11 Beacon Street, Suite 710
Boston, MA 02108-3002
Phone: 617-723-6100
Fax: 617-723-6111
www.cobth.org

June 13, 2017

Ms. Seema Verma
Centers for Medicare & Medicaid Services
Department of Health and Human Services,
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Re: FY 2018 Inpatient Prospective Payment System Proposed Rule (RIN 0938-AS98)

Dear Ms. Verma:

The Conference of Boston Teaching Hospitals, on behalf of our member hospitals, appreciates this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) hospital inpatient prospective payment system (IPPS) proposed rule for fiscal year (FY) 2018. I have highlighted below several concerns with the proposed rule and recommendations we urge CMS to adopt.

PROPOSED USE OF WORKSHEET S-10 DATA FOR MEDICARE DSH

COBTH supports the existing CMS policy of using low-income patient hospital days as a proxy for care provided to uninsured patients to determine DSH payments and strongly opposes the proposed change to begin relying on Worksheet S-10 data in FY2018.

In past years, CMS has refrained from using the Worksheet S-10 data because of concerns over the validity and accuracy of data. We have seen no evidence to indicate that hospital reporting of the data has improved or that such data is more accurate, nor has there been any additional guidance to create greater uniformity in reporting.

When CMS considered a similar move to the S-10 in FY2017, CMS stated that a report performed by a CMS contractor found a high correlation with charity care filed on the Internal Revenue Service Form 990 with Worksheet S-10. However, as acknowledged by CMS, public hospitals which heavily depend on Medicare DSH payments do not report to the IRS. The finding of a high correlation with IRS data does not provide any evidence that the S-10 data is now more reliable – it simply indicates there is a correlation with another set of data that has not been reviewed for accuracy.

The proposed policy will transition the basis of distribution of DSH dollars from a hospital day - a standard well-defined and uniform data point to one that is non-standard and defined differently by every hospital across the country (hospital charity care and bad debt). The amount of uncompensated care reported by a hospital is dependent on how that hospital individually defines and writes-off care provided to patients who are unable to pay and who meet certain financial criteria as defined by the hospital. Uncompensated

care is being reported inconsistently given that charity care and accounting practices vary between hospitals. S-10 data on hospital uncompensated care is too unreliable and suspect to serve as the basis of distributing billions of DSH dollars. Use of the S-10 data also runs counter to other CMS data sources and reimbursement formulas where the agency seeks uniformity and standardization.

Therefore, before CMS proceeds to use Worksheet S-10 data to redistribute billions of Medicare DSH dollars which hospitals heavily rely on, the data needs to be further evaluated for uniformity and validity. This is of utmost importance given the fixed pool of uncompensated care funds that all hospitals share. Given the lack of clarity, differing interpretations, and overlap of data reported on multiple elements of the S-10, we do not believe CMS is in a position at this point to verify that this data is reliable and data reported by one hospital will not unfairly penalize other hospitals.

Medicare DSH funding is critical to hospitals around the country - especially safety net hospitals - and care must be taken to ensure that any changes to not destabilize these hospitals and the care they provide. We therefore strongly urge CMS to continue using the proxy data until such time as the Worksheet S-10 data is more reliable.

In the event that CMS does begin using the S-10 data in FY18, it must reflect the true uncompensated care costs of hospitals, including bad debt, charity care and government payment shortfalls from Medicaid and other non-Medicaid state programs. If Worksheet S-10 is eventually utilized to obtain this data we support use of the bottom-line of the S-10 (Line 31). In addition to charity care and bad debt, the cost of medical care provided to low-income patients not paid by state Medicaid programs must be recognized in determining the level of uncompensated care provided by hospitals. This is a significant burden placed on hospitals, especially states like Massachusetts that have expanded Medicaid coverage under the Affordable Care Act. In addition, the cost-to-charge ratio in line 1 currently does not include **graduate medical education** costs. COBTH recommends including these costs, which can be derived from Worksheet B, column 24, line 118. Graduate medical education should be recognized as it is a significant cost incurred by teaching hospitals that care for all patients, including low-income Medicare, Medicaid, and uninsured patients.

By continuing to partially incorporate low-income insured days in the calculation of DSH payments, CMS will ensure that hospitals that treat Medicaid patients and low-income Medicare dual-eligible beneficiaries can continue to fulfill their mission to treat the vulnerable. Beneficiaries dually eligible for Medicare and Medicaid are more likely to experience chronic illness and typically are costlier to treat. By omitting the low-income insured days proxy once it transitions to the S-10, CMS would overlook the important role of certain hospitals that treat disproportionate numbers of dually eligible beneficiaries. Because of the high cost of treating these patients and the underpayment associated with Medicaid, including a low-income insured days proxy in the Factor 3 calculation will provide a more complete measure of each hospital's commitment to providing uncompensated care.

AUTOLOGOUS/ALLOGENEICMS-DRG REASSIGNMENT

CMS has recategorized Autologous HSCT as a Non-Operating Room procedure. CMS interprets non-OR care episodes as being significantly less resource intensive and as a result shifts 20 autologous and allogeneic ICD-10 PCS transfusion codes from operating room (OR) status to non-OR status. While this coding shift may be clinically appropriate, it resulted in an inappropriate reassignment of these codes into various MS-DRGs. These ICD-10 PCS codes that would have grouped into one of our three MS-DRGs, were reassigned into 70 different MS- DRGs with significantly lower payment rates. If the agency does not correct the grouping logic in the final rule, future reimbursement rates will be significantly lower that the already inadequate current rates.

We urge CMS to reassign the identified ICD-10 PCS transplant transfusion codes back into the appropriate MS-DRGs following standard pre-major diagnostic category grouping logic.

ALLOGENEIC HCT CELL ACQUISITION

The proposed rule once again fails to reimburse for bone marrow/stem cell transplant acquisition costs separate from the MS-DRG payment for Allogeneic HSCT. In contrast, solid organ programs receive separate payment from CMS for the costs of acquiring the organ used for transplantation.

We urge CMS to amend the proposed rule to provide for the reimbursement of cell acquisition costs.

Thank you for your consideration of these concerns.

Sincerely,

John Erwin
Executive Director
Conference of Boston Teaching Hospitals