CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

June 25, 2018

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

SUBJECT: CMS–1694–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 2019 Rates; Proposed Quality Reporting Requirements for Specific Providers; Proposed Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs (Promoting Interoperability Programs) Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Medicare Cost Reporting Requirements; and Physician Certification and Recertification of Claims; Proposed Rule, Federal Register (Vol. 83, No. 88), May 7, 2018

Dear Administrator Verma:

The California Hospital Association (CHA), on behalf of our more than 400 member hospitals and health systems, appreciates the opportunity to submit comments on the Centers for Medicare & Medicaid Services' (CMS) proposed rule outlining rate updates and policy changes to the Medicare inpatient prospective payment system (IPPS) for federal fiscal year (FFY) 2019.

In summary:

- CHA opposes CMS' proposal to proceed in weighting Worksheet S-10 at two-thirds for FFY 2019. While we applaud the agency's efforts to clarify the instructions, make significant changes in policy to allow for uninsured discounts and afford hospitals the opportunity to update their data, we believe that significant issues remain with the data. We suggest that CMS use one year of S-10 data (FFY 2015), weighted at the current one-third, and low-income patient days, weighted at two-thirds, for FFY 2019 and 2020. This will give CMS and hospitals additional time to improve that data and CMS more time to appropriately redistribute the uncompensated care pool payments to hospitals.
- CHA applauds CMS for its efforts to reduce the quality measure reporting burden on hospitals. However, we urge the agency to clarify in the final rule how the proposed measure removals will impact public reporting, including Hospital Overall Star Ratings.
- While we appreciate the de-duplication of measures across quality programs and understand the need to update program-scoring methodologies accordingly, we are concerned that continued volatility in pay-for-performance programs does not allow for meaningful conclusions about hospital performance improvement. We urge CMS to finalize proposals with stability going forward.

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- CHA supports CMS' proposal to extend current requirements that hospitals report on four self-selected electronic clinical quality measures (eCQMs) for one calendar year quarter of data for the 2019 reporting year. We urge the agency to finalize the same flexibility for reporting year 2020 as hospitals begin reporting on a reduced eCQM measure set.
- CHA supports the proposed 90-day reporting period for 2019 and 2020 for the Medicare and Medicaid Promoting Interoperability programs and appreciates that CMS has increased flexibility under its proposed changes to the scoring methodology. However, we urge the agency to make additional changes, including more evenly distributing weights across the objectives as hospitals transition to new editions of electronic health record technology and adjust to the new scoring methodology.
- In response to CMS' request for information on promoting electronic interoperability, CHA encourages the agency to take a broad – rather than piecemeal – approach to updating the Conditions of Participation (CoPs), and consider implications across the delivery system while engaging in a robust stakeholder engagement process. CHA believes its premature to consider a specific change to the CoPs at this time.
- CHA supports CMS' proposal to reduce documentation requirements for inpatient admission orders and welcomes additional dialogue with the agency on additional burdensome regulatory issues that could be further addressed under the Patients Over Paperwork Initiative.

MEDICARE DISPROPORTIONATE SHARE HOSPITAL (DSH) AND UNCOMPENSATED CARE PAYMENTS

Section 3133 of the Affordable Care Act (ACA) required that, beginning in FFY 2014, eligible hospitals receive 25 percent of the Medicare DSH payments they would have received had the ACA not been enacted. Section 3133 refers to these payments as "empirically justified Medicare DSH payments." The remaining 75 percent of Medicare DSH payments, referred to as "uncompensated care payments," are reduced by the percentage change in the number of uninsured individuals from FFY 2013 and distributed to each hospital eligible for Medicare DSH based on its share of national uncompensated care costs.

CMS continues this methodology for FFY 2019 Medicare DSH payments, and proposes to continue its transition from distributing uncompensated care payments based on low-income patient days to using Worksheet S-10 of the Medicare cost report. Under CMS' proposal, uncompensated care payments would be distributed to each hospital in FFY 2019 using one year of low-income patient days (FFY 2013 Medicaid inpatient days and FFY 2016 Medicare SSI days) and two years of uncompensated care costs from Worksheet S-10 (FFY 2014 and FFY 2015). Although CMS did not release proposals related to its plans beyond FFY 2019, the FFY 2019 IPPS proposed rule indicates a likelihood that CMS will distribute future uncompensated care payments based completely on Worksheet S-10 beginning with FFY 2020.

CMS indicates its plans to selectively review Worksheet S-10 for hospitals with aberrant or extreme data, but does not indicate any plans to establish a desk audit process before it begins to use solely these data in distributing uncompensated care payments**. CHA urges CMS to consider our comments and to revisit its position. More specifically, we urge CMS to allow providers as much time as possible to amend the FFY 2016 cost reports and articulate a process for audit of this data in the final rule.**

As explained below, while **CHA applauds CMS' efforts to clarify the instructions, make significant changes in policy to allow for uninsured discounts and afford hospitals the opportunity to update their data, we remain concerned that — absent a systematic data audit — CMS continues to make**

more than $8 billion dollars in uncompensated care payments to hospitals based on data that are not yet reliable or valid for purposes of payment.

CHA recognizes and understands CMS' position about the use of Worksheet S-10, as well as the concerns raised by stakeholders about continued use of proxy data. Though we would prefer that CMS discontinue the use of Worksheet S-10 data, we do not believe it is a solution the agency will consider. Therefore, absent delaying its use altogether we recommend that CMS strongly consider using the most recent year of Worksheet S-10 data (2015) — which is more likely to be consistently reported — instead of a combination of 2014 and 2015.

Specifically, CHA opposes CMS' proposal to proceed in weighting Worksheet S-10 at two-thirds. We also believe the use of two years of unaudited Worksheet S-10 data presents a number of challenges. Instead, we suggest that CMS use one year of S-10 data (FFY 2015), weighted at the current one-third, and low-income patient days, weighted at two-thirds, for FFY 2019 and 2020. CHA agrees with continuing to use FFY 2016 Medicare SSI days in combination with either FFY 2012 and FFY 2013 Medicaid inpatient days, weighted equally, or FFY 2013 Medicaid inpatient days weighted at two-thirds. This is one of several options the agency should consider to afford CMS and hospitals additional time to improve CMS' ability to appropriately redistribute the uncompensated care pool to hospitals.

Worksheet S-10 Reported Data Continue to Have Major Shortcomings
As previously mentioned, CHA appreciates the agency's response to comments — including a white paper issued by CHA — about the reporting instructions' lack of clarity, which resulted in variation in hospital reporting and unexplainable aberrant data. The late 2017 release of Transmittal 11, along with a *Medicare Learning Network Matters* article and frequently asked questions, was welcome and much-needed guidance for the field. We urge CMS to continue its efforts to engage with stakeholders in addressing these and other outstanding questions. Shared understanding of reporting expectations is the only way to ensure reliable and valid data reporting and auditing.

Following the release of these instructions, CMS allowed hospitals a brief, four-month period (September 29, 2017, through January 2, 2018) to resubmit both their FFY 2014 and FFY 2015 cost reports in accordance with the revised instructions outlined in Transmittal 11. Revisions submitted during that period were used in the FFY 2019 uncompensated care distribution analysis conducted by CMS as part of the rulemaking process**. In conversations with hospitals and cost report experts around the country, CHA has learned that — while these changes were welcome — many hospitals did not have sufficient time or internal financial or personnel resources to comply. While CMS notes that more than half of providers took this opportunity to amend their cost reports, it is clear that the accuracy of those updates remains in question.**

In addition, in speaking with our members and cost report experts, it is our understanding that a subsequent review of data conducted by CMS and the MACs in March and April largely focused on the FFY 2015 data, and perhaps paid much less attention to equally troubling FFY 2014 data. While we do not know the scope of CMS' outreach to providers, we are concerned about the potential of significant differences in uncompensated care reporting from FFY 2014 to FFY 2015, not because of meaningful changes in how much uncompensated care individual hospitals actually provided but because of the

differences in how hospitals completed and revised (or did not revise) their S-10 forms for the two years in question.

In summary, despite CMS' national provider call and education provided by CHA, other state hospital associations and numerous cost report experts, CHA believes the following factors have contributed to inaccurate reporting by many hospitals around the country:

- On average, it took cost report consultants — experts in the field of reporting — 50 to 80 hours per hospital client to pull data necessary for accurate reporting and compile supporting documentation in preparation for future audit. From October 1 through January 2, excluding holidays, only 62 business days were available to complete this work. There was simply not sufficient time for many hospitals and their partners to understand the changes and accurately report.
- Several hospitals in California and around the country were subject to EHR audits by the Office of Inspector General at various points throughout the year. Hospitals that were audited after the revised instructions were released reported that, following submission of revised Worksheet S-10 data, additional errors were found — attributable to the short timeline. Hospitals that had undergone an EHR audit prior to the release of updated instructions felt more prepared to respond under the short timeline but, after further review, also noted inconsistencies in their reporting.
- For the FFY 2014 and 2015 cost report years, CMS also changed what hospitals can include in their reporting — most notably, whether hospitals may consider uninsured discounts. This required a complete review of patient-level data to ensure accurate reporting, a daunting and time-consuming task that, for some hospitals, was simply not achievable due to limited personnel and financial resources.
- Hospitals with inadequate internal financial management tracking systems were at an extreme disadvantage in meeting this timeline because much of their work had to be done manually, leading to further variation in reporting.

While the policy and instructional changes made by CMS have significantly improved shared understanding of expectations for reporting, we believe the agency underestimates the significant impact this has had on the data reported. Therefore, we believe it remains premature — and inconsistent with sound financial management concepts — to distribute more than $8.25 billion in federal uncompensated care payments based on largely unaudited Worksheet S-10 data.

In the proposed rule, CMS stipulates that it believes that Worksheet S-10 data has improved, based on its review of the impact of shifts in payments as well as its continued reliance on a study comparing Worksheet S-10 to Schedule H of Internal Revenue Service Form-990 for a subset of not-for-profit hospitals. We respectfully disagree. After analyzing the data line by line and hospital by hospital, aberrant and unexplainable data persist.

CHA continues to believe that reliable and valid data are achievable if we continue to examine the data and ask critical questions. Regardless of our disagreement over CMS' current proposed policy position to continue to use this data, we endeavor to ensure compliance with the policies once they are adopted. CHA believes the agency is falling short in ensuring adherence to its newly revised instructions, putting providers at risk of future audits. We also understand that hospitals have a

significant role to play in improving the data, and stand ready to work with the agency in doing so. However, as stated previously, we believe that CMS and hospitals need additional time to understand these shortcomings and make mid-course corrections. This is the only way to avoid significant payment variations that will occur from year to year for so many hospitals across the country, exposing them to substantial financial risk and jeopardizing access to care for Medicare beneficiaries.

In our endeavor to contribute to the understanding of the reported data's shortcomings, CHA contracted with Toyon & Associates — a nationally recognized cost report and reimbursement firm based in California — to review the Worksheet S-10 data as well as cost reports resubmitted by hospitals following Transmittal 11's release. Our analysis focused on DSH hospitals for which Worksheet S-10 data are used to determine uncompensated care payments.

The analysis indicates that there continue to be major shortcomings in the Worksheet S-10 data and continued confusion among hospitals about how to accurately fill out certain elements of the Worksheet S-10 cost report. CMS' assumption — that because half of hospitals submitted revised cost reports, those reports must be accurate — is flawed, as evidenced by the data analysis. CHA believes the problems with the Worksheet S-10 data are more widespread than CMS plans to address before FFY 2019. Additionally, we believe its plan to selectively review cost reports with the most aberrant data or the largest increases in uncompensated cost reports following Transmittal 11 is insufficient, given the magnitude of the inconsistencies and the importance of accurately allocating over $8 billion dollars in uncompensated care funds to hospitals. Our findings are summarized below and have been attached for your review and consideration. We welcome the opportunity to discuss this analysis with you.

Overstated Charity Care Coinsurance and Deductibles
In Transmittal 11, CMS made a change in policy indicating that a hospital's cost-to-charge ratio (CCR) would not be applied to the deductible and coinsurance amounts for non-reimbursed allowable Medicare bad debt or insured patients approved for charity care.

Our analysis found significant variation in reporting of charity care coinsurance and deductibles, with many hospitals reporting them as a percent of total charity care far above the national average of less than 8 percent. **Specifically, 445 hospitals in FFY 2014 (19 percent) reported charity care coinsurance and deductibles at more than 25 percent of total charity care charges; 230 of these hospitals submitted FFY 2014 changes to Worksheet S-10 without accounting for this issue**. For FFY 2015, 561 hospitals (23 percent) report charity care coinsurance and deductibles at more than 25 percent of total charity care charges, and 268 of them submitted FFY 2015 changes without accounting for this issue. This indicates that not applying a CCR to charity care deductibles and coinsurance has led to an increase in — and likely an overstatement of — these amounts. In contrast to CMS' conclusion that resubmission of cost reports suggests improvement in Worksheet S-10 data, our analysis found that these problems existed in a large number of resubmitted cost reports.

