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June 24, 2019

The Honorable Seema Verma
Administrator
Center for Medicare and Medicaid Services
7500 Security BLVD
Baltimore, MD

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.***

Dear Administrator Verma:

On behalf of the New Jersey Hospital Association (NJHA) and its over 400 hospital, health system, PACE and post-acute members, thank you for the opportunity to comment on the Centers for Medicare & Medicaid Services' Fiscal Year 2020 Hospital Inpatient Prospective Payment Systems proposed rule.

NJHA strongly urges CMS to reconsider the proposed Medicare Area Wage Index (AWI) redistribution policy included in the FY 2020 Inpatient Prospective Payment System proposed rule.

The proposed policy, which is intended to benefit rural hospitals, will have a deleterious effect on New Jersey hospitals' ability to continue competing for skilled labor, offering innovative health care services, and providing world-class care to millions of patients each year.

Since its creation in 1983, the Medicare Area Wage Index has been used by CMS to adjust fee-for-service payment rates for hospitals according to the facility's geographic location, recognizing that certain costs beyond the hospitals' control vary between metropolitan and nonmetropolitan areas. By design, hospitals in higher-wage areas receive higher Medicare payments than hospitals in labor markets where the input price of labor is lower. The fundamental rationale for geographic adjustment is to create a payment structure that adjusts payments for the input price differences, such as employee compensation, that providers face when they provide care.

In the FY 2020 IPPS proposed rule, CMS suggests increasing payments for hospitals in the lowest 25 percent of the wage index, beginning in 2020 and continuing for four years. To offset this

increase, CMS proposes redistributing payments from hospitals with a wage index above the 75th percentile.

Every New Jersey hospital would be negatively affected by this redistribution policy. The state would stand to lose an estimated $15 million in FY 2020 alone.

While we support federal initiatives to address the myriad challenges faced by rural hospitals, we cannot support a policy that blindly redistributes Medicare payments without addressing the underlying issues. The proposed policy would redistribute dollars that are currently used to address one issue, the high cost of labor in urban markets, to hospitals that face significant – but nonetheless unrelated – challenges. The proposed policy would, in turn, create new challenges for urban hospitals, including the ability to attract and retain top talent, without addressing any of the underlying disparities that necessitate the AWI in the first place.

At the same time, New Jersey's hospitals face many of the same challenges as their rural counterparts, including increased regulatory burden, a shift away from inpatient care and downward pressure on payments from public and private payers alike. New Jersey hospitals also operate within several of the nation's highest wage labor markets, and compete for their workforce with hospitals in other high-wage areas, such as New York and Philadelphia. **The proposed redistribution to the Medicare Area Wage Index will only serve to exacerbate these challenges while not actually addressing the challenges faced by hospitals located in rural and other nonmetropolitan areas.** Should CMS rescind this proposal and instead put forward a new policy that provides true support to the underlying issues rural hospitals face without punitive redistribution from high wage areas, NJHA would firmly support it.

Also included in the proposed rule is a change to the way the "rural floor" is calculated. The proposal removes urban to rural hospital reclassifications from the calculation of the rural floor wage index value beginning in FY 2020.

New Jersey is classified as an all-urban state, and therefore one of three states without a rural floor. Since the elimination of the imputed rural floor in the FY 2019 IPPS Final Rule, New Jersey has been shortchanged compared to 47 other states. The lack of a rural floor creates an anomaly which subjects hospitals in all-urban states to a financial and competitive disadvantage.

CMS specifically asks for feedback on the impact of the elimination of the imputed rural floor. NJHA estimates the imputed rural floor's benefit to New Jersey in FY 2019 would have been approximately $13 million. The elimination of this policy, which is fundamental to the area wage index and 47 other states benefit from, is added to the total tally of cuts and disadvantageous policies from which hospitals in high wage and all-urban states suffer.

NJHA strongly supports a permanent fix to the geographic disadvantage faced by hospitals in New Jersey and other all-urban states.

