Washington State Hospital Association

June 24, 2019

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

RE: CMS-1716-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 2020 Rates; Proposed Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Promoting Interoperability Programs Proposed Requirements for Eligible Hospitals and Critical Access Hospitals

Dear Ms. Verma:

On behalf of the Washington State Hospital Association's 109 member hospitals, we appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) IPPS proposed rule. The focus of our comments is the proposed changes to the wage index component of Medicare hospital payments and the proposed change to criteria for payment for ambulance services provided by critical access hospitals.

Proposed changes to wage index component of Medicare payment

WSHA appreciates CMS's concern regarding wage index calculations and payments. Wage index is an important tool to ensure variations in cost of labor between hospitals based on location and it is important that the differences are properly reflected in hospitals' Medicare payment. We support CMS's interest in ensuring real differences in labor costs are accurately measured.

We do not agree to the proposal to raise the wage index component of the hospitals in the bottom quartile by reducing the wage index for other hospitals. The proposal's approach to reduce variation through reductions undermines the purpose of the wage index adjustment, that is to provide support for hospitals that experience high labor costs due to regional differences. While we do understand CMS' concern that wage index for some specific regions may have been artificially inflated through employment of rural floor and reclassification, we disagree with the assumption that it accounts for the bulk of variation in geographic wage index levels. We do not oppose efforts to increase payment for hospitals that currently are paid at the lowest levels but do not think it should be done through reductions and adjustment to the wage index component payments to all other hospitals. This improperly penalizes all Prospective Payment System (PPS) hospitals that are not in the bottom quartile, regardless of the cause of their wage index situation. We believe the proposal has the potential to harm many more hospitals than it helps.

Under the proposed rule, all 49 of Washington state's prospective payment hospitals would experience reductions in the wage index component of their Medicare payment, 41 as a result of being in the top quartile, and all 49 as a result of the general wage index budget neutrality reduction. For many Washington hospitals, this is in addition to other wage index reductions occurring for their region.

Medicare generally pays significantly less than the actual cost of care, and reductions to payment further harm hospitals' ability to provide services to members of their community. This is particularly true of hospitals where Medicare and Medicaid, which both pay less than cost, comprise a large proportion of their payor mix. Some of our hospitals are in rural and suburban areas, and while not at the bottom quartile, still struggle with labor costs as they need to compete with urban hospitals for labor in addition to dealing with payor mix issues. Reducing a component of Medicare payment for our hospitals threatens the financial viability of hospitals and their ability to provide needed services.

Proposed changes to CAH ambulance payment

We appreciate CMS' interest in reviewing the current provision that limits payment for ambulance services provided by a critical access hospital (CAH) when there is another ambulance service located within 35 miles. We support the proposed change that would exclude consideration of other ambulance providers or suppliers that are not legally authorized to furnish ambulance services to transport individuals either to or from the CAH.

We ask CMS to consider an additional change that we believe is consistent with the intent of the proposal and would provide sustainable payment for CAH operated services that are functionally the only provider of ambulance services to a CAH and its community. There are many cases where there is another ambulance service within 35 miles of a CAH, but the ambulance does not serve the CAH or the CAH's community due to geographic and/or economic factors, rather than legal constraints. For example, in many cases the other ambulance service does not serve the CAH or its adjacent community, other than interfacility transport or in the event of a regional emergency that exceeds the capacity of the local service. We ask that CMS consider amending the proposal to allow reimbursement at 101 percent of cost for CAH ambulance services that can demonstrate they are the single source of ambulance services for their communities other than these unusual circumstances.

We thank you for the opportunity to comment on this proposed rule. Please contact Andrew Busz if you have questions.

Sincerely,

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