, even if the charity care patient receives a partial discount and does not pay the patient's obligation (what would normally be considered a bad debt). Otherwise, a charge inappropriately could be included on both line 19 and line 26. CMS also should ensure that line 19 captures the full scope of charity care provided, including hospitals' costs associated with offering and providing physician and other professional services. For our full comments on CMS' proposed changes to the Medicare cost report, we refer CMS to the attached NAPH letter. (See Attachment 1).

c. <u>CMS should revise its definition of hospital-based professionals so that it does not exclude professionals who work in ambulatory care settings.</u>

CMS proposes to define hospital-based professionals as those who furnish at least 90 percent of their services in an inpatient hospital, emergency department, or outpatient hospital setting, as defined by place of service codes used to designate provider-based status. NAPH urges CMS to reconsider this overly-broad definition, since it would inappropriately exclude eligible professionals who practice in outpatient centers and clinics merely because they provide patient care in an office or clinic that is located in a facility owned by a hospital. CMS should instead adopt a definition that recognizes the costs that must be incurred to implement EHR systems in these settings and excludes physicians only when a hospital's inpatient EHR system would obviate the need in that setting.

The statutory language of the ARRA excludes hospital-based professionals from the EHR incentive programs. The ARRA defined a hospital-based professional as "an eligible professional, such as a pathologist, anesthesiologist, or emergency physician, who furnishes substantially all of such services in a hospital setting (whether inpatient or outpatient) and through the use of the facilities and equipment, including qualified electronic health records, of the hospital." ARRA, Pub. L. 111-5, §§ 4101(a); 4201(a). This language itself indicates that Congress was focused on the types of professionals most likely to be providing care in an inpatient setting or in the emergency department (which is an outpatient department), not the outpatient departments that serve primarily as sources of ambulatory care for their communities. Congress attempted to clarify this point in the ARRA Conference Report, stating that "[t]his policy does not disqualify otherwise eligible professionals merely on the basis of some association or business relationship with a hospital...includ[ing] professionals who are employed by a hospital to work in an ambulatory care clinic." Conf. Rept. 111-6, p.741, 752 (Feb. 12,

2009). A letter from Senator Stabenow to Secretary Sebelius describes this intent and a related colloquy with Senator Baucus on this point.

> [T]he intent is to avoid double payment to hospitals and physicians where no extra cost is incurred by or on behalf of physicians for establishing and maintaining the EHR. It was not the intent of Congress to apply this restriction to all physicians such as those that may be part of an integrated health system if the health system's clinical facilities are operated as provider-based. I respectfully request that HHS follow Congressional intent and develop provisions that distinguish between the "Hospital-Based Eligible Professionals" where no additional EHR cost is incurred beyond the expense typically borne by the hospital, and the group practice physicians who provide patient services within an integrated health system at "provider-based" facilities and use a unified health system medical record.

Letter from Sen. Stabenow to Sec. Sebelius (May 8, 2009); *see also* Sen. Stabenow colloquy with Sen. Baucus, Cong. Rec. S1670-71 (Feb. 5, 2009).

Excluding professionals from receiving incentive payments solely based on whether they practice in a facility that is provider-based does not effectively accomplish Congress' intent, as explained by Senator Stabenow, of avoiding double payment for EHR costs. In fact, NAPH members reported that implementing an EHR in an ambulatory setting requires significant costs in addition to the cost of implementing the inpatient EHR. Even where these systems are designed to be interoperable, ambulatory EHRs are very different from inpatient EHRs due to the inherent differences between the types of care provided. It is not unusual for physicians associated with NAPH members' health systems to contribute financially to these separate costs of the ambulatory EHR.

CMS' proposed definition of hospital-based professional essentially precludes support through either hospital or professional incentive payments for implementing EHR in provider-based clinic settings. CMS acknowledges in the Proposed Rule that because hospital incentives are based on inpatient volumes, a hospital with a significant network of provider-based outpatient facilities will receive no additional funding to assist these clinics with the cost of implementation. The proposed interpretation of hospital-based professional excludes providers caring for patients in all types of provider-based outpatient care settings from receiving EHR incentive payments directly on the professional side. CMS expresses concern that as result, investment in ambulatory EHRs might lag behind hospitals' investment in inpatient EHRs. NAPH is similarly concerned that a narrow definition of hospital-based professionals will result in ambulatory care EHRs lagging behind inpatient implementation and will hamper the goal of coordinated care between the inpatient and outpatient setting. **NAPH urges CMS to narrowly interpret hospital outpatient setting so that professionals working in non-emergency room outpatient settings can qualify for incentive payments.** This is consistent with the attempts to narrow the definition in the Congressional report language and as expressed by Senator Stabenow, and will ensure that resources are available for implementation of ambulatory EHRs to be used in a synergistic manner with the inpatient EHR.

