Minnesota Hospital Association

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The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

Submitted electronically through www.regulations.gov.

RE: Comments on Proposed Rule CMS 42 CFR Parts 412, 413, and 495 [CMS–1716–P] RIN 0938–AT73 Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2020 Rates; Proposed Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Promoting Interoperability Programs Proposed Requirements for Eligible Hospitals and Critical Access Hospitals.

Dear Ms. Verma:

On behalf of our 141 member hospitals and health systems, the Minnesota Hospital Association (MHA) offers the following comments and suggestions regarding the Centers for Medicare & Medicaid Services' (CMS) proposed rules for 2020 Inpatient Prospective Payment Systems for Acute and Long-Term Care Hospitals (Proposed Rule).

MHA generally supports the recommendations and detailed comments submitted by the American Hospital Association (AHA). Rather than duplicating AHA's analysis and suggestions, MHA's comments will focus on the topics of most concern to Minnesota's hospitals and health systems. Some of MHA's comments may differ or be more nuanced positions from those conveyed by the AHA.

Specifically, we are providing comments and recommendations in the following areas:

- Area Wage Index modifications
- Disproportionate Share Hospital (DSH) Payment Calculation
- Graduate Medical Education (GME) payments
- New Technology Add-on Payments
- Reclassification of certain secondary diagnosis codes
- Adoption of quality measures

Area Wage Index Modifications

MHA's greatest concerns with the Proposed Rule pertain to the suggested changes to the Area Wage Index (AWI) and related policies that would further disadvantage Minnesota's already low-cost and high-quality care delivery system for Medicare beneficiaries. ***MHA respectfully requests that CMS exclude its proposed AWI changes from the final rule.*** If CMS is intent upon moving forward with changes in federal fiscal year (FFY) 2020, it should do so only with new funding and in a manner in which no state's or region's AWI decreases rather than in a budget-neutral manner as proposed.

Addressing AWI Disparities between High and Low Wage Index Hospitals

CMS noted that many comments from the Wage Index Request for Information (RFI) in the FFY 2019 IPPS proposed rule reflected *"a common concern that the current wage index system perpetuates and exacerbates the disparities between high and low wage index hospitals."* Another common thread was concern over the rural floor calculation allowing a limited number of hospitals to manipulate the AWI system to achieve a higher rural floor for a particular state, at the expense of other states, thereby further increasing AWI disparities.

In response, CMS proposes to reduce the disparity between high and low wage index hospitals by increasing the AWI for hospitals with a wage index value in the bottom quartile of the nation. This increase would be half of the difference between the hospital's pre-adjustment wage index, and the 25th percentile wage index value across all hospitals. Effective FFY 2020, this policy would be in effect for at least four years purportedly to give those hospitals time to increase employee compensation.

MHA appreciates CMS acknowledging that Medicare payment rates are below the actual cost of care delivery as well as the need for hospitals' compensation levels to be sufficient to recruit and retain the highly educated and skilled workforce necessary to provide Medicare beneficiaries with meaningful access to high quality care. ***MHA does not support the CMS proposal to make across the board adjustments for hospitals in the lowest AWI quartile.***

The suggested approach attempts to remedy Medicare's low payment rates and perceived inequities in its payment formula for certain hospitals by further reducing payments to other hospitals. This approach would not solve the fundamental problems with Medicare payment rates. In other words, budget-neutral solutions to a system that is underfunded across-the-board only shifts the degree of underfunding and inequities; it does not solve or mitigate the inequities.

The AWI reflects the actual wages paid in an area. Could there be adjustments made to better recognize variability of wage rates within wage catchment areas? Yes. Will increasing Medicare payments to better recognize local costs be welcomed? Of course.

