

June 21, 2019

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1716-P
P.O. Box 8013
Baltimore, MD 21244-1850

File Code: CMS-1716-P

Re: 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 Administrator Verma:

The Healthcare Financial Management Association (HFMA) would like to thank the Centers for Medicare & Medicaid Services (CMS) for the opportunity to comment on the *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* (hereafter referred to as the Proposed Rule) published in the Federal Register on April 24, 2019.

HFMA is a professional organization of more than 42,000 individuals involved in various aspects of healthcare financial management. HFMA is committed to helping its members improve the management of and compliance with the numerous rules and regulations that govern the industry.

Introduction

HFMA would like to commend CMS for its thorough analysis and discussion of the many Medicare payment decisions addressed in the 2020 Proposed Rule. Our members would like to comment on the specific proposals related to:

- Proposed FY2020 MS-DRG Documentation and Coding Adjustment
- Proposed Changes to Specific MS-DRG Classifications
- Proposed Changes to Add-On Payments for New Services and Technologies for FY2020
- Proposed Payment Adjustment for Medicare Disproportionate Share Hospitals (DSH) for FY2020

Below, please find specific comments on the items above.

Proposed FY2020 MS-DRG Documentation and Coding Adjustment

To comply with The American Taxpayers Relief Act of 2012 (ATRA), CMS anticipated that a cumulative -3.2% adjustment to the Medicare Market Basket Update would achieve the \$11 billion recoupment. As a result, it imposed a -0.8% payment adjustment in FY 2014 and an additional -0.8% on top of previous cuts each subsequent year through FY 2016.

However, in the FY 2017 final rule, CMS adopted an additional 0.7% payment cut on top of the cumulative -3.2% adjustment based on the Agency's analysis that the actual amount recouped was lower than its original estimates. Failure to restore the additional 0.7% will make this reduction in hospital payments a permanent part of the baseline calculation of the IPPS rates, which was not Congress's legislative intent. This is evidenced in the following:

- CMS recouped 3.9% of overpayments (sum of Documentation and Coding adjustments for FFYs 2014 through 2017) whereas MACRA section 414(b)(B)(i) indicated 3.2%. The difference of 0.7% becomes a permanent reduction.
- MACRA section 414(b)(B)(i) mandated a positive adjustment of 0.5% for each of FFYs 2018 through 2023 to offset the 3.9% recoupment adjustments of previous years, the add-back of 0.5% over 6 years equals only 3.0%, thereby making the difference of 0.9% permanent reductions.
- PL 114-225, the 21st Century Cures Act, was enacted on December 31, 2016. Section 15005(b)(B)(iii) replaces the FFY 2018 0.5% add-back with 0.4588% but retains the positive 0.5% for FFYs 2019 through 2023. Consequently, the total "add-back" equals 2.9588%, making the difference of 0.009412% permanent reductions.

HFMA strongly recommends CMS use its authority under section 1886(d)(5)(I) to make "exceptions and adjustments to such payment amounts...as the Secretary deems appropriate" to restore the additional 0.7% payment documentation and coding payment cut in FY2020 to restore payment equity to hospitals and comply with Congressional intent.

Proposed Changes to Specific MS-DRG Classifications

In the rule, CMS proposes numerous changes to the classification of ICD-10 diagnosis codes to the major complication and comorbidity (MCC) and complication and comorbidity (CC) list. HFMA's members have significant concerns regarding some of these proposals which are identified in the tables listed in Attachment 1 and Attachment 2.

Further, given the increasing understanding of how socioeconomic factors like access to stable housing impact health outcomes, HFMA's members strongly support CMS's proposal to add the ICD-10 code for homelessness (Z59.0) to the list of CCs. Additionally, we recommend the following Z codes be added to the CC list so that it captures the full range of housing issues that impact health outcomes.