Excluding professionals practicing in hospital ambulatory care settings from the EHR incentive programs would limit the benefit of EHR adoption in all communities, and especially in inner-city and rural settings. These inner-city and rural practice sites, which utilize an ambulatory EHR that is comparable or equivalent to the EHR platform used in traditional private practice settings, provide anchors to community-based services in their markets. In many cases, they are, in fact, the only available source of ambulatory care to thousands of people. Further, many of these clinic settings are being transformed to serve as the "medical home" for their patients, making EHR adoption, and therefore funding, critically necessary. Providing EHR incentive payments to professionals practicing in hospital ambulatory care settings will better support coordination along the continuum of care for patients.

We further ask CMS to provide a definition of "covered professional services" for purposes of the Medicaid incentive payments to clarify that the evaluation of whether a provider is hospital-based for Medicaid purposes will use Medicaid claims or encounter data. The Medicaid regulatory definition of "hospital-based professional" cross-references 42 C.F.R. § 495.4 (see 42 C.F.R. § 495.304(c)), which relies on the phrase "covered professional services." Although this phrase is defined in the Medicare section of the regulations as meaning professional services paid under the Medicare physician fee schedule, there is no definition for Medicaid purposes, which could cause potential confusion. The preamble clarifies that CMS contemplates a Medicaid-specific analysis. 75 Fed. Reg. at 1906-07 ("For Medicaid purposes, we are proposing that State Medicaid agencies make the determination about whether or not an EP is hospital-based by analyzing an EP's Medicaid claims data, or in the case of EPs who deliver care via Medicaid managed care programs, by analyzing either encounter data or other equivalent data sources.") In order to make this clear, CMS should provide an appropriate definition of "covered professional services" in proposed 42 C.F.R. § 495.302 that clarifies that for Medicaid purposes, "covered professional services" means professional services paid by the Medicaid program.

d. <u>Exclusion of certain inpatient bed days from the calculation of the Medicare and Medicaid shares is not required by statute and is contrary to the goals of the hospital incentive programs.</u>

CMS has proposed to calculate the Medicare share by excluding inpatient bed days not paid under the IPPS, which includes bed days in psychiatric units of acute care hospitals. 75 Fed. Reg. at 1912-1913. CMS has further proposed in the preamble that for purposes of the Medicaid formula, they will count only those days that would count as inpatient bed days for purposes of the Medicare incentive payment calculation, thus presumably also excluding days in psychiatric units from the Medicaid share. *Id*. at 1938. We believe these policy decisions are contrary to the legislative language of the ARRA, inconsistent with the policy goals of the HIT incentive programs, and in particular penalize hospitals that are already being significantly underpaid for treating the most vulnerable of Medicaid patients. **We ask that CMS clarify that inpatient bed days in psychiatric units of acute care hospitals should be included in the Medicare and Medicaid share calculations for hospital incentive payments.**

The statutory language of the ARRA requires inclusion of all inpatient bed days paid under Part A, including payments for patients in psychiatric units of acute care hospitals that are

eligible for HIT incentive payments under both the Medicare and Medicaid programs. ARRA Section 4102(a), adding Section 1886(n)(2)(D), states that the Medicare share is "the fraction the numerator of which is the sum (for such period and with respect to the eligible hospital) of—(I) the estimated number of inpatient bed days...which are attributable to individuals with respect to whom payment may be made under part A...." While inpatient bed days in psychiatric units may be paid under a separate Medicare prospective payment system, the payments and the services are still under Part A. 42 U.S.C. §1395d. There is no language in the definition of the Medicare share otherwise requiring the exclusion of these days.

Similarly, the statutory language defining the Medicaid share also does not require the exclusion of these inpatient bed days. Section 4201(a) of ARRA, adding Section 1903(t)(5)(C) of the Social Security Act, states that the Medicaid share should be calculated like the Medicare share, "except that there shall be substituted for the numerator under clause (i) of such section the amount that is equal to the number of inpatient bed days (as established by the Secretary) which are attributable to individuals who are receiving medical assistance under this title" and who are not dual eligibles. Medicaid defines hospital services to include services provided in the psychiatric unit of an acute care hospital (42 C.F.R. §§ 440.10, 440.160), and Medicaid patients receiving these services are receiving medical assistance under the Medicaid program, so these bed days should be included based on the statute.

CMS' rationale for excluding these inpatient bed days is that this is the methodology used in determining Medicare's share of costs for direct graduate medical education and disproportionate share hospital payments, given the historical exclusion of psychiatric units from the IPPS. However, this exclusion of psychiatric units is an artifact of an old cost-based reimbursement system that no longer exists and reliance on it does not seem consistent with the goals of the HIT incentive program.

