June 24, 2019

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1716-P, Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: CMS-1716-P, Medicare Program: 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 more than 200 member hospitals and health systems, the Florida Hospital Association appreciates the opportunity to provide comments on the above-referenced proposed rule for the Hospital Inpatient Prospective Payment System (IPPS) for fiscal year (FY) 2020. Our comments will focus on the proposed changes to the wage index for lower wage providers, Medicare disproportionate share (DSH), and the refinements based on revisions to the list of major complications and comorbidities (MCCs).

Area Wage Index

We commend you for your decision to address the fundamentally flawed Medicare wage index. The wage index has disadvantaged hospitals in states like Florida for decades and we applaud CMS for proposing relief through CMS' *Agenda to Re-think Rural Health*. Adjusting the wage index for states disadvantaged by the current formula is a justifiable way to maintain a degree of wage index protection for hospitals in states that have seen their rural floor drop significantly over the years. In this proposed rule, CMS states "that addressing this systemic issue does not need to wait for comprehensive wage index reform given the grouping disparities between low- and high-wage index hospitals, including rural hospitals that may be in financial distress and facing potential closure."

When the IPPS system was developed, Congress gave broad discretion to the Secretary of HHS to develop a system to account for area wage differences. The law allows the Secretary to establish rules which specify the source of wage data, the frequency of its collection, and the factor to be applied. In administering the wage index, federal law requires the Secretary to adjust the proportion of IPPS payments attributable to "wages and wage related costs" for "area differences in hospital wage levels," as referenced in Section 1395ww(d)(3)(E)(i). This calculation must be updated yearly on the "basis of a survey" of wage-related costs. Beyond these basic requirements, "no particular methodology for developing the indices [was] specified [by Congress]."

As recently noted by the Sixth Circuit, "[t]he legislative history confirms that Congress intended to grant the Secretary exceptionally broad discretion to determine the wage index." Last year's Labor-HHS Appropriations report also included language to encourage the Secretary and Administrator to use this authority in "addressing regional disparities in Medicare access." The report called on HHS and CMS to "take into account ideas and suggested reforms for the area wage index stated in the comments received as part of the request for public comments on wage index disparities published in the proposed rule."

CMS has proposed substantial modifications to the wage index calculation methodology, with the goal of increasing payment rates for hospitals in the lowest-cost areas of the country. Specifically, CMS proposes to increase the wage index for hospitals that currently have a wage index which falls under the 25th percentile wage index value of 0.848. If finalized, the methodology change would increase hospital payments for a number of low-wage index and rural Florida hospitals.

The Medicare wage index, which adjusts hospital payments for geographic market differences like wages and cost of living, has been a perennial issue for struggling low-wage index hospitals. The area wage index is intended to recognize differences in resource use across type and location of hospitals. If these resource differences are not adequately accounted for by Medicare payment adjustments, hospitals can be put under significant fiscal pressure. Furthermore, the current wage index disparity has a profound impact on the ability of low-wage index hospitals to recruit and retain talented personnel who directly care for patients or support patient care in some manner.

Addressing this disparity is of vital importance for Florida hospitals as the labor market in Florida has been confronted with unique challenges due to public health emergencies and disasters, e.g., Hurricane Michael. These disasters place an enormous strain on health care systems and have the potential to disrupt the delivery of health services and compromise patient care. Adequate staffing during and after a disaster is critical to ensuring hospital surge capacity, continuity of care, and patient safety.

We applaud CMS' efforts to reform the wage index. The disparity between the high and low wage indices has become an unrealistic reflection of actual cost. We agree with CMS' methodology to compress the wage indices for the top 75th and bottom 25th percentile, using a budget neutral methodology that only affects those two quartiles.

We also applaud CMS' efforts in curtailing manipulations of the wage index by disallowing urban hospital wage data to be used in the calculation of a rural floor. However, we disagree that there should be a five percent stop-loss due to this change. This manipulation has resulted in overpayments relative to the hospital's wage data; therefore, we do not see any need to establish a stop-loss for those hospitals at the detriment of every other hospital across the country, even if for only one year.

As proposed, a budget neutrality factor is being applied to all IPPS hospitals to primarily benefit those hospitals located in three states. It is unfortunate that payments to more than 3,172 IPPS hospitals nationwide are being reduced to offset increased payments to

approximately 146 hospitals. Under this proposal, these 146 hospitals (4.4% of total IPPS hospitals) are estimated to receive more than $138M (87.1% of total payments).

Medicare DSH Uncompensated Care Pool

CMS is proposing to complete the transition from using Medicaid days and SSI data to the Medicare cost report Worksheet S-10 data as the basis for determining the uncompensated care portion of the Medicare DSH payments. In addition, CMS is proposing to utilize the audited FY2015 S-10 worksheet and requests comments about utilizing the FY2017 data as the basis for determining each hospital's share of the uncompensated care payments.

Using a single year to determine the uncompensated payment rate can create large changes in individual hospital payments. Hospitals have been calling for consistency and predictability for some time in order to stabilize remuneration. To reduce annual fluctuation in payments caused by using a single year of S-10 data, FHA encourages CMS to consider utilizing a blend of historical S-10 worksheets. This blending would smooth variation in Medicare DSH payments.

In order to ensure appropriate uncompensated care payments, FHA continues to support utilizing the most accurate data available. FHA continues to urge CMS to refine its guidance for the completion of and use of Worksheet S-10 data. CMS' implementation of a transition to Worksheet S-10 data is sound. The transition away from the use of Medicaid days and SSI data to determine uncompensated care payments was, and is, necessary and appropriate. For FY2020, CMS should distribute uncompensated care payments based on Worksheet S-10, rely on the most accurate data and continue to utilize a multi-year lookback until more thorough audits have been completed following the revised instructions issued in September 2017.

Comprehensive MCC/CC Analysis

As outlined in the FY2008 inpatient PPS final rule, the categorization of diagnoses as a Major Complication or Comorbidity (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. Following a comprehensive review of the CC and MCC lists for a single year (FY2019), CMS is proposing a change in the severity level designation for 1,492 ICD-10-CM diagnosis codes for FY2020. Severity levels provide distinction for risk stratification and are necessary tools to capture the degree to which a patient's medical complexities should influence healthcare decisions made by providers, patients, families and caregivers.

Analysis of the proposed changes detailed by CMS shows that the net result would be a decrease of 145 codes designated as an MCC, a decrease of 837 codes designated as a CC, and an increase of 982 codes designated as a non-CC. According to CMS, these proposals are based on review of FY2019 data as well as consideration of the clinical nature of each of the secondary diagnoses and the severity level of clinically similar diagnoses.

Because not enough information on these proposed MCC/CC changes has been provided to allow for meaningful comment, we ask that CMS not finalize the proposed changes. We are concerned with such sweeping changes, especially given the lack of transparency in determining severity level modifications. We cannot support this proposal without additional transparency,

clinical clarity, and analysis of multiple years of MedPAR files across provider types. The information provided as a part of the proposed rule is insufficient and has even been identified to be inaccurate as published in the *Federal Register* with numerous typographical errors and misleading column headings.

The financial impact of the MCC/CC proposals could be significant for many high acuity hospitals, not just from the perspective of Medicare payments, but also from that of commercial insurers that base their payments on the MS-DRG methodology. With such a high potential for impacting individual providers, CMS needs to make more information available before these proposed changes are implemented.

Thank you for your consideration of these comments. We look forward to working with you on these and other issues impacting our members and the patients they serve. Should you have any questions or comments, please email me at kathyr@fha.org.

Sincerely,

Kathy Reep
Vice President/Financial Services