NJHA has consistently opposed marginal changes to the calculation of the AWI rural floor without resolving the underlying inequity faced by all-urban states. We continue to advocate for the current

rules to remain in place until there is a broader solution. For this reason, **NJHA opposes the proposed elimination of urban to rural reclassifications for the purposes of calculating the rural floor wage index**. NJHA implores CMS to pursue a permanent solution to this disparity.

We strongly urge CMS to reconsider its proposed AWI redistribution and rural floor policies, and ask instead that you work with Congress to develop a more effective long-term solution for rural hospitals that does not disproportionately harm urban providers.

CMS proposes to utilize FY 2015 S-10 data to determine each Medicare DSH hospital's share of uncompensated care in FY 2020. The agency states that the FY 2015 data are the best available because they are from the most recent year for which CMS has allowed data to be resubmitted; CMS previously used these data to determine uncompensated care payments, making the data subject to public comment and scrutiny; and they were recently audited by CMS. However, the agency also sets forth the use of unaudited FY 2017 data as an alternative in response to provider concerns about the accuracy and consistency of the FY 2015 data audit.

NJHA believes that audits – and, by extension, ongoing refinements to the audit process – result in data that are more appropriate for use in Medicare disproportionate share hospital (DSH) payments. **Thus, we support the use of FY 2015 S-10 data to determine each Medicare DSH hospital's share of uncompensated care in FY 2020.** Furthermore, given the improvements made to the S-10 instructions for the FY 2017 cost report, we strongly recommend that CMS audit the FY 2017 data in the near term and utilize it in determining FY 2021 uncompensated care payments. In addition, we believe that there is room for improvement in the audit process and have outlined several recommendations that support clarity, consistency and completeness in audit implementation. We also recommend, in light of the potential for undue fluctuations when utilizing a single year of data, that CMS monitor payments over time and, if necessary, consider utilizing more than one year of data after FY 2021.

CMS proposes to increase the rate of new technology add-on payments (NTAPs) for all new technologies from 50% to 65% of the marginal cost, which would apply to CAR T given CMS's proposal to continue NTAPs for both CAR T products. **We appreciate the proposed change in NTAP rate, and believe this proposal is a step in the right direction. However, we continue to believe that a higher NTAP for CAR T is needed to ensure beneficiary access to these therapies. We, therefore, urge CMS to make NTAPs for CAR T at a uniform rate of 100%.** While it is not a permanent solution, a uniform NTAP of 100% of the cost of the CAR T product would provide much needed support to bolster provider efforts in meeting patient needs.

We also urge CMS to consider an alternative method of determining the cost of the CAR T therapy. Doing so will facilitate more accurate information for determining NTAPs and outlier payments, as well as future weight-setting for a potential CAR T Medicare-severity diagnosis-related group (MS-DRG) or a pass-through payment.

Further, we support the application of indirect graduate medical education (IME) and Medicare DSH adjustments to the full DRG payment under a new MS-DRG for CAR T, in recognition of the purpose and usage of the two programs. According to the Medicare Payment

Advisory Commission (MedPAC), teaching hospitals "have always had higher Medicare inpatient costs per discharge" compared to other hospitals. While some portion of this cost is due to direct costs of medical education, other reasons for higher costs among teaching hospitals include: "unmeasured differences in patients' severity of illness, inefficiencies in the use of services associated with residents' learning by doing, and greater use of emerging technologies." Since the IME program was intended to address the higher provider costs associated with these characteristics, these payments are relevant for *all* cases and are especially applicable to CAR T cases, which represent both high severity of illness as well as the use of emerging technology. Similarly, the goals of the Medicare DSH program – to address higher costs associated with serving lower income populations and provide relief for uncompensated care – support the application of DSH adjustment to all discharges. The IME and Medicare DSH programs were intended to address the overall resource use in a hospital that supports medical training and/or patient care for low-income individuals; neither were meant to be selectively applied on a case-by-case basis.

