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June 24, 2019

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 2020 Inpatient Prospective Payment System Proposed Rule (RIN 0938-AT73)

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) 2020. I have highlighted below several concerns with the proposed rule and recommendations we urge CMS to adopt.

REDISTRIBUTIVE CHANGES TO ADDRESS WAGE INDEX DISPARITIES

While COBTH shares CMS's concern with the disparities that exist currently under the Medicare Wage Index, we do not feel that the proposal put forward for addressing these disparities in the FY2020 IPPS proposed rule is how CMS should proceed. Simply put, CMS is proposing direct changes to certain hospitals' wage index values. Beginning in FY 2020, low wage index hospitals would have their wage indexes increased, while high wage index hospitals would have their wage indexes decreased to maintain budget neutrality. COBTH member hospitals situated in the Greater Boston area are high wage index hospitals, but this is due to multiple contributing factors including the cost of living and average wages in Boston, Massachusetts which are far higher than the national average.

COBTH understands that CMS's goal in raising the wage index of the lowest quartile of hospitals is to allow low wage index hospitals to increase wages and attract & maintain a stable workforce. However, it should be noted that COBTH hospitals and other high wage index intuitions are also facing staffing difficulties stemming from a national physician and nursing shortages, operating in a high cost environment (as compared to the national average), and increasing upward pressure on wages in an expanding economy. Although COBTH supports CMS's goal to address difficulties faced by low wage index hospitals, we urge CMS to tackle these issues in a more thoughtful and comprehensive manner that improves the standing of low wage index hospitals without impairing the standing of high wage index hospitals.

URBAN-TO-RURAL RECLASSIFICATION: CHANGES TO THE TREATMENT OF URBAN HOSPITALS RECLASSIFIED AS RURAL

COBTH is concerned with CMS's proposed changes to the treatment of urban hospitals that reclassified as rural under the FY2019 IPPS. CMS is proposing to calculate the rural floor without including the wage data of certain hospitals that have reclassified as rural under section 1886(d)(8)(E) of the Act (as implemented at § 412.103). CMS states that "in the case of Massachusetts...the geographically rural hospital in Nantucket would still be included in the calculation of the rural floor for Massachusetts, but a geographically urban hospital reclassified under § 412.103 would not." We appreciate that CMS has provided for a two year transition for this proposal that would prevent an immediate reverting of the rural floor wage index to FY2018 levels, however we would respectfully request that CMS continue to consider the wage data of hospitals reclassified under §412.103.

CAR T-CELL THERAPY & CANCER HOSPITAL REIMBURSEMENT

Due to our nation's continued investments in medical research and academic medicine, new innovations in cancer treatments continue to be developed and made available to patients. In particular, new innovations in the field of immunotherapy such as Chimeric Antigen Receptor (CAR) t-cell therapy has offered new hope and treatment options to millions of cancer patients across the country. New emerging cell therapy treatments such as CAR t-cell therapy remain highly complex and costly treatments, and the cancer hospitals that offer these procedures to patients are reimbursed under the Tax Equity & Fiscal Responsibility Act (TEFRA).

Cancer hospital payment under TEFRA was designed to address existing reimbursement challenges under a Medicare PPS based on averages which cannot appropriately configure payment for providers who only treat cancer patients, and are at the forefront of care for the sickest patients. However, despite the fact that TEFRA payments were meant to make up reimbursement shortfalls for high cost cancer treatments, current TEFRA reimbursement rates are based on cancer care treatment costs that are 12 – 15 years old. As such, current TEFRA reimbursements are often inadequate for new types and modalities of treatment including immunotherapies & emerging treatments like CAR t-cell therapy. Therefore, COBTH recommends that:

- CMS implement a prompt and automatic adjustment for cancer hospitals providing CAR T therapy in recognition that it is a reasonable cost directly related to patient care under TEFRA.
- The agency should ensure and expedite processes for reimbursement under TEFRA more generally, beyond the provision of CAR T, as there are many other shifts in care that have caused reimbursement to become severely outdated since 2004-2006.
- The agency should allow hospitals to apply for rebasing to a year that more accurately reflects the current state of cancer care.

Thank you for your consideration of our recommendations. COBTH's member hospitals are also members of the Association of American Medical Colleges (AAMC) and strongly support the in-depth comments submitted by AAMC on behalf of the nation's academic medical centers and teaching hospitals.

Sincerely,

A handwritten signature in black ink, appearing to read "A. Lebovitz". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

Alec Lebovitz
Government & Community Affairs Specialist
Conference of Boston Teaching Hospitals