Notably, CMS is clearly aware of some of the most egregious aberrant data related to the coinsurance and deductible reporting. We applaud the agency's work with Medicare Administrative Contractors (MACs) to identify and notify the hospitals that differed most significantly, and allow them additional time to revise or correct data following the January 2 deadline. Several California hospitals received notification from Noridian and took steps to address the issue by April 20, 2018, as requested. However, in most instances, providers were given one week to make changes to one or both cost reports. CHA is

concerned not only that the time allowed was not sufficient, but also that this is a systemic issue far exceeding the limited number of hospitals that were given an opportunity to correct data. The widespread nature of this problem is reason enough for CMS to begin a timely and robust desk audit.

Understated Charity Care Coinsurance and Deductibles and Non-Reimbursable Medicare Bad Debt
In addition, we found that the amount reported for uncompensated care is internally inconsistent on the cost report. In these cases, the amount appears to be reduced by the hospital's CCR, although CMS' instructions in Transmittal 11 no longer require this adjustment. To determine the uncompensated care distribution, CMS uses actual amounts reported on Worksheet S-10 — even when it appears the hospital has incorrectly applied a CCR to non-reimbursable Medicare bad debt or deductible and coinsurance amounts written off to charity (using a pre-Transmittal 11 calculation to determine uncompensated care cost). This applies to 189 hospitals in FFY 2014 cost reports and 45 hospitals in FFY 2015 cost reports. While the numbers are small, the variation between the years of data is significant and must be addressed.

Medicare Bad Debt Issues
Our analysis found 809 cases in which the hospital has Medicare allowable bad debt elsewhere on the cost report, but those amounts are not incorporated in Worksheet S-10 in the Healthcare Cost Report Information System. Additionally, in 31 cases the hospital reports no total bad debt but does report Medicare bad debt — an impossible scenario. While 31 is not a high number of cases, the issue is indicative of the need for CMS to intervene with MACs to implement appropriate edits or other interventions that would help providers report accurately.

Other Issues
Our analysis — and a common audit finding — shows many hospitals incorrectly report "insured" charity care on Worksheet S-10, line 20, column 2 (which is not reduced by CCR). Cost report instructions state these amounts, which include non-covered Medicaid charges, must be reported as "uninsured" on Worksheet S-10, line 20, column 1 and reduced by CCR. This instruction is very confusing as Medicaid patients are insured, yet hospitals are directed to report non-covered charges in the column for uninsured patients. Understandably, this instruction is commonly misinterpreted. By incorrectly reporting these amounts on Worksheet S-10, line 20, column 2, non-covered Medicaid charges are not being reduced by the CCR and may be contributing to the overstatement of charity care costs.

CMS is trimming data where uncompensated care costs are more than 50 percent of total costs, which applies to four hospitals. However, uncompensated care costs are between 25 and 49 percent of total hospital costs in an additional 65 cases. As the national average is 6 percent, these data suggest overstated uncompensated care costs. Absent further exploration (i.e., audits), these findings cannot be verified. Before proceeding to use these data of questionable accuracy, CHA believes CMS should further examine these hospitals' costs.

In the proposed rule, CMS indicates that it has instructed the MACs to review situations in which a hospital has an extremely high ratio of uncompensated care costs to total operating costs. If the hospital cannot justify its reported uncompensated care amount, CMS proposes to use the ratio of uncompensated care costs to total costs from a different year (either FFY 2015, FFY 2016 or FFY 2017) and apply it to the hospital's operating cost for the aberrant year. CMS indicates that it plans to employ a similar process for reviewing data from hospitals that had the largest increases in uncompensated care

costs as a result of resubmitting their FFY 2014 or FFY 2015 cost reports. That is, if the hospital cannot justify its reported costs, CMS will use the hospital's ratio of uncompensated care costs to total costs from a different year and apply it to the hospital's operating cost for the aberrant year.

CHA does not believe that CMS' suggested actions will sufficiently address the data problem with Worksheet S-10. The data anomalies CHA found suggest that the Worksheet S-10 data contain significant problems beyond those that can be corrected by the processes CMS proposes. CMS and the MACs need additional time to understand the data reported so that appropriate trim policies can be implemented going forward.

Rather than addressing only the most extreme cases, CHA recommends slowing the transition to use of Worksheet S-10 to allow for further examination of the data and development of an action plan to make improvements over time. In addition, using one year of data allows for closer examination and development of effective policies. We understand that this process will take time and will evolve, but — absent additional work to improve the data — we do not support the speed at which the agency is moving to fully implement use of Worksheet S-10 data.

CHA urges CMS to work with the field in investing resources to improve the data's accuracy. CHA looks forward to working with CMS on additional refinements, but — at a minimum — suggests that the agency:

- Include edits to ensure internal consistency between the same amounts reported on different worksheets.
- Include edits within the cost report to ensure that reported amounts and calculated amounts are equal, or that data entry is not permitted for amounts that can be calculated from other information on the cost report.
- Begin immediately to establish a desk review audit similar to that used for the wage index, as discussed further below.

Worksheet S-10 data are now the source of uncompensated care information for all hospitals. This data set is publicly available and downloadable. It will be accessed by various stakeholders, media, researchers, state and federal agencies, and others. Hospitals and CMS must work together to ensure its accuracy, as the current variation is unexplainable due to multiple policy and instruction changes that have occurred in the last 18 months. While we are not surprised that the data remain a challenge, we do believe they can, and will, improve over time. CMS must make this an agency priority and dedicate the resources necessary to undertake this work.

In the meantime, overstatement of uncompensated care for any single hospital rewards that hospital with higher payments, at the expense of all other hospitals — even those that have reported uncompensated costs correctly. Similarly, a hospital that underreports uncompensated care payment disadvantages itself and rewards all other hospitals with higher uncompensated care payments, even if those hospitals reported uncompensated costs incorrectly. **Not auditing these data is inconsistent with ensuring proper payments. It is critical that CMS ensure these data are reported consistently, accurately and according to government auditing standards as soon as possible.**

Desk Audit Program for Worksheet S-10

Like uncompensated care, the Medicare wage index results in payments to hospitals based on reported wage costs. CMS has established rigorous and detailed instructions for the hospital wage index from its many years of experience working with hospital-reported wage data. It has also established an annual process through which hospitals:

- Submit their wage index data
- Are under deadlines to revise and correct initially submitted data
- Are subject to CMS-developed annual audit protocols and desk review audits from MACs
- Can work with MACs to resolve desk audit discrepancies
- Can use a multi-step appeals and correction process before the data are used for hospital payment

The process has recently also been more centralized, leading to more consistent and reliable audits by MACs — a welcome change for health systems that found themselves subject to variation in audits depending on which MAC was doing the audit.

As stated in our FFY 2014 and subsequent comments, CHA suggests that a similar process be established for Worksheet S-10 data, to ensure consistently reported and reliable uncompensated care data that result in accurate uncompensated care payments. The processes are analogous in that there is a similar four-year lag between the cost report data that CMS uses for the wage index and to distribute uncompensated care payments (FFY 2015 cost report data to determine FFY 2019 payments). The only difference is that CMS uses a three-year average of data for uncompensated care (FFY 2013 through FFY 2015) and one year for the wage index (FFY 2015), although CMS itself suggests going to one year of data at some future point when the data are more stable.

One limitation of our recommendation is that CMS is already using one year (FFY 2014) of unaudited data and proposes to use two years (FFY 2014 and FFY 2015) of data to distribute uncompensated care payments. CHA's proposal would require CMS to either change its current plans for use of Worksheet S-10 until the data can be audited, or use partially unaudited data until an audit process can be established.

CHA proposes balancing these alternatives by continuing to **use one year of Worksheet S-10 data (FFY 2015), weighted at one-third, and low-income patient days, weighted at two-thirds, for FFYs 2019 and 2020.** CHA's proposal has the following advantages:

- Hospitals have been given more of an opportunity to fix potential issues associated with FFY 2015 S-10 worksheet data. Our analysis found it to be slightly more accurate than FFY 2014 data. However, we acknowledge that this will likely disadvantage hospitals that had the resources to update both years of data and believe their reporting is accurate.
- This proposal allows time, over the next two years, to fully audit FFY 2016 data to establish a baseline for subsequent audits. We urge the agency engage in provider education simultaneously with audit to ensure shared expectations and understanding of reporting instructions.
- It is consistent with CMS' prior statements to begin a desk review audit process analogous to the IPPS wage index on FFY 2017 Worksheet S-10 data that will be used for the FFY 2021 payment distribution.

- It avoids distributing more than $8 billion based on data that are clearly erroneous and inconsistently reported. It would also improve the likelihood that data are distributed in a manner consistent with government accounting practices.
- It avoids using FFY 2014 low-income patient data, which are affected by Medicaid expansion under the ACA — a major concern motivating CMS to move to using Worksheet S-10 data beginning with FFY 2018.

In FFY 2021, CMS could reevaluate the quality of the Worksheet S-10 data and either 1) phase-in the new data over a multi-year period to minimize annual payment redistribution and allow continued improvements in data quality, or 2) consider moving to one year of Worksheet S-10 data, dependent on consistency and quality, as suggested in the FFY 2019 IPPS proposed rule.

PROPOSED CHANGES FOR FFY 2019 AREA WAGE INDEX AND REQUEST FOR INFORMATION

CHA is generally supportive of the proposed changes outlined for the area wage index (AWI) for FFY 2019. We appreciate the agency's continued refinement, as well as its close oversight of MACs in this process. CHA believes that, while far from perfect, the audit process established by CMS and the MACs for AWI has evolved over time and resulted in a robust data set that is reliable and accurate for payment purposes. While we agree there are inherent flaws in the AWI policies, addressed below, CHA believes that the underlying data reported by hospitals remain reliable and valid and have improved due to this process. CHA strongly believes the CMS central office's oversight of MACs has improved the data submitted by providers. Though we may, from time to time, disagree on the policy approach, we certainly agree that uniformity in this process has been essential in limiting unexplained variation and appreciate the agency's attention to this important issue.

Request for Public Comments on Wage Index Disparities

CMS notes in the proposed rule that a significant amount of time has elapsed since the Medicare Payment Advisory Commission, Acumen, the Institute of Medicine and CMS examined disparities between the wage index values for individual hospitals and among different geographic areas. For that reason, it invites public comment on regulatory and policy changes to improve the Medicare wage index that addresses this issue.

CHA agrees that, while years have passed since a number of reports and recommendations were released, the fundamental underlying policies that plague the AWI remain. Most notably, the policy application is budget neutral to the IPPS and creates winners and losers regardless of an individual hospital's labor costs, which vary significantly across the nation.

The AWI is an imperfect index and, therefore, fraught with challenges. It is currently used to arrive at 69.8 percent of the payment for each Medicare inpatient and outpatient discharge in California. In addition, its use in other prospective payment systems (for example, inpatient rehabilitation facilities, long-term care hospitals and inpatient psychiatric facilities) cannot be forgotten or discounted. Further, Medicare's AWI (which includes reclassification and rural floor adjustment) is used to adjust fee-for-service payments in California's Medicaid program, known as Medi-Cal, under an acuity-based system that uses all patients refined diagnosis related groups. Our state is not alone in its use of the AWI in the Medicaid program.

In addition, the AWI is used currently by both payers and providers in privately negotiated contracts, including capitated rates, and it is built into the methodology of performance-based programs that measure total costs of care. Looking at the AWI in only one payment system underestimates the overwhelming number of complicating factors that would arise for providers in both acute and post-acute care settings. **CHA urges CMS to solicit input from all providers, not just hospitals, should it continue this process of further examining the AWI.**

Approximately 60 cents of every dollar spent by hospitals in the United States goes toward wages and benefits for those who directly care for patients or support patient care in some manner. These professionals are required to attain higher levels of education and, in many cases, complete clinical training in their area of specialty. As a result, they receive higher wages than workers in other service industries. Additionally, health care workers — especially nurses — historically have been in high demand. This shortage drives up the cost of labor. Nationwide, in the last decade, wages for all private industries have climbed 26 percent; hospitals experienced a 30 percent increase over the same period (BLS 2018).

In California, the percentage of growth exceeds the national average, with employment costs for hospitals increasing 32 percent since 2007 and growing at approximately 2.9 percent annually (BLS 2018).

The labor market in California has several unique challenges that must be accounted for in any payment adjustment for labor costs:

- Competition for labor is fierce due to mandatory nurse-to-patient staff ratios.
- The ratios, compounded by the greater influence of union organization in California (especially in northern California), contribute to increased labor costs.
- California's outdated licensing regulations governing hospital operations significantly limit the scope of practice for non-physician clinicians and institutional flexibility, thereby creating shortages and contributing to high labor costs for these high-demand positions.