But the Proposed Rule is premised on the mistaken assumption that particular hospitals will increase local employee salaries, and further, on its failure to account for all of the other demands on hospitals' resources. Medicare reimbursement only represents a portion of hospitals' overall revenue stream and employee salaries are only one component of hospitals' overall expenses. The agency's proposal makes an illogical leap that increasing one limited area of a hospital's revenue stream will result in an increase in one of its expenses, salaries. Hospitals

could potentially use the modest increase in revenue to invest in health information technology, replace aging equipment or make deferred maintenance repairs to facilities instead.

Budget Neutrality Offset for the Opportunity to Increase Employee Compensation

For the four years in which the proposed higher payments to select hospitals would apply, CMS would impose a budget neutrality adjustment on other hospitals to offset these costs. CMS suggests targeting hospitals above the 75th percentile wage index value, those it deems to be *"high wage index hospitals,"* with cuts equivalent to 4.3% of the difference between their individual wage index and the 75th percentile wage index value for all hospitals.

The proposal by CMS to create a budget-neutral approach to "level" the AWIs is unfair and misguided. Merely because a hospital's AWI is above the 75th percentile does not mean that its Medicare payments are closer to covering its actual costs of care. It is entirely possible that a hospital above the 75th percentile loses more money per Medicare beneficiary served than a hospital with an AWI below the 25th percentile.

In other words, CMS's AWI leveling approach is fundamentally premised on the assumption that a hospital's AWI does *NOT* reflect the actual labor costs in the area. If that assumption is correct and the AWI methodology is simply unreliable, then CMS should not rely on the AWI as a basis for redistributing payments for the purpose of trying to raise labor costs at certain hospitals. On the other hand, if CMS believes the AWI is an adequate reflection of labor costs, then cutting payments to high wage index hospitals is based on a faulty assumption that it is better suited to absorb a cut in Medicare rates than a low wage index hospital is to weather keeping its current Medicare rates.

In short, if the AWI is flawed, CMS should determine how it is flawed and propose changes that will more accurately reflect labor costs in different markets. If the AWI is not flawed, then artificially increasing one area's index at the expense of another area's index ultimately undermines the core purpose of the AWI - to measure the labor costs in particular markets – because CMS will be enhancing or cutting payments regardless of the actual labor costs hospitals experience.

One-year Cap on Cuts to High Wage Index Hospitals

As the proposed changes to the FFY 2020 wage index calculation could lead to large, sudden decreases in some hospitals' AWI values, CMS would cap a hospital's FFY 2020 wage index cut so its AWI value would not fall below 95% of its FFY 2019 AWI value. This cap would be removed in FFY 2021 and those hospitals will bear the full force of the proposed cut to their AWI value. CMS also intends to apply a budget neutrality adjustment of 0.998349 to the FFY 2020 IPPS rate to account for this transition, thereby effectively imposing a cut on hospitals that do not meet its "high wage index" description.

As stated above, MHA does not support the overall CMS proposal to adjust the AWIs in the manner that CMS has outlined. While capping cuts to hospitals for a year mitigates the short-term impact of a poorly designed and misguided policy, the policy remains poorly designed and misguided.

Wage Index Reclassifications

Use of Wage Index Data Post-Urban to Rural Reclassification

In order to ensure that the rural floor policy remains as one *"designed to address anomalies of some urban hospitals being paid less than the average rural hospital in their States,"* CMS proposes to remove wage index data from urban hospitals that reclassify as rural when calculating each state's rural floor beginning FFY 2020. This seems reasonable. MHA suggests that CMS monitor its impacts and reassess whether it accomplishes the intended policy goals.

Urban to Rural Reclassifications: Easing Administrative Burden

Currently, hospitals wishing to apply for an urban to rural reclassification must mail the application to the CMS Regional Office, and may not submit through fax or other electronic means. The Proposed Rule would eliminate this restriction and allow these applications to be submitted by mail, fax, or other electronic methods. While MHA hopes applications submitted via fax are rare, we applaud this streamlining and modernizing of the reclassification process.