In the proposed rule, CMS proposes several significant reductions to the relative weights of certain MS-DRGs – a move that could potentially limit patients' access to these vital services. For example, CMS's calculations of the relative weight for MS-DRG 215 ("Other Heart Assist System Implant") would lead to a *nearly 30% reduction* in FY 2020, which is on the heels of a 20% reduction in FY 2018. Decreases of this magnitude over a short time period will negatively impact hospitals that care for critically ill patients who require the implantation of a heart pump in the O.R. or cardiac catheterization laboratory after heart attacks or decompensating heart failure. **CMS has previously been urged to phase in substantial fluctuations in payment rates in order to promote predictability and reliability for the hospital field.** We appreciated that the agency stemmed the payment decrease for MS-DRG 215 for FY 2019, and we urge CMS to again consider such an approach in this **situation or when the relative weight for any MS-DRG is drastically reduced in a given year, particularly when it follows a significant decline in recent years.**

In the proposed rule, CMS is conducting another comprehensive review of the CC/MCC lists, applying the same methodology used in FY 2008. As such, it proposes a change in the severity level designation for a staggering 1,492 ICD-10-CM diagnosis codes. Eighty-seven percent of the changes (1,301 codes), would be shifted down in severity. CMS says these proposals are based on a review of the data as well as consideration of the clinical nature of each of the secondary diagnoses and the severity level of clinically similar diagnoses.

We strongly urge CMS not to finalize its proposals because it: provided insufficient information to adequately explain its changes; provided inaccurate information in certain instances; and applied its methodology and treated similar codes inconsistently.

Together, these shortcomings have rendered us unable to meaningfully comment on the proposals. We urge the agency to instead work toward providing more information and transparency on their methodology and data in future rulemaking. CMS also should strongly consider phasing in any future changes given the impacts such modifications would have on hospitals and the patients they serve.

The Hospital Readmissions Reduction Program (HRRP) imposes penalties of up to 3.0% of base inpatient PPS payments for having "excess" readmissions rates for selected conditions when compared to expected rates. CMS proposes mostly minor updates to the program in the proposed rule. Additionally, CMS will continue to implement the socioeconomic adjustment approach mandated by the 21st Century Cures Act of 2016 that it adopted in the FY 2018 inpatient PPS final rule.

Hospitals and health systems continue to agree that avoiding unnecessary hospital readmissions is an important goal. Hospitals' efforts to reduce readmissions are improving care and achieving significant savings for the Medicare program. **However, NJHA urges CMS to monitor and respond to ongoing concerns about the HRRP that threaten the fairness and sustainability of the program. First and foremost, the agency should engage with the field to evolve its approach to socioeconomic adjustment.** In FY 2019, CMS took an important step toward improving the HRRP's fairness by implementing the congressionally mandated socioeconomic adjustment approach that places hospitals into dual-eligible peer groups to calculate their penalties. This adjustment provided some much-needed relief to hospitals caring for the nation's poorest communities. But Congress intended for this adjustment to be a starting point and granted CMS the ability to update the approach beginning in FY 2021. It is essential that CMS's socioeconomic adjustment approach keeps up with the evolving measurement science around accounting for social risk factors.

We are further concerned that at least some of the measures in the program may be approaching "topped out" status, and urge CMS to consider phasing out these measures. Commendably, CMS has proposed new measure removal criteria for the HRRP, as detailed in the next section of this letter. Yet, by the numerical criteria CMS has used in other programs, it appears that the measures in the HRRP may be "topped out" in performance, raising questions about the benefit of keeping the measures in the program.

NJHA strongly supports CMS's proposal to add the same measure removal criteria to the HRRP that are used in other CMS hospital quality measurement programs. However, we also encourage CMS to strengthen these criteria by considering the use of numerical criteria to determine "topped out" performance.

To date, the HRRP has lacked measure removal criteria, and CMS has never removed measures from the HRRP. We are pleased that CMS recognizes the need to assess whether the measures in the HRRP have sufficient performance variation, relevance and value to patient care for retention in the program. The use of the same eight measure removal factors in the HRRP that already are in other CMS programs also should foster alignment and consistency.

