June 14, 2019

 **D R A F T**

Ms. Seema Verma

Administrator

Centers for Medicare & Medicaid Services

Department of Health and Human Services

Attention: CMS-1677-P

P.O. Box 8013

Baltimore, MD 21244-8013

File Code: CMS–1716-P

***RE: CMS-1716-P, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2020 Rates; Proposed Rule***

Dear Ms. Verma:

On behalf of its member hospitals, the Michigan Health & Hospital Association (MHA) appreciates this opportunity to provide comments to the Centers for Medicare & Medicaid Services (CMS) regarding the proposed rule to update the hospital Inpatient Prospective Payment System (IPPS) for fiscal year (FY) 2020. The proposed rule is estimated to provide a $79 million, or 1.9%, increase to Michigan hospitals in FY 2020, which is less than the projected 5.5% to 7% increase in healthcare inflation for 2020. The absence of adequate Medicare payments challenges the financial viability of Michigan hospitals and their ability to provide care to Medicare and other patients. The latest Medicare margins data reflects that statewide Medicare fee-for-service (FFS) pays Michigan PPS hospitals approximately 5 percent less than the cost of providing care to Medicare beneficiaries, resulting in an annual shortfall of $335 million.

Our comments regarding the IPPS proposed rule focus on:

* Requesting additional funding to reduce disparities in the Medicare wage index. The MHA objects to the CMS proposal to increase the area wage index values for hospitals in the bottom quartile at the expense of those in the top quartile.
* Objecting to the proposed use of a single year of Worksheet S-10 data for allocating the nearly $8.5 billion uncompensated care (UCC) payment pool among all eligible hospitals. We also urge the CMS to implement an annual review of Worksheet S-10 data for all hospitals.
* Delaying the proposed changes in severity level assignment for approximately 1,500 ICD-10-CM procedure codes.
* Restoring the ATRA Documentation and Coding Offset.
* Increasing the New Technology Add-on Payments (NTAP).
* Paying for Chimeric Antigen Receptor T-cell (CAR-T) Therapy services on a reasonable cost basis.
* Releasing the final program factors for the three Medicare quality-based programs prior to Oct. 1.
* Opposing the CMS use of the same measure or a variation of it in multiple quality-based programs
	+ Objecting to the proposed new electronic clinical quality measure, Hospital Harm –opioid-related adverse events, since it is not yet endorsed by the National Quality Forum.

**WAGE INDEX CHANGES**

The area wage index (AWI) is used to adjust Medicare operating and capital payments for geographic variations in labor costs. For FY 2020 and at least four years, the CMS proposes to reduce disparities in the Medicare AWI among hospitals that have a low AWI value and those with a high AWI by increasing the AWI for hospitals in the bottom quartile funded by a decrease in the AWI for those in the top quartile. The MHA appreciates the CMS’ recognition of hospitals with low wage rates. In the past this was recognized for the frontier states with an increase to 1.0 and funded by new funds. We believe that the CMS could implement a similar solution for low wage hospitals with new funding as it has done to date. It is inappropriate for the CMS to arbitrarily reduce the wage index for high wage hospitals to achieve budget neutrality. The high AWI is the result of **actual** wages and benefits paid to employees, not an arbitrary amount selected and reported by hospitals. Any reduction in Medicare payments would force hospitals to reduce staff, immediately implement wage and benefit reductions for staff and/or reduce services to accommodate this arbitrary reduction in Medicare payments. Hospital wages and benefits are high in certain CBSAs to be competitive with the prevailing wages and benefits for other area industries.

The wage index has been a controversial issue for roughly a decade and the disparity among geographic areas continues to grow, further challenging the ability of some hospitals to recruit staff. The MHA recognizes this, since we have disparities among the Michigan CBSAs. We suggest that the CMS convene a meeting of interested parties to thoroughly vet all underlying issues, not just symptoms, to develop an AWI policy that will address the core issues that have created these problems. While the MHA ardently supports improving the wage index for hospitals with low wage rates, especially in our rural areas, t**he MHA opposes the CMS’ proposed improvement of AWI values for some hospitals funded by a payment cut for other hospitals, especially when Medicare pays less than the cost of providing care.** We believe that the CMS can readily locate additional funds to increase the AWI for hospitals in low-wage areas.