By reducing the Medicare and Medicaid shares, CMS is limiting the amount of EHR costs for which an acute care hospital that includes a psychiatric unit may receive payment under these programs. This reduction in the value of the incentive payments will be particularly harmful to safety net hospitals, like NAPH members, treating significant populations of Medicare and Medicaid patients suffering from mental illness. CMS cannot be suggesting that it is not critical to incorporate EHR in these departments of the hospital. Yet, the result of this policy is to limit the availability of capital for EHR investment to hospitals that are already facing extremely low reimbursement rates for psychiatric services, leaving even less of a margin for implementing EHR. Given that such a policy is not required by the ARRA, CMS should instead implement regulations that do not penalize acute care hospitals that have chosen to care for this extremely vulnerable population.

CMS should also clarify that discharges from psychiatric units of acute care hospitals may be included in calculating the discharge-related amount for both Medicare and Medicaid incentive payments. The statute states that the discharge related amount is determined "based upon total discharges for the eligible hospital (regardless of any source of payment)." ARRA § 4201(a)(1) (adding Social Security Act § 1886(n)(2)(C)). Acute care hospitals with psychiatric units are "eligible hospitals," as they are "subsection (d)" hospitals as defined under the ARRA and the proposed regulations. The language of Section 1886(n)(2)(C)

of the Social Security Act makes clear that Congress did not intend to discriminate between discharges based on payor, so it would not make sense for CMS to exclude certain discharges based on whether or not they are paid under the Medicare IPPS.

CMS has proposed to similarly exclude nursery days from the calculation of the Medicare and Medicaid shares. 75 Fed. Reg. at 1912. We would ask CMS to clarify the rationale for this policy. NAPH members often treat newborns with significant care needs and long inpatient stays, a significant proportion of whom are covered by Medicaid. Exclusion of these days would likely decrease some hospitals' Medicaid share, resulting in lower hospital incentive payments. These newborns are Medicaid patients receiving medical assistance under the Medicaid program, so these bed days should be included based on the language of the statute. **We further urge CMS to reconsider the preamble language and permit the inclusion of nursery days in calculating the Medicare, and in particular, the Medicaid shares of EHR costs in the hospital incentive formulas.**

3. **Specific Comments on Medicaid Incentive Program**

NAPH recognizes that CMS faces complexity in implementing EHR incentive programs across both Medicare and Medicaid in a consistent manner, and appreciates that CMS has attempted to ease administrative and implementation burdens for hospitals trying to qualify for incentives under both programs by aligning the meaningful use requirements. NAPH supports the goals behind the EHR incentive programs and appreciates that these goals can only be accomplished if every hospital becomes a meaningful EHR user. For these reasons, NAPH urges CMS to establish consistent meaningful use criteria and quality reporting requirements for hospitals seeking incentives from both the Medicare and Medicaid programs.

At the same time, the Medicare and Medicaid programs have significant differences, and Congressional intent behind the Medicaid EHR incentive program differs from the Medicare EHR incentive program. Under the Medicaid program, hospitals do not have to meet the meaningful use requirements to qualify for the first year of payments. Rather, they only have to show that they are adopting, implementing, and upgrading their EHR to be able to meet the meaningful use requirement for the second payment year. The Medicaid program also does not contain a penalty for failure to become a meaningful user. These provisions suggest Congressional acknowledgment that hospitals could receive payments from the Medicaid program (before they are meaningful EHR users) to help meet the Medicare meaningful use criteria. We appreciate that CMS' rule acknowledges this difference and includes provisions to help states provide funding to hospitals before FY 2011, the start of the Medicare program. We encourage CMS to make any effort it can to ease the administrative burden on state Medicaid programs so that states can begin distributing the EHR incentives as quickly as possible. **NAPH also appreciates CMS's recognition that states may front load the majority of the Medicaid funding to providers in the first two years, and asks CMS to encourage states to take advantage of this opportunity to get capital funding to needy Medicaid providers as quickly as possible.** These efforts will allow funding to reach hospitals that typically lack resources to make the necessary investments that would qualify them as meaningful EHR users. **NAPH also encourages CMS to conduct an annual assessment of hospitals' EHR adoption status so**

that resources can be targeted to hospitals that may need additional assistance to become meaningful EHR users.

Given the critical importance of the Medicaid incentive payments, and the Medicaid program overall, to NAPH members, we ask CMS to address the following specific concerns and needs for clarification.

a. CMS should not require hospitals to meet the Medicare meaningful use timeline for Medicaid incentive payments.

