June 24, 2019

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue S.W., Room 445-G
Washington, DC 20201

Ref: CMS-1716-P: 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 130-member hospitals and health systems, the North Carolina Healthcare Association (NCHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) hospital inpatient prospective payment system (IPPS) proposed rule for fiscal year (FY) 2020.

Revision of The Calculation of The New Technology Add-On Payment

CMS is proposing to adjust the new technology add-on payment by increasing the amount of the maximum add-on payment from 50 percent to 65 percent**. We commend CMS for recognizing the concerns raised by commenters and other stakeholders regarding the add-on payment and support CMS increasing the percentage from 50 percent to 65 percent**. However, the proposal still does not ensure hospitals and health systems are properly reimbursed for the financial burden of new technology for innovative treatments. The proposal limits the payment to roughly 65 percent of the costs of the new medical service or technology, which is not adequate reimbursement. New technology for innovative treatments can be expensive. CMS refusing to adequately pay for the Medicare services associated with innovative technology burdens hospital systems and other payors. **As such, NCHA urges CMS to establish a proper long-term solution for hospitals that ensures they are adequately reimbursed for the financial burden of new technology.**

Wage Index Disparities Between High and Low Wage Index Hospitals

As noted by healthcare stakeholders, the current wage index system perpetuates and exacerbates the disparities between high and low wage index hospitals. CMS is proposing to reduce the disparities between high and low wage index hospitals by increasing the wage index values for hospitals below the 25th percentile and decreasing the wage index values for hospitals above the 75th percentile. **NCHA commends CMS for acknowledging stakeholder concerns and strongly supports CMS reducing the disparities between high and low wage index hospitals.** A majority of the hospitals that benefit from this proposal are rural hospitals who greatly need, and warrant, the increased reimbursement. However, even with the suggested changes, Medicare wage expenditures for all hospitals (including low wage index hospitals) are still not reimbursed at cost by CMS. **As such, NCHA urges CMS to update regulations for FY 2020 to ensure all hospitals receive proper wage index adjustments so Medicare reimbursement reflects actual wage cost.**

Rural Floor

We commend CMS for acknowledging concerns that hospitals in a limited number of states could use hospital reclassifications, from urban to rural, to inappropriately influence the rural floor wage index value. To address this concern, CMS is proposing to remove urban to rural hospital reclassifications from the calculation of the rural floor wage index value beginning in FY 2020. NCHA supports this proposal. However, while the proposal by CMS attempts to reduce the known errors with the current wage index system, it does not eliminate the national application of the rural floor enacted by the Affordable Care Act (ACA) of 2010. Therefore, the adverse consequences of a nationwide rural floor budget neutrality recognized by CMS, Congress, and the Medicare Payment Advisory Commission, (MedPAC) is flawed and could still be manipulated. The Medicare payment wage index system will still reward hospitals in certain states at the expense of most other hospitals across the nation. **NCHA continues to oppose the continued application of the nationwide rural floor budget neutrality adjustment as it prohibits the Medicare wage index system from accomplishing its objective of ensuring wage payments accurately reflect actual wage costs.**

Transition to S-10

In FY 2018, CMS began incorporating the cost report Worksheet S-10 data on hospital charity care and bad debt to determine the amount of uncompensated care each hospital provides. For FY 2020, CMS is proposing to continue using S-10 data but instead of using data from a rolling three-year period, CMS is proposing to use a single year of data on uncompensated care costs from Worksheet S-10 of the Medicare cost report for FY 2015. **NCHA supports CMS proposal to continue using Worksheet S-10 of the Medicare cost report to determine the amount of uncompensated care provided by hospitals.** However, CMS should consider still using rolling data from multiple years since using a single year could skew the distribution. In any given year, outside factors could influence hospital's financials that do not truly reflect their operations. Using data from multiple years could safeguard financial year "one-offs" from skewing the data. **If a one-year period is used to determine the amount of uncompensated care for each hospital, NCHA urges CMS to monitor the results to ensure it is accurate and fair in determining uncompensated care.**

Changes to Hospital Payment Reductions for Excessive Readmissions

The Hospital Readmissions Reduction Program (HRRP) is a Medicare value-based purchasing program that reduces payments to hospitals with excess readmissions. The program was established with the ACA beginning October 1, 2012, with the intent to achieve the national goal of improving healthcare for Americans by linking payment to the quality of hospital care. CMS is proposing four changes to the program for FY 2020. One of the changes is a new measure removal policy. The new removal policy proposed by CMS is consistent with their "Meaningful Measures" initiative previously adopted in other quality reporting and quality payment programs. The "Meaningful Measures" initiative is an attempt to streamline and prioritize the means in quality measure and value programs and is an attempt to strike a better balance between value and burden. **Therefore, NCHA supports the proposed criteria and commends CMS for recognizing the need to assess the HRRP program measures to ensure measures actually add value.**

When applying the HRRP adjustment, the 21st Century Cures Act requires CMS to assess penalties based on a hospital's performance relative to other hospitals with a similar proportion of patients who are dually eligible for Medicare and full-benefit Medicaid (known as the sociodemographic adjustment approach). CMS has identified two circumstances in which the current definition of dual eligible may lead to underreporting the number of dual-eligible beneficiaries. Therefore, CMS is proposing updating the program's definition of "dual-eligible" to allow for a 1-month "look back" period in data sourced from the State Medicare Modernization Act (MMA) files to determine dual-eligible status for beneficiaries who die in the month of discharge. **NCHA supports CMS's proposed "look back" period that will allow for a more accurate identification of "dual-eligible" beneficiaries. At the same time, we**

advocate the sociodemographic adjustment continue to be monitored by CMS and improved, as needed.

Promoting Interoperability Programs

NCHA continues to commend CMS's effort to ease barriers for interoperability programs by implementing a reporting period of a minimum of any continuous 90 days for calendar year 2021.

Thank you for your consideration of our comments. If you have any questions, please contact me (slawler@ncha.org, 919-677-4229), Jeff Weegar, Vice President Financial Policy (jweegar@ncha.org, 919-677-4231) or Ronnie Cook, Finance and Managed Care Consultant (rcook@ncha.org, 919-677-4225).

Sincerely,

Stephen J. Lawler
President
North Carolina Healthcare Association