- Inadequate housing (Z59.1)
- Extreme poverty (Z59.5)

- Problem related to housing and economic circumstances (Z59.9)
- Dependent relative needing care at home (Z63.6)
- Need for assistance at home and no other household member able to render care (Z74.2)
- Bed confinement status (Z74.01)
- Need for continuous supervision (Z74.3)

Similarly, given the impact mental health has on physical outcomes, HFMA strongly supports the addition of several mood, delusional disorders and anxiety disorders (F.06.30, F06.31, F06.4, F22) to the CC list.

Proposed Changes to Add-On Payments for New Services and Technologies (NTAP) for FY2020

Proposed Change to the Calculation of the Inpatient New Technology Add-On Payment: CMS proposes that beginning with discharges on or after October 1, 2019, if the costs of a discharge involving a qualifying new technology exceed the full DRG payment (determined by applying cost-to-charge ratios [CCRs] as described in §412.84(h)) including payments for indirect medical education (IME) and DSH, but excluding outlier payments), Medicare will make an add-on payment equal to the lesser of (1) 65% (increased from 50%) of the costs of the new medical technology; or (2) 65% (increased 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 medical services.

HFMA's members appreciate CMS's efforts to increase the NTAP. However, even if the payment percentage is increased to 65%, the hospital that provides a service that qualifies for the NTAP will still lose money on the case, regardless of how efficient it is. The current payment formula is defined in statute so we realize that CMS cannot, without Congressional intervention, pay the full cost of the qualifying new technology. **However, we ask that CMS increase the NTAP payment percentage to 100% to reduce the losses hospitals experience when they provide services involving new technologies.**

Payment Methodology for CAR T Therapies: The proposed rule asks a series of questions regarding MS-DRG weight setting, wage index adjustment, and add-on payments (DSH and IME) for discharges that include CAR T therapy. HFMA's members appreciate CMS's interest in the process for setting Medicare payments for cases that involve CAR T therapies. Based on comments from our members, we believe the current MS-DRG (including NTAP and outliers) payment for cases that involve CAR T is insufficient to cover the cost of the therapy and related inpatient stay.

Given the high acquisition cost of CAR T therapies, many of our members at the institutions that provide these lifesaving therapies are not setting their charges at a level that equals the acquisition price, once the charge is multiplied times the hospital's cost-to-charge ratio. As an example, YesCarta's list price is \$373,000.¹ Assuming a hospital's drug cost-to-charge ratio is at the 2020 national average (.19), it would need to charge approximately \$1.9 million for the full acquisition cost of the drug (which does not include the cost of special handling) to be incorporated into the formula used to set MS-DRG weights.

¹ Schoenberg, S., “[Gene therapy: Revolutionary health care with a blockbuster price tag](#),” MassLive, January 27, 2019.

While setting charges at this level (\$1.9 million) would allow for accurate reporting of the input cost for the therapy, many hospitals are unwilling to include a seven-figure line-item charge on a patient's bill. Even though the charge is accurate from the standpoint of arriving at the cost to provide the service based on CMS's reimbursement and weight-setting formulas, the optics of such a charge are incongruent with these organizations' not-for-profit missions to serve patients and the communities in which they're located. As a result, the payment calculation for NTAP and outlier payments for each case do not cover the cost to provide the service. Future MS-DRG weights calculated with this data will also not accurately reflect the resource use necessary to provide the service. Therefore, access to this life-saving therapy will be limited under CMS's current methodology.