We understand that CMS has proposed to require Medicaid hospitals to follow Medicare's meaningful use adoption schedule, with the goal of harmonizing the meaningful use criteria across Medicare and Medicaid. NAPH urges CMS in the final rule, however, to acknowledge the different purpose and structure of the Medicaid incentive funding and permit states to deviate from this strict timeline. The Medicaid and Medicare EHR incentive programs begin and end in different years—the Medicaid program can begin as early as FY 2010 and end as late as FY 2021, and the Medicare program begins in FY 2011 and ends no later than FY 2016. In addition, Medicaid incentive payments can be made over a period of 3 to 6 years that need not be consecutive; whereas, Medicare incentive payments are paid over 4 consecutive years. Given that CMS' proposed meaningful use adoption schedule only allows hospitals a maximum of 4 years (and by no later than FY 2015) to reach stage 3 of meaningful use requirements, hospitals seeking Medicaid incentives could be required to meet stage 3 meaningful use requirements for their first payment year. Furthermore, the Medicare meaningful use adoption schedule was designed so that hospitals would meet stage 3 standards by the time the penalty begins in FY 2015; however, there is no similar penalty in Medicaid.

CMS has inappropriately imposed the Medicare meaningful use timeline on the Medicaid incentive payment program. Under any phased-in approach to meaningful use, CMS should clarify which stage of meaningful use criteria hospitals need to meet for both Medicare and Medicaid payments, without sacrificing needed flexibility in the Medicaid EHR incentive program. Any meaningful use adoption schedule that CMS proposes for Medicaid should allow for the statutory language that indicates that Medicaid payment years need not be consecutive and that Medicaid payments maybe made through 2021. We think Congress intended to include this flexibility in the Medicaid program to permit a different implementation schedule from the Medicare program and to allow hospitals to qualify for Medicaid incentives separate from the progression of the Medicare adoption schedule. As an alternative, CMS could, for example, permit all Medicaid providers to be treated like Medicare providers who meet the standard in FY 2011, plus the additional first year of payments before they meet the standard. Under such a schedule, a Medicaid provider would not have to meet stage 3 until their 6th year of payments (i.e., the hospital could have one year of payments before meeting the standard, two years at stage 1, two years at stage 2, and then stage 3). States would retain their ability to front-load the payments in earlier years rather than making the payments over the full six years, but this policy would ensure that states have the flexibility intended by Congress and that more of the incentive payments reach Medicaid providers.

In addition, given that for the first year of payments, providers only have to demonstrate adopting/implementing/upgrading, rather than meaningful use, CMS should clarify what providers need to demonstrate during the 90-day reporting period and whether the 90-day reporting period only applies to the first payment year under the meaningful use standard.

b. CMS should clarify that Medicaid hospital incentive payments should not be treated as hospital payments for other Medicaid purposes.

CMS should clarify that Medicaid hospital should not be treated as hospital payments for other Medicaid purposes, for example as payments that would be included in the hospital-specific disproportionate share hospital (DSH) payment limit calculation, or as inpatient or outpatient hospital payments that are limited by the upper payment limits. Based on the structure of these payments under the Medicaid statute, the incentive payments are clearly intended to be administrative payments and not payments for inpatient or outpatient hospital services. These payments are additional, separate payments meant to assist and encourage investment in EHRs. Requiring their inclusion in payment calculations could displace funds currently provided to safety net institutions seeking resources to provide services to Medicaid populations, rather than provide additional support.

CMS should clarify in the final rule that the Medicaid EHR incentive payments to hospitals should not be included in the DSH calculation.

c. CMS should retain its requirement that Medicaid incentives be paid directly to providers without any deduction or rebate, including in states using certified public expenditures.

CMS has proposed to require state Medicaid agencies to "provide assurances to the Department that amounts received with respect to sums expended that are attributable to payments to a Medicaid provider for the adoption of EHR are paid directly to such provider (or employer or facility to which assigned payments), without any deduction or rebate." Proposed 42 C.F.R. § 495.350(a). This is also required under the State Medicaid HIT plan requirements at § 495.332(c).

NAPH strongly supports this provision, as it helps ensure that the funding gets to the providers who need it for investing in EHRs. Particularly, given that these payments are made at a 100 percent matching rate and that the state has an enhanced matching rate for associated administrative expenses, CMS should ensure that the providers who need these funds actually receive these funds. Further, **CMS should clarify that use of certified public expenditures (CPE) or intergovernmental transfers in the context of the Medicaid EHR incentive payments would be inappropriate, since these payments do not have a non-federal share. If CMS does permit use of CPEs in the Medicaid EHR incentive payment context, CMS must require that states pass through the matching funds to providers.**

d. CMS should confirm that Section 1115 populations are included in the calculation of Medicaid patient volume for purposes of eligibility for Medicaid incentive payments.

