NATIONAL ASSOCIATION OF URBAN HOSPITALS

Private Safety-Net Hospitals Caring for Needy Communities

March 27, 2003

Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8010
Baltimore, MD 21244-8010
Attention: CMS-1243-P

Re: 42 CFR Part 412 (CMS-1243-P)

To Whom It May Concern:

I am writing in my capacity as executive director of the National Association of Urban Hospitals to convey our comments on 42 CFR Part 412, CMS-1243-P, a proposed regulation change entitled "Medicare Program: Proposed Change in Methodology for Determining Payment for Extraordinarily High-Cost Cases (Cost Outliers) Under the Acute Care Hospital Inpatient Prospective Payment System."

The National Association of Urban Hospitals and the Importance of This Regulation

The National Association of Urban Hospitals (NAUH) advocates for adequate recognition and financing of private urban safety-net hospitals that serve America's needy urban communities. These private, 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 private, 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.

Medicare's cost outlier policy is important to NAUH because most urban safety-net hospitals also are tertiary-care hospitals. Historically, the sickest patients and the most difficult cases in our communities end up in our hospitals, and some of these cases end up being Medicare cost outliers or at least candidates for Medicare cost outlier status. These few cases can have an enormous impact on the financial performance of urban safety-net hospitals. That financial performance, in turn, has a considerable impact on access to care for our entire communities, including Medicare recipients, low-income residents, and the uninsured. Consequently, even small nuances in policy change have a potentially dramatic impact on our hospitals. For this reason, we wish to convey our views on the proposed changes in the Medicare cost outlier regulation.

10 Pidgeon Hill Drive • Suite 150 • Sterling, VA 20165 • (703) 444-0989 • Fax: (703) 444-3029

NAUH's Recommendations

If the Centers for Medicare & Medicaid Services (CMS) intends to adopt and implement the proposed regulation, the National Association of Urban Hospitals has four specific recommendations.

1. ***The method for determining future thresholds must reflect the changes in the regulation.***

NAUH believes that the method for determining future thresholds for cost outlier status must be changed to reflect the broader effects of this proposed regulatory change. If CMS uses its purely historical approach to recalculating the threshold, the inclusion of the data that led to the proposed regulation change will result in the threshold being set too high. This would result in failure to pay out the targeted amount of DRG payments as outlier payments and the rejection of legitimate claims for outlier status. We believe that the method for determining the threshold should reflect this consideration and produce a lower threshold that, under more stringent requirements, will enable all legitimate claims to qualify for cost outlier status.

2. ***The threshold must be recalculated at the same time that you change the regulation.***

NAUH believes that implementing the proposed regulation without simultaneously recalculating the threshold for qualification for cost outlier payments would detract from the desired impact of the regulation change. Specifically, implementing the new regulation without recalculating the threshold, while having the desired effect of deterring those whose aggressive charge increases have resulted in significant cost outlier payments, would not benefit in any way those that have incurred legitimate extraordinary expenses caring for Medicare recipients. Changing the regulation without also simultaneously changing the threshold would reduce the number of eligible claims – including legitimate claims by providers that have genuinely incurred exceptional costs on selected Medicare inpatient cases – because the vulnerabilities of the old method have had the effect of artificially raising the threshold and, as stated in the proposed role, "have caused the threshold to increase dramatically for 2003." Hospitals have felt the pain of the ever-increasing threshold, especially with the increases in that threshold over the last several years. In particular, hospitals whose ratio of costs to charges have not changed in recent years have seen their outlier payments dwindle. These hospitals have legitimate outlier claims that should be treated as such. Finally, because implementing the new regulation and lowering the threshold without precisely calculating the appropriate level of that new threshold could very well reduce the number of qualified claims, this could prevent CMS from reaching the congressionally targeted goal for outlier payments of five to six percent of total DRG payments plus outlier payments.

NAUH recognizes that the effort to recalculate the threshold could take some time, but we believe this would be time well-spent. Accordingly, we urge CMS to postpone implementation of the regulation until it has recalculated the threshold; we believe this could be completed by October 1, 2003. If postponement is considered undesirable, we recommend temporarily using the 2002 threshold, not the 2003 threshold, until the recalculation can be completed because we believe the 2002 threshold more appropriately reflects the goals and impact of the new regulation.

10 Pidgeon Hill Drive • Suite 150 • Sterling, VA 20165 • (703) 444-0989 • Fax: (703) 444-3029

3. Only reconcile cost outlier payments for hospitals whose ratios of costs to charges have increased or decreased by more than 15 percent from the previous year.

The proposed regulation calls for potentially reconciling all cost outlier claims based on settled cost reports. We believe that this imposes too great a burden on hospitals that have experienced legitimate Medicare cost outlier cases. If you choose to reconcile every cost outlier claim, it could take as long as two years after hospitals submit their cost reports for the final payments to be determined. Consequently, hospitals will not know what their true outlier payments are until several years after the close of their fiscal year. This is hardly prospective. Because the primary objective of the proposed regulation is to put an end to overly aggressive charge increases by those filing claims for cost outlier payments, we believe that flagging claims by providers that have increased or decreased their cost-to-charges ratio by more than 15 percent would have the desired impact of calling CMS's attention to claims that perhaps deserve additional scrutiny without placing such a heavy burden on all providers.

4. Implement a severity-based DRG system.

The technology underlying the Medicare DRG system has greatly improved in the 30 years since its adoption. A DRG system that more precisely captures the severity of patient illness or injury would encompass many, if not most, of the Medicare hospital cases that are currently reimbursed on a cost outlier basis (it also would reimburse providers much more accurately and appropriately for the services they provide). This would significantly reduce the number of cost outlier payments that CMS would make annually and eliminate a great deal of the additional paperwork, review, and analysis associated with those payments. The Medicare Payment Advisory Commission (MedPAC) agrees with this approach and has endorsed the replacement of the current Medicare DRG system with a severity-based system, and we believe that CMS has the authority to make this change. NAUH supports MedPAC's recommendation and urges CMS to adopt a severity-based DRG system.

*   *   *

We appreciate your consideration of our recommendations and welcome any questions you may have regarding their intention, interpretation, or implementation.

Sincerely,

Ellen Kugler, Esq.
Executive Director

10 Pidgeon Hill Drive • Suite 150 • Sterling, VA 20165 • (703) 444-0989 • Fax: (703) 444-3029