June 24, 2019

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-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; Proposed Rule (Federal Register, Vol. 84, No. 86, May 3, 2019)

Dear Ms. Verma:

On behalf of our more than 200 member hospitals and nearly 50 health systems, the Illinois Health and Hospital Association (IHA) is taking this opportunity to comment on the proposed rule establishing new policies and payment rates for acute and long-term care acute hospital inpatient services for federal fiscal year (FFY) 2020. IHA commends the Centers for Medicare & Medicaid Services (CMS) for its thorough analysis to develop this rule. However, IHA has concerns with several provisions, and presents the following comments for your consideration:

PROPOSED CHANGES TO THE INPATIENT ACUTE HOSPITAL PPS (IPPS):

- **Medicare Disproportionate Share Hospital (DSH) Program:** IHA presents the following comments pertaining to individual components of the Medicare DSH methodology:

  - **Use of Medicare Cost Report Worksheet S-10:**
    Despite suggesting that Worksheet S-10 would not be implemented until possibly FFY 2021, citing recent analyses, CMS implemented a three-year transition to the complete use of Worksheet S-10, starting in FFY 2018, essentially reducing the preparation period by three years. Because FFY 2020 is the third year of the three-year transition, CMS proposes to base its calculation of the Factor 3 uncompensated care variable entirely on Worksheet S-10 data. Given the many changes in the S-10 instructions over the last few years, IHA continues to have
concerns about the use of S-10 data and believes that the S-10 uncompensated care data was not appropriate for use in FFY 2018 or FFY 2019, nor is it appropriate for use in FFY 2020 going forward. Consequently, IHA is recommending that CMS suspend its usage of Worksheet S-10 until no earlier than FFY 2021, as the agency had originally stated in its FFY 2017 IPPS final rule. An alternate recommendation is that CMS increase the transition period from the current three years (which, in FFY 2020, will be completely exhausted) to a minimum of five years, extending the transition period by two years.

- **Use of audited 2015 or unaudited 2017 Medicare cost report data:** For FFY 2020, CMS proposes to utilize a single year of Medicare cost report data, based on the audited FFY 2015 S-10 Worksheet; it would then discontinue using the three year averaging process for the uncompensated care factor calculation methodology. If one year of data is used, CMS has also requested comments as to whether the “as filed” FFY 2017 S-10 data should be used in lieu of the audited FFY 2015 S-10 data. Given that only 25% of the FFY 2015 S-10 Worksheets were audited in 2019 and many audit adjustments were later reversed due to a differing interpretation of patient payments, it seems inappropriate to use this data until all hospital data is reviewed and consistent audit criteria is applied. Additionally, as S-10 instructions have now been revised several times in the last few years, IHA recommends that the use of FFY 2017 S-10 also be delayed until there is final and consistent instructions and review of data.

- **Addressing Wage Index Disparities Between High and Low Wage Index Hospitals:** CMS proposes to increase the wage index for those hospitals whose wage index value falls within the bottom quartile (25%) of the nation. This increase would be half of the difference between the hospital’s pre-adjustment wage index, and the 25\(^{th}\) percentile wage index value across all hospitals. For the four years to which CMS’ proposal to increase payments to hospitals in the lowest quartile of wage index values would apply, CMS is proposing to create a budget neutrality adjustment to offset these increases; CMS will identify those hospitals, who conversely, are above the 75\(^{th}\) percentile wage index value; those hospitals would each then have their wage index reduced by 4.3% of the difference between their individual wage index and the 75\(^{th}\) percentile wage index value for all hospitals. IHA supports raising the floor for those hospitals in the bottom quartile but does not recommend that this should be applied in a budget neutral fashion by lowering the top quartile.

- **Change in the Fixed Outlier Payment Threshold:** To maintain outlier payments at 5.1% of total IPPS payments, CMS is proposing a fixed outlier threshold of $26,994 for FFY 2020, which is 4.75% higher than the FFY 2019 outlier threshold of $25,769. This proposal would effectively decrease the number of cases that would qualify for outlier
payments. **IHA is concerned that these continued annual increases in the threshold could lead to service reductions, consequently affecting access to services for Medicare beneficiaries.**

- **Ability to Count Resident FTEs Training in a Critical Access Hospital (CAH):** Under current CMS policy, Critical Access Hospitals (CAHs) that train residents in approved programs are paid 101% of reasonable cost. Current regulations are unclear as to whether or not CAHs are “non-provider” sites for Direct Graduate Medical Education (DGME) and Indirect Medical Education (IME) payments. Additionally, there is concern that current policy creates barriers to the training of residents in rural areas, and also hinders collaborative efforts between hospitals and CAHs to recruit and retain physicians in rural areas. CMS proposes that, for cost reporting periods beginning October 1, 2019, a hospital may include FTE residents training at a CAH in its FTE count as long as the CAH meets the non-provider setting requirements. **IHA supports this proposal.**

- **CAH Cost Reimbursement for Ambulance Services Under Certain Conditions:** Currently, Medicare pays for ambulance services provided by CAHs (or CAH-owned entities) at 101% of reasonable costs as long as that entity is the only provider of ambulance services within a 35-mile drive of the CAH, or if there are no ambulance services within a 35-mile drive of the CAH and that entity is the closest provider of ambulance services to the CAH. In all other cases, those services are paid under the Ambulance Fee Schedule.

  Ambulance service providers that are not legally authorized to transport individuals to or from the CAH must meet these criteria under the current regulations, thus leading to a CAH being unable to support the costs of providing ambulance services to its area. CMS proposes to exclude ambulance service providers without legal authorization to transport individuals to/from a CAH from consideration of the mileage criteria for ambulance services within 35 miles of the CAH. Under CMS’ proposal, such services would be reimbursed at 101% of cost. **IHA supports this proposal.**

- **CAR-T Cell Therapy Reimbursement:** CAR T-cell treatments are eligible for new technology add-on payments for FFY 2020, assuming that CMS adopts the proposal to continue such payments for these treatments. There had been a request to create a new MS-DRG specifically for CAR T-cell treatments, however CMS is not proposing this change for FFY 2020 due to the limited number of cases in which they are used, thus making the creation of a CAR T-cell therapy-specific MS-DRG appear premature. **IHA strongly recommends that CMS continue payments for CAR-T cell treatments.**
Ms. Verma, thank you again for the opportunity to comment. If you have any questions or comments regarding this letter, please contact Sandy Kraiss, Vice President of Health Policy and Finance, at 630-276-5522 or skraiss@team-iha.org.

Sincerely,

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