NAPH requests that CMS confirm that populations covered by Medicaid Section 1115 demonstrations should be included in the calculation of Medicaid patient volume for purposes of determining eligibility for professionals and hospitals under the Medicaid incentive program. The ARRA states that an eligible professional must have "at least 30 percent of the professional's patient volume…attributable to individuals who are receiving assistance under this title..." and that a hospital must have "at least 10 percent of the hospital's patient volume...attributable to individuals who are receiving medical assistance under this title." ARRA § 4201(a). Populations covered by Medicaid Section 1115 demonstrations are still covered under Title XIX. CMS has already recognized that Section 1115 waiver populations should be considered eligible for Medicaid in the context of the Medicare DSH calculation. 42 C.F.R. Section 412.106 states that "a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan or under a waiver authorized under section 1115(a)(2) of the Act on that day...." CMS should clarify proposed 42 C.F.R. 495.304(c) accordingly.

Attachment 1 to NAPH Detailed Comments

National Association *of* Public Hospitals *and* Health Systems

1301 Pennsylvania Avenue, NW
Suite 950
Washington, DC 20004
202 585 0100 tel / 202 585 0101 fax
www.naph.org

August 27, 2009

Ms. Michelle Shortt
Director, Regulations Development Group
Office of Strategic Operations and regulatory Affairs
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard, Room C4-26-05
Baltimore, Maryland 21244-1850

Ref: CMS–2552–10: Agency Information Collection Activities: Proposed Collection; Comment Request

Dear Ms. Shortt:

The National Association of Public Hospitals and Health Systems (NAPH) appreciates the opportunity to submit comments on the above-captioned Proposed Collection. NAPH represents more than 140 metropolitan area safety net hospitals and health systems. NAPH members predominantly serve the uninsured and patients covered by public programs—23 percent of the inpatient services provided by NAPH members is to Medicare beneficiaries, another 34 percent to Medicaid recipients, and 19 percent to uninsured patients. About 20 percent of NAPH members' revenues are derived from treating Medicare patients, and another 50 percent from payments for treating low-income, uninsured, and Medicaid patients.

NAPH recognizes the importance of collecting accurate and consistent data and applauds the Centers for Medicare & Medicaid Services' (CMS) efforts to improve and streamline the Hospital and Health Care Complexes Cost Report. The following comments offer suggestions for improving the quality of data collected by CMS and identify new reporting requirements that may impose a significant burden on hospitals given their existing accounting systems. NAPH focuses here on Worksheet S-10, which is of particular concern to safety net hospitals because data reported on this worksheet are used to make changes to the Medicare disproportionate share hospital (DSH) formula.

1. Worksheet S-2 – New Requirement to Report Medicaid Days

The draft Worksheet S-2, part I, line 21 proposes that hospitals report the number of Medicaid days during the cost report period. Hospitals already report this information, which is used in the disproportionate patient percentage (DPP) calculation, on Worksheet S-3, part I. This proposal seems contrary to CMS' efforts to streamline the cost report by imposing a redundant requirement on hospitals to report the Medicaid days information used for the DPP calculation on two different worksheets.

The draft Worksheet S-2, part I, line 21 also requires hospitals to keep track of and report Medicaid days with a level of detail that is not required for the calculation of the DPP. Specifically, the draft worksheet requires hospitals to report the number of in-state and out-of-state Medicaid paid and eligible days, as well as Medicaid HMO days and other Medicaid days. Since CMS has not changed its policy with respect to the calculation of the DPP for purposes of determining the Medicare DSH adjustment percentage, there is no reason to increase the reporting burden on hospitals by adding line 21 to Worksheet S-2. Additionally, because such details are not required for the DPP calculations, most hospitals do not track Medicaid days in the detail that CMS is requesting. For example, whether Medicaid paid for days is irrelevant in determining the number of Medicaid days for the DPP calculation because so long as the patient was eligible for Medicaid, the days associated with that patient count as Medicaid days. Also, since both in-state and out-of-state Medicaid days count as Medicaid days for purposes of the DPP calculation, there is no additional benefit to be gained by reporting this information separately. NAPH urges CMS not to add to the burdens on hospitals and eliminate line 21 from Worksheet S-2.