Any reform to the AWI must account for variations across the country and not assume a homogenous labor market. Despite the challenges of an index that uses hospital-provided wage data, we believe it is the most suitable method to fully capture these differences. Substituting another data source would mask the true differences in labor markets. CHA has long opposed the use of an alternative data source, such as Bureau of Labor Statistics data, for AWI calculations.

In 2013, CHA vetted, and largely adopted as policy, principles and recommendations outlined in the American Hospital Association (AHA) Draft Medicare Area Wage Index Task Force's 2013 report, with one notable exception: the recommendation that "Congress should increase the wage indexes that are less than 1.0 using an exponential methodology similar to what is done with the geographic adjustment factor currently used by CMS in adjusting capital payments." This recommendation, in a budget-neutral system, is nothing more than a shift of dollars from hospitals located in areas with a wage index above 1.0 to hospitals located in areas with a wage index below 1.0. There is no empirical evidence to support such a shift and, in 2013, it was estimated that it would cause a $1.3 billion shift in Medicare payments from hospitals in high-wage states to those in low-wage states.

The concept of any empirically derived floor or, alternatively, a capped ceiling — like other short-term fixes in a budget-neutral system — would not make these policies any more equitable and would only create a system similar to what we have today. **CHA agrees that fundamental wage index reform is needed, but that new money is required to ensure that states with above average labor costs are not unfairly penalized.**

The principles that guided the AHA taskforce's work would be a first step in guiding this reform, and we urge the agency to revisit the AHA report and begin a more formal stakeholder engagement process. The taskforce recommendations seek to improve the consistency of the wage index data, limit the amount of volatility in the improved system, ensure that there is an adequate transition from the current to the improved system, and decrease the problem of circularity. CHA looks forward to working with CMS and Congress on workable solutions that address the very significant differences within and among states across the nation.

OUTLIER PAYMENTS

To maintain outlier payments at 5.1 percent of total IPPS payments, CMS proposes an outlier threshold of $27,545 for FFY 2019. The proposed threshold is 3.21 percent higher than the current (FFY 2018) outlier threshold of $26,601. **CHA urges CMS to revisit its outlier calculation for the FFY 2019 outlier threshold, as we understand that a recent AHA analysis has found an error related to an incorrect national average CCR used in the calculation.** We appreciate CMS' willingness to look closely at this analysis, as well as others, in an effort to ensure accuracy in the outlier threshold from year to year.

GRADUATE MEDICAL EDUCATION PAYMENTS

Hospitals that are part of the same Medicare graduate medical education (GME) affiliated group are permitted to apply their indirect medical education (IME) and direct GME full-time equivalent (FTE) caps on an aggregate basis, and to temporarily adjust each hospital's caps to reflect the rotation of residents among affiliated hospitals during an academic year. A new urban teaching hospital that qualifies for an adjustment to its FTE cap may enter into a Medicare GME affiliation agreement only if the resulting adjustment is an increase to its direct GME and IME FTE caps. To promote flexibility, CMS proposes to revise the regulations to specify that new urban teaching hospitals may form a Medicare GME affiliated group and, therefore, be eligible to receive both decreases and increases to their FTE caps, beginning with affiliation agreements entered into for the July 1, 2019 – June 30, 2020, residency training year. **CHA supports this proposal**.

UPDATES TO MS-DRGS

Chimeric Antigen Receptor (CAR) T-Cell Therapy

CAR T-cell therapy is a cell-based gene therapy in which a patient's T-cells are genetically engineered to add a chimeric antigen receptor that will bind to a certain protein on the patient's cancerous cells. The CAR T-cells are then administered to the patient by infusion. More specifically, two CAR T-cell therapy drugs, KYMRIAH™ and YESCARTA™, received FDA approval in 2017.Both manufacturers submitted applications for new technology add-on payments for FFY 2019. These new and innovative treatments far exceed the cost of other therapies.

CMS examined the existing Medicare Severity Diagnosis Related Groups (MS-DRGs) to identify cases most similar to CAR T-cell therapy procedures. Given that CAR T-cell procedures involve a type of autologous immunotherapy in which the patient's cells are genetically transformed and then returned

to the patient, CMS' clinical advisors believe that patients receiving CAR T-cell therapy would have similar clinical characteristics and comorbidities to patients receiving treatment for other hematopoietic carcinomas treated with autologous bone marrow transplant. **For FFY 2019, CMS proposes to assign cases reporting the use of CAR T-cell therapy (ICD-10-PCS procedure codes XW033C3 and XW043C3) to MS-DRG 016. CHA supports this proposal.**

In addition, CMS discusses an alternative suggestion to create a new MS-DRG for procedures involving CAR T-cell therapy, but notes that if a new MS-DRG were to be created, a new technology add-on payment may no longer be needed. Because a new MS-DRG must be established in a budget-neutral manner, CMS is concerned that, over time, payments will be redistributed from core hospital services to specialized hospitals, which might affect payment for core services. **Given the costliness of these technologies, CHA shares CMS' concern about the payment redistributive effect, and we are deeply concerned about beneficiary access to CAR T-cell therapy.** Specifically, YESCARTA™ and KYMRIAH™ have list prices of $373,000 and $475,000, respectively. In addition to the cost of the therapy, there also are extremely high patient care costs – both before and after infusion of the therapy – including multiple-week stays in the intensive care unit. **CHA appreciates CMS' willingness to consider multiple options for adequately paying for these services and ensuring access to these lifesaving treatments, while also ensuring payment adequacy and limiting the potential redistribution of dollars.**

A leading California academic medical center with experience in providing this treatment notes that CAR T-cell therapy is similar procedurally to autologous bone marrow (MS-DRG 016). However, the two procedures can be distinguished by the burden the procedures impose on patients undergoing them. Physicians have observed that autologous bone marrow patients usually have a manageable level of toxicity. Conversely, CAR T-cell therapy patients admitted for inpatient care are more likely to need intensive care unit services following the administration of CAR T-cell therapy. The effects of CAR T-cell therapy could be an argument for creating a distinct MS-DRG for it.

Clinicians performing CAR T-cell therapy do not yet know if it will be adequate on its own, or if its administration will be the bridge to a patient later having an organ transplant. While the typical length of an inpatient stay for a CAR T-cell therapy patient necessitating an inpatient stay is seven to 14 days, CAR T-cell therapy patients needing a transplant typically have a length of stay of 14-21 days. A CAR T-cell therapy patient's disease burden is determined by whether the patient needs an inpatient admission, and its length.

CAR T-cell therapy is more costly than most all other treatments provided. Hospitals performing this therapy report that Medicare outlier payments would not be enough to cover the costs a hospital would incur. We think CAR T-cell therapy is an innovative procedure with life-saving potential, but adequate payment is necessary to ensure access for beneficiaries. We appreciate CMS' attention to this very important issue.

CMS invites public comments on alternative approaches, including alternatives in the context of the pending new technology add-on payment applications for these new therapies. Based on feedback that hospitals would be unlikely to set charges different from the cost of CAR T-cell therapy drugs, CMS mentions another suggestion — to allow hospitals to use a cost-to-charge ratio of one for charges associated for determining outlier payments and for the purposes of a new technology add-on payment. This change would result in a higher outlier payment, higher new technology add-on

payment or the determination of higher costs for IPPS-excluded cancer hospital cases. CHA is concerned that this assumption may be too strong in that hopsitals are required to have a set of uniform charges and that payments made to providers under contract to private plans will also dictate how the charge is to be set. Should you have a private contract that pays a percent of charges, in order to cover the cost of the service under a specific contract, the charge structure may need to align. We agree with the agency that this issue is complex and look forward to additional dialogue on this topic.

CHA appreciates the thought and consideration given to this matter both by the agency and our national hospital association colleagues. To help ensure beneficiary access to this therapy in the short term, we support the comments expressed by the American Hospital Association and others. We urge the agency to take several actions, including but not limited to the following for FFY 2019:

- Assign CAR T-cell therapy to MS-DRG 016, as proposed.
- Approve CAR T-cell therapy for new technology add-on payments (NTAPs).
- Increase the NTAP marginal reimbursement to 100 percent for CAR T-cell therapy.
- Solicit additional input and provide more clarity on reimbursement mechanisms for PPS-exempt cancer hospitals providing CAR T-cell therapy.

In order to ensure the integrity of the inpatient PPS and beneficiary access in the long-term, additional solutions will be necessary. This is especially true given that both new and existing therapies are expected to be approved for additional indications. The current payment systems – of any payer, not just Medicare – were not built to sustain access to therapies with costs of these magnitudes. As technology continues to advance, such therapies will become more and more prevalent, and it is critical that CMS set a precedent that ensures beneficiary access to care. This requires not only appropriate payment, but also provider certainty of coverage determinations, as one post-care-provision denial would be devastating to both providers and beneficiaries. We urge CMS to continue to engage all stakeholders to ensure we have long-term sustainable solutions that can be adapted over time and account for innovations that transform how we treat disease.

POST-ACUTE CARE TRANSFER POLICY

As required by Section 53109 of the Bipartisan Budget Act of 2018 (BBA), CMS proposes to make conforming amendments to 42 CFR §412.4(c) to include discharges to hospice care occurring on or after October 1, 2018, as qualified post-acute care discharges. It also proposes that a hospital billing Patient Discharge Status code of 50 (Discharged/Transferred to Hospice-Routine or Continuous Home Care) or 51 (Discharged/Transferred to Hospice-General Inpatient Care or Inpatient Respite) would be subject to the post-acute care transfer policy in accordance with this statutory amendment. **Despite our concerns expressed to Congress on the potential unintended consequences of this payment policy, CHA supports the method through which CMS proposes to implement the law.**

MEDICARE PART A HOSPITAL INPATIENT ADMISSION ORDERS DOCUMENTATION

CMS states in the proposed rule that — despite the discretion granted to medical reviewers to determine that admission order information taken from the medical record satisfies the written hospital inpatient admission order requirement — medically necessary inpatient admissions are being denied payment due to technical discrepancies with the documentation of inpatient admission orders. These discrepancies include missing practitioner admission signatures, as well as missing co-signatures and signatures occurring after discharge, and have occasionally become a primary reason for payment

denial. CMS proposes to remove the requirement that written inpatient admission orders, including physician admission and progress notes, are a prerequisite for Medicare Part A payment. Specifically, a written inpatient admission order (including physician admission and progress notes) would no longer be required to be present in the medical record as a specific condition of Medicare Part A payment. The proposal does not change the requirement that a patient is considered an inpatient if they have been formally admitted under an order for inpatient admission.

CHA applauds CMS' efforts to ensure that these unnecessary and costly technical denials are limited. **CHA fully supports this proposal and welcomes additional dialogue with the agency on additional regulatory burdensome issues that could be further addressed under the Patients Over Paperwork Initiative.**

REVISIONS TO PHYSICIAN CERTIFICATION OF AN INPATIENT STAY

Sections 1814(a)(2) and 1835(a)(2) of the BBA require a physician to certify and periodically recertify the medical necessity of certain types of covered services provided to Medicare beneficiaries. If the information can be found in the medical record, the information does not need to be repeated in the certification statement. 42 CFR §424.11(c) specifies it will suffice for the certification statement to indicate where in the medical record the information can be found.

CMS is concerned that requiring the certification statement to state where the information can be found is resulting in unnecessary denials of Medicare claims, even when that information may be readily apparent to the reviewer. For this reason, CMS is revising 42 CFR §424.11(c) to relocate the statement indicating where in the medical record the information can be found to the end of the immediately preceding paragraph (b), which describes similar kinds of flexibility that are currently afforded in terms of completing the required statement. **CHA applauds CMS for recognizing this burdensome and redundant requirement and fully supports its revision.**

MEANINGFUL MEASURES INITIATIVE AND DE-DUPLICATION OF MEASURES ACROSS PROGRAMS

As part of its Meaningful Measures Initiative, CMS conduced a holistic review of all hospital quality and pay-for-performance programs, including the Inpatient Quality Reporting (IQR), Hospital Value-Based Purchasing (VBP), Hospital Readmissions Reduction (HRR) and Hospital-Acquired Conditions (HAC) Reduction programs. CMS expanded on its Meaningful Measures framework to articulate what it believes to be the appropriate focus for each program — HAC on patient safety, HRR on readmissions, and VBP on clinical outcomes, patient experience, cost and efficiency. The IQR Program would then include measures that are not covered in the other programs. Under this framework, CMS proposes to remove a total of 39 measures from the IQR Program, including seven electronic clinical quality measures and 21 measures that would be "de-duplicated" and retained in other programs.

CHA applauds the agency for its efforts to reduce the reporting burden on hospitals. We have long advocated for a more meaningful, parsimonious measure set that provides hospitals with clinically important information for performance improvement.