Although CAR T therapy is technically a pharmaceutical therapy, our members believe this innovative treatment has more in common with solid organ transplants, in the sense that both are high-cost, low-volume events. Further, the patient's white blood cells are harvested, modified to intensify the immune system's response to cancer, and then re-transplanted into the patient. Like solid organ transplants, much of the need for inpatient services related to CAR T therapy is to manage potentially fatal side effects of the treatment. **Given the high-cost and low volume of these services, HFMA's members strongly recommend CMS base payment for the CAR T therapeutic agent on a reasonable cost basis. Instead of including the cost of the CAR T agent in the MS-DRG payment, CMS should make separate payments for the therapy and related inpatient hospital stay. The MS-DRG payment would be based, as it is today, on all of the services provided from the beginning of the "three-day window" through discharge, excluding the CAR T therapy. A separate payment based on the Average Sales Price (ASP) for the CAR T therapeutic agent should be made in cases where the claim indicates such an agent was used during the course of the inpatient admission. This would result in payments for the specific agent that are more accurate and better reflect the cost of the service, thereby improving access to these lifesaving therapies.**

However, if CMS does not elect to adopt the methodology described above, HFMA's members believe that the full MS-DRG operating payment (including adjustments for wage index, DSH, and IME applied to the total base operating amount for the MS-DRG) should be made, for several reasons. First, we do not believe CMS has the statutory flexibility to selectively choose when it wants to apply these adjustments. Second, electing not to apply these factors (or somehow reducing the amount of payment related to the CAR T therapy that these factors are applied to) will increase losses on these services, further reducing access to these lifesaving therapies.

Proposed Payment Adjustment for Medicare DSH for FY2020

Make CMS Audit Instructions for Worksheet S-10 Publicly Available: Although CMS stated in the FY2018 proposed rule that it is working on audit instructions for Medicare Administrative Contractors (MACs), it will not make these (or any other audit guidance) publicly available. In general, HFMA's members have long considered this stance inappropriate and counterproductive. CMS has stated in the FY2017 IPPS/LTCH PPS final rule (81 FR 56964), for program integrity reasons, CMS desk review and audit protocols are confidential and are for CMS and MAC use only. We respectfully disagree that providing hospitals details on how CMS will audit the S-10 would cause integrity issues. On the contrary, providing hospitals detailed specifics on how to report items on S-10 and how they will be reviewed would aid

hospitals in providing more accurate data. This will reduce hospital and MAC costs related to the audit and appeals process (if one existed for Factor 3). While we believe there is no malicious intent, inconsistent reporting of the data could unknowingly damage another provider's payments. This policy of opacity results in the various MACs (and sometimes different offices of the same MAC) taking different interpretations of CMS's audit guidance. This could also lead hospitals to make their own interpretations, creating inconsistencies in reporting.

Specific to the S-10, guidance for completing the worksheet is limited to vague instructions (as discussed in further detail below). Further, unlike other worksheets that have an impact on payment and are audited by the MACs, the Provider Reimbursement Manual (PRM) is silent on the treatment of non-Medicare bad debt and charity care. This silence is appropriate, as each hospital's financial assistance policy and broader community benefit strategy reflects the needs of its community. However, in this vacuum, our members who have undergone "meaningful use audits" or were subject to audits of their uncompensated care for FY2015, report that MACs have disallowed charity care, citing justifications ranging from arbitrary federal poverty limits, to inappropriately citing section 312 of the PRM, which pertains to determining indigence for purposes of identifying Medicare bad debt. Further, in instances where a health system is subject to multiple MACs, we've had our members report that each MAC made inconsistent audit adjustments to uncompensated care amounts claimed on worksheet S-10. This suggests that MACs are not interpreting and applying CMS's audit instructions in a standardized manner. **Given HFMA members' experience with these audits, we strongly encourage CMS to recognize the uniqueness of the circumstances surrounding worksheet S-10 and release the audit criteria for non-Medicare bad debt and charity care claimed on the worksheet.**

Improve Instructions/Form for Worksheet S-10: Line 26 of worksheet S-10 includes both patients for which the full balance was written off to bad debt expense and patients where only cost sharing was written off to bad debt expense. The cost sharing portion 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 the line 28 by the hospital's cost-to-charge ratio (CCR).

