

June 12, 2017

Ms. 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-1677-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 2018 Rates; Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Electronic Health Record (EHR) Incentive Program Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Provider-Based Status of Indian Health Service and Tribal Facilities and Organizations; Costs Reporting and Provider Requirements; Agreement Termination Notices; Proposed Rule (*Federal Register*, Vol. 82, No. 81, April 28 2017)

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 formally 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) 2018. IHA commends the Centers for Medicare & Medicaid Services (CMS) for its thorough analysis to develop this rule. However, IHA has strong 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 revised DSH methodology:

- **Medicare Cost Report Worksheet S-10:** In the past, CMS had considered using Worksheet S-10 of the Medicare cost report as the source for charity care, bad debt and other data to measure uncompensated care. However, in the FFY 2017 final IPPS rule, CMS acknowledged that this worksheet is still comparatively new and has only been used for payment purposes in restricted ways, such as to provide a source of charity care charges in computing electronic health record incentives. In addition, stakeholders have asserted that hospitals have not had enough time to learn how to present

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accurate and consistent data in this form, and that the definitions and instructions issued thus far by CMS are confusing and contradictory. Consequently, the agency decided to defer the implementation of Worksheet S-10 until no later than FFY 2021 to allow sufficient time to address those concerns.

Despite suggesting that Worksheet S-10 would not be implemented until possibly FFY 2021, citing recent analyses, CMS proposes a three-year transition to the complete use of Worksheet S-10, starting in FFY 2018. This essentially reduces the preparation period by three years. However, IHA continues to have concerns about the data which CMS uses to base its conclusions. ***IHA reiterates its position that the S-10 uncompensated care data is not appropriate for use in FFY 2018 and its usage should be delayed because of the following:***

- **Definition of Uncompensated Care:** A broad definition of uncompensated care costs will be important in accurately measuring a hospital's unreimbursed costs, and it will ensure the most appropriate basis for distributing DSH payments based on uncompensated care payments in the future. Currently, Worksheet S-10 contains two major categories of cost. The first, summarized on line 19, is defined as the unreimbursed costs of Medicaid, State Children's Health Insurance Program and other state and local government indigent care programs. The second, summarized on line 30, is defined as the uncompensated care costs of charity care and bad debt, but does not include the unreimbursed costs of services to Medicaid patients.

CMS proposes that, beginning in FFY 2018, uncompensated care costs would be defined to include line 30 of the Worksheet S-10. The agency also proposes that Medicaid shortfalls reported on line 19 of Worksheet S-10 (i.e. the unreimbursed costs of Medicaid, State Children's Health Insurance Program and other state and local government indigent care programs) would **not** be included in the definition of uncompensated care. ***IHA continues to strongly recommend that the definition of uncompensated care include all unreimbursed and uncompensated care costs, including the unreimbursed costs of Medicaid, State Children's Health Insurance Program and other state and local government indigent care programs reported on line 19 of Worksheet S-10.*** This could be achieved by using Line 31 of the Worksheet.

Worksheet S-10 does not completely account for the costs incurred by hospitals in treating the uninsured. Hospitals may incur costs of treating uninsured patients that are not categorized as either charity care or non-Medicare bad debt and, consequently, are not appropriately reported on Worksheet S-10. For example, hospitals may provide discounts to uninsured individuals who are unable or unwilling to provide income information to the hospital. **Consistent**

with IHA's recommendation that CMS adopt a broad definition of uncompensated care costs, we also recommend that these "discounts" for uninsured individuals be included. These are clearly costs that hospitals incur in providing treatment to the uninsured. To not include them would inappropriately penalize these hospitals and would run contrary to the underlying intent of uncompensated care payments under the Affordable Care Act (ACA).