Elimination of Copy Requirement to CMS

Currently, hospitals applying for a wage index reclassification must submit the applications and supporting documentation to the MGCRB in the method prescribed by the MGCRB, with an electronic copy sent to CMS. Because the MGCRB requires such documentation to be submitted electronically through the Office of Hearings Case and Document Management System (OH CDMS) for FFY 2020 and subsequent reclassifications, the Proposed Rule would eliminate the requirement for hospitals to send a copy to CMS. This will reduce administrative burden on hospitals. MHA applauds this streamlining of the reclassification process and encourages CMS to continue seeking similar opportunities to reduce unnecessary and avoidable duplication of effort for Medicare providers.

Disproportionate Share Hospital (DSH) Payment Calculation

Adjustment to Factor 3 Determination

CMS began to phase-in the use of data reported on Line 30 of Worksheet S-10 (Charity Care and Non-Medicare Bad Debt Expense) of the Medicare cost report in order to determine the UCC payment factor (Factor 3), starting with FFY 2014 cost reports for DSH payments in FFY 2018. CMS had used Medicaid and Medicare SSI days as a proxy for uncompensated care in Factor 3 since FFY 2014 because of concerns with data variability and lack of reporting experience with Worksheet S-10. However, in the FFY 2018 IPPS final rule, CMS claimed that the correlation between Factor 3 values calculated using data on uncompensated care from Worksheet S-10 and those calculated using data from the IRS Form 990 has improved.

For FFY 2020, CMS is proposing to utilize a single year of Medicare cost report data from the audited FFY 2015 S-10 Worksheet, and to discontinue the three year averaging process for Factor 3. Additionally, CMS seeks public comment on whether FFY 2017 S-10 data should be used in lieu of the audited FFY 2015 S-10 data.

MHA members remain concerned about the accuracy and consistency of Worksheet S-10 data. Last year's audit of FY2015 S-10 data revealed inconsistencies both in the reporting by hospitals and in the auditing by Medicare Administrative Contractors (MACs). MHA's members reported that the MACs requested a very large amount of data to justify the uncompensated care data, yet the MACs had very little time to adequately evaluate it. This first-year's audit should be seen as only the first step in a multi-year process that needs to occur before the audit standards can be regarded as reliable.

MHA asks that CMS take additional steps and time to ensure the accuracy, consistency and completeness of these data. Also, MHA discourages CMS from using FY2017 data because they have not been audited.

Uncompensated Care Costs

MHA supports the CMS proposal to define uncompensated care costs as the cost of all charity care and non-Medicare bad debt. This definition enjoys widespread acceptance and captures the issues of uninsured levels and uncompensated care burdens faced by hospitals in both Medicaid expansion and non-expansion states.

MHA has concerns with the proposal to expand the definition of uncompensated care to include discounts to the uninsured. These discounts do not represent actual "costs" of providing care to uninsured unless the discount puts the patient's financial obligation at a below-cost amount. However, this will vary dramatically among individual hospitals and individual patients.

Minnesota's hospitals and health systems have provided discounts to the uninsured for more than ten years in accordance with our members' voluntary agreements with the Minnesota Attorney General's Office. Even under this relatively uniform standard, the amount of each hospital's discount is variable based on payer mix, charge levels, and services provided.

Non-Medicare bad debt and charity care provide a more standardized, reliable and broadly supported definition of uncompensated care. Including discounts to the uninsured would inject a highly variable and potentially manipulated factor.

Graduate Medical Education (GME) Payments

Minnesota has a large number of critical access hospitals (CAHs) in rural communities who struggle to recruit providers necessary to maintain access to high quality care. MHA supports removing barriers to training caregivers in CAHs and to recruiting providers to establish their practice in rural communities. CAHs provide valuable training for residents. And training providers in rural settings is correlated with recruiting them to practice in rural areas.