Five-Star Methodology Implications

While CHA applauds the administration's efforts to address the duplication of measures in and across programs, we are disappointed that the rule did not address the implications for the CMS hospital star ratings program. Over time, CMS has made significant changes in the five-star ratings methodology. The

addition or removal of measures will have implications for hospital ratings going forward. More specifically, CMS proposes to remove the following three measures that are currently in use in the five-star methodology:

- Influenza Immunization Measure (NQF# 1659)
- Median Time from ED Arrival to ED Departure for Admitted ED Patients Measure (NQF #0495)
- Admit Decision Time to ED Departure Time for Admitted Patients Measure (NQF #0497)

One of these measures is included in the Effectiveness of Care domain, and two are included in the Timeliness of Care domain. Absent any analysis of the removal of these changes, it could be premature to exclude them. Variation in hospital star ratings from year to year, due only to the change in measures and methodology — rather than hospital performance — is difficult for consumers to understand and why we have long opposed the use of a "one size fits all" approach and assignment of one rating.

We also urge CMS to clarify how the methodology would be altered to account for the removal of de-duplicated measures from the IQR Program. The current methodology for star ratings suggests that CMS draws measures from only the IQR and outpatient quality reporting (OQR) programs. As a result, it is not clear whether the measures would remain in the star ratings methodology, or whether the methodology would be altered to include measures that are in one of the value payment programs.

Despite our previously articulated concerns in 2015 and again in 2017 related to the approach CMS has taken in assigning a five-star rating, CHA urges CMS to move quickly to determine what, if any, impact the measures' removal will have on hospital ratings and to address these issues through the subregulatory process as soon as possible.

We note that CMS recently postponed the release of the July star ratings to further analyze the impact of changes to some star ratings measures and to address stakeholder concerns. CMS states that it will gather feedback from a multidisciplinary technical expert panel and a work group of provider leaders, and will then set a public comment period. As the administration continues to review the measures and their appropriateness for performance-based and public reporting, we urge the agency to make any changes to the five-star methodology through formal notice and comment. To date, CMS has used a subregulatory process to develop, implement and revise the methodology. We believe this process could be greatly improved if brought forward through the rulemaking process. Given the agency's emphasis on prioritizing transparency, it follows that the five-star methodology would be included in notice and comment and review across programs. The IPPS rulemaking process is a perfect opportunity to realign all the programs, policies and public reporting timelines — including the five-star ratings.

CHA remains concerned that giving hospitals one, all-inclusive five-star rating is inherently fraught with challenges. While we appreciate the improvements CMS has made to address some of the limitations in the methodology, the premise of one overall rating remains a challenge.

INPATIENT QUALITY REPORTING PROGRAM AND ELECTRONIC CLINICAL QUALITY MEASURE REPORTING

As noted above, CMS proposes several changes to the IQR Program to support the goals of the agency's Meaningful Measures Initiative — most significantly, the removal of 39 measures, including seven eCQMs, for FFY 2020-23 payment determinations.

As part of its focus on reducing regulatory burden, CMS proposes to add a new measure removal factor to its previously finalized list of seven factors. The proposed Factor 8 would allow the removal of a measure for which CMS has determined the costs associated with a measure outweigh the benefit of its continued use in the program. CMS proposes to include this new measure removal factor across all of its quality reporting and pay-for-performance programs. **CHA supports the addition of proposed Factor 8 and appreciates that CMS will weigh the often-significant provider and clinician information collection and reporting burden associated with quality measurement usefulness in Medicare programs.**

Proposed Removal of eCQMs
CMS proposes to extend current requirements that hospitals report on four self-selected eCQMs for one calendar year (CY) quarter of data for the CY 2019 reporting/FFY 2021 payment years. CMS also proposes to remove seven of the 15 eCQMs currently available to hospitals for reporting under the Hospital IQR Program beginning with the CY 2020 reporting year. CHA appreciates CMS' recognition that hospitals continue to experience operational challenges in implementing eCQM reporting, and we support maintaining the current eCQM reporting requirements. Further, we support the timeline under which CMS proposes to remove seven measures from the eCQM measure set to ensure that hospitals currently preparing for reporting any of the removed measures in 2019 will not be forced to choose new measures under a reduced timeline, should the proposal be finalized. **However, we urge CMS to finalize additional flexibility for reporting year 2020 for hospitals that may be implementing new eCQM measures by extending the requirements that hospitals report on four self-selected eCQMs for one calendar year quarter of data for the CY 2020 reporting/FFY 2022 payment years**.

We also urge CMS to take steps to improve its eCQM validation process. The validation of eCQM measures presents a number of unique challenges that require significant work on the part of providers, vendors and CMS. For example, the measurement specifications have continually evolved over time, and the validation process must ensure that the data are accurately and appropriately being validated back to the corresponding eCQM specification for the correct period. This is no small undertaking, and one that may be very challenging for providers and contractors to complete efficiently. This example is just one of many that providers fear will create significant burdens as they work with the agency through this process.

Therefore, **CHA recommends that CMS not underestimate this process going forward, but rather dedicate additional resources to ensure that lessons learned in this process can be shared in a timely and transparent manner. Providers — both those going through the process and those subject to the process in the future — should benefit from the learnings of other providers. CHA is very concerned that data that may be captured for the purposes of the measure may not be easily reported out for validation, and that a manual process or other workaround may be needed. CMS and providers will be unable to determine the time and resources necessary until they begin to implement this process. The agency should prioritize understanding the limitations of the data and their reporting, sharing best practices and ensuring that the process improves and produces accurate and reliable data.**

CHA believes the agency should continue to note improvements to the process so that it may be refined to ensure that measures are reliable, accurate and appropriate for inclusion in the program. Finally, while not stated in the proposed rule, we ask CMS to again state in this year's final rule that the accuracy of eCQM data submitted for validation will not affect a hospital's validation score in FFY 2021 and beyond.

Possible Future Hospital IQR Program Measures
CMS seeks public comment on the possible future inclusion of two new measures in the Hospital IQR Program, including a measure that assesses hospital-wide mortality and an eCQM addressing hospital harm opioid-related adverse events. CHA provided comments to the Measure Applications Partnership (MAP) and raised a number of concerns for each of the measures under consideration.

CMS notes that it has developed two versions of a hospital-wide mortality measure — Claims-Only, Hospital-Wide, All-Cause Risk Standardized Mortality Measure and Hybrid Hospital-Wide, All-Cause Risk Standardized Mortality Measure — and seeks comment on whether to propose one or both. **CHA opposes the inclusion of either measure as currently developed**. In testing on the claims-only measure, of the 4,793 hospitals included in the analysis, only 102 hospitals (2.1 percent) show up in the "better" category, and only six hospitals (0.1 percent) in the "worse" category. The vast majority of hospitals — 92.4 percent — are no different in their mortality under this measure. CHA believes strongly that, if CMS is committed to its initiative of implementing meaningful measures, the results of this measure testing would not meet the criterion with so little differentiation. In our view, with only six hospitals nationwide performing worse than the national average, CMS should not put forth additional resources toward implementation.

While we stated in our comments to the MAP that the hybrid measure was slightly improved, we noted a number of concerns with both proposed measures, as well as all-cause mortality measures in general. The all-cause mortality measure is a risk-standardized measure, not a risk-adjusted measure, meaning that it compares a hospital to national average rather than making a meaningful comparison to another hospital. We do not believe this positively contributes to consumer understanding of differences in quality among hospitals in their communities — especially in a measure with so little differentiation. Such measures are more often used in epidemiology and not in performance improvement. Further, the measures lack appropriate exclusions that are present in condition specific mortality measures.

CHA also opposes the potential future inclusion of the Hospital Harm—Opioid-Related Adverse Events eCQM as currently developed. We agree that measurement of adverse events is an important metric, and the growing abuse of opioids and the treatment of patients with dependencies is a national priority. However, as noted in our comments to the MAP, Phase 1 feasibility testing of the measure capturing naloxone use without prior opioid administration over 24 hours found an error rate of 4.3 to 12.8 percent. We remain concerned that these results will only be magnified on a broader testing example; the high variation is very problematic. Finally, we remain concerned that such a measure would create a chilling effect among providers in the administration of naloxone. Rethinking the approach to measurement in this area would be the prudent next step.

Accounting for Social Risk Factors in the Hospital IQR Program
In the proposed rule, CMS states that it is considering two methods to account for social risk factors in the Hospital IQR Program. **CHA appreciates that CMS is taking steps to recognize the impact of social risk factors in quality measurement, as recommended by the National Quality Forum and numerous other stakeholders, including CHA.**

The first method would calculate differences in outcome rates among patient groups within a hospital while accounting for their clinical risk factors, and would allow comparison of those differences across hospitals. The second approach would assess outcome rates across hospitals for subgroups of patients,

such as dually eligible patients, allowing comparison among hospitals on their performance in caring for their patients with social risk factors. As a first step, CMS plans to include stratified data on the Pneumonia Readmission measure (NQF #0506) data for dually eligible patients in hospitals' confidential feedback reports, beginning in fall 2018 and using both methodologies identified above.

The science of quality measurement is dynamic, and we encourage CMS to evaluate a number of options for improving the risk adjustment and peer group approach. CHA strongly urges the robust use of risk adjustment — including adjustment for sociodemographic status, where appropriate — to ensure providers do not perform poorly on performance measures simply because they care for more complex patients. The evidence continues to mount that sociodemographic factors beyond providers' control — such as the availability of primary care and physical therapy, easy access to medications, appropriate nutrition and other supportive services — influence performance on outcome measures. For example, a January 2016 report issued by the National Academy of Medicine found evidence that a wide variety of social risk factors may influence performance on certain health care outcome measures, such as readmissions, costs and patient experience of care.

In addition, the Improving Medicare Post-Acute Care Transformation Act required the Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation to conduct a study of risk adjustment for sociodemographic status on quality and resource use measures, and to incorporate them as feasible and appropriate through future rulemaking. This report demonstrates that clinicians, hospitals and post-acute providers alike are more likely to score worse on CMS pay-for-performance programs when they care for large numbers of poor patients. Together, these reports provide evidence-based confirmation of what hospitals and other providers have long known — patients' sociodemographic and other social risk factors matter greatly when trying to assess the performance of health care providers.

Unfortunately, failing to adjust measures for sociodemographic factors when necessary and appropriate can adversely affect patients and worsen health care disparities, because the penalties divert resources from hospitals and other providers that treat large proportions of vulnerable patients. It also can mislead and confuse patients, payers and policymakers by shielding them from understanding important community factors that contribute to poor outcomes. **CHA urges the agency to incorporate sociodemographic adjustment into quality or cost measures used to assess performance.**

In addition, the ideal data for use in either peer groupings or direct risk adjustment should 1) have a conceptual and statistical relationship to the measure itself (in this case, readmission rates), 2) use a readily available data source and 3) be collected in a consistent way using standardized definitions. Dual-eligible status has all three of these characteristics, which is why we remain supportive of its use in adjusting readmission penalties.

Nevertheless, dual-eligible status also has important limitations as a risk adjustor. Most notably, the generosity of state Medicaid program benefits varies, and in the long run, the adjustor may be sensitive to differences in state-level decisions to expand Medicaid. Dual-eligible status also may not fully reflect the poverty in communities. For example, it would not reflect the proportion of undocumented immigrants in communities, as such individuals would not be eligible for either Medicare or Medicaid.

The use of peer groups obviates the need to change the risk adjustment models for underlying quality measures. However, the use of peer groupings involves somewhat subjective choices about where to set parameters of each group. Hospitals at the upper end of one quintile and those at the lower end of the next quintile would have similar proportions of dual-eligible patients, but would be placed into different quintiles for performance comparison purposes. This is true regardless of the number of peer groups chosen to evaluate performance. **CHA urges CMS to proceed in any stratification of a measure in a transparent manner, making all data available in advance of release and providing additional supporting documentation of its rationale for stratification.**

HOSPITAL VALUE-BASED PURCHASING PROGRAM

As part of its Meaningful Measures Initiative, CMS proposes to remove a number of measures from the Hospital IQR Program but retain them for the VBP Program. In order to make this change, CMS proposes to modify the regulatory text to clarify that, while Hospital VBP measures must be selected from the set of Hospital IQR Program measures that have been published on *Hospital Compare* for at least one year, these measures are not required to remain in the Hospital IQR Program. **CHA supports this proposal.**

Proposed Removal of Measures and Re-Weighting of Domains

Under proposed Factor 8 and consistent with the agency's Meaningful Measures Initiative, CMS proposes to remove 10 measures from the Hospital VBP Program, reducing the total number of VBP Program measures for FFY 2021 from 15 to seven. Beginning in 2022 there would be eight measures, including the previously finalized Chronic Obstructive Pulmonary Disease (COPD) Mortality measure. Of the removed measures, the six patient safety measures would remain in the HAC Reduction Program, and the elective delivery and payment measures would remain in the IQR Program.

Because of this proposal, by FFY 2021, no measures would remain in the Safety domain. As a result, CMS proposes to re-weight the remaining three domains. CMS proposes to weight the Clinical Outcomes domain at 50 percent and continue to weight the Person and Community Engagement domain, which includes the Hospital Consumer Assessment of Healthcare Providers and Systems measure, and Efficiency/Cost Reduction domain, including the Medicare Spending Per Beneficiary (MSPB) measure, at 25 percent each. CMS notes that it also considered an alternative under which each domain would be weighted at one-third of the total performance score.