- **Inclusion of Direct Graduate Medical Education (GME) Costs in Cost-to-Charge Ratio:** Because the source of the cost-to-charge ratio (CCR) calculation on Worksheet S-10 is Worksheet C, those costs do not include the cost of direct GME. However, charges as reported in Column 8 include overhead charges that do account for direct GME. CMS does not propose to include GME costs in the cost to charge ratios in the rule. **To correct this inconsistency, IHA recommends that the formula for calculating the CCR be modified to include direct GME costs.**

Direct GME costs are allowable costs, but historically have been excluded on Worksheet C of the Medicare cost report because the Medicare program calculates a separate add-on payment for its share of those costs. However, those costs represent a significant portion of the overhead costs of teaching hospitals. **Including direct GME costs on Worksheet S-10 would more accurately match charges with costs.**

- **Audit of Worksheet S-10:** The FFY 2017 final IPPS and the proposed FFY 2018 IPPS rule both reference the use of the 2014 cost report as the basis for the implementing Worksheet S-10 data. Because of the lack of consistent instructions and definitions on the preparation of that worksheet that were available to hospitals during that time, CMS allowed hospitals to submit revised 2014 worksheets no later than Sept. 30, 2016. CMS acknowledged that these revised worksheets would probably be more accurate because more clarity had been provided by the agency during the past two years, and hospitals became more comfortable with the reporting requirements. CMS also offered that audit instructions would be provided to Medicare Administrative Contractors (MACs) on the review of those worksheets. The post-audit, revised S-10 schedules would ultimately be used in the calculation of the uncompensated care cost (UCC) component of the Medicare Disproportionate Share Hospital payment adjustment.

Currently, to our knowledge, no audits of hospitals' revised Worksheet S-10s have been performed by the MACs. In fact, we are not aware if audit instructions have even been disseminated from CMS to the MAC. Therefore, it is

presumptuous of CMS to propose to transition to the use of a cost report worksheet data which is unaudited. Hospitals are unable to project future Medicare DSH payments because it is unclear what information the MACs will request on audit and how that information would be incorporated into the payment calculation. It is also unclear as to what appeal rights hospitals would have if there is disagreement over the treatment of an item that is reported on the worksheet. The time required to resolve timely appeals also makes an immediate transition to the worksheet impractical.

To avoid the application of different audit processes by different contractors, IHA requests that CMS make public the instructions for MACs relative to auditing the amounts reported on Worksheet S-10 to ensure that these instructions are applied consistently among contractors across all regions. IHA strongly urges CMS to audit the S-10 data prior to proposing its use to verify that it is correct and complete. In addition, once CMS ensures the accuracy and consistency of the Worksheet S-10 data, we agree that transitioning to its use, either through a phase-in approach and/or a stop-loss policy, is appropriate. We also believe that if a phase-in approach is used, a longer time period (e.g., a five-year transition) than the three-year proposed transition period may be warranted, such as the 10 year, extended transition CMS implemented to phase-in the capital PPS several years ago. Implementation of these recommendations would help mitigate large payment fluctuations and promote stability in DSH payments to hospitals.

We also suggest that CMS allow hospitals to estimate the amount to be written off and provide final documentation at the time of audit. Current Worksheet S-10 instructions require hospitals to submit additional documentation of charity care write-offs after the cost report is submitted to comply with the current requirement of reporting only amounts written off related to services during the cost-reporting period. As discussed above, charity write-offs related to the prior year will occur after the cost report has been submitted.

- **Charity Care for Insured Patients:** The instructions for completion of Worksheet S-10 limit the definition of charity care to deductible and/or coinsurance amounts only, disregarding the total charges for services. Consequently, for patients with high-deductible plans, the hospital could only include the amount that the insurance plan has determined to be the patient's responsibility, the "allowable amount," as charity care. That amount is multiplied by the hospital's specific cost-to-charge ratio (CCR) to determine the cost. This effectively understates the cost of the charity. For example, assume a \$1,000 charge for patient services, a CCR of .25 and the patient's responsibility is \$400. Per current S-10 instructions, the cost of care would equal \$100 (\$400 times .25) versus \$250

(\$1,000 times .25), which is the amount that conforms to industry standards and official financial statements.