Applying a hospital's CCR to the amount on Line 28 will underestimate the cost of bad debt and is incorrect, as it mixes "apples and oranges." The CCR is the relationship between a hospital's cost and its charges in a given cost reporting period. It can be used to arrive at a proxy for a hospital's cost of services provided to a patient if it is multiplied by the hospital's charges from that same period. However, deductibles, coinsurances based on the negotiated payment rate, and the portion of allowable, non-reimbursable Medicare bad debt are not marked up to reflect the charged amount. Therefore, it is inappropriate to attempt to arrive at the cost of bad debt expense by multiplying uncollectable deductibles, coinsurance based on the negotiated rate, and the portion of allowable Medicare bad debt that is non-reimbursable times a hospital's cost-to-charge ratio. Doing so underestimates the true cost of forgone revenue resulting from uncollectible accounts. Given the increased cost sharing many insured individuals currently face, a growing portion of a hospital's bad debt is related to deductibles, coinsurance and copayments. **Similar to how charity care is handled on worksheet S-10, CMS needs to create separate columns for insured and uninsured patients. The column for uninsured patients should be multiplied by a hospital's cost-**

to-charge ratio to arrive at the cost of bad debt. The column for insured patients (which should include amounts related to Medicare allowable, non-reimbursable bad debt) should not.

Clarify Instructions/Provide Examples for Worksheet S-10: CMS's refinements to worksheet S-10 in November 2016 (Transmittal 10) have greatly improved the instructions. However, our members provide specific examples of where the appropriate treatment of uncompensated care cost is not immediately clear, based on the revised instructions. This leaves the handling of these relatively common cases up to the discretion of both hospital reimbursement staff and the MACs' auditors, which will lead to inconsistent treatment across hospitals for similar cases. Included in Attachment 3 are examples submitted by HFMA's members. **We ask that CMS provide guidance (either regulatory or sub-regulatory) on the treatment of these cases for purposes of worksheet S-10.** We believe this guidance is necessary to improve the comparability of the uncompensated care data collected from hospitals and the equity of the allocation of Uncompensated Care DSH payments.

Calculation of Factor 3 for FY2020: The 2020 IPPS rule proposes to use audited S-10 uncompensated care costs from FY2015. As an alternative, CMS suggests it would consider using the unaudited S-10 uncompensated care data from FY2017 stating that revisions to cost report instructions should result in more consistently reported, accurate data.

In the 2017 IPPS final rule CMS increased from one to three the number of years it used to calculate 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." At the time, CMS's rationale was driven by the use of Supplemental Security Income (SSI) ratios (which are notoriously unstable year-to-year) and were part of the formula that used the traditional DSH components to calculate Factor 3. However, the same rationale applies to the broad disparities in how CMS's audit protocols for uncompensated care (which are relatively new and unavailable to providers) are applied to charity care and bad debt (non-Medicare allowable) hospitals listed on worksheet S-10.

HFMA strongly supports the use of audited data and therefore does not believe it is appropriate to use one year of unaudited data as CMS suggests in its alternative proposal to use 2017 data as a source for factor 3. However, given our members' concerns that the MACs have not applied the audit criteria consistently, we do not believe it is appropriate to only use one year of data from FY2015, either.

Therefore, we believe CMS should continue using three years-worth of data has it has done since the FY2017 final rule. Given that 2015 is audited, we recommend using FY2015, FY2016 and FY2017. While this is an imperfect solution, over time, more of the data used to determine factor 3 will have undergone an audit. It will also provide multiple years' worth of data to protect hospitals from aberrant audit results, given there is currently no appeals mechanism to contest inappropriate audit adjustments.

Create an Appeals Process for Disallowed Uncompensated Care: CMS must provide hospitals a mechanism to appeal adjustments to the 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 uncompensated care payment will have a material payment impact on hospitals, it does not "settle" on the cost report. We believe it is appropriate to create a process by which disallowed uncompensated care could be appealed to the Provider Reimbursement Review Board (PRRB), like other items on the Medicare cost report.