**ALLOCATION OF UNCOMPENSATED CARE POOL PAYMENTS**

For FY 2020, the CMS proposes to use FY 2015 Worksheet S-10 data to allocate the nearly $8.5 billion uncompensated care (UCC) pool. The CMS audited the 2015 worksheet S-10 data for approximately 600 hospitals, or roughly 25% of all hospitals that are eligible for disproportionate share hospital (DSH) payments. The CMS also seeks comment on whether the use of 2017 worksheet S-10 data is a better data source for this distribution. Since the CMS implemented the DSH formula mandated by the Affordable Care Act in FY 2014, it has used three years of data to mitigate the impact of significant swings from year-to-year. **The MHA recommends that the CMS continue to use three years of data rather than only one year of data for allocating the UCC pool. Specifically, the MHA recommends that the CMS calculate the FY 2020 UCC factor 3 for each hospital based on two-thirds of their FY 2019 UCC factor 3 and one-third of their FY 2017 factor 3.**

In addition, the MHA encourages the CMS to take several steps regarding the use of Worksheet S-10 data, including:

***Publicly Releasing the CMS Audit Instructions for Worksheet S-10***

While the CMS stated in the FY 2018 proposed rule that it was working on audit instructions for the Medicare Administrative Contractors (MACs), it did not make these publicly available; instead, it indicated that, for program integrity reasons, the CMS desk review and audit protocols are confidential and are for use only by the CMS and the MAC. **The MHA believes that the CMS should be transparent and release the audit instructions and S-10 guidance, which would provide hospitals with necessary details on how to report items on worksheet S-10**. Information regarding how they will be reviewed would help hospitals provide more accurate data and potentially reduce inconsistencies in data reporting.

***Improve Instructions/Form for Worksheet S-10***

Total Bad Debt Expense reported on Line 26 of worksheet S-10 includes claims where the balance was written off to bad debt expense and claims where only the patient liability amount was written off to bad debt expense. The patient liability amount includes Medicare patients. Reimbursable Medicare bad debt expense (listed on line 27.01) is removed to arrive at non-Medicare bad debt expense on line 28 (includes balances-after-insured, uninsured patients, and Medicare allowable, non-reimbursable bad debt). Line 29 calculates the cost of non-Medicare bad debt expense by multiplying Line 28 by the hospital’s cost-to-charge ratio (CCR).

Applying a hospital’s CCR to the amount reported on Line 28 is not appropriate and understates the cost of bad debt. The CCR reflects the relationship between a hospital’s cost and charges and can be used to arrive at a proxy for the cost of services provided to a patient. Given the patient liability amounts faced by many insured patients today, an increasing portion of a hospital’s bad debt is related to deductibles, coinsurance and copayments. **Similar to the handling of charity care on worksheet S-10, the MHA recommends that the CMS create separate columns for insured and uninsured patients on the worksheet.** The column for uninsured patients, which is reported at charges, should be multiplied by a hospital’s CCR to approximate the cost of bad debt. The column for insured patients (which should include amounts related to Medicare allowable, nonreimbursable bad debt) should not be reduced to cost, since it is inappropriate to reduce the patient liability amounts to cost.

***Clarify Instructions/Provide Examples for Worksheet S-10***

Through Transmittal 10 in November 2016, theCMS made refinements to worksheet S-10 that improved the reporting instructions. However, hospitals continue to provide examples where the appropriate treatment of UCC cost is unclear based on the revised instructions. As a result, the handling of these cases is often left to the discretion of both hospital reimbursement staff and the MAC auditors, leading to inconsistent treatment across hospitals. **The MHA requests** **that the CMS provide guidance regarding the treatment of these cases for purposes of worksheet S-10** to improve the comparability of the UCC data collected from hospitals and the resulting allocation of UCC DSH payments.

***Calculation of Factor 3 for FY 2020***

The CMS proposes to use audited S-10 UCC costs from FY 2015. As an alternative, the CMS suggests that the agency would consider using the unaudited S-10 UCC data from FY 2017 cost reports, indicating that revisions to cost report instructions should result in more consistency in the data reported.

In the 2017 IPPS final rule, the CMS implemented a change to use three years of data instead of one for calculating factor 3 to mitigate undue fluctuations in the amount of uncompensated care payments to hospitals from year to year and smooth over anomalies between cost reporting periods. The CMS’ primary rationale was the use of Supplemental Security Income ratios (which are unstable from year to year) that were part of the formula that used the traditional DSH components to calculate Factor 3.

While the MHA supports the use of audited data, we object to using only one year of data. Using three years of data will minimize unpredictable payment swings from year to year.