Concerns have been raised about CAHs not being considered as "nonprovider" sites for Direct Graduate Medical Education (DGME) and Indirect Medical Education (IME) payments. This policy creates barriers to training residents in rural areas and hinders collaborative efforts

between Prospective Payment System (PPS) hospitals and CAHs for purposes of training, recruiting and retaining physicians in rural areas.

The ACA made several changes to the requirements that a hospital must meet to include residents' training in a nonprovider setting as part of the hospital's FTE count, including incurring the cost of the residents' salaries and fringe benefits. However, while a CAH is considered to be a provider in many contexts, the term "nonprovider" is not defined in statute for purposes of determining whether in the context of training providers a CAH should be regarded as a nonprovider. This has led to ambiguity regarding training opportunities for residents at CAHs.

CMS is proposing that, for cost reporting periods beginning October 1, 2019, "a hospital may include FTE residents training at a CAH in its FTE count as long as it meets the nonprovider setting requirements currently included at 42 CFR 412.105(f)(1)(ii)(E) and 413.78(g). [CMS is] not proposing to change [its] policy with respect to CAHs incurring the costs of training residents." MHA supports this clarification that for purposes of DGME and IME payments, CAHs are considered to be nonproviders, and we encourage CMS to look for other ways to encourage proliferation of training experiences in rural settings, as well as of collaborations between hospitals to educate and train our health care workforce.

New Technology Add-on Payments

In this Proposed Rule, CMS includes the following proposals:

- Discontinue add-on payments for three medical services/technologies;
- Continuing new technology add-on payments for nine technologies; and
- Seeking comment on implementation of add-on payments for 17 technologies.

CMS has issued a Request for Information (RFI) regarding the "New Technology Add-On Payment Substantial Clinical Improvement" criteria. Commenters requested that CMS provide greater clarity on what constitutes "substantial clinical improvement" in order to better understand the New Technology application process and to better predict which applications will meet the criteria. CMS is considering revisions to its criteria under both the IPPS new technology and the OPPS transitional pass-through payment policies and is seeking public comment on what sort of additional guidance and details would be useful.

Based on stakeholder concerns that the new technology add-on payment policy does not adequately reflect the costs of new technology or adequately support healthcare innovation, CMS is proposing to raise the 50% cap on new technology add-on payments. Specifically, CMS is proposing that, for discharges beginning October 1, 2019:

> *[I]f the costs of a discharge involving a new technology… exceed the full DRG payment (including payments for IME and DSH, but excluding outlier payments), Medicare will make an add-on payment equal to the lesser of: (1) 65 percent of the costs of the new medical service or technology; or (2) 65 percent 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 would be limited to the full MS-DRG payment plus 65 percent of the estimated costs of the new technology or medical service.*

MHA supports these proposed changes, although our members believe the 65% level is insufficient to provide the incentive and mitigate the financial risks associated with delivering these expensive new-technology services. We respectfully suggest increasing the add-on payment factor to 80% or 85%.

MHA is pleased that CMS recognizes the mismatch between current Medicare payment rates and policies and the technology, training and expenses necessary to deliver cutting-edge, high-quality care in the midst of clinical discoveries and improvements. Certainly, the adjustments for new-technology add-on payments are in the right direction.

MHA encourages CMS to take a more comprehensive view because we question whether the use of add-on payments, instead of creating a new DRG for example, are the best vehicle for ensuring Medicare payments are adequate to support the care its beneficiaries require. Likewise, the add-on payment approach is an isolated strategy that neglects to account for the interaction of new technology and Medicare payment policies. For example, many of the patients who require services with new, extraordinarily expensive technologies are frail or medically complex and are best served in an inpatient setting. Yet, Medicare payment policies such as the two-midnight rule, observation status, site-neutral payments and other recently manufactured attempts to restrict payments to hospitals exacerbate Medicare's underpayments and financial losses for hospitals that deliver services with these new technologies.