- **96-Hour Certification Requirement for Critical Access Hospitals (CAHs):** In response to strong advocacy efforts on the part of IHA and others, CMS proposes to soften the application of the 96-hour attestation requirement for critical access hospitals. As a condition of payment for inpatient services provided at a CAH, the law requires that a physician certify that a Medicare patient may be reasonably expected to be discharged or transferred within 96 hours of admission. IHA has strongly objected to the enforcement of this provision by Medicare contractors due to the judgmental pressure it places on the admitting physicians, as well as the great inconveniences it places on Medicare patients and their families.

CMS proposes that it will direct its various Medicare contractors to make reviews for compliance with the 96-hour rule a low priority for reviews beginning on or after Oct. 1, 2017; **IHA fully supports this proposal.**

- **Hospital Wage Index for Acute Care Hospitals:** For those hospitals that have been approved for reclassifications to other core-based statistical areas (CBSAs) in the past, and would experience negative financial impacts, CMS, consistent with its prior rulemaking, proposes that those hospitals must file a request to withdraw its reclassification status no later than 45 days after publication of the proposed rule. This policy has always been problematic because the Wage Index Public Use File used to develop the values published in the proposed rule is subject to correction if errors were made by the Medicare Administrative Contractor (MAC) when transmitting providers' wage index and occupational mix data to CMS. Hospitals could withdraw their reclassification status based on information in the proposed rule, and with the publication of the final rule wage index values, discover that their original reclassified status was more desirable. This "Catch 22" situation continues in FFY 2018.

Hospitals cannot make an informed decision concerning their reclassification status based on values in a proposed rule that are likely to change. **Therefore, IHA strongly recommends that in order to avoid these paradoxical situations in the future, CMS revise its current policy to permit hospitals to withdraw their reclassification status within 45 days of publication of the final rule.**

- **Readmissions Reduction Program (RRP) Socioeconomic Adjustment for FFY 2019:** For FFY 2018, CMS only proposes that the performance period would include claims from the three-year period from July 1, 2013 through June 30, 2016. The 21st Century Cures Act mandated the application of a socio-economic adjustment to hospital-specific penalties, as determined in CMS' Readmission Reduction Program in **FFY 2019**. CMS is proposing to implement the socio-economic adjustment, focusing on dual-eligible

coverage (Medicare and Medicaid) patients, in a budget-neutral manner. The identification of the dual-eligible patients and grouping of hospitals into one of five peer groups is based upon information provided to CMS by the individual states; however, this information has not yet been made publicly available. **IHA has long supported the inclusion of a socio-economic adjustment in the RRP to account for the fact that a hospital's readmissions history is impacted by the poverty, availability of resources and other factors beyond the hospital's control. But IHA is currently withholding specific comments on the proposed adjustment methodology pending review of CMS' release of the aforementioned state files.**

- **Public Reporting of Accreditation Organizations (AO) Survey and Certification Results:** The proposed regulation would require accrediting organizations to post hospital survey results for the last three years as well as deficiencies and any correction plans. The Illinois Health and Hospital Association and its members support all efforts to increase transparency of healthcare information among all stakeholders in the field, including especially, Medicare beneficiaries. However, we are concerned that the plethora of information already available could prove overwhelming and difficult to understand for most beneficiaries and their families. In addition, there must be a precise and consistent methodology for collecting and disseminating this information, allowing for sufficient vetting of the process by stakeholders. Our members expressed similar concerns when CMS published its Hospital Star Ratings last year.

Our concerns about the public reporting of AOs are:

- Long and confusing survey reports. Developing a more user-friendly summary for each survey report that the general public and patients would understand could be more beneficial;
- Information in surveys collected about smaller hospitals/communities potentially could be traced to a particular employee or patient, jeopardizing patient confidentiality; and
- The potential for hospital staff to become hesitant about discussing issues (problems) because they are worried about the ramifications.

