COBTH
CONFERENCE OF BOSTON TEACHING HOSPITALS

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

July 10, 2020

Submitted electronically via www.regulations.gov

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1859

RE: CMS-1735-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 2021 Rates

Dear Administrator Verma:

The Conference of Boston Teaching Hospitals, on behalf of our 12 member hospitals, appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) hospital impatient prospective payment system (IPPS) proposed rule for fiscal year (FY) 2021. Below we highlight several concerns with the proposed rule and recommendations we urge CMS to adopt.

Price Disclosure Requirements
COBTH is deeply concerned about CMS's continued efforts to require the disclosure of negotiated rates for inpatient services, and supports the ongoing legal challenge to the Hospital Price Transparency Final Rule led by the American Hospital Association (AHA). In addition to the legal questions around CMS's authority to require the disclosure of this information, negotiated rates are based on a variety of factors that are unique to the health care provider and insurance company that participate in the negotiation. Further, the disclosure of negotiated rates will not help patients, as negotiated rates do not reflect the patient's out-of-pocket financial obligations established in their health insurance plans. We urge CMS to withdraw this proposal and instead work with hospitals, health care providers, and insurance companies to ensure that patients have all the information they need to make the best decisions about their care.

We are also concerned that CMS proposes using this information to replace the current relative weight methodology to move closer toward a "market-based payment system" beginning in FY2024. In the proposed rule, CMS fails to explain how such a change would align with the statutory requirement of MS-DRG relative weights to reflect "the relative hospital resources used with respect to discharges classified within that group" and instead appears to conflate market price and cost. And, as stated above, rates are established between providers and payers based on a variety of factors, and are not relevant to the methodology for choosing Medicare fee-for-service reimbursement rates.

COBTH
CONFERENCE OF BOSTON TEACHING HOSPITALS
11 Beacon Street, Suite 710
Boston, MA 02108
Phone: 617-723-6100
Fax: 617-723-6111
www.cobth.org

CMS specifically requests comment on providing a transition to the new methodology. As with any significant change in reimbursement methodology, should CMS move forward with this policy, COBTH urges the agency to provide ample transition time and clarity about the impact of changes by region and institution, making efforts to minimize disruptions to the reimbursement system and provide certainty to hospitals and health care providers.

Redistributive Wage Index

While COBTH shares CMS's concerns with the disparities that exist under the current Medicare Wage Index, we believe that continuation of CMS's efforts to address these disparities in the FY21 IPPS proposed rule is not a fair way to proceed. CMS proposes continuing to increase the wage indexes of low wage index hospitals, while decreasing those of high wage index hospitals to maintain budget neutrality. COBTH members hospitals are located in the Greater Boston area and are high wage index hospitals, but this is due to many contributing factors, including the high cost of living and average wages in Boston, Massachusetts.

COBTH understands CMS's goal of helping hospitals in the lowest quartile for the wage index to increase wages to attract and maintain a stable workforce. However, this policy ignores that COBTH members and other high wage index hospitals also face staffing difficulties due to the ongoing national physician and nursing shortage, operating in a high-cost environment compared to the national average, and increasing upward pressure on wages. Additionally, COBTH's hospitals are under severe and unprecedented financial pressure as a result of their response to the COVID-19 crisis. Although COBTH generally supports CMS's goal of addressing challenges faced by lower wage index hospitals, we urge CMS to tackle these issues in a more thoughtful manner that improves the standing of low wage index hospitals without impairing the standing of others. This is especially important while all hospitals are facing significant financial uncertainty.

CAR-T Therapy and Cancer Hospital Reimbursement

COBTH strongly supports CMS's effort to create a new MS-DRG for chimeric antigen receptor T-cell therapy (CAR-T) that better reflects the costs incurred by inpatient hospitals providing these novel treatments. We also support CMS's proposal to exclude clinical trial cases from the relative weight for new MS-DRG 018, which, if included, would inappropriately deflate reimbursement for these therapies.

We do have concerns, however, about the elimination of new-technology add-on payments (NTAP) for these therapies. CAR-T is still a new therapeutic category that is considerably more expensive than most other treatments, and even with the new MS-DRG, hospitals will likely struggle to break even on providing these treatments. We urge CMS to consider the appropriateness of using NTAPs to help make hospitals whole on offering these treatments, which in turn will help improve patient access.

COBTH
CONFERENCE OF BOSTON TEACHING HOSPITALS
11 Beacon Street, Suite 710
Boston, MA 02108
Phone: 617-723-6100
Fax: 617-723-6111
www.cobth.org

Additionally, COBTH urges CMS to continuously evaluate the appropriateness of a single MS-DRG to reimburse for the entire category of CAR-T therapies. As additional CAR-T therapies are approved, various volumes and prices for these therapies will contribute to a single relative weight, which may result in significant under-reimbursement for particularly novel and expensive therapies. We hope to continue a dialogue with CMS to provide the hospital perspective on how to reimburse for these therapies most appropriately as the category continues to evolve.

Further, despite these promising updates, we continue to be concerned about the reimbursement methodology for cancer hospitals, which 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 do not appropriately account for payment for providers who only treat cancer patients and are typically caring for the sickest patients. TEFRA payments were meant to help make up reimbursement shortfalls for high-cost cancer treatments, but 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 therapies. 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 update reimbursement under TEFRA, beyond the provision of CAR-T, as there are many other shifts in care that have caused reimbursement to become severely outdated since the mid-2000s, and
- CMS should allow hospitals to apply for rebasing to a year that more accurately reflects the current state of cancer care.

Kidney Transplants Involving Medically Complex Donor Organs

COBTH also supports CMS's proposal to increase payments for transplant hospitals utilizing medically complex donor organs. Seven of COBTH's 12 members are Organ Procurement and Transplantation Network-designated kidney transplant centers, representing the majority of kidney transplant centers in the Commonwealth of Massachusetts. The Organ Donation Advisory Group, made up of large Organ Procurement Organizations, has found that transplants that use medically complex donor organs (notably, donors over age 60 and donors after circulatory death) often result in transplant recipients receiving hemodialysis during an inpatient stay, significantly increasing the costs of such a stay over one associated with a normal kidney transplant.

As we work to increase the number of donor organs available to our patients, the existing payment system fails to reflect the added costs associated with the ultimately successful transplant of these more complex organs. We strongly support efforts to ensure that kidney transplant MS-DRGs better reflect the cost of all associated care, and are committed to ensuring all or our patients are able to access donor organs.

COBTH
CONFERENCE OF BOSTON TEACHING HOSPITALS

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

Thank you for your consideration of our comments. 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. Please do not hesitate to be in touch with any questions or if we can provide additional information on these or other matters.

Sincerely,

Patricia McMullin
Executive Director
Conference of Boston Teaching Hospitals