Reclassification of certain secondary diagnosis codes

Downgraded Designations

The Proposed Rule includes significant severity classification changes to more than 1,000 secondary diagnosis codes. Not surprisingly, the majority of these changes are downgrading the designation to reduce Medicare expenses. Many of these reflect the shifting of status of secondary diagnoses codes from Complications and Comorbidities (CC) to Non-CC.

Our review of CMS' supplemental data file released with the proposed rule shows a number of inconsistencies that merit closer attention before CMS proceeds with any reclassification of neoplasm codes as well as many others. In the rule, CMS describes its methodology to assess resource utilization associated with all of the secondary diagnosis codes proposed to be downgraded to see if the presence of the code represents increased resource utilization, average resource utilization, or lower-than-average resource utilization.

MHA is confused as to why CMS would downgrade a code from CC to Non-CC when its average resource utilization score is higher than 1.5, which indicates that the presence of the secondary diagnosis requires more resources to treat the condition appropriately. While we might understand shifting some codes from CC to Non-CC status if their C1 score is 1.1 or 1.2, and therefore, the differential costs in resources for the hospital because of the secondary diagnosis is

less significant. But, when CMS knows and expects that the presence of a particular secondary diagnosis is accompanied by the need for hospitals to use more resources for effective treatment, and its C1 score is closer to CC status than Non-CC status, downgrading the status of that diagnosis code not make sense.

Unless and until CMS can explain the underlying rationale for proposing these downgrades, **MHA opposes these provisions of the Proposed Rule** and suggests that CMS engage providers in further discussions regarding its underlying intentions.

Homelessness and social determinants of health classifications

MHA supports adding Homelessness (Z59.0) to the CC list. There is ample evidence demonstrating that homeless patients require a significant amount of additional resources and efforts by the hospital, including coordinating social and health care services.

Homelessness, however, is not the only socio-economic factor that impact a patient's health and significantly changes the resources necessary to appropriately treat the primary diagnosis. Accordingly, **MHA suggests that CMS add codes Z59.0 through Z59.9 to the list of CCs**.

Adoption of Quality Measures

National Quality Forum measures

For many years, MHA has supported using only measures that have been developed through the National Quality Forum's (NQF) open, consensus- and evidence-based process that engages relevant stakeholders. NQF and its measures hold widespread acceptance among health care providers, payers, policy makers and regulators throughout the country. Accordingly, **MHA continues to encourage CMS to adopt only measures for the Hospital Inpatient Quality Review program that have been endorsed by NQF**.

Opioid Related Events measure

Consistent with our position on NQF-endorsed measures discussed above, **MHA opposes the proposal to add the Hospital Harm – Opioid Related Events measure**. NQF has not endorsed this measure. Since use of Naloxone in inpatient care remains extremely rare, there is little reliable evidence on which to use this factor as a quality indicator.

Moreover, the use of Naloxone alone is not an indicator of the quality of care a patient received. In fact, the reverse of the proposed measure is more appropriate for assessing quality of care: number of inpatients after 24 hours who die from opioid overdoses because Nalaxone was *not* administered.

As a matter of public policy, in the midst of the opioid crisis, CMS should be taking actions to encourage hospitals to stock and use Nalaxone when necessary to save lives. By adding the

proposed measure, CMS would be creating a disincentive to having Nalaxone at the ready. Hospitals do not know when an inpatient might have an anaphylactic reaction, but we do not use administration of epinephrine to save his/her life as an indication of poor quality care.

Cesarean birth measure

Again, because it does not have NQF's endorsement, **MHA opposes the potential addition of the cesarean birth measure**. NQF withdrew its endorsement of that measures and the concerns that resulted in its decision have not been resolved.

As always, we appreciate the opportunity to comment on CMS' proposed rules. If you have any questions, please feel free to contact me at (651) 659-1415 or jschindler@mnhospitals.org.

Sincerely,

Joseph A. Schindler

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