Consequently, IHA requests that CMS delay implementation of this provision until there is industry-wide acceptance that this information is valid and that there is understanding of the data on the part of Medicare beneficiaries.

- **Documentation and Coding Adjustment:** The final FFY 2017 IPPS rule included a provision that implemented one of the sections of the American Taxpayer Relief Act (ATRA) of 2014, which mandated a 0.8 percent reduction for each year during the four-year period from FFY 2014 through FFY 2017. In accordance with that law, CMS imposed the 0.8 percent reduction in FFY 2014, 2015 and 2016. However, instead of incorporating the last of the four 0.8 percent reductions in FFY 2017, CMS implemented

a reduction amount to 1.5 percent, which is in non-compliance with the ATRA requirement; there is no provision in the FFY 2018 rule to restore this 0.7 percent excess reduction. **Therefore, IHA strongly recommends that CMS restore the excess 0.7 percent reduction to the standardized rates in the FFY 2018 final rule.**

PROPOSED CHANGES TO THE LONG-TERM CARE HOSPITAL PPS (LTCH-PPS):

- **Proposed Reduction in LTCH Site-Neutral Payment Rates:** CMS estimates that the overall impact of all proposed changes affecting Medicare payments to LTCHs in FFY 2018, as compared to payments made in FFY 2017, is a *reduction* of 3.75 percent. A significant component of this reduction increase is the estimated impact of a 22 percent reduction in the LTCH site-neutral payment rates. Much of this decrease is due to the sunset of the 50 percent / 50 percent blending of LTCH standard rates and LTCH site-neutral rates applied in 2016 and 2017. In 2018, 100 percent of the payment for qualifying site-neutral cases will be made according to the site-neutral policy.

We are particularly concerned about the enormity of this decrease for our Illinois Long-Term Acute Care Hospitals, as this significant reduction could reduce services or possibly close facilities. There are only seven IHA LTCH members; those that treat patients with significant and complex conditions are especially financially vulnerable. A reduction of services in any of these providers would severely hurt access for beneficiaries in their communities. **While we recognize that the transition to the full site-neutral payment policy is set in statute, IHA strongly encourages CMS to review and apply the most current data relating to such claims as is available; this may mitigate potentially devastating impacts on LTCH providers and consequently, to Medicare beneficiaries who need these services.**

- **Proposed Delay of Full Implementation of the “25 Percent Rule”:** The 25 Percent Rule payment policy implements a reduction to the LTCH-PPS payment amount when the percentage of an LTCH’s Medicare patients from any one referring hospital exceeds 25 percent. Once that threshold is reached, payment for all subsequent Medicare discharges, within the reporting period from that one referring hospital, is the lower of the LTCH-PPS rate of the Acute IPPS rate. Various pieces of previous legislation delayed full implementation of that policy; however that delay sunsets for cost reporting periods beginning in 2017.

CMS is proposing to pause implementation of the 25 Percent Rule because it believes that the LTCH site-neutral policy, referenced above, may render it obsolete. **IHA strongly supports this approach, but also recommends that CMS permanently discontinue the 25 Percent Rule policy.**

- **Fixed Cost Outlier Threshold:** CMS proposes an increase to the fixed-loss, standard-rate outlier threshold of approximately 37.1 percent, when compared to the threshold amount in FFY 2017. The rationale is that this amount is required to maintain Medicare outlier payments at 7.975 percent. **IHA is concerned that this increase will result in significant financial losses for hospitals that treat a comparatively high volume of outlier cases; consequently, we recommend a reduced outlier amount to be included in the final rule.**

Ms. Verma, thank you again for the opportunity to comment. If you have any questions or comments regarding this letter, please contact Tom Jendro, Senior Director of Finance, at 630-276-5516 or tjendro@team-ihh.org.

Sincerely,

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