

July 10, 2020

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

Re: CMS-1735-P, Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (85 FR 32460)

Dear Ms. Verma:

On behalf of our more than 200 member hospitals and nearly 40 health systems, the Illinois Health and Hospital Association (IHA) appreciates the opportunity to comment on the federal fiscal year (FFY) 2021 Inpatient Prospective Payment System (IPPS) proposed rule. IHA commends the Centers for Medicare & Medicaid Services (CMS) for its thorough analysis in the development of this rule, particularly as this analysis occurred in tandem with CMS' unprecedented response to the COVID-19 pandemic. We appreciate the numerous flexibilities established by CMS through waivers and guidance, and value the administration's collaboration as we continue to tackle this virus and ensure the provision of effective quality healthcare for all Illinoisans.

Given all the issues and challenges that our hospitals are confronting at this time, IHA requests that CMS reexamine some of the proposed changes to the IPPS for FFY 2021. Specifically, we urge CMS to consider the following recommendations:

- Forgo or delay the collection of median negotiated payments through Medicare cost reports for the purposes of recalculating Medical Severity-Diagnosis Related Group (MS-DRG) weights;
- Make changes to the reporting of Medicare bad debt effective beginning October 1, 2020, rather than effective retroactively for cost reports ending prior to October 1, 2020; and
- Strengthen the audit protocols used when auditing Medicare cost report worksheet S-10.

Market Based MS-DRG Relative Weight Estimation

Generally, we appreciate that CMS has begun describing how it will use information required under CMS-1717-F2 (i.e., the price transparency rule). Further, we agree with CMS' recognition that chargemaster rates rarely reflect true market costs, which

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coincidentally is one of the hospital industry's main arguments against certain requirements under the price transparency rule. However, CMS' proposed use of these data to modify the MS-DRG weighting methodology does present some concerns, particularly in light of the current COVID-19 pandemic.

Foremost, as the administration is aware, the price transparency rule is at the center of an ongoing legal challenge. Ideally, CMS would cease all price transparency implementation and data collection efforts until the legal system reaches a final decision on the legality of this rule. Despite the district court's ruling, IHA maintains that CMS does not have the legal authority to require hospitals to make public their payer-specific negotiated.

Additionally, Section 2718(e) of the Public Health Service Act requires hospitals to make public their standard charges, which have long been defined as a hospital's usual or customary chargemaster charges and not negotiated payment rates. Additionally, CMS itself has defined "charges" as the regular rates established by the provider for services rendered to both Medicare beneficiaries and to other paying patients. As stated in the Provider Reimbursement Manual (PRM), No. 15-1, Ch. 22, charges should be ... uniformly applied to all patients ..., and thus by CMS' own definition a payer-specific negotiated charge cannot be considered a standard charge, simply because the same charge is not applied to all patients. Further, CMS has established in this IPPS proposed rule that the PRM clearly reflects the agency's intentions (see section on Medicare Bad Debt, below). It is counterintuitive that CMS would disregard the PRM when it comes to the definition of "charges" but rely on it heavily when it comes to questions of Medicare bad debt.

IHA also has significant concerns regarding the intent of the price transparency rule. We outlined these concerns in our [comments](#) to CMS, submitted on Sept. 27, 2019, and the proposed data collection in this IPPS rule only heightens our reservations. CMS originally stated that the price transparency rule is specifically meant to provide consumers with information on their out-of-pocket medical costs, allowing them make informed financial decisions when deciding where to seek care. However, it is clear that CMS intends to use these data in other ways, as this proposed rule's data collection would use payer-specific negotiated rate information to change the calculation of MS-DRG relative weights. Relative weights should reflect the resources used to treat patients within each MS-DRG group rather than the price paid for such treatment. That is why the current cost-based methodology more appropriately reflects resource use, as it considers how much each facet of treatment costs a provider (i.e., resource use) and then distributes those costs across all MS-DRGs. However, market prices are typically less dependent on the actual cost of a good, but rather the demand for a good and the market advantage an individual firm has. Therefore, changing the calculation of MS-DRG relative weights to reflect market prices would likely reflect how much leverage an individual third-party payer has and the value society places on a group of services, but may fail to reflect hospital resource use altogether. Thus, we request that CMS reexamine this proposal, and

provide a better explanation as to why basing IPPS MS-DRG relative weights on market prices would more accurately reflect hospital resource use than the current methodology.