The HAC Reduction Program imposes a 1% reduction on all Medicare inpatient payments for hospitals in the top quartile of certain risk-adjusted national HAC rates. The HAC Reduction Program's measure set and scoring methodology are unchanged. However, CMS proposes two updates to the program. First, CMS proposes to adopt the same measure removal criteria that are proposed for the HRRP. Second, CMS proposes several minor updates to the HAC Reduction Program's healthcare-associated infection (HAI) measure validation process.

We support CMS's proposal to add new measure removal criteria to the HAC reduction program. However, we also encourage CMS to consider adopting quantitative criteria for assessing whether a measure is "topped out."

We support CMS's proposed clarifications and updates to the HAC Reduction Program measure validation process. Each year, CMS randomly selects 400 hospitals for validation of both their HAI measures in the HAC program, and chart-abstracted measures from the hospital IQR program. In addition, the agency selects an additional 200 hospitals to undergo "targeted" validation of their HAI and IQR measures. CMS proposes two updates to the validation process. First, CMS would now select up to 200 hospitals for its "targeted sample." CMS believes this policy would allow it to remove hospitals that do not have a sufficient volume of HAI measure data from the targeted sample. Second, CMS would not validate HAI measure cases in which all positive blood or urine cultures are obtained on the first or second day following hospital admission. CMS has found that, for the most part, cases fitting this criterion are community-acquired infections rather than "true" HAIs.

We understand that CMS cannot change the statutory requirements of the HAC Reduction Program. **However, we continue to urge CMS to take a number of steps to improve the program's fairness.** This includes phasing out the Patient Safety Indicator (PSI) measure. NJHA urges CMS to remove the deeply flawed PSI measure from the HAC Reduction Program and all other hospital quality reporting and pay-for-performance programs. Simply put, PSIs lack the accuracy, validity and usefulness to be suitable for any public reporting and pay-for-performance use.

Additionally, CMS should require that measures newly added to the HAC Reduction Program be publicly reported for at least a year before tying the measure to hospital payment. By statute, CMS is required to publicly report hospital performance on all measures in the HAC program. However, the program does not currently require that CMS publicly report new program measures before tying the measures to hospital payment. We believe public reporting is an essential step before tying a measure to payment that allows for all stakeholders to ensure there are no adverse unintended consequences of reporting a measure.

Lastly, removing the measure overlap between the VBP and HAC Programs. CMS proposed to remove the measure overlap between these two programs in last year's inpatient PPS proposed rule, and we are disappointed the agency chose not to move forward. We believe that using the same measures in programs with different scoring methodologies and data reporting periods simply creates confusion for hospitals, rather than a stronger incentive to improve performance.

NJHA supports CMS's proposed reporting period of a minimum of any continuous 90-day period in CY 2021. **CMS believes that this is an appropriate length of time and that the proposal offers stability to the program.**

In addition, we support CMS's proposal to convert the Query of Prescription Drug Monitoring Program (PDMP) E-prescribing bonus measure "query of PDMP" from

numerator/denominator performance scoring to an attestation measure. As has been previously noted, PDMP integration with certified EHRs is not widespread and many eligible hospitals and CAHs are likely to need to enter data manually into the certified EHR to document the completion of the query and conduct manual calculation of the measure. We understand that laws in several states do not permit PDMP data to be brought into and stored within a certified EHR, thereby extending the need for manual data entry and manual calculation of the measure indefinitely. We believe moving to a "yes/no" attestation will significantly lessen administrative burden.

Additionally, NJHA would also like to associate itself and register support for the American Hospital Association's (AHA) detailed comments on Medicare DSH Payments, Chimeric Antigen Receptor T-Cell (Car T) Therapy, Changes to MS-DRG Classifications, Reductions in MS-DRG Payments, Comprehensive CC/MCC Analysis, Hospital Readmissions Reduction Program (HRRP), Hospital-Acquired Condition (HAC) Reduction Program, Hospital Value-Based Purchasing (VBP) Program and Promoting Interoperability Program.

We thank you for the opportunity to provide these comments on this proposed rule and look forward to working with you in the future to find solutions that will benefit all hospitals. Should you have any questions, please do not hesitate to contact Jonathan Chebra, Senior Director of Federal Affairs, at jchebra@njha.com or 609-275-4100.