Given concerns that the audit criteria have not been consistently applied, t**he MHA recommends that the CMS continue using three years of data, consistent with its practice since FY 2017. As previously stated, we recommend that the CMS calculate the FY 2020 factor 3 using two-thirds of the final FY 2019 factors and one-third of the FY 2017 factors. In addition, the MHA encourages the CMS to review the data for all hospitals using a desk review process similar to that used annually for reviewing wage index data.** We believe this would help improve consistency across the data.

***Create an Appeals Process for Disallowed Uncompensated Care***

**The CMS must provide hospitals with a mechanism to appeal adjustments made to data reported on worksheet S-10.** Currently, hospitals are only allowed to appeal adjustments that have a material settlement impact on the cost report. While the data used to calculate the UCC payment will have a material payment impact on hospitals, it is not a settlement item on the Medicare cost report. **The MHA believes that the CMS should create a process by which disallowed UCC cost could be appealed to the Provider Reimbursement Review Board, consistent with other items on the Medicare cost report.**

**PROPOSED CHANGES TO SEVERITY LEVEL ASSIGNMENTS**

In the FY 2008 IPPS final rule, the CMS described its process for establishing three different levels of Complications or Comorbidities (CC) severity into which it would subdivide the diagnosis codes. The categorization of diagnoses as a Major Complications or Comorbidities (MCC), a CC or a non-CC was accomplished using an iterative approach in which each diagnosis was evaluated to determine the extent to which its presence as a secondary diagnosis resulted in increased hospital resource use.

In the FY 2018 IPPS final rule, the CMS provided notice of its plans to conduct a comprehensive review of the CC and MCC lists for FY 2019, similar to the FY 2008 comprehensive review.

The CMS’ clinical advisers recommended a change in the severity level designation for nearly 1,500 ICD-10-CM diagnosis codes. The net result of the proposed changes would be a decrease of 145 codes designated as MCC, a decrease of 837 codes designated as CC, and an increase of 982 codes designated as non-CC, which restructures many Medicare Severity Diagnosis Related Groups (MS-DRGs) to non-CC status**. Since FY 2008, many routine inpatient cases have shifted to the outpatient setting, leaving only the more compromised patients or highly acute patients in the inpatient setting. The proposed CMS changes don’t comport with reality experienced by hospitals. The MHA urges the CMS to delay implementation of these changes until the agency provides adequate data.**

**FULL RESTORATION OF ATRA DOCUMENTATION AND CODING OFFSET**

The CMS implemented a 0.8% cut to the annual marketbasket update in FYs 2014-2016 to recoup the effect of documentation and coding changes that it believed do not reflect real changes in patient acuity. For FY 2017, the CMS increased this cut from 0.8 percentage points to 1.5 percentage points to achieve the $11 billion targeted by the American Taxpayer Relief Act (ATRA). In total, these cuts reduced hospital inpatient payments by 3.9%. The CMS mandated a positive 0.5% adjustment for each year from FY 2018 through FY 2023 to offset the previous recoupment. The 21st Century Cures Act subsequently reduced the FY 2018 “add-back” from 0.5% to 0.4588%. Cumulatively after all negative and positive adjustments, hospitals will have a permanent payment reduction of approximately 1%.

**The MHA believes that the CMS should restore the full 3.9% that was withheld from hospitals. We recommend that the CMS use its authority and adjust hospital payment amounts to return the payments previously withheld from hospitals.**

**PROPOSED CHANGE TO ADD-ON PAYMENTS for NEW SERVICES & TECHNOLOGIES (NTAP)**

*Proposed Change to the Calculation of the Inpatient New Technology Add-On Payment*: The CMS proposes that, beginning with discharges on or after Oct. 1, 2019, if the costs of a discharge involving a qualifying new technology exceeds the full DRG payment (determined by applying CCRs, including payments for indirect medical education and DSH, but excluding outlier payments), Medicare will make an add-on payment equal to the lesser of:

* + 65% (up from 50%) of the costs of the new medical technology.
	+ 65% (up from 50%) of the amount by which the costs of the case exceed the standard DRG payment. Unless the discharge qualifies for an outlier payment, the additional Medicare payment is limited to the full MS-DRG payment plus 65% of the estimated costs of the new technology or services.