CHA appreciates and supports CMS' proposal to de-duplicate measures and remove the six patient safety and three episode-based payment measures from the Hospital VBP Program. We have long advocated for such a policy that would avoid potentially penalizing a hospital on the same measures in two separate pay-for-performance programs. Further, we previously opposed the inclusion of the episode payment measures and agree that they would be duplicative of the MSPB measure.

Hospitals are entering the sixth year of this program, and there has not been a year without a significant change in the methodology. It is nearly impossible to determine, based on provider performance over time, whether hospitals are doing better overall under this program or if trend performance is more appropriately attributed to another methodological reason. Every year, CMS introduces a new set of confounding factors that make predictability of performance under this program a significant challenge for hospitals. Congress intended this program to drive change and to improve hospital performance. CHA believes it has done so, but at a cost to providers that have made improvements but lack the ability to drive performance improvement initiatives because the entire program is a moving target.

CHA is generally supportive of CMS' proposed re-weighting to address the elimination of the safety domain, and believes the de-duplication of measures is long overdue. However, we remain concerned that changes in the methodology have continued to create volatility in the program and do not allow meaningful conclusions to be drawn about hospital performance improvement. We urge CMS to finalize a proposal with stability for the program going forward. It is critically important that we afford providers a level of predictability and a chance to accelerate change.

MODERNIZING THE HOSPITAL CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS SURVEY

CMS does not propose changes to the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey and would retain it in both the IQR and VBP programs. While CHA continues to support the use of the HCAHPS, we believe the agency should undertake a review of how it uses all surveys in the Consumer Assessment of Healthcare Providers & Systems (CAHPS) family and consider approaches to modernizing how the survey is administered. This assessment should begin with an examination of CAHPS survey requirements across all of its reporting programs to minimize the number of surveys that patients must respond to in a given time. A patient's course of care often crosses multiple care settings and providers within a given time period, and the CAHPS program has surveys for nearly every setting, including for physicians, hospitals, dialysis facilities and home health agencies. Patients who receive care in two or more of these settings could receive multiple surveys. Typically, surveys are not distributed until days or weeks after a patient has received their care. This may create confusion about which provider or facility is actually being assessed. A patient may inadvertently attribute a positive or negative experience to the wrong provider.

In addition, we strongly urge CMS to explore more modern and economical survey administration approaches for the HCAHPS and all other CAHPS surveys, such as emailed or web-based surveys. While we appreciate the value of assessing the patient experience across the care continuum, the use of multiple surveys means more time spent by patients to answer surveys, and more resources expended by providers to administer them. Moreover, for the purposes of CMS reporting programs using CAHPS tools, providers are permitted to use only two survey administration modes – mailed surveys and telephone surveys. Mailed surveys are relatively inexpensive to administer, but often suffer from low response rates and a significant time lag. Telephonic surveys typically yield a higher response rate and provide more timely results, but are much more expensive to administer.

We strongly encourage CMS to work with the CAHPS Consortium to develop guidelines for emailed and web-based surveys for the entire CAHPS family. Once this guidance is developed, CMS should permit the use of emailed and web-based surveys in CMS reporting programs. To date, the Agency fo Healthcare Research and Quality (AHRQ) has provided very limited guidance on appropriate procedures for using electronic survey methodologies. Yet, electronic survey administration modes, such as email and web-based portals, make survey data collection and aggregation timelier and less expensive, and may allow hospitals to increase sample size without greatly increasing cost. In developing guidance for emailed and web-based surveys, AHRQ also should engage with hospitals and other providers that have been using emailed and web-based surveys to informally collect data on patient experience.

HOSPITAL-ACQUIRED CONDITIONS REDUCTION PROGRAM

Under its Meaningful Measures framework, CMS believes that the HAC Reduction Program should be focused on making care safer and reducing harm. After review, CMS has determined that the existing six

HAC Reduction Program measures are appropriate for this program and should be retained. To avoid duplication, CMS proposes to remove these measures from the Hospital VBP and IQR programs.

CHA has long advocated for the removal of the infection measures from the Hospital VBP Program and strongly supports this proposal. We understand the agency's position that these measures are more appropriate for the HAC Reduction Program and appreciate that hospitals will be able focus their patient-safety improvement efforts under one program with one set of preview reports.

Notably, we are disappointed that CMS has failed to remove PSI-90 from the HAC penalty program. While we appreciate the measure developer's attempt to improve the measure and CMS' adoption of those revisions, the re-weighting of the individual components of PSI-90 does virtually nothing to improve the underlying lack of reliability and accuracy with individual component PSI measures. **CHA continues to have significant concerns about this measure and its ability to generate data on which providers can act. Based on the National Quality Forum (NQF) committee's review, our members' experience and a variety of published studies, PSI-90 continues to fall well short of the standard needed for NQF endorsement or use in public accountability applications. CHA continues to oppose the inclusion of PSI-90 in the IQR and all other hospital performance-based programs.**

Changes to HAC Reduction Program Scoring Methodology
CMS proposes to change the weighting of the HAC Reduction Program domains in calculating the total HAC score beginning with FFY 2020. The proposal is intended to address concerns that measure weightings become disproportionate when a hospital only has a score on one or two Domain 2 measures. CMS discusses two alternative approaches to re-weighting the domain scores and proposes its preferred approach — the equal measure weight approach — that would eliminate the domains and weight each of the six measures equally in calculating the total HAC Reduction Program score. Alternatively, the variable domain weight approach would retain the two domains and vary the weights applied to each domain depending on the number of Domain 2 scores a hospital reports.

Despite the inherent flaws in this program, as outlined in current law, and our request to eliminate PSI-90, CHA supports CMS' proposal to remove domains and weight each measure equally. We do not support a higher weight of the PSI-90 measure and, as previously stated, would like to see it removed from this program.

As hospital performance continues to improve over time, we remain concerned that — regardless of improvements made — approximately 25 percent of hospitals will remain subject to the penalty. **CHA urges CMS to work with Congress to find a more meaningful way to meet the goals and objectives of reducing harm while continuing to incentivize providers to make improvements.**

PROPOSED CHANGES TO MEDICARE AND MEDICAID EHR INCENTIVE PROGRAMS
CMS proposes a number of significant changes to the Medicare and Medicaid EHR Incentive programs, including renaming the programs the Medicare and Medicaid Promoting Interoperability Program and substantially revising changes to the scoring methodology that determines whether a hospital has met the meaningful use requirements. CHA appreciates CMS' stakeholder outreach in its efforts to better understand the challenges hospitals face under the current program requirements. We also share CMS' goal of focusing on interoperability to ensure meaningful exchange of health information that supports improved quality of care for our patients. While we recognize the important steps CMS proposes to

increase flexibility and reduce burden on providers, we offer a number of additional comments that support improved use of EHRs throughout the health care continuum.

Certification and Reporting Requirements
CMS proposes no changes to its previously finalized policy for 2019 under which eligible hospitals and CAHs must use EHR technology certified to the 2015 Edition of Certified EHR Technology (CEHRT). For CY 2018, eligible hospitals and CAHs have the option to use EHR technology certified to the 2014 Edition, the 2015 Edition or a combination thereof. In addition, CMS proposes to extend the current 90-day reporting period for reporting years 2019 and 2020. **CHA appreciates that CMS has proposed a 90-day reporting period as hospitals transition to 2015 Edition CEHRT, and adjusted proposed changes in the scoring methodology. CHA urges CMS to implement a 90-day reporting period whenever it makes changes to the program.**

While we recognize the majority of hospitals are prepared to transition to 2015 Edition CEHRT in 2019, we urge CMS to consider flexibility for small and rural hospitals with limited resources. A number of the vendors used by small and rural hospitals, in the earlier stages of meaningful use, have not moved to certify products that will meet the 2015 CEHRT requirements. These vulnerable hospitals are left to consider expensive overhauls to their EHR systems as they continue to face unique financial challenges. As the financial incentives for meaningful use have sunset, these hospitals find it challenging to further invest in technology upgrades with uncertainty as to how long the new products will remain compliant. For example, one rural hospital in California reports that the most basic 2015-certified EHR product available to it will cost at least $1.5 million, even as the same hospital continues to pay off the loans for its current EHR product. These costs are unsustainable, as 83 rural hospitals nationally — three in California — have closed since 2010. We urge CMS to explore additional flexibilities that will allow small, rural hospitals and CAHs to continue to advance efforts to electronically share information, and give further consideration to limiting payment penalties and/or granting additional hardship exemptions for these uniquely burdened and financially challenged hospitals.

Proposed Scoring Methodology for Eligible Hospitals and CAHs
Beginning in 2019, CMS proposes a new methodology for determining meaningful use under the Promoting Interoperability Program that would require eligible hospitals and CAHs to report on four objectives and six measures. Rather than meeting individual measure performance thresholds, CMS would award points for each measure based on performance or participation. A hospital would be required to report on all of the measures and achieve at least 50 points to meet the meaningful use requirements.

CHA appreciates that CMS has taken steps to reduce the measure set and increase flexibility to allow hospitals to focus on the unique priorities and care of their patient population. We are also pleased that CMS has removed measures from the program — such as view, download and transmit — that rely on actions outside of the hospital's control. However, we note that the program continues to maintain an all-or-nothing component that requires hospitals to report on all of the measures, in addition to achieving a score of at least 50 points. We urge CMS to consider policies that would further increase flexibility, such as a base and performance score approach similar to the Promoting Interoperability Program structure under the Merit-Based Incentive Payment System (MIPS).

For example, CMS could implement the availability of bonus points in the scoring methodology beyond 2019. More specifically, CMS could extend the availability for bonus points in the ePrescribing Objective for its two new proposed measures beyond 2019. Similarly, CMS could allow hospitals and CAHs that have prepared to report on more than two Public Health and Clinical Data Exchange measures to receive bonus points for additional reporting, as is allowed for clinicians under MIPS. We urge CMS to continue to prioritize aligning these programs with clinician reporting to ensure that both hospitals and clinicians continue to be equally incentivized and work together on implementation.

Most importantly, we urge CMS to reconsider its proposed weighting structure and more evenly distribute weights across the four objectives as hospitals transition to new editions of EHR technology and adjust to the new scoring methodology. CMS has proposed a weighting structure that places an inappropriate and disproportionate weight on measures that continue to be challenging for hospitals to meet, despite their best efforts. Under the Health Information Exchange objective, both measures — the newly named Support Electronic Referral Loops and newly proposed Support Electronic Referral Loops by Receiving and Incorporating Health Information — would be worth 20 points each. The newly proposed measure combines the existing Stage 3 Request/Accept Summary of Care and Clinical Information Reconciliation measures.

Hospitals continue to experience operational challenges in implementing the Clinical Information Reconciliation measure, especially when receiving health information from multiple care settings with varying levels of health information technology. **Currently, hospitals are working with vendors to develop technology that can electronically address duplication in the medical record; no such technology exists at this time. As a result, clinicians must spend valuable time and resources away from the bedside to go through medical records, reconcile all information and eliminate duplications. This increases costs to the system, despite the expectation that technology do the exact opposite.**

CHA strongly urges CMS to consider a lower weight for the Clinical Information Reconciliation measure until technology that addresses duplication in the medical record is widely available. This administration has been focused on reducing costs and regulatory burden. Lowering the weight of this measure would allow the agency to continue to encourage and push for achievement in this measure, while remaining aligned with its overall regulatory goals and health care cost reduction initiatives.

Similarly, CMS proposes a 40-point weight for the single measure in the Provider to Patient Exchange objective: Provide Patient Electronic Access to Their Health Information. While CHA strongly supports providing patients with access to their health information, we continue to have significant concerns with the requirements to provide the information through the application of a patient's choice. **California hospitals report that it has been difficult, if not impossible, for EHR vendors to implement workflow upgrades and other changing requirements in a timely way to ensure providers can meet these requirements. Despite 2015 Edition CEHRT requirements, hospitals continue to report a lack of available application programming interfaces (API) from vendors. CMS should not continue to mandate requirements that are not supported by the agency's certification criteria and enforcement of that certification. Doing so puts providers at significant risk of financial penalty and makes for a challenging competitive marketplace.**

In addition, hospitals have expressed significant concerns about the security of these applications, as well as patient understanding of the privacy of their data after it has been provided by the hospital via

API. Currently, no comprehensive framework addresses the oversight and enforcement mechanisms specific to patient-directed health applications, as well as their specific rights, obligations and duties. As vendors utilize their own processes for approving these applications via a one-time review, there is also no framework for ongoing reviews or to address complaints should security concerns arise following the application's approval. **CMS should work with the Office of the National Coordinator for Health Information Technology (ONC) to develop such a standardized approval and oversight framework.**

As an example, CMS could look to its framework under the Blue Button 2.0 initiative that will allow applications developers to connect Medicare beneficiaries to their Medicare claims data via the Blue Button API. **In the absence of a standardized vetting process and oversight framework for applications, and as API and applications become more widely available, we urge CMS to reduce the weight of the Provider to Patient Exchange objective and its corresponding measure.**

Further, the measure's requirement to connect "any application" of the patient's choice, without allowing hospitals to evaluate the app for security or test that it functions as expected, poses particular challenges for systems security and assumes a level of experience with the use of APIs that has not yet been achieved. **To ensure a measured transition that allows the development of a comprehensive vetting process and oversight framework, and that provides time for providers to develop competence in using and securing APIs, we recommend that CMS revise the second part of the measure to read:**

> (ii) "The eligible hospital or CAH ensures the patient's health information is available for the patient (or patient-authorized representative) to access using **at least one** application that is configured to meet the technical specifications of the API in the eligible hospital or CAH's CEHRT."

