

# NATIONAL ASSOCIATION OF URBAN HOSPITALS

*Private Safety-Net Hospitals Caring for Needy Communities*

June 4, 2010

Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
P.O. Box 8011  
Baltimore, MD 21244-1850

**Attention: File Codes CMS-1498-P and CMS-1498-P2**

To Whom It May Concern:

I am writing on behalf of the National Association of Urban Hospitals (NAUH) to convey our views on the proposed FY 2011 Medicare inpatient prospective payment system regulation, published as “Medicare Program: Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Long Term Care Hospital Prospective Payment System, etc.” This was published in the *Federal Register*, Vol. 75, No. 85, May 4, 2010, pp. 23851–24362.

NAUH is particularly concerned about two aspects of the proposed regulation: the adjustments to the market basket increase that result in a negative update for FY 2011 and the proposed outlier threshold for FY 2011. We address these two issues separately below.

## **Inpatient Rates**

The proposed rule calls for a 2.4 percent increase in the market basket adjustment for inpatient services. This increase, however, would be more than offset by a downward adjustment of 2.9 percent related to hospital coding practices. Other changes bring the overall reduction to minus 0.1 percent.

NAUH objects to this proposal to reduce inpatient payments on several grounds.

First and foremost, health care costs are rising, not falling. Any Medicare adjustment that fails to keep pace with rising costs will damage the financial health of hospitals. This is especially a challenge for private, non-profit urban safety-net hospitals, so many of which are losing money in a struggling economy in the face of the rising number of uninsured people that has increased the demand for uncompensated care and the growing number of low-income people who have lost their health insurance and now depend on Medicaid, a notorious under-payer, for their care. It is absolutely essential that Medicare at least carry its own weight in these troubled times, and any adjustment that fails to reflect growing hospital costs will damage the health care system as a whole and especially damage the urban health care safety net at the very time when the need for that safety net is greater than it has been at any time in Medicare’s history.

Second, CMS already adjusted rates downward in the past to reflect its concern about hospital coding practices. This adjustment is redundant – and, we believe, overkill.

Third, NAUH questions CMS's reduction of the case-mix index in response to its belief that the index has risen solely because of hospital coding practices. The MS-DRG system was introduced in part because it would more accurately reflect the severity of illness of Medicare patients than the previous DRG system. We believe this is precisely what has occurred: that the level of severity is greater than CMS had anticipated and the MS-DRG system has captured this greater level of severity. Many hospitals have upgraded their information systems in recent years, and such upgrades have improved their ability to document accurately and precisely the nature and extent of their patients' maladies. This, we believe, is not necessarily "upcoding;" it is just as likely "right-coding" – doing a better job of exactly what CMS is asking them to do. Further, with the aging of the Medicare population, we find it entirely plausible for there to be more medical complications and more comorbidities, which would be a reasonable cause for a rise in the case-mix index.

And fourth, passage of the Patient Protection and Affordability Care Act (PPACA) has already necessitated a decrease in Medicare inpatient payments of 0.25 percent in the current (2010) fiscal year and will require another cut of 0.25 percent in FY 2011. The legislatively mandated cut for FY 2011, on top of the cuts CMS proposes in this regulation, will unquestionably hurt many hospitals – especially urban safety-net hospitals, because of the large numbers and high proportions of low-income and uninsured patients they serve. We urge CMS to consider the cumulative impact of these two cuts and to increase, not decrease, Medicare inpatient payments in FY 2011 in keeping with the clear rise in the cost of delivering hospital inpatient care.

## **Outliers**

NAUH objects to CMS's proposal to raise the outlier threshold from its current level of \$23,140. The proposed regulation to which we are responding calls for raising this threshold to \$23,970 in FY 2011 while the supplemental proposed regulation, necessitated by the passage of PPACA and published in the *Federal Register* on Friday, May 21, 2010, calls for raising it even more, to \$24,165.

Congress mandates that outliers account for between five and six percent of Medicare inpatient payments. In the current fiscal year, according to CMS, outlier payments are on target to account for only 4.7 percent of total Medicare inpatient payments – well below the congressional target. This has been the case for most of the past decade, and increasing the threshold, even in light of CMS's intention to reduce inpatient rates, makes it unlikely that outlier payments will reach even the lowest level of the desired range in FY 2011 as well.

Reaching this target is important, and NAUH believes it is especially important to private, non-profit urban safety-net hospitals. All hospitals take on outlier cases in good faith, and for most of the past decade, that good faith has been rewarded with inadequate reimbursement. Too often, moreover, the victims of this inadequate reimbursement are urban safety-net hospitals, so many of which are tertiary-care hospitals that provide the very types of services that become outlier cases. These hospitals are at a financial disadvantage compared to their peers in many ways; outlier policy should not be among them. For this reason, NAUH urges CMS to lower the outlier threshold, not to raise it, so that Medicare inpatient payments will fall within the congressionally mandated target range for outlier payments.

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The National Association of Urban Hospitals advocates for adequate recognition and financing of private, non-profit, urban safety-net hospitals that serve America's needy urban communities. These urban safety-net hospitals differ from other hospitals in a number of key ways: they serve communities whose residents are much older and poorer; they are far more reliant on Medicare and Medicaid for revenue; they provide far more uncompensated care; and unlike public safety-net hospitals, they have no statutory entitlement to local or state funds to underwrite their costs. NAUH's role is to ensure that when federal officials make policy decisions, they understand the implications of those decisions for these distinctive urban safety-net hospitals. NAUH pursues its mission through a combination of vigorous, informed advocacy, data-driven positions, and an energetic membership with a clear stake in the outcome of public policy debates.

NAUH appreciates the opportunity to present these comments to CMS and invites questions about the concerns we have raised.

Sincerely,

Ellen J. Kugler, Esq.  
Executive Director