We appreciate efforts by the CMS to increase the NTAP. However, even if the payment percentage is increased from 50% to the proposed 65%, hospitals that provide qualifying NTAP services will still experience a loss. While the current payment formula is defined in statute and may require congressional action to remedy, we believe it is knowingly inappropriate for the CMS to expect hospitals to provide these services to patients with a Medicare payment that is less than the cost of the new technology. **The MHA requests that the CMS increase the NTAP payment percentage to 100% to eliminate these losses.**

*Payment Methodology for CAR-T Therapies*: The proposed rule seeks input on several issues for discharges that include CAR-T therapy. Hospitals have indicated that the current MS-DRG payment (including NTAP and outliers) for cases involving CAR-T is insufficient to cover the cost of care.

The CMS payment mechanism for CAR-T therapies fails to provide full reimbursement for this cost due to the application of the hospital’s CCR rather than a method that specifically addresses the higher cost of CAR-T. **Given the high cost and low volume of these services, the MHA recommends that the CMS establish a payment for the CAR-T therapeutic agent on a reasonable cost basis similar to solid organ transplants.**

Instead of including the cost of the CAR-T agent in the MS-DRG payment, the CMS should make separate payments for the therapy and related inpatient hospital stay. A separate payment based on the Average Sales Price for the CAR-T therapeutic agent should be made in cases where the claim indicates it was used. This change would result in payments for the specific agent that are more accurate and better reflect the cost of the service.

**TIMING FOR RELEASE OF QUALITY-PROGRAM FACTORS**

Historically, the CMS has finalized factors for the value-based purchasing, readmissions reduction and hospital-acquired conditions reduction programs after the beginning of the fiscal year, which has meant that hospitals do not know their actual payment adjustment for these programs until several months into the new fiscal year. For the FY 2019 programs, the CMS did not release final factors until February. This delay is problematic for hospitals, since these factors impact their Medicare payments back to Oct. 1. Hospitals are subject to CMS deadlines for data submission related to the quality-based programs. If the deadlines are too close to the beginning of the fiscal, we recommend that the CMS revise these deadlines or the timeframes for the quality program data elements to ensure the final factors can be released prior to Oct. 1. Late release of this data by the CMS creates unnecessary administrative burden for the MACs and hospitals related to the reprocessing of claims. In addition, hospitals are left in limbo, not knowing their final Medicare payment rate until months after the start of the federal fiscal year. This is further compounded by the Medicare Advantage plans using those factors. **The MHA recommends that the CMS release final program factors before Oct. 1, prior to the beginning of the fiscal year.**

**USE OF A MEASURE IN MULTIPLE QUALITY-BASED PROGRAMS**

The CMS did not propose changes to the value-based purchasing (VBP) program measure set or scoring methodology. However, the CMS proposes to adopt the same administrative requirements for submitting, reviewing, correcting and validating healthcare-associated infection (HAI) data that is used in the Hospital-Acquired Condition (HAC) reduction program. The requirements would take effect with data reported starting Jan. 1, 2020, and impact FY 2022 payments. The CMS proposes minor updates to the HAI measure validation process. While the CMS’ proposal to use the same HAI measure administrative requirements across the VBP and HAC programs is an improvement, **the MHA remains opposed to the use of the same measure or a variation of it in multiple quality-based programs.** It is inappropriate to penalize hospitals multiple times for the same issue. If the CMS adopts the proposed change, we request that the CMS clarify how the results of the HAI measure validation in the HAC reduction program would affect the ability of a hospital to participate in the VBP program.

**PROPOSED NEW ELECTRONIC CLINICAL QUALITY MEASURES (eCQMs)**

The CMS proposes two new eCQMs related to the safety of opioid prescribing and administration:

* Safe use of opioids – concurrent prescribing.
* Hospital Harm – opioid-related adverse events.

The MHA opposes the proposed adoption of the Hospital Harm – opioid-related adverse events measure, since it is not yet endorsed by the National Quality Forum (NQF). In addition, the Measure Applications Partnership, which reviews all measures proposed by the CMS prior to rulemaking, urged the CMS to consider the impact of the measure on chronic opioid users by either excluding them from the measure or including chronic opioid use status in risk adjustment. Consistent with our comments in past years regarding new measures, **the MHA opposes the use of measures that have not been endorsed by the NQF.**

**SUMMARY**

The MHA appreciates this opportunity to provide comments to the CMS regarding this proposed inpatient rule. If you have questions regarding this comment letter, please contact Vickie Kunz at (517) 703-8608 or vkunz@mha.org.

Sincerely,

Marilyn Litka-Klein

Vice President, Health Finance

Policy and Health Delivery