We also recommend that CMS provide an exclusion for this measure in FFY 2019 for hospitals and CAHs that cannot successfully identify an app that meets their security needs.

Proposed New Measures under the ePrescribing Objective
CMS proposes to add two new measures under the ePrescribing objective: Query of Prescription Drug Monitoring Program (PDMP) and Verify Opioid Treatment Agreement. Both of the measures would be optional in 2019, with five bonus points available for each measure. CMS proposes that the measures would be required in 2020.

The Query of PDMP measure would require the hospital to use data from CEHRT to conduct a query of a PDMP for at least one electronically prescribed Schedule II opioid, except where prohibited and in accordance with applicable law. In the proposed rule, CMS acknowledges that PDMP integration is not currently in widespread use for CEHRT. California's PDMP is moving toward an electronic interface with hospital and provider EHRs, as required by state law. However, to date, the state has not developed or implemented the needed API, making it impossible for California hospitals to meet this measure without manually entering data into the CEHRT. **We agree that consultation of a PDMP is important for tracking prescribed controlled substances; however, the technology to integrate this process into the EHR is still under development. The administrative burden and financial resources required — absent technology to assist — do not align with the agency's goals of streamlining and simplifying this**

program. Therefore, CHA urges CMS to retain the measure as optional in 2020 and make it available for bonus point scoring.

The Verify Opioid Treatment Agreement measure would require the hospital to identify the existence of a signed opioid treatment agreement for patients to whom a Schedule II opioid was electronically prescribed by the hospital using CEHRT during the EHR reporting period, if the total duration of the patient's Schedule II opioid prescriptions is at least 30 cumulative days within a six-month look-back period, and to incorporate the agreement into CEHRT. In the proposed rule, CMS acknowledges that opinions about opioid treatment agreements vary among health care providers, including objections to their use. Further, while some hospitals and health systems have implemented the use of such agreements, there is no standard — and CMS does not propose to define an opioid treatment agreement as a standardized electronic document. CMS also does not propose to define the data elements, content structure or clinical purpose for a specific document to be considered a ''treatment agreement.''

CMS also recognizes that hospitals typically do not prescribe opioid medications for more than a few days, if at all. Because the measure would only include patients for whom a hospital prescribed an opioid for at least 30 days, it is likely only a limited set of data would be available for this measure. As such, the burden and costs associated with implementing and reporting the measure would outweigh the benefit of required reporting. While we understand the importance of identifying cases of potential overutilization of opioids, the measure would be more appropriate in ambulatory settings. **CHA does not support inclusion of this measure in the program and urges CMS not to finalize its proposal to require use in 2020.**

Public Health and Clinical Data Exchange Objective
Under the newly renamed Public Health and Clinical Data Exchange objective, CMS proposes to require that hospitals attest to the Syndromic Surveillance Reporting measure and at least one additional measure from the following options: Immunization Registry Reporting, Clinical Data Registry Reporting, Electronic Case Reporting, Public Health Registry Reporting and Electronic Reportable Laboratory Result Reporting. **In California — and likely in other states — Syndromic Surveillance Reporting is not currently available to all hospitals. While some county-run systems accept this reporting, other counties are not currently accepting new hospital participation, and others are not able to accept this data at all. State budgets and county priorities will dictate the speed of adoption and are very much out of the hospital's control. Hospitals stand ready to report, but without willing partners these goals are unachievable. Due to these limitations, we urge CMS to allow for additional flexibility in this objective. Specifically, CMS should allow hospitals to choose reporting on *two* of any of the available measures under the objective, rather than requiring syndromic surveillance for all hospitals. With the agency continuing to make this a priority, progress would be allowed to continue at the state and local levels while still accounting for the variation around the country.**

eCQM Reporting for Hospitals and CAHs Under Promoting Interoperability Programs
Beginning with the 2020 reporting period, CMS proposes to reduce the number of available eCQMs from 16 to eight, to align with policies proposed for the IQR Program. CMS proposes to remove the same seven eCQMs as the IQR Program, plus one additional eCQM: Median Time from ED Arrival to ED Departure for Discharged ED Patients (NQF 0496) (ED-3). ED-3 is an outpatient measure and, therefore, not part of the Hospital IQR Program measure set. Removing this measure would align eCQMs for the

two programs. CMS proposes removal for the FFY 2022 payment determination/CY 2020 reporting period rather than an earlier date because stakeholders have previously emphasized the time needed for vendors and hospitals to make eCQM changes.

CHA supports this proposal and appreciates that CMS has taken steps to remove measures that have been technically challenging for hospitals to implement and validate. We also appreciate that CMS will give hospitals adequate time to choose their measures for reporting by retaining the current measure set for reporting year 2019. Further, as noted in our comments on the IQR Program, we encourage CMS to improve its eCQM validation process to ensure measures that are retained for reporting remain appropriate.

REQUEST FOR INFORMATION ON PROMOTING ELECTRONIC INTEROPERABILITY

CMS seeks feedback on promoting interoperability and, specifically, on how it could use the Medicare and Medicaid CoPs to advance electronic exchange of health information in support of care transitions between hospitals and community providers. As an example, CMS says it might consider revising the hospital CoPs to require that hospitals electronically transfer medically necessary patient information to the other facility when a patient is transferred. Similarly, the agency might require that hospitals electronically send discharge information to a patient's community provider when possible, and to provide discharge instructions electronically to patients or a third-party application, if requested.

CHA appreciates the work undertaken by CMS in recent years to promote a regulatory framework for the Medicare CoPs, which supports our collective goals of high-quality, patient-centered care in a rapidly changing health care delivery system. The hospital CoPs in particular are still in need of updating, as many have not kept pace with changes in care delivery or hospital and health system organization and integration. Recent changes in law have demanded more fully integrating health care services, putting the patients' health, safety, well-being and preferences at the forefront. Our regulatory framework must more fully address these changes in both the acute and post-acute care settings. Should CMS proceed down this path, we urge the agency to look more broadly at all the CoPs and prioritize all contemplated revisions. A piecemeal approach that does not consider implications across the delivery system will likely lead to the need for additional revisions sooner rather than later. The CoPs must be looked at in total, through a shared lens of overarching and agreed-upon principals — not in silos.

To that end, we request that CMS take this opportunity, under a relatively new administration, to demonstrate leadership in this area and consider a more formal stakeholder engagement process as part of its Patients over Paperwork Initiative. With the initiative's goals as the framework for engagement, working with providers across the continuum of care on a more refined set of guiding principles will assist the agency in prioritizing its work so that providers can anticipate and prepare for what will likely be significant revisions to the CoPs — along with anticipated payment and other regulatory changes that, if not timed sequentially, will pose significant operational and financial challenges. An opportunity to share our perspectives, offer suggestions and participate in an ongoing dialogue about these and other changes with the agency would help foster better understanding and shared expectations, and would allow the field adequate preparation time.

Any revisions, additions or removal of CoPs — regardless of the care setting to which they apply — must address not only the current way care is delivered, but also future care delivery. It is imperative that the development of interpretive guidance be done in consultation with revisions to the CoPs. Surveyor

training and oversight of the process must be a top priority for the agency. CHA looks forward to working with CMS on these and other CoP changes.

In response to CMS' more specific request for comments, CHA has previously noted that we support policies and practices for effective and sustainable transitions of care, and commend CMS' previous efforts to update existing CoPs to align with current practices and to clarify expectations of providers. However, we continue to believe appropriate oversight must be balanced with the need for flexibility and innovation, and keeping pace with the current state of health information technology (HIT).

CHA believes it is premature for CMS to consider requiring interoperability of providers until all have an effective EHR system and can participate effectively in the electronic exchange of information. Before CMS considers revisions to the CoPs that would require electronic transfer of health information, it must survey the HIT landscape of the entire health system, not just that of acute care hospitals. While hospitals and health systems have made great strides in the adoption of EHRs under the Medicare and Medicaid EHR Incentive programs, and continue the work under the Promoting Interoperability programs, the use of EHRs is not as widespread in other care settings. Some of the most critical junctures for the exchange of health information are during transitions to care settings such as post-acute and behavioral health providers, who were not incentivized to adopt certified EHR technology under the meaningful use programs. As a result, it is often not possible to effectively exchange electronic information with these providers.

CMS must also understand additional operational challenges that currently present barriers to interoperability. Due to a lack of standardized patient identifier, hospitals continue to have challenges in patient matching. Hospitals experience major challenges in transferring health information for medically indigent patients, who often do not have a primary care provider and may not have a permanent address.

Hospitals also often lack the appropriate contact information when transferring health information to community providers or payers. Section 4003 of the 21st Century Cures Act requires the Health and Human Services Secretary to "directly or through partnership with a private entity, establish a provider digital contact information index for providers and facilities." To date, this digital contact information index has not been established. **CHA urges CMS to work with the Department of Health and Human Services to develop this directory as soon as possible. Until the government helps providers solve the problems of patient matching and fully implements a system of accurate provider and payer contact information, hospitals must choose between complying with federal requirements and opening themselves up to risk of penalty under state and federal law for a privacy breach if protected health information is inadvertently sent to the wrong place or provider. That penalty, in California, comes with a significant fine.**

Any future changes to requirements for electronic transfer of health information must also consider the various legal barriers to increased sharing of health information. In comments on CMS' previously proposed changes to the regulations at 42 CFR §482.13, CHA noted that we believe proposed revisions to the CoPs on patients' right to access their own health information are unnecessary and further confuse the body of law surrounding health information privacy. The Health Insurance Portability and Accountability Act (HIPAA) currently requires hospitals to provide patients access to their medical information with limited exceptions, including certain medical records related to research; prisoners'

records where access might jeopardize the health or safety of the patient or other inmates; mental health records where access is reasonably likely to endanger the life or physical safety of the patient; and psychotherapy notes.

Portions of existing regulation (42 CFR Part 2) restrict sharing of substance use disorder (SUD) information, which further complicates the exchangeof health information in some cases. Clinicians treating patients for any condition need access to their complete medical histories — including information related to SUD — to ensure their patients' safety and delivery of the highest quality care. Partitioning a patient's record to keep SUD diagnoses and treatments hidden from the clinicians entrusted to care for them, as required by 42 CFR Part 2, is dangerous for the patient, problematic for providers and contributes to the stigmatization of mental and behavioral health conditions. To ensure compliance with 42 CFR Part 2, clinicians must maintain two separate computer systems and two separate medical records. This requirement adds burden and expense, but without benefit. CHA supports efforts to make statutory changes that would amend 42 CFR Part 2 to align with HIPAA for the purposes of treatment, payment and health care operations. Such changes are required before hospitals and other community providers can meaningfully share health information.

These and other issues must be considered both through notice and comment rulemaking, as well as through stakeholder dialogue. CHA stands ready to work with the agency to identify the challenges and opportunities, and solve problems together. Our goals are shared, and we urge CMS to make this a priority going forward. There is tremendous opportunity to advance the regulatory framework in which care is provided, lower costs and decrease burden and — most importantly — make our health care system more patient-friendly.

REVISIONS TO REQUIREMENTS FOR SUBMITTING A MEDICARE COST REPORT

Provider Cost Reimbursement Questionnaire

The Provider Cost Reimbursement Questionnaire, Form CMS-339, was incorporated into all Medicare cost reports as a worksheet, except for the Organ Procurement Organization (OPO) and Histocompatibility Laboratory cost report, Form CMS-216. In this rule, CMS proposes to:

- Incorporate the Provider Cost Reimbursement Questionnaire, Form CMS-339, into the OPO and Histocompatibility Laboratory cost report, Form CMS-216.
- Revise the regulations to no longer state that a cost report will be rejected for lack of supporting documentation if it does not include a Provider Cost Reimbursement Questionnaire (Form CMS-339).
- Clarify that a provider must submit all necessary supporting documents for its cost report, consistent with recordkeeping requirements in 42 CFR §§413.20 and 413.24.

CHA supports this proposal.

