Submitted Electronically

June 18, 2018

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
P.O. Box 8011
Baltimore, MD 21244-1850

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 2019 Rates, etc. (CMS-1694-P)*

Dear Mrs. Verma:

The Florida Hospital Association (FHA), on behalf of its more than 200 member hospitals and health systems, welcomes the opportunity to comment on the Medicare proposed rule entitled "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 2019 Rates, etc." published in the *Federal Register* on April 24, 2018. The proposed rule would revise the hospital inpatient prospective payment system (IPPS), the long-term care hospital (LTCH) payment system, and quality reporting requirements for specific providers. In this letter, we are submitting comments on the following issues:

- Uncompensated care payments and the use of S-10 data
- Documentation and coding adjustment
- Hospital readmissions reduction program – socioeconomic adjustment
- Transparency in hospital pricing

Uncompensated Care Payments and the Use of S-10 Data

For several years, CMS has discussed using the cost report's Worksheet S-10 data for hospital charity care and bad debt to determine the amount of uncompensated care each hospital provides, in place of the current formula of Medicaid and Medicare SSI days. In FY2018, 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 FY2019, CMS proposes to continue phasing in the S-10 data and also continue to use data from a rolling three-year period to estimate uncompensated care payments. Specifically, for FY2019, CMS would use FY2014 and 2015 Worksheet S-10 data in combination with FY2013 Medicaid days and SSI ratios to determine the distribution of uncompensated care payments.

The FHA supports the proposals to continue to phase in the use of the Worksheet S-10 to compute uncompensated care costs. Using S-10 data, coupled with selective auditing of cost reports submitted by hospitals reporting the highest levels of uncompensated care, will lead to far better estimates of uncompensated care costs at disproportionate share hospitals than using Medicaid and Medicare SSI days as a proxy for uncompensated care. We also believe that any negative effects of this transition can be eased due to the $1.5 billion increase in the

disproportionate share pool due to the change in the data source, similar to the effect of the $1 billion increase in FY2018.

The use of the S-10 will also create more balance between Medicaid expansion and non-expansion states. 2014 was the first year for expansion under the Affordable Care Act (ACA) – moving forward with Worksheet S-10 beginning with FY2014, and now adding in 2015, addresses the inequity of expansion/non-expansion in distributing disproportionate share dollars. The current proxy measure – Medicaid patient days – provides added funding to hospitals in expansion states who are also being paid for the patient stays under their state Medicaid program. Those days are not uncompensated.

In addition, using the S-10 will have the effect of increasing the share of the uncompensated care pool that goes to hospitals with high levels of uncompensated care in the emergency department and relatively few Medicaid days. Actual measures of uncompensated care should be used to distribute these uncompensated care dollars. The shift to using the S-10 will have the effect of increasing the share of the uncompensated care pool that goes to hospitals with high levels of uncompensated care. Hospitals with large numbers of Medicaid inpatient days but relatively little uncompensated care will receive a smaller share of the uncompensated care pool.

Finally, we urge CMS to look again at the impact of including Medicaid shortfalls in the calculation of uncompensated care, particularly if often-discussed legislation were to phase out or otherwise end Medicaid expansion. CMS should look to their proposal from three years ago if expansion were ended to address Medicaid shortfalls when states are on a more even footing for Medicaid coverage. Such a review should not delay the continued transition to the S-10, but rather be addressed in future proposals for capturing all uncompensated care.

Documentation and Coding Adjustment

The proposed rule would increase inpatient PPS rates by 1.75 percent in FY2019, after accounting for inflation and other adjustments required by law. Specifically, the update includes an initial market-basket update of 2.8 percent, less 0.8 percentage points for productivity and 0.75 percentage points mandated by the ACA.

In FY2017, when completing the final recoupment required under the American Taxpayer Relief Act for perceived overpayments tied to coding and documentation, CMS finalized a cut that was almost two times what it had planned and lawmakers had expected. CMS did not correct for this discrepancy when implementing the reduction for 2018, nor have they proposed a correction in 2019, and, as a result, hospitals are now left with a larger permanent cut than Congress intended when legislating the restorations under the Medicare Access & CHIP Reauthorization Act of 2015. We urge CMS to restore the excess cuts and help ensure that our hospitals have sufficient resources to continue providing quality care in their communities.

Hospital Readmission Reduction Program – Socioeconomic Adjustment

CMS proposes, for FY2019, to implement the socioeconomic adjustment to calculating readmissions penalties as mandated by the 21st Century Cures Act. The law requires a budget-neutral approach in which readmission penalties are based on hospitals' performance relative to other hospitals with a similar proportion of patients who are dually eligible for Medicare and Medicaid. The FHA recognizes that readmission performance is impacted by poverty; availability of resources for caregiver support, transportation, and medication assistance; and

other factors beyond a hospital's control. While we support the inclusion of a socioeconomic adjustment in the readmissions reduction program, the FHA continues to have concerns that CMS is combining data collected under both ICD-9 (which ended on September 30, 2015) and ICD-10. We urge CMS to look closely at the use of the combined data and to address its impact in the final rule.