2. Worksheet S-10 – Data Collection Regarding Uncompensated and Indigent Care Data

NAPH strongly supports CMS' efforts to collect accurate uncompensated care data and to fulfill the mandate contained in Section 112 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA). The BBRA requires CMS to collect "data on the costs incurred by the hospital for providing inpatient and outpatient hospital services for which the hospital is not compensated"[3] in order to reexamine the adequacy of the existing Medicare DSH formula in targeting payments to hospitals that serve a disproportionate share of low-income patients in accordance with the DSH statute.[4] NAPH further supports efforts to revise the initial S-10 efforts, since that worksheet did not collect useful data. NAPH believes that the proposed Worksheet S-10 is much improved, although we have a number of comments that we think will further improve the worksheet as a data collection instrument.

a. Uncompensated and Indigent Care Cost Computation

The draft Worksheet S-10 requires hospitals to use the cost-to-charge ratio calculated using Worksheet C, part I, line 202, columns 3 and 8 for determining the cost of Medicaid, state Children's Health Insurance Program (CHIP), other state or local indigent care programs, and uncompensated care. This is the cost-to-charge ratio that Medicare uses to determine the cost of

[3] H.R. 3426, § 112(b) (1999), enacted by reference in Pub. L. 106-113, 113 Stat. 1501, Div. B, § 1000(a)(6) (1999).
[4] 42 U.S.C. § 1395ww(d)(5)(F).

the Medicare program based on Medicare's reasonable cost methodology and it excludes significant costs. For example, this cost-to-charge ratio does not include teaching costs because Medicare pays for these costs using a separate methodology. However, because the purpose of Worksheet S-10 is to determine the true total "costs incurred by the hospital for providing inpatient and outpatient hospital services," there is no reason to use the Medicare reasonable cost methodology; instead a broader cost-to-charge ratio should be used so that the entire cost of patient care is captured.

To better account for the full cost of treating Medicaid, CHIP, other state and local indigent care, and uncompensated care patients, NAPH proposes that CMS use an amount from Worksheet A that includes all patient care costs as the cost portion of the cost-to-charge ratio. We suggest using the total of Worksheet A, column 3, lines 1 through 98, reduced by the amount on Worksheet A-8, line 10. This amount more accurately reflects the true total cost of hospital services provided, as opposed to the Medicare reasonable cost methodology, and is more consistent with the statutory mandate in the BBRA. For the charge portion of the cost-to-charge ratio, we suggest Worksheet C, column 8, line 200.

Alternatively, for hospitals that already report the cost of uncompensated and indigent care to the state, CMS could allow these hospitals to input the cost-to-charge ratios they use for state Medicaid and indigent reporting purposes. These cost-to-charge ratios better reflect the cost of treating indigent patients and can be verified by the state. If these cost-to-charge ratios are not available, hospitals can also report the cost information they generate for compliance with the DSH reporting and audit rule.[5]

b. Medicaid Revenues

The draft Worksheet S-10 requires hospitals to report Medicaid revenues on lines 2, 3, 4, and 5. As drafted, line 2 can include either all Medicaid net revenue, including DSH and supplemental payments, or only base Medicaid net revenue—i.e., without DSH and supplemental payments. For consistency and uniformity purposes, NAPH believes that line 2 should be changed to include only base Medicaid net revenue, line 3 should include DSH net revenue, line 4 should include non-DSH supplemental net revenue, and line 5 should be the sum of lines 2, 3, and 4.

With respect to line 2, the draft instructions specifically permit hospitals to subtract associated provider taxes or assessments from any payments received in determining the hospital's net revenues from Medicaid. NAPH strongly urges CMS to also allow hospitals to subtract associated intergovernmental transfers. From a hospital's perspective, money that the hospital transferred to the state should be offset against payments received by the hospital because, similar to provider taxes and assessments, transfers reduce the value of revenue received by the hospital. If CMS does not allow intergovernmental transfers to be deducted from payments received from Medicaid, then Worksheet S-10 would overstate Medicaid net revenues and understate the difference between payments and costs of the Medicaid program. Similarly, in situations where public hospitals certify public expenditures as representing Medicaid

[5] Medicaid Program Disproportionate Share Hospital Payments Final Rule, 73 Fed. Reg. 77904 (Dec. 19, 2008) (to be codified at 42 C.F.R. pts. 447, 455).

payments, hospitals should be permitted to only include net payments received from the Medicaid program rather than the full value of the amount certified.

In addition, the draft instructions for line 2 define "net revenue" as "payments received or expected for Title XIX covered services delivered during this cost reporting period." Hospitals typically account for payments when received, which may include services provided during a preceding cost reporting period. In general, we urge CMS not to depart from usual hospital accounting practices when defining "net revenue" or other terms. Although we understand CMS' desire to match net revenues with services, complying with CMS' definition would require significant alteration of existing accounting systems. NAPH urges CMS to consider the additional burden (both time and money) this requirement would place on hospitals.

