June 15, 2018 D R A F T

Ms. Seema Verma

Administrator

Centers for Medicare & Medicaid Services

Department of Health and Human Services

Attention: CMS-1677-P

P.O. Box 8013

Baltimore, MD 21244-8013

File Code: CMS–1694-P

***RE: CMS-1694-P, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2019 Rates; Proposed Rule***

Dear Ms. Verma:

On behalf of its member hospitals, the Michigan Health & Hospital Association (MHA) appreciates this opportunity to provide comments to the Centers for Medicare & Medicaid Services (CMS) regarding the proposed rule to update the hospital Inpatient Prospective Payment System (IPPS) for fiscal year (FY) 2019. The proposed rule is estimated to provide an $84 million, or 1.9 percent, increase to Michigan hospitals in FY 2019, which is less than the projected 5.2 percent increase in healthcare inflation for 2019. The absence of adequate Medicare payment rates challenges the financial viability of Michigan hospitals and their ability to provide care to Medicare beneficiaries and other patients. The latest Medicare margins data reflects that, on average, when all services are considered, Medicare fee-for-service (FFS) pays Michigan PPS hospitals approximately 3 percent less than the cost of providing care to Medicare beneficiaries resulting in a shortfall of $207 million.

The MHA will submit a separate comment letter on the long-term care hospital (LTCH) proposed rule. Our comments regarding the IPPS proposed rule focus on:

* Request for information on pricing transparency
* Payment for Chimeric Antigen Receptor (CAR) T-cell Therapy services
* Restoration of ATRA-mandated documentation and coding offset
* Reductions in MS-DRG relative weights
* Correction to low volume payment adjustment formula
* Worksheet S-10 data for uncompensated care payment allocations
* Request for information on interoperability
* Changes to the hospital inpatient quality reporting program
* The use of ICD-9 and ICD-10 data for the hospital readmissions reduction program
* The use of the Patient Safety Indicator (PSI)-90 measure in the Hospital Acquired Conditions Reduction program
* Medicare cost report submission requirements

**TRANSPARENCY**

(*Federal Register* pages 20,548 – 20,549)

The CMS proposes to require that hospitals publish a list of their current standard charges via the internet in a machine-readable format effective Jan. 1, 2019, to be updated at least annually (page 20549 of proposed rule). This could be in the form of the chargemaster or another form of the hospital’s choice.

The MHA strongly supports healthcare transparency inclusive of both price and quality. We are also supportive of the flexibility the CMS proposes to allow hospitals to post charges in a form their choice. It recognizes that hospitals may already be posting this type of information for their patients and allows them to maintain existing operations, avoiding administrative burden and cost. Charge transparency from hospitals is important for some patients while patient-specific copayments, coinsurance, and deductible balances should be available from Medicare, Medicare Advantage, Medicaid and commercial plans for many others.

The MHA comments on price transparency follow. We believe the information outlined in these recommendations will improve healthcare transparency and provide patients with the information they desire:

* **CMS Request**: Should “standard charges” be defined to mean: average or median rates for the items on the chargemaster; average or median rates for groups of services commonly billed together (such as for an MS-DRG), as determined by the hospital based on its billing patterns; or the average discount off the chargemaster amount across all payers, either for each item on the chargemaster or for groups of services commonly billed together? Should “standard charges” be defined and reported for both some measure of the average contracted rate and the chargemaster? Or is the best measure of a hospital’s standard charges its chargemaster?

**MHA Response**: Under federal uniform billing requirements, hospitals must charge every patient the same amount for the same service. This is accomplished using the chargemaster. The chargemaster should be the definition of standard charges. However, patients desire information on their out-of-pocket responsibility which is different by payer (Medicare, Medicaid, and commercial). The MHA recommends the CMS grant hospitals flexibility to post the information they believe is appropriate for their market.

* **CMS Request**: What types of information would be most beneficial to patients, how can hospitals best enable patients to use charge and cost information in their decision-making, and how can CMS and providers help third parties create patient-friendly interfaces with these data?

**MHA Response**: The patient out-of-pocket amount (copayment, coinsurance and/or deductible) is desired by patients to make informed healthcare purchasing decisions. In addition, when choosing a provider, patients have several other factors to consider including facility quality and patient safety, physician privileges, and access to services. We must collectively work to ensure patients understand that an inpatient stay or outpatient hospital visit may include services from multiple providers including a surgeon, hospital, and anesthesiologist