Should CMS move forward with data collection, we request that the proposed collection of median negotiated rates via Medicare cost reports be postponed for at least one year. We request this delay for several reasons. First, this proposal assumes that the collection of median negotiated rates will not significantly burden hospitals because such data are already being collected and displayed. Unfortunately, neither CMS nor hospitals could predict the current COVID-19 pandemic. Many of our hospitals faced challenges implementing the price transparency rule before the onset of COVID-19, let alone after. Illinois hospitals spent the first half the year preparing for and responding to COVID-19, and they continue preparing for the coming second surge that may coincide traditional flu season. Therefore, many of our hospitals, particularly rural and safety net hospitals, have not begun building the necessary infrastructure to comply with the price transparency rule, and cannot easily supply median negotiated rates.

Second, CMS' proposal has the potential to significantly impact hospital budgets. As the research presented in the proposed rule from Baker et al, and Maeda and Nelson, concluded, MA payments generally correlate with Medicare fee-for-service (FFS) payments while other third-party payer payments do not. This proposed data collection requires the reporting of two medians: the median negotiated rate among MA plans, and the median negotiated rate among all third-party payers (including MA plans). Because CMS is requesting both, it makes sense that CMS may look toward whichever reported median would result in lower Medicare FFS payments, particularly as a stated goal of modifying MS-DRG weights is to lower costs in the Medicare program. A delay in implementation would allow our hospitals more time to analyze the potential impact of this rule on their budgets, including additional months adapting to the impact of COVID-19 on healthcare utilization and payment.

Third, CMS states in the proposed rule that "Sections 1815(a) and 1833(e) of the [Social Security] Act provide that no Medicare payments will be made to a provider unless it has furnished the information, as may be requested by the Secretary [of the U.S. Department of Health and Human Services], to determine the amount of payments due the provider under the Medicare program." CMS appears to suggest that hospitals that fail to provide median negotiated rates on Medicare cost reports beginning with cost reporting periods ending on or after Jan. 1, 2021 will not receive any Medicare reimbursement. This punitive action is exceptionally harsh, particularly when compared to the price transparency rule civil monetary penalty noncompliance amount of \$300 per day. We respectfully request that CMS reconsider this proposed penalty. If hospitals do not receive Medicare reimbursement, they will simply be unable to provide care to America's most vulnerable citizens, an acute problem during a pandemic that involves a virus that disproportionately infects and kills individuals over the age of 65.

Finally, the proposed rule states: “we believe that because hospitals are already required to publicly report payer-specific negotiated charges, in accordance with the hospital price transparency final rule, that the additional calculation and reporting of the median payer-specific negotiated charge will be less burdensome for hospitals.” Should the price transparency rule stand, hospitals will provide negotiated rates on their websites. It would seem that CMS could extract the data they need from the machine-readable files posted by hospitals, making additional reporting on the Medicare cost report redundant and misaligned with the Patients over Paperwork initiative.

In summary, IHA respectfully asks CMS to either forgo or delay enforcement of this proposed data collection and any market based changes to the calculation of MS-DRG weights. Hospitals deserve the opportunity to begin the long road to financial recovery from COVID-19, the first wave of which is not even over yet. This proposed data collection clearly aims to lower Medicare FFS payments; considering the average Medicare margin for Illinois hospitals is -9%, it seems disingenuous to pursue data that would lead to even lower reimbursement at this time. Further, it appears that CMS would have access to these data via the price transparency rule, which we also request be delayed due to the American Hospital Association’s ongoing lawsuit and COVID-19. Finally, should CMS move forward with finalizing data collection at this time, we urgently request that they amend the proposed penalty of withholding all Medicare payment should hospitals fail to comply.

Proposed Revisions of Medicare Bad Debt Policy

IHA generally supports CMS’ efforts to clarify and codify its Medicare Bad Debt Policy, particularly as changes to reporting requirements seem to occur every few years. We agree that it will be easier for both hospitals and Medicare Administrative Contractors (MACs) to approach this topic more efficiently with specific definitions and requirements in place. For example, we support the proposed clarification and codification of the distinction between non-indigent beneficiaries and indigent beneficiaries for the purposes of Medicare bad debt.

Our general concern with this section is CMS’ assumption that all MACs have been enforcing bad debt guidelines as stated in the PRM. CMS appears to rely on this assumption as a rationale for making several proposed changes effective retroactively. IHA strongly urges CMS to reconsider this decision, and instead make any changes effective October 1, 2020. While CMS states in this proposed rule that its intention is for all hospitals to follow the PRM, our members have indicated variation in the implementation of these bad debt practices. It is clear that enforcement of PRM guidelines by MACs has been inconsistent, leading to mixed results in practice.