NAPH also urges CMS to be specific with its use of the term "revenue". For line 8, CMS should use the term "net revenue" rather than "revenue" in order to clearly differentiate between payments (net revenues) and charges (gross revenues). Using these terms interchangeably causes unnecessary ambiguity and would render the data collected useless for analytical purposes. (This comment also applies to lines 12 and 16.)

c. Charity Care Charges, Costs, and Associated Issues with Bad Debt

NAPH understands that collecting information regarding charity care charges and costs is necessary to implement the statutory mandate to examine "costs incurred by the hospital for providing inpatient and outpatient hospital services for which the hospital is not compensated."[6] Accordingly, the draft Worksheet S-10 endeavors to obtain the full uncompensated cost of charity care patients, as opposed to the cost of the charity care provided by the hospital. The draft Worksheet S-10 requires hospitals to report the value of their charity care at full charges along with payments by patients approved for partial charity care. For patients approved for partial charity care, the draft instructions for lines 19 and 22 would require hospitals to report the entire value of all services provided to the partial charity care patients (at full charges) on line 19 and any payment these patients make on line 22. NAPH believes that this method would appropriately capture the most complete and accurate value of charity care provided and is most consistent with the statute.[7]

In order to appropriately determine the costs associated with charity care patients, we believe that CMS should further clarify that full charges associated with a charity care patient are to be included on line 19 and not on line 26, even if the charity care patient receives a partial discount and does not pay the patient's obligation (what would normally be considered a bad debt). Otherwise, a charge inappropriately could be included on both line 19 and line 26. In conformance with this recommendation, we strongly suggest that the draft instructions for line 22 be revised to only include payments ***received*** from patients approved for partial charity care

[6] H.R. 3426, § 112(b) (1999), enacted by reference in Pub. L. 106-113, 113 Stat. 1501, Div. B, § 1000(a)(6) (1999).
[7] NAPH recognizes that the proposed S-10 methodology differs from industry guidelines geared toward determining the value of charity care provided. Methodologies geared toward determining the value of charity care, as opposed to uncompensated costs, record only the charity care eligible portion of full charges for a charity care patient that receives a discount on charges and do not take into account payments by that patient. However, this method does not truly determine the uncompensated cost of caring for the charity care patient.

services, and not also payments ***expected*** from these patients. Despite the existence of a patient share, many charity care patients may not pay their share, and it makes no sense to count ***expected*** payments in the context of determining the costs which remain uncompensated.

d. Grants, Donations, Endowment Income, Government Appropriations or Transfers

The draft Worksheet S-10 requires hospitals to report private grants, donations, or endowment income restricted to funding charity care on line 17 and government grants, appropriations, or transfers for support of hospital operations on line 18. While both of these lines are under the heading of uncompensated care, the instructions are silent as to how the information from these two lines will be used. NAPH strongly urges CMS to clarify that lines 17 and 18 are for informational purposes and not for use in determining the value of uncompensated care provided by hospitals. Accounting for these voluntary funding sources in the determination of the full uncompensated cost of charity care patients understates the true cost of these patients and could jeopardize the future availability of these funds if grantors and donors realize that their contributions will be offset against any supplemental funding from the Medicare program. Alternatively, CMS should clarify its purpose for these two lines and allow for public comments before requiring hospitals to submit additional information.

In addition, while line 17 is appropriately limited to private grants, donations, or endowment income restricted to funding charity care, it neglects to account for the cost of complying with rules associated with receiving these funds. NAPH believes that CMS should only count the net value of these funds as being available to supplement a hospital's charity care.

Line 18, as drafted, would require hospitals to report all government grants, appropriations, or transfers for support of hospital operations. Because this line is under the heading of uncompensated care, NAPH strongly urges CMS to limit the reporting of government funding sources specifically restricted to funding charity care. Moreover, in order to ensure that funds are not double counted, CMS should clarify in its instructions that DSH payments reported under lines 2 and 5 should not be reported here again. Funds from charity care pools also should not be reported here if the underlying sources are DSH funds previously accounted for in lines 2 and 5. Similarly, any other funds already included in lines 2, 5, 9, and 13 should not be reported here.

NAPH also strongly urges CMS to exclude funds received from the Section 1011 program[8] because undocumented immigrants seeking emergency services may not have the necessary documentation to be deemed eligible for charity care under hospitals' charity care policies. If charges associated with these patients cannot be included in overall charity care charges, then funds received to offset these charges should not be used to offset a hospital's overall charity care charges. Furthermore, the Section 1011 program has not been reauthorized.

e. State or Local Indigent Care Programs

[8] Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 1011, 117 Stat. 2066, 2432.