PRRB Board Appeals

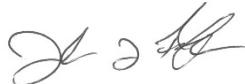
To reduce the backlog of PRRB appeals, the proposed rule suggests developing regulations governing the timing of the data for determining DSH payments based on Medicaid-eligible days. Under this solution, a provider would submit a cost report with Medicaid days based on the best available Medicaid eligibility data at the time of the filing and could request a “reopening” when the cost report is settled without filing an appeal.

CMS would issue directives requiring MACs to reopen cost reports for this issue at a specific time and set a realistic time period during which the provider could submit an updated Medicaid day count.

HFMA strongly supports CMS instructing the MACs to allow Medicare cost reports to be reopened to submit an updated, more accurate Medicaid day count. It is not uncommon for it to take 12 months or more to determine Medicaid eligibility for some patients due to a state’s eligibility policies and the documentation the patient is required to submit. As a result, the number of Medicaid days submitted on the as-filed cost report can be significantly lower (as much as 15%) than the Medicaid day count 12 months later. **HFMA strongly recommends hospitals have the ability to reopen their cost reports to add additional days within 15 months of the filing and when the MAC audits the cost report.**

HFMA looks forward to any opportunity to provide assistance or comments to support CMS’s efforts to refine and improve the FY2020 IPPS. As an organization, we take pride in our long history of providing balanced, objective financial technical expertise to Congress, CMS and advisory groups. We are at your service to help CMS gain a balanced perspective on this complex issue. If you have additional questions, you may reach me or Richard Gundling, Senior Vice President of HFMA’s Washington, DC, office, at (202) 296-2920. The Association and I look forward to working with you.

Sincerely,



Joseph J. Fifer, FHFMA, CPA
President and Chief Executive Officer
Healthcare Financial Management Association

About HFMA

HFMA is the nation's leading membership organization for more than 42,000 healthcare financial management professionals. Our members are widely diverse, employed by hospitals, integrated delivery systems, managed care organizations, ambulatory and long-term care facilities, physician practices, accounting and consulting firms, and insurance companies. Members' positions include chief executive officer, chief financial officer, controller, patient accounts manager, accountant, and consultant.

HFMA is a nonpartisan professional practice organization. As part of its education, information, and professional development services, HFMA develops and promotes ethical, high-quality healthcare finance practices. HFMA works with a broad cross-section of stakeholders to improve the healthcare industry by identifying and bridging gaps in knowledge, best practices, and standards.

Attachment 1: Table 6I.2.—Proposed Deletions to the MCC List--FY 2020

ICD10 Code Proposed For Removal from MCC List	HFMA Recommendation
End Stage Renal Disease (N18.6)	ESRD not be downgraded from an MCC to a CC
Sickle-cell Disorders (D57.-)	Sickle-cell Disorders not be downgraded from the MCC list: Hemoglobin SS (Hb-SS) disease with acute chest syndrome; Hb-SS disease with splenic sequestration; Sickle-cell/Hb-C disease with acute chest syndrome; Sickle-cell/Hb-C disease with crisis, unspecified; Sickle-cell thalassemia with acute chest syndrome; Sickle-cell thalassemia with crisis, unspecified; Other sickle-cell disorders (with acute chest syndrome, with splenic sequestration, with crisis, unspecified)
Cardiac Arrest (I46.-)	Cardiac Arrest group (I46.-) not be downgraded: <ul style="list-style-type: none"> • Cardiac arrest due to underlying cardiac condition (I46.2) • Cardiac arrest due to other underlying condition (I46.8) • Cardiac arrest, cause unspecified (I46.9)
Ventricular fibrillation (I49.01)	Ventricular fibrillation not be downgraded to the CC list.
Ventricular Flutter (I49.02)	Ventricular Flutter not be downgraded to the CC list.
Stage 3 and Stage 4 Pressure Ulcers (L89.-)	Stage 3 and Stage 4 Pressure ulcers not be downgraded to the CC list.
Unspecified severe protein-calorie malnutrition (E43)	Unspecified severe protein-calorie malnutrition not be downgraded from the MCC list.