Transparency in Hospital Pricing

As patients face increased exposure to health care costs, they have an urgent need for meaningful and transparent price information. The FHA and its members are committed to providing price, quality, and other information that patients need to make informed health care decisions. We believe that price transparency must be provided in a manner that is clear, readily accessible to the patient and that offers an opportunity to make meaningful comparisons among providers. Price transparency information must also be paired with other information that defines the value of services for the patient. Price alone is not sufficient to enable patients and others to make an informed choice of providers. Information on quality is also needed to ensure that a provider offers the desired level of value.

Under current law, hospitals are required to establish, and make public, a list of their standard charges. However, CMS is creating more specific guidelines, effective January 1, 2019, which would require hospitals to make available a list of their current standard charges via the internet in a machine-readable format and to update this information at least annually, or more often, as appropriate. This could be in the form of the charge master itself or another form of the hospital's choice, as long as the information is in machine-readable format.

For patients, the relevant charge information is their potential out-of-pocket costs for a given service or course of treatment, not standard charges. Over 90 percent of individuals in the U.S. have health coverage, and their payer – whether Medicare, Medicaid or a private insurance plan – establishes their cost-sharing obligations, which takes into account whether the plan covers the service, whether the provider is in the plan's network, the plan's cost-sharing requirements, and, if applicable, where the individual is in their deductible. Hospitals contract with more than 1,300 payers nationally, and the vast majority offer multiple health plans with different benefit structures. Payers are the best source of information on what a covered individual's out-of-pocket costs may be for a given service.

Despite this, patients do ask providers for cost estimates and will continue to do so. Hospitals and health systems help patients obtain answers to these questions by collaborating with insurers. Once a provider has identified the patient's need for a specific diagnostic service or care protocol, hospital financial counselors work with the patient and insurer to establish what the patient's cost-sharing obligation may be. This is a hands-on process with hospital staff connecting with insurers via their websites and call centers to obtain patient-specific information. The counselors may need to repeat this process multiple times as the course of care may change from diagnostic to treatment or for any number of other reasons. For these patients, a list of standard charges would be meaningless.

For the 10 percent of the population that is uninsured, availability of standard pricing information could be helpful and is already available consistent with federal law, as well as state law in Florida and many other states. Not-for-profit hospitals also have requirements regarding posting of charge information and financial assistance policies under the Internal Revenue

Service. Providers can, and do, respond to inquiries from uninsured individuals with information on their standard charges, as well as information on any financial assistance policies the hospital may offer.

CMS is also considering potential actions that would further their objective of hospitals undertaking efforts to engage in consumer-friendly communication of their charges to help patients understand what their potential financial liability might be for services they obtain at the hospital. These actions would enable patients to compare charges for similar services across hospitals. Therefore, CMS is seeking information regarding barriers that prevent providers from informing patients of their out-of-pocket costs; changes that are needed to support greater transparency around patient obligations for their out-of- pocket costs; what can be done to better inform patients of these obligations; and what role providers should play in this initiative. It also is considering making information regarding hospital non-compliance with the requirements public and intends to consider additional enforcement mechanisms in future rulemaking.

The health care payment system is complex. There are many different sources of price and quality information, many different benefit designs for patients that are insured, and an increasing variety of payment models and quality indicators. There are many unknowns in health care that makes pricing of care in advance particularly challenging. The path to diagnosis and treatment can vary significantly based on the underlying issue and the appropriate care pathway for a given individual. Research suggests that few health care services are actually "shoppable."

Given these complexities, we recommend that CMS work with providers and insurers to identify the top 25-50 procedures or services for which providers and payers could make reliable pricing information available to patients in advance. Providers and payers would then need to collaborate to develop tools to help inform patients. Transparency efforts should also remain flexible to adapt to changing health care payment and delivery models.

Instead of focusing on punitive measures at this point, we encourage CMS to convene providers, payers, insurers, patients, and employers to explore ways to increase patients' health care literacy, especially around their health plan benefit design. It is vital that any communication regarding pricing to the patient be accompanied with information both on quality of care and on the importance of following through with a prescribed course of treatment to assure the best outcomes and not sway patient behavior away from receiving needed care.

The FHA appreciates the opportunity to provide these comments for consideration in finalizing the IPPS rule for FY2019 and we stand willing to work with CMS and other stakeholders in developing tools to provide meaningful, useful and valuable information to our patients and communities. If there are any questions, please do not hesitate to contact me at kathyr@fha.org.

Sincerely,

Kathy Reep

Kathy Reep
Vice President/Financial Services