Intern and Resident Information System (IRIS) Data

Teaching hospitals are paid by Medicare for their IME and direct GME costs based on the number of residents training in a hospital. However, residents may train in more than one hospital. For purposes of IME and direct GME payment, no individual may be counted as more than one FTE. For each hospital where the resident trains, the resident counts as a partial FTE based on the proportion of time worked at the hospital to the total time worked. IRIS is used to collect and report information on

residents training in approved residency programs and used by CMS to ensure that residents are not counted as more than one FTE.

CMS collected the IRIS data from hospitals on a diskette. Because providers no longer use diskettes to furnish these data to contractors, CMS proposes to remove the regulation's reference to a diskette and instead reference "Intern and Resident Information System data." **CHA supports this proposal.**

CMS further notes that two reports by the Office of Inspector General (Report No. A-02-13- 01014, August 2014 and Report No. A-02-15-01027, July 2017) cited the need for CMS to develop procedures to ensure that no resident is counted as more than one FTE in the calculation of Medicare IME and direct GME payments. In response, CMS proposes the IRIS data must contain the same total counts of direct GME FTE residents (unweighted and weighted) and of IME FTE residents as the total counts of direct GME FTE and IME FTE residents reported in the hospital's cost report, or the cost report will be rejected for lack of supporting documentation. This will be effective for cost reports filed on or after October 1, 2018. **CHA is concerned that this does not allow for updating of these data at a later date. It is our understanding that these data are updated after the submission of the cost report, as the information is not complete until months later and must be resubmitted in order to be accurate. CHA asks CMS to clarify in the final rule how it will address this issue.**

Medicare Bad Debt Reimbursement
Section 1861(v)(1) of the Social Security Act (the Act) and the regulations at 42 CFR §413.89 provide authority for Medicare to reimburse a portion of Medicare uncollectible deductible and coinsurance amounts to those entities eligible to receive reimbursement for Medicare bad debt. The Provider Cost Reimbursement Questionnaire (Forms CMS-339 and 216) described above requires the provider to submit supporting documentation with the cost report to substantiate its claims for Medicare bad debt reimbursement. That documentation, known as the "Medicare bad debt listing," requires information such as the patient's name, dates of service, the beneficiary's Medicaid status, if applicable, the date that collection effort ceased, and the deductible and coinsurance amounts.

Effective for cost reporting periods beginning on or after October 1, 2018, CMS proposes to reject a cost report for lack of supporting documentation if it does not include a detailed bad debt listing that corresponds to the bad debt amounts claimed in the provider's cost report. This proposal is consistent with a provider's recordkeeping and cost reporting requirements of 42 CFR §§413.20 and 413.24, and would facilitate the contractor's review and verification of the cost report.
CHA appreciates that CMS is working to ensure accurate reporting of the bad debt amounts claimed on the cost report. However, we believe it is important that CMS balance the burden of such documentation, as this data collection may be significant. CHA urges CMS to gather stakeholders to discuss best practices for consistent data collection requests across all the MACs and to seek out innovative and less burdensome ways of documentation that would support our shared goals of accurate reporting.

In addition, we wish to bring to CMS' attention recent changes in revenue recognition per Federal Accounting Standards Board update 2014-09 Topic 606 and its implications for hospital reporting of bad debt on the Medicare costreport. In an effort to promote shared understanding and accurate reporting of bad debt going forward, we encourage CMS to consider additional clarifying guidance on Topic 606 and Medicare cost reporting specific to Worksheet S-10. We anticipate operational

and financial implications for hospitals, and encourage CMS to work with stakeholders in soliciting input and updating the frequently asked questions to further promote accurate and consistent reporting across providers going forward.

DSH Payment Adjustment
Medicare DSH payments are based, in part, on the hospital's number of patient days for patients who are eligible for Medicaid, but were not entitled to benefits under Medicare Part A. While hospitals are required to maintain documentation of Medicaid-eligible days, they are not required to submit a listing of Medicaid-eligible days that corresponds to those claimed in their cost report. Currently, contractors must request this information when it is not submitted by the DSH-eligible hospital with the cost report. An audit may reveal an overstatement of a hospital's Medicaid-eligible days. However, an audit of these data may not take place for more than a year after the cost report has been submitted, and tentative program reimbursement payments are often issued to a provider upon the submission of the cost report.

CMS proposes that — effective for cost reporting periods beginning on or after October 1, 2018 — a cost report will be rejected for lack of supporting documentation if it does not include a detailed listing of the hospital's Medicaid-eligible days that corresponds to the Medicaid-eligible days claimed in the hospital's cost report for determining the hospital's DSH payment adjustment. If the hospital submits an amended cost report that changes its Medicaid-eligible days, CMS would require an amended listing or an addendum to the original listing of the hospital's Medicaid-eligible days that corresponds to the Medicaid-eligible days claimed in the hospital's amended cost report.

The proposed rule indicates that this new proposed requirement would not be burdensome to hospitals because they are already required to collect, maintain and submit this data when requested. CMS indicates that the proposed requirement would facilitate the contractor's review and verification of the cost report, without the need to request additional data from the provider.

CMS further states that the proposal would not affect a hospital's ability to submit an amended cost report, within 12 months after the hospital's cost report is due, that reflects updated information on Medicaid-eligible patient days after the hospital receives updated Medicaid eligibility information from the state. Although the current proposal would still permit the submission of an amended cost report, we do not believe it is appropriate to require the submission of a Medicaid-eligible days listing that is known to be incomplete or to include days that have not been verified by the state. **CHA urges CMS to reconsider this requirement since a complete and accurate listing of Medicaid-eligible days may not be available, through no fault of the provider, when the cost report is submitted.**

Charity Care and Uninsured Discounts
Currently, there is no requirement for a DSH-eligible hospital to submit supporting documentation with its cost report to substantiate charity care or other discounts in order for cost report submission to be acceptable. When DSH-eligible hospitals do not submit this documentation with the cost report, contractors must request it. The proposed rule indicates that requiring this supporting information to be submitted with the cost report would facilitate the contractor's review and verification of the cost report, without the need to request additional data from the provider.

Effective for cost reporting periods beginning on or after October 1, 2018, CMS proposes to reject cost reports that do not include a detailed listing of charity care or uninsured discounts. The listing should include information such as the patient name, dates of service, insurer (if applicable) and the amount of charity care or uninsured discount that corresponds to the amount claimed in the hospital's cost report. CMS indicates that — because the existing burden estimate for a DSH-eligible hospital's cost report already reflects the requirement that these hospitals collect, maintain and submit this data when requested — there is no additional burden associated with its proposal.

As previously noted, CHA supports CMS' request for data to support the accurate reporting of uncompensated care; it is appropriate that the agency subsequently request that hospitals provide information about charity care or other discounts upon submission of the cost report. However, we restate our concerns about how that data should be maintained and submitted. CHA encourages CMS to quickly bring together stakeholders and MACs to discuss best practices for submitting this data, as the size and scope of the data sets will be significant.

Home Office Allocations
A chain organization consists of a group of two or more health care facilities that are owned, leased or otherwise controlled by one organization. When a provider claims costs on its cost report that are allocated from a home office (also known as a chain home office or chain organization), the Home Office Cost Statement is required for reimbursement. Chapter 21, Section 2153 of the *Provider Reimbursement Manual, Part 1* states that each contractor servicing a provider in a chain must be furnished with a detailed Home Office Cost Statement as a basis for reimbursing the provider for cost allocations from a home office or chain organization.

In the proposed rule, CMS indicates the following concerns:

- Many cost reports that have home office costs allocated to them are submitted without a Home Office Cost Statement as a supporting document.
- There are home offices or chain organizations that are not completing a Home Office Cost Statement to support the costs they are allocating to the provider cost reports.
- Some providers paid under a PPS mistakenly believe that a Home Office Cost Statement is no longer required.

CMS indicates that home office costs reported in the provider's cost report may impact future rate-setting and payment refinement activities. The proposed rule further indicates that having this information submitted with the cost report would facilitate the contractor's review and verification of the cost report, without needing to request additional data from the provider.

CMS proposes, effective for cost reporting periods beginning on or after October 1, 2018, to reject cost reports that do not include a Home Office Cost Statement completed by the home office or chain organization with amounts that correspond to those on the provider's cost report. CMS indicates that this proposal will result in no additional provider burden because the existing burden estimate for a provider's cost report already reflects the requirement that providers collect, maintain and submit this data. **CHA supports this proposal.**

CHANGES TO REGULATIONS GOVERNING SATELLITE FACILITIES AND EXCLUDED UNITS

To ensure that a "hospital within a hospital" (HwH) — defined as a "hospital that occupies space in a building also used by another hospital, or in one or more separate buildings located on the same campus as buildings used by another hospital" — is separate and distinct from the hospital that it is within, CMS has established "separateness and control (S&C) requirements." Effective October 1, 2017, CMS only requires HwHs to meet the separateness and control requirements when the IPPS-excluded hospital (such as an LTCH, children's or cancer hospital) is within an IPPS hospital.

CMS now proposes to extend exemption to S&C requirements to satellite units when co-located with an IPPS-excluded hospital. A satellite facility that is co-located with an IPPS-excluded hospital must still meet the S&C requirements to be excluded from the IPPS.

CMS also proposes that, for cost reporting periods beginning on or after October 1, 2019, an IPPS-excluded hospital would no longer be precluded from having an excluded psychiatric or rehabilitation unit. CMS proposes to specify that an IPPS-excluded satellite facility of an IPPS-excluded unit (e.g., a satellite of an IPPS-excluded rehabilitation or psychiatric unit) of an IPPS-excluded hospital (e.g., an LTCH, children's or cancer hospital) would not have to comply with the S&C requirements so long as the satellite of the excluded unit is not co-located with an IPPS hospital. CMS proposes to revise regulatory language to specify that an IPPS-excluded hospital may not have an IPPS-excluded unit of the same type (psychiatric or rehabilitation) as the hospital (for example, an inpatient rehabilitation facility may not have an inpatient rehabilitation facility unit).

CHA strongly supports the proposal to exempt certain co-located HwHs and satellite facilities from the S&C criteria.

LTCHs operate as one component of the post-acute care (PAC) continuum, along with inpatient rehabilitation facilities, skilled-nursing facilities and home health agencies. As health care reform continues and our health care delivery system evolves to one that emphasizes value over volume, greater coordination and collaboration are needed among and between individual levels of the PAC continuum. Alternative payment models, such as bundled payment for episodes of care, hold great promise for controlling costs while also supporting optimal outcomes for patients. LTCHs and other PAC providers play a critical role in this process, but are often limited by outdated provider-specific regulations — including the separateness criteria. CHA appreciates CMS' willingness to consider greater flexibility for LTCHs that are co-located with non-IPPS hospitals, and believes that this change will provide an opportunity for post-acute care facilities and providers at all levels to work together more effectively.

HOSPITAL REQUIREMENTS TO PUBLICLY LIST STANDARD CHARGES AND PRICE TRANSPARENCY REQUEST FOR INFORMATION

The Affordable Care Act established section 2718(e) of the Public Health Service Act. This provision requires each hospital operating within the United States to make public a list of its standard charges for items and services including for diagnosis-related groups according to guidelines established by the Secretary. In the FFY 2015 IPPS/LTCH rule (79 FR 50146), CMS reminded hospitals of their obligation to comply with this provision by making public a list of their standard charges (whether the chargemaster itself or another form of their choice), or their policies for allowing the public to view a list of those charges in response to an inquiry. In order to promote greater price transparency for patients, CMS proposes to require hospitals to make available a list of their current standard charges online in a machine-readable format and to update this

information at least annually, or more often as appropriate. **CHA supports this proposal, as it is consistent with California state law, and urges the agency to continue to align with state laws to not increase the regulatory and administrative burden for hospitals.**

Request for Information on Price Transparency
California state laws AB 1627 (Chapter 582, Statutes of 2003) and AB 1045 (Chapter 532, Statutes of 2005) already require submission of data to the California Office of Statewide Health Planning and Development (OSHPD). Hospital charges and the regulations implementing these provisions are available at on the OSHPD website. Under these laws, hospitals in California are required to submit annually by July 1:

- A charge description master (a comprehensive list of items and services for which a hospital charges)
- A list of average charges for 25 common outpatient procedures
- An estimate of the percentage increase in gross revenue due to price changes

As noted above, California has some of the most consumer-friendly state laws in the country when related to transparency and financial assistance policy. We appreciate CMS' concerns and request for additional information in light of the fact that patients continue to have challenges in obtaining "price information." CHA shares those concerns and appreciates the dialogue on this important issue.

In reading the request for information, we were struck by the language used and reminded of the complexities of this issue. As a field, we do not have a common set of definitions for the terms "price," "cost" and "charge." Going forward, we urge the agency to adopt the HFMA price transparency task force report definitions of several key terms that we believe will promote shared understanding and allow for meaningful dialogue. Further, as members of the task force, we support the HFMA recommendations and urge CMS give full consideration to them going forward.

As a first step, it is important to first disentangle "cost" from "price." When searching for an airline ticket, the price we see is the cost to the purchaser, not the cost to the airline and service partners that need to deliver the product.

