760 Alexander Road | PO Box 1 | Princeton, NJ 08543-0001 | 609-275-4000 | www.njha.com

July 10, 2020

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1735-P
7500 Security Boulevard
Baltimore, MD 21244-1850

Delivered Electronically

Re: **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 2021 Rates; Quality Reporting and Medicare and Medicaid Promoting Interoperability Programs 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 2021 Hospital Inpatient Prospective Payment Systems proposed rule.

Medicare Area Wage Index (AWI)

NJHA strongly urges CMS to reconsider the proposed Medicare Area Wage Index (AWI) redistribution policy included in the FY 2021 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.

NJHA strongly urges CMS to reverse or otherwise delay the adoption of the Office of Management and Budget core-based statistical areas for acute care hospitals and other

facilities. In the preamble to the proposed rule, CMS acknowledges that hospitals currently located in CBSA 35614 (New York-Jersey City-White Plains, NY-NJ) that would be located in new CBSA 35154 (New Brunswick-Lakewood, NJ) under the proposed changes to the CBSA-based labor market area delineations would experience a nearly 17 percent decrease in the wage index as a result of the proposed change. Even with the proposed transition policy that includes a five percent cap on reductions for FY 2021, the reduction in payments to New Jersey hospitals would be significant – and the cuts beginning in FY 2022 would be disastrous.

New Jersey remains at the epicenter of the COVID-19 outbreak in the United States, and health facilities throughout the state have endured unprecedented financial hardship as a result of the pandemic. **Moreover, CMS acknowledges that making such impactful changes in between decennial censuses is unusual.** Now is not the time to break with tradition that calls for adopting major revisions to CBSAs following the release of labor market data from the decennial censuses. Doing so would unduly harm NJ hospitals and other health facilities. **NJHA respectively yet strongly requests that CMS reverse or delay these changes until data from the decennial census can be factored into the delineations.**

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.

Lastly, the rule proposal utilizes out-of-date employment and commuting data from 2010–2015. The counties affected most by this change (Middlesex, Monmouth, Ocean, and Somerset) during this period were experiencing and/or recovering from the economic fallout of Superstorm Sandy, the fourth-worst storm in U.S. History. Sandy inflicted more than $70 billion in economic damage to New Jersey, leading to employment losses of 4,200 jobs in Q4 2012 alone.[1] **This period of economic downturn, uncertainty, and recovery is not a representative sample**, and absolutely should not be used to determine Medicare payments to hospitals in those counties.

[1] Mantell, N., et al. "The economic and fiscal impacts of Hurricane Sandy in New Jersey." *New Brunswick, NJ: Rutgers Regional Report, Issue Paper* 34 (2013).

If, despite relying on data that is out-of-date and likely flawed, CMS decides to move forward and implement the new New Brunswick-Lakewood, NJ CBSA in FFY 2021 -- choosing not to delay the proposal until the decennial census data is available or until after the COVID crisis -- we respectfully ask in that case that CMS implement the proposal more incrementally to protect all providers in the new CBSA from the possible flawed data and to promote Medicare wage index payment stability. Thus, we ask that CMS implement the change gradually under which payment for (a) FFY 2021 would be based on 100 percent of all the affected providers FFY 2020 wage index, (b) FFY 2022 would be based on 97.5 percent of all the affected providers FFY 2020 wage index, (c) FFY 2023 would be based on 95 percent of all the affected providers FFY 2020 wage index, and (d) FFY 2024 would be based on 90 percent of all the affected providers FFY 2020 wage index. We expect that the affected providers would be subject in FFY 2025 to the changes made by CMS based on the 2020 decennial data.

Publication of Negotiated Rates

In the FY 2021 Inpatient Prospective Payment System (IPPS) proposed rule, CMS proposes to require hospitals to include on the annual Medicare cost report what the agency calls "market-based payment rate information."[2] Specifically, every hospital would be required to report "(1) The median payer-specific negotiated charge that the hospital has negotiated with all of its Medicare Advantage (MA) organizations ... by MS-DRG; and (2) the median payer-specific negotiated charge the hospital has negotiated with all of its third-party payers, which would include MA organizations, by MS-DRG."[3] The agency also requests comment on incorporating this information in the IPPS MS-DRG relative weights beginning in FY 2024. NJHA **believes that both proposals are unlawful and urges CMS not to finalize them**.