The draft Worksheet S-10 collects uncompensated costs of other state or local indigent care programs above the uncompensated care section and does not include these costs in the total of all non-Medicare uncompensated care in line 30. Unlike Medicare or Medicaid, many state or local indigent care programs are not insurance programs, but rather sources of funding to help subsidize hospitals' overall uncompensated costs. As such, NAPH urges CMS to include the uncompensated portion of state or local indigent care programs in line 30 as part of total uncompensated care.

f. Exclusion of Physician and Other Professional Services

The draft Worksheet S-10 excludes physician and other professional services when calculating charity care and bad debt expenses (lines 19, 22, and 26). In addition to employing physicians and paying community specialists directly for providing care to patients, many NAPH member hospitals also subsidize the cost of physician services to ensure that vulnerable patients continue to have access to necessary physician care. To the extent that CMS is trying to determine the full uncompensated cost of charity care and other low income patients, CMS should allow hospitals to include, in the calculation of charity care and bad debt expenses only, the portion of hospitals' uncompensated costs arising from the provision of physician and other professional services. Because these are actual costs incurred by hospitals in caring for charity care and other low-income patients, NAPH suggests that CMS add additional lines to capture these costs, along with all other uncompensated care costs.

g. Exclusion of the Cost of Treating Underinsured Patients

The draft Worksheet S-10 specifies that for patients covered by a public program or private insurance who would otherwise qualify for charity care, only unpaid deductible and coinsurance payments required by the payer can be included as charity care. It is unclear whether services that are not covered by the public program or private insurance plan can be included here. Because these patients are in essence uninsured for these uncovered services, NAPH strongly urges CMS to clarify that insured patients with uncovered services are deemed uninsured. The value of these services should be included as charity care if they are unpaid.

h. Bad Debt Expenses

The draft Worksheet S-10 requires hospitals to reduce bad debt expenses to cost using a cost-to-charge ratio. When bad debt refers to copayments and deductibles that are not calculated based on charges, this may be inappropriate. For example, many insurance companies have agreements with hospitals to pay a portion of the cost of the services provided to their members and members may be responsible for a copayment amount also based on cost. If the patient doesn't pay this copayment amount after reasonable collection efforts, then the value is written off as bad debt. However, the amount written off is already valued at cost; applying a cost-to-charge ratio to this amount would be inappropriate and would significantly undervalue total bad debt expenses. NAPH suggests that CMS eliminate line 29 and alter line 30 accordingly.

The draft Worksheet S-10 also specifically prohibits hospitals from including obligations of the insurer rather than the privately-insured patient as part of bad debt. This would include

nonpayment by the insurer due to lack of prior authorization and late billing. Because not every element of this process is within the control of hospitals, it would be unfair to penalize hospitals for real expenses incurred in providing patient care. So long as a hospital made a reasonable effort to bill the insurer for its portion, CMS should allow all associated unpaid debt to be counted as bad debt. NAPH strongly urges CMS to clarify that the exclusion of the insurer's obligations from total bad debt expenses applies only if a hospital did not make an attempt to bill the insurer.

i. Medicare Shortfall

Worksheet S-10's stated purpose is to collect data on the cost incurred by the hospital for providing inpatient and outpatient hospital services for which the hospital is not compensated, including uncompensated and indigent care data. NAPH believes that costs for services rendered to all indigent patients should be included, including those eligible for both Medicare and Medicaid. NAPH urges CMS to consider including a section in Worksheet S-10 for the Medicare program.

j. Charity Care Charges for EHR Technology Incentive Payments under ARRA

The draft Worksheet S-10 instructions note that "Charity care charge data, as referenced in section 4102 of the American Recovery and Reinvestment Act of 2009, may be used to calculate the EHR technology incentive payments made to §1886(d) hospitals and critical access hospitals." If CMS intends to use Worksheet S-10 for this purpose, we believe that there are other modifications that are appropriate. Under ARRA, EHR technology incentive payments must be calculated for a "hospital." For Medicare, ARRA uses the term "eligible hospital," which is defined as a subsection (d) hospital,[9] and for Medicaid, ARRA uses the terms "children's hospital" or "acute care hospital."[10] Given that multiple hospitals may operate under one provider number, NAPH believes that data should be collected at the hospital level, as opposed to the provider number level. To allow for such a conclusion with respect to both the Medicare and Medicaid programs' EHR technology incentive payments, CMS should facilitate the reporting of charity care charges; total discharges; and Medicare, Medicaid, and total inpatient bed days on a separate line for each hospital operating under a single provider number.

CMS also should ensure that lines 19 and 20 capture the full scope of charity care provided. As mentioned above, hospitals' costs associated with offering and providing physician and other professional services should be included in lines 19 and 20 to fully account for the value of a hospital's charity care.

* * * * *

[9] 42 U.S.C. § 1395ww(n)(6)(B).
[10] 42 U.S.C. § 1396b(t)(2)(B).

NAPH appreciates CMS' consideration of these comments. Our members, who are dedicated to serving entire communities, including poor and uninsured individuals, are acutely sensitive to changes in Medicare payment policy that have the effect of reducing payments or increasing the administrative burden on our hospitals. If you have any questions about these comments, please contact Lynne Fagnani or Claudine Swartz at (202) 585-0100.

Sincerely,

Larry S. Gage
President