Similarly, when we talk about "price" and price "transparency" in health care, generally we are describing the price of the service to the purchaser; not the cost it takes to deliver that product to the recipient of the service. While other consumer industries perform a single function — such as airlines flying passengers from point A to point B — hospitals do far more than provide a unit of service, such as a knee replacement.

Hospitals provide emergency services to those who cannot pay, conduct groundbreaking research and train the physicians and health care professionals of tomorrow. These services have great societal benefits, but they also incur costs that consumers may not realize when making purchasing decisions.

Hospital "prices" are also affected by the uniqueness of the communities they serve. Micro-economies, geographical differences and demographics of all the patients served, the level of discount and charity care provided to the uninsured and underinsured, or their share of patients covered by public programs like Medicaid — all factor into the unit "price" of a knee replacement that a hospital can offer. Because

many of those costs are not paid for in full by anyone, hospitals must make up the difference by "cost-shifting," which increases the unit cost of a knee replacement relative to other hospitals.

A singular focus on price is a significant and complicated issue. A concerted effort to address price must coincide with a concerted effort from our health and policy leaders to recognize the *costs* of the entire system to make that price more meaningful. This is particularly important for those who are uninsured.

More importantly, however, is the role of the payer. Over 90 percent of individuals in the U.S. have health coverage, and their payer – whether Medicare, Medicaid or a private insurance plan – establishes their cost-sharing obligation. That obligation takes into account whether the plan covers the service, whether the provider is in the plan's network, the plan's cost-sharing requirements and, if applicable, the individual's deductible. Hospitals contract with more than 1,300 payers nationally, and the vast majority offer multiple (sometimes dozens or more) health plans with different benefit structures. Payers are the best source of information on what a covered individual's out-of-pocket costs may be for a given service.

Despite this, patients ask providers for cost estimates and will continue to do so. Hospitals and health systems help patients obtain answers to these questions by collaborating with insurers. Once a provider has identified the patient's need for a specific diagnostic service or care protocol, hospital financial counselors work with the patient and insurer to establish the patient's cost-sharing obligation. This is a hands-on process, with hospital staff connecting with insurers via their websites and call centers to obtain patient-specific information. The counselors may need to repeat this process multiple times, as the course of care may change for any number of reasons.

For the 10 percent of the population that is uninsured, availability of standard pricing information could be helpful and is already available consistent with federal law. Providers can and do respond to inquiries from uninsured individuals with information on their standard charges, as well as information on any financial assistance policies the hospital may offer.

Given the challenges associated with making price information more easily accessible, we discourage CMS from taking a punitive approach against providers who cannot meet all patient expectations for price transparency. First, as previously mentioned, providing exact price estimates for most services is not possible given the inherent uncertainty of health care.

Second, the challenge may be compounded by a patient's lack of understanding of their health coverage. Hospitals and health systems report that an increasing number of patients, particularly those in high-deductible health plans, are surprised by their out- of-pocket cost because they do not understand how their coverage works.

Instead of focusing on punitive measures at this point, we encourage CMS to convene providers, insurers, patients and employers to explore ways to increase patients' health care literacy, especially around their health plan benefit design. We stand ready to work with the administration on this endeavor.

CHA appreciates the opportunity to share our comments on these important issues. If you have any questions, please do not hesitate to contact me at (202) 488-4688 or akeefe@calhospital.org, or my colleague Megan Howard, senior policy analyst, at (202) 488-3742 or mhoward@calhospital.org.

Sincerely,
/s/
Alyssa Keefe
Vice President, Federal Regulatory Affairs

Enclosure: CHA Analysis of Worksheet S-10, Toyon and Associates (March 2018)

TOYON ASSOCIATES, INC.

FOCUSED FINANCIAL RESULTS

Uncompensated Care

Medicare Cost Report Worksheet S-10
HCRIS Analysis

HCRIS Data-Sets
September 2017
March 2018

May 17, 2018

Uncompensated Care Recognition Services

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FOCUSED FINANCIAL RESULTS

Scope of Analysis

- To evaluate the dependably of HCRIS Uncompensated Care (UC) data reported on Medicare cost report WS S-10*.
- UC cost was calculated from FFY 2014 and FFY 2015 cost reports per the September 2017 and March 2018 HCRIS.
- WS S-10 revisions between the September and December HCRIS:
  - FFY 2014 Cost Reports – 1,434 DSH hospitals (60%).
  - FFY 2015 Cost Reports – 1,610 DSH hospitals (67%).

- February 15, 2018: Date of 2014 and 2015 HCRIS data used in the **FFY 2019 IPPS Proposed Rule** (CMS initially planned on using data from the December 30, 2017 HCRIS in development of the Proposed Rule).

- May 30, 2018: CMS may use HCRIS data per the May 30, 2018 HCRIS release in development of the **FFY 2019 IPPS Final Rule** (CMS initially planned on using data from the March 31, 2017 HCRIS in development of the Final Rule).

*This analysis excludes the cost report trim, UC data for non-DSH hospitals (according to the FFY 2019 Proposed Rule Final Rule), All Inclusive Rate Providers (AIRP), Maryland hospitals Puerto Rico hospitals, and Indian Health Services (IHS)/Tribal hospitals.

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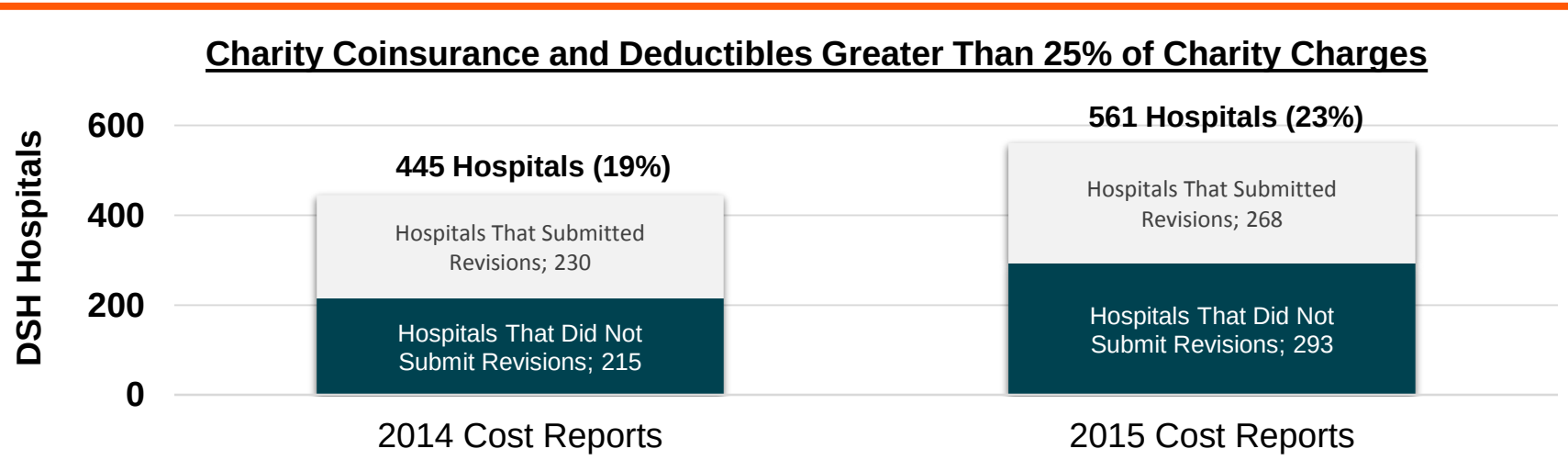
FOCUSED FINANCIAL RESULTS

Charity Coinsurance and Deductibles

- Approximately 20% of DSH hospitals are reporting charity coinsurance and deductibles (C+D) more than 25% of total charity care charges.
  - ✓ The national average is less than 8%.
  - ✓ Nearly half the hospitals identified as over-reporting C+D submitted UC cost changes in the March HCRIS.
  - ✓ CMS sent letters to some hospitals requesting them to verify or amend C+D by April 20, 2018.
- *Why is this important?* New CMS instructions under T11 no longer reduce charity C+D by the CCR. Any amounts, incorrectly reported as C+D, will result in an overstatement of total UC cost.



According to the FFY 2019 Proposed Rule, 2,391 hospitals receive Medicaid DSH UC payments based on UC Cost as reported on the 2014 and 2015 cost reports. The Proposed Rule shows 2,485 total DSH hospitals for FFY 2019.

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FOCUSED FINANCIAL RESULTS

Charity Coinsurance and Deductibles

Prior Charity Cost Calculation

Determination of Charity Care Cost
Transmittal 10 Using Hypothetical Hospital Data

- In this example, the hospital reported charity C+D at $30M (key "C" below).
- Prior to T11, the $30M was reduced by the CCR (to $6M), resulting in $25M of CC cost.

Line Number and Description	Col 1: Uninsured Patients	Col 2: Insured Patients	Col 3: Total
Cost to Charge Ratio	20% (A)		
Line 20: Charity care charges and uninsured discounts	$100,000,0000 (B)	$30,000,000* (C)	$130,000,000 (D = B+C)
Lin 21: Cost of patients approved for charity care and uninsured discounts	$20,000,000 (E = A*B)	$6,000,000 (F = A*C)	$26,000,000 (G = E+F)
Line 22: Payments received from patients for amounts previously written off as charity care	$1,000,000 (H)	$0 (I)	$1,000,000 (J = H+I)
Line 23: Cost of charity care (line 21 minus line 22)	$19,000,000 (K = E-H)	$6,000,000 (L = F-I)	$25,000,000 (M = K+L)

*This example assumes no charges for patient days beyond the indigent care program's length-of-stay limit were reported (line 20, col 2 and line 25). If these amounts were reported, they would be reduced by cost to charge ratio (no change in this part of the calculation from transmittal 10 to transmittal 11).

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FOCUSED FINANCIAL RESULTS

Charity Coinsurance and Deductibles

New Charity Cost Calculation

Determination of Charity Care Cost
Transmittal 11 Using Hypothetical Hospital Data

- In this example, the hospital reports the same exact data (including the C+D at $30M in key "C").
- Under T11, the $30M is not reduced by the CCR, resulting in $49M of CC cost ($24M greater than T11).
- Any amounts reported as part of the $30M – that are not related to charity C+D – will overstate CC cost.

Line Number and Description	Col 1: Uninsured Patients	Col 2: Insured Patients	Col 3: Total
Cost to Charge Ratio	20% (A)		
Line 20: Charity care charges and uninsured discounts	$100,000,0000 (B)	$30,000,000 (C)	$130,000,000 (D = B+C)
Line 21: Cost of patients approved for charity care and uninsured discounts	$20,000,000 (E = A*B)	$30,000,000 (F = C)	$50,000,000 (G = E+F)
Line 22: Payments received from patients for amounts previously written off as charity care	$1,000,000 (H)	$0 (I)	$1,000,000 (J = H+I)
Line 23: Cost of charity care (line 21 minus line 22)	$19,000,000 (K = E-H)	$30,000,000 (L = F-I)	$49,000,000 (M = K+L)

*This example assumes no charges for patient days beyond the indigent care program's length-of-stay limit were reported (line 20, col 2 and line 25).
If these amounts were reported, they would be reduced by cost to charge ratio (no change in this part of the calculation from transmittal 10 to transmittal 11).

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Other Observations

1. <u>High UC Cost Amounts</u>

National DSH Average of UC Cost as Percentage of Total Hospital Cost is ~6%

- There are 4 cases of UC data representing between 50% and 99% of total hospital costs. CMS adjusts the UC data for these hospitals.
- There are 65 cases of UC data representing between 25% and 49% of total hospital costs.

2. <u>Uncompensated Care Cost at "Face Value" From HCRIS</u>

- There are 234 UC amounts in the FFY 2019 Proposed Rule that are not calculated under the T11 method, rather calculated under T10.
- This appears to occur when a hospital's cost report has not been revised since the issuance of T11 in September 2017.

Other Observations (Continued)

3. <u>Negative UC Values Reported on Hospital Cost Reports</u>

- There are 65 cases of negative amounts reported on WS S-10 (all inputs are required to be positive). This can result in an incorrect determination of UC cost.
- In rare cases, cost report "calculation fields" arrive at a negative number (WS S-10 Line 23). Cost report instructions under T11 do not allow charity care cost to be less than zero.

4. <u>Medicare Bad Debts</u>

- Toyon is investigating HCRIS data, as Medicare bad debt amounts are not flowing over to WS S-10, Line 27 and/or 27.01 in 809 cases.
  - ✓ In the FFY 2019 Proposed Rule, it appears CMS is using UC cost at "face value" and therefore CMS' amounts include Medicare bad debts.
  - ✓ There are also 31 cases of UC data with no reported total bad debt (line 26) – but, Medicare bad debts flow from other areas of the cost report and are reported as a subscripted (on lines 27 and 27.01).

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FOCUSED FINANCIAL RESULTS

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