CMS cites no authority to require hospitals to furnish median payer-specific negotiated charge information by MS-DRG. Instead, CMS relies exclusively on a rule the agency promulgated in 2019, denominated by CMS as the "Hospital Price Transparency Final Rule,"[4] to require disclosure of negotiated charge information by MS-DRG. CMS explains that "[t]he payer specific negotiated charges used by hospitals to calculate these medians would be the payer-specific negotiated charges for service packages that hospitals are required to make public under the requirements we finalized in the Hospital Price Transparency Final Rule (84 FR 65524) that can be cross-walked to an MS-DRG. 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 he additional calculation and reporting of the median payer-specific negotiated charge will be less burdensome for hospitals."[5]

The Hospital Price Transparency Final Rule is scheduled to go into effect on Jan. 1, 2021, but it has been challenged by the AHA and other hospitals on statutory, procedural and constitutional

[2] 85 Fed. Reg. 32,460, 32,464 (May 29, 2020).
[3] 85 Fed. Reg. at 32,791.
[4] 84 Fed. Reg. 65,524 (Nov. 27, 2019).
[5] 85 Fed. Reg. 32,460, 32,465 (May 29, 2020). We note that, because there is no comparator in the statement, it is not clear what CMS means when it says that reporting median payer-specific negotiated charges is "less burdensome for hospitals."

grounds. Although the district court denied hospitals' motion for summary judgment,[6] the hospitals have appealed that decision to the United States Court of Appeals for the District of Columbia Circuit. The appeal will be fully briefed by the end of August, and the parties are requesting oral argument as soon after that as possible. Because the information to be furnished under the proposed rule would be derived from information collected under the Hospital Price Transparency Final Rule, the new information collection requirement suffers from the same legal infirmities: It is not authorized by statute and violates both the Constitution and Administrative Procedure Act. Moreover, if the hospital price transparency final rule is found unlawful, then CMS's requirement for disclosure of median payer-specific charge information by MS-DRG would similarly be unlawful.

The same is true as to the potential approach to change the method of calculation for MS-DRG relative weights beginning in FY 2024. CMS says that it is considering adopting in the FY 2021 IPPS final rule a "change to the methodology for calculating the IPPS MS–DRG relative weights to incorporate this market-based rate information, beginning in FY 2024. . . ."[7] But if it is unlawful to require disclosure of median payer-specific negotiated charge information by MS-DRG, then CMS could not use that information to change relative weights.

In addition, it would be arbitrary and capricious to use median payer-specific negotiated charge information by MS-DRG to change relative weights. As set forth in section 1886(d)(4)(A) of the Act, relative weights are intended to reflect "the relative hospital resources used with respect to discharges classified within that group" and not the relative price paid. CMS currently uses "a cost-based methodology to estimate an appropriate weight for each MS-DRG."[8] In proposing to use median payer-specific negotiated charges to set MS-DRG relative weights, CMS has not adequately explained why it thinks market price rather than costs is a better measure of hospital resources used. Instead, the agency appears to *conflate market price with cost*.

The rationales CMS uses for basing MS-DRG relative weights on price (e.g., promoting transparency, bringing down the cost of health care, wanting to move beyond the chargemaster, etc.) have nothing to do with whether median payer-specific negotiated charges are a measure of "hospital resources used" as the Medicare statute requires. Rather, CMS proposes to use this information to "advanc[e] the critical goals of [Executive Orders] 13813 and 13890, and to support the development of a market-based approach to payment under the Medicare FFS system."[9] But that is not the statutory test. Simply put, we believe CMS has not adequately explained why basing IPPS MS-DRG relative weights on market price would result in relative weights being based on hospital resources used. As such, it would be arbitrary and capricious to adopt this proposal. *See Motor Veh. Mfrs. Ass'n v. State Farm Ins.*, 463 U.S. 29 (1983).

NJHA is hopeful that the appeals court will rule on the challenge to the hospital price transparency final rule before the end of this year. Should the hospital price transparency final rule be found unlawful, CMS would have no legal basis for requiring hospitals to disclose their median payer-

[6] *American Hospital Assn, et al. v. Azar*, No. 19-CV-3619 (D.D.C. June 23, 2020).

[7] 85 Fed. Reg. 32,460, 32,465 (May 29, 2020).
[8] *Id.* at 32,791.
[9] *Id.*

specific negotiated charges by MS-DRG. **If, despite the NJHA's concerns about CMS's proposals to collect data and base IPPS MS-DRG relative weights on median payer-specific negotiated charges, the agency nevertheless elects to finalize them, it should not do so unless and until (1) the court upholds the hospital price transparency final rule, (2) the agency has adequately explained the basis for concluding that payer-specific negotiated charges by MS-DRG reflect resources used, and (3) stakeholders have had another opportunity to comment on the proposal.**

Medicare DSH Proposals

Under the DSH program, hospitals receive 25 percent of the Medicare DSH funds they would have received under the former statutory formula (described as "empirically justified" DSH payments). The remaining 75 percent flows into a separate funding pool for DSH hospitals. This pool is reduced as the percentage of uninsured declines and is distributed based on the proportion of total uncompensated care each Medicare DSH hospital provides.