We also question CMS’ proposal to amend section 413.89(e)(2) to specify that when a provider receives a partial payment within the minimum 120-day collection effort period, the provider must then continue the collection effort for an additional 120 days. We agree that when there is potential for beneficiaries to pay their bills, unpaid Medicare deductible and copayment

amounts should not be recorded as bad debt. However, CMS contends that restarting the 120-day collection period is not burdensome to providers and requires little additional resources. CMS also states providers “have financial incentives to issue bills to patients as soon as possible to collect the outstanding debt and remove it from their financial records.” These financial incentives are for hospitals to remain solvent and have enough cash on hand to keep their doors open. Thus, IHA requests that CMS establish an upper limit on the number of consecutive 120-day periods that can occur should a patient make a payment. Furthermore, CMS should establish a reasonable threshold for restarting the 120-day collection period. A nominal payment would not suggest that an individual has the means or intention of paying down an entire bill in a timely manner.

Finally, CMS proposes to codify terminology and processes pursuant to the Financial Accounting Standards Board’s (FASB) Accounting Standard Update (ASU) 2014-09, Revenue from Contracts with Customer (Topic 606). While implemented in 2018, Topic 606 was not codified nor outlined in the PRM and MACs were inconsistent in enforcing it. Topic 606 requires hospitals to present Medicare crossover bad debt as “implicit price concessions” on their external financial statements, while internally hospitals must track Medicare crossover bad debt via a separate bad debt expense account to comply with CMS policy. While any change from standard practice will be initially burdensome, concurrent conflicting policies seem unpractical and misaligned with the Patients over Paperwork initiative. IHA requests that CMS select one process for accounting for Medicare crossover bad debt, codify that process, and eliminate the need for hospitals to keep two sets of books. Further, as CMS states, “Topic 606 requires different reporting of providers and terminology for bad debts (implicit price concessions).” Thus, IHA also respectfully suggests that any changes to the treatment of Medicare crossover bad debt, once codified, be effective starting with the next federal fiscal year going forward rather than be effective retroactively.

Proposal to use Audited fiscal year (FY) 2017 Data to Calculate Factor 3 for FY 2021, and One Year of Data Thereafter

IHA applauds CMS’ actions to make the calculation of Medicare disproportionate share hospital (DSH) payments more transparent by using publicly available data from Medicare cost report worksheet S-10. Additionally, we are confident that CMS follows strict audit sampling protocols, particularly because so much money is dependent on the Medicare DSH formula. However, given our worksheet S-10 audit experience in Illinois, we are concerned about the proposal to use audited FY 2017 data in calculating Factor 3 for FY 2021 payments.

According to our internal records, 22 Illinois hospitals experienced a FY 2017 worksheet S-10 audit, one of which was for a hospital that is not eligible for Medicare DSH payments. The remaining 21 audits represent 20% of Medicare DSH payment-eligible hospitals in Illinois, and 76% of these 21 hospitals also had their FY 2015 worksheet S-10s audited. While we recognize that CMS employs auditing standards as approved by entities such as the American Institute of Certified Public Accountants (AICPA) and the Government Accountability Office, we are

concerned that these audits appear to remain among a limited pool of hospitals. This concern deepens when we see that 30% of hospitals nationwide experienced swings in Medicare DSH payments by at least 25%, 12% of hospitals experienced swings by at least 50%, and 3% of hospitals experienced swings by over 100%. Frankly, using a single year of data has so far added considerable volatility to hospital payments.

Further, internal analysis indicates that almost 60% of Illinois hospitals eligible for Medicare DSH payments (59 out of 104) will in fact receive lower payments if a single year of audited S-10 data is used rather than a 3-year average of S-10 data.

Given the magnitude of payments potentially impacted by these audits, we respectfully suggest that CMS work to expand the number of hospitals that they audit. Several of our audited hospitals experienced significant changes to their FY 2017 worksheet S-10 data, and we are unsure how CMS extrapolates the results of these 21 audits to the universe of Medicare DSH-eligible hospitals. Expanding the pool of audits would yield results that are more representative of all Medicare DSH-eligible hospitals. We would further extend this recommendation to CMS' proposal to use the most recent available single year of audited worksheet S-10 data to calculate Factor 3 for all subsequent fiscal years. We are particularly concerned with this proposal as CMS states that "the number of audited hospitals may change from year to year depending on audit experience and the availability of audit resources." We agree that having a consistent policy moving forward makes sense and provides hospitals with some consistency year over year on this issue in terms of process. We ask that CMS expand and solidify this process in order to ensure that hospitals are receiving their fair share of payments, and do not face dramatic swings in payment year to year.

Ms. Verma, thank you again for the opportunity to comment on this proposed rule.

Sincerely,

A.J. Wilhelmi
President & CEO
Illinois Health and Hospital Association