Attachment 2: Table 6J.2.—Proposed Deletions to the CC List –FY 2020.

ICD10 Code Proposed For Removal from CC List	HFMA Recommendation
Chronic kidney disease stage 4 (N18.4)	Chronic kidney disease stage 4 not be downgraded from a CC to non-CC
Chronic kidney disease stage 5 (N18.5)	Chronic kidney disease stage 5 not be downgraded from a CC to non-CC
Chronic systolic (congestive) heart failure, chronic diastolic (congestive) heart failure, and chronic combined systolic and diastolic heart failure	Chronic systolic (congestive) heart failure, chronic diastolic (congestive) heart failure, and chronic combined systolic and diastolic heart failure not be downgraded from a CC to non-CC
Body Mass Index (Z68.1, Z68.41, Z68.42)	Body mass index not be downgraded from the CC list.
Bacteremia (R78.81)	Bacteremia be removed from the CC list and added to the MCC list.
Severe persistent asthma with (acute) exacerbation (J45.51)	Severe persistent asthma with (acute) exacerbation be removed from the CC list and added to the MCC list.
Moderate protein-calorie malnutrition (E44.0)	Moderate protein-calorie malnutrition be removed from the CC list and added to the MCC list.

Attachment 3: Examples of Cases Where Reporting on Worksheet S-10 Is Unclear

Scenario I: A patient is insured under a third-party insurance company that does not have a contractual relationship with a hospital. The patient accumulated \$100,000 of inpatient charges and the third-party

insurance company has negotiated with the hospital that they will pay 10% of charges after the patient meets their out-of-network deductible of \$10,000. The patient qualifies for 100% of charity care.

According to the instructions, Worksheet S-10 requires the hospital to "Enter in column 1, the full charges for uninsured patients and patients with coverage from an entity that does not have a contractual relationship with the provider who meet the hospital's charity care policy or FAP."

In the above example, does "total charges" represent the \$100,000 original charge, or \$10,000 in charges the patient is responsible for (the deductible)? If it is the latter, please confirm that the \$10,000 should be entered into column 2.

Scenario II: A patient is insured under a third-party insurance company that has a contractual relationship with the hospital. However, the patient has exhausted their benefits (reached maximum benefits), and the patient would be responsible to pay the contracted amount for the services. This amount would be reduced from full charges. If the patient is eligible for assistance under the financial assistance policy (FAP), how would this be reported (Column 1 vs. Column 2)? While the amount is not a deductible or co-insurance, the full charges were reduced based on the hospital's contracted amount (similar to how deductible and co-insurance responsibility amounts are calculated). For purposes of this example, please assume that based on the hospital's FAP the patient is eligible for a partial write-off of the amount due.

Scenario III: A patient is insured under a third-party insurance company that has a contractual relationship with the hospital but has a patient responsibility related to non-covered charges. If the patient is eligible for financial assistance under the FAP, how would this be reported (Column 1 vs. Column 2)? The instructions only clearly state the handling of "In addition, enter in column 1, charges for non-covered services provided to patients eligible for Medicaid or other indigent care programs if such inclusion is specified in the hospital's charity care policy or FAP and the patient meets the hospital's policy criteria."

Scenario IV: A patient has a catastrophic coverage plan or a limited benefit plan in which the insurer covers the patient for \$1,000 per day. How would this be reported on Worksheet S-10 (Column 1 vs. Column 2) under the below example:

The insurance company has a contractual relationship with the hospital. The patient has accumulated \$85,000 of charges and the insurance company paid the hospital \$5,000 (\$1,000 per day). The hospital posts the contracted allowance for the services of \$20,000. The patient is responsible for the remaining balance of \$60,000. The patient is granted 100% charity care under the hospital's FAP and the \$60,000 is written off to charity care. Please advise how this should be reported on Worksheet S-10 (Column 1 vs. Column 2).