The estimated DSH amount determined by the former statutory formula is derived from historical data, including the number of Medicaid enrollees. According to a Kaiser Family Foundation analysis, the economic downturn and increased unemployment related to the coronavirus has resulted in approximately 12 million people who experienced job loss by May 2020 becoming eligible for Medicaid. That number is expected to rise to nearly 17 million people by January 2021, as unemployment benefits expire and more individuals are no longer able to receive subsidies for marketplace insurance plans. Furthermore, some models have projected as many as 21 million new Medicaid enrollees if unemployment rises to 20 percent. At the time the DSH estimates for FY 2021 were developed, the Actuary could not have anticipated the stark economic changes resulting from the COVID-19 public health emergency. It is imperative that the Office of the Actuary (OACT) update its estimate of the Medicare DSH amount to more accurately reflect increased Medicaid enrollment for 2020 and 2021. Revising the estimated DSH amount will improve the accuracy of both the empirically justified payments and the uncompensated care pool and more closely account for the additional costs associated with providing care to a larger portion of low-income patients.

In addition, as noted above, CMS adjusts the 75 percent pool to reflect changes in the percent uninsured. Since FY 2018, CMS has applied the percent uninsured estimated by OACT and based on National Health Expenditure Accounts (NHEA) data. According to the proposed rule, the NHEA historical data currently run through 2018. However, the ongoing COVID-19 emergency has highlighted severe limitations of the use of historical data. Specifically, the 9.5 percent uninsured percentage that OACT has estimated for both FY 2020 and FY 2021 does not account for extensive unemployment and economic hardship resulting from the COVID-19 crisis. For example, according to Pew Research Center and the Bureau of Labor Statistics, unemployment increased markedly, from 3.8 percent in February to as high as 16.3 percent in May. Accordingly, some recent estimates indicate that 5-9 million individuals could lose their health insurance due to the effects of COVID-19, leaving as many as 40 million individuals uninsured. Inputting these estimates into the NHEA projection results in approximately 11-12 percent uninsured, and would lead to more than $1 billion in additional funds in the 75 percent pool for uncompensated care payments. Thus, current OACT projections significantly underestimate the percent of individuals that are uninsured and would lead to artificially reduced DSH payments in FY 2021. Hospitals

across the country have been – and continue to be – on the front lines of the COVID crisis, providing essential care to those who need it, including those that may not be insured. Given the serious impact that the pandemic has had on the U.S. economy and unemployment, we strongly urge CMS to use more recent and representative data or otherwise apply an upward adjustment to estimate a more appropriate percent uninsured for the FY 2021 75 percent DSH pool.

S-10 Worksheets

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.

CAR-T DRG Codes

In the 2021 IPPS proposed rule, CMS announced its intention to remove the existing CAR T ICD-10 procedure codes (XW033C3 or XW043C3) from MS-DRG 016 (Autologous Bone Marrow Transplant with CC/MCC or T-cell Immunotherapy) and assign them to a new MS-DRG 018 (Chimeric Antigen Receptor (CAR) T-cell Immunotherapy). This new MS-DRG 018 represents a significant weight increase from MS-DRG 016. NJHA appreciates CMS' continued focus on the reimbursement complexities for this innovative technology. Additionally, UPHS supports CMS' decision to exclude cases that are part of a clinical trial from the relative weight determination and also to pay these cases exclusive of the cost of the CAR T-cell product. We agree CAR T-cell therapy is sufficiently different from other treatments to warrant its own MS-DRG.

However, the increased DRG payment does not sufficiently cover the product acquisition cost ($373,000) or consider other costs associated with the inpatient care such as nursing, diagnostic studies, room and board, etc. **Medicare's reimbursement must be sufficient to not only cover the acquisition cost of the CAR-T therapy but cover the inpatient medical costs associated with administering these therapies.**

Sincerely,

Neil Eicher

Neil Eicher, MPP
Vice President, Government Relations & Policy
New Jersey Hospital Association
Work: 609-275-4088
Cell: 732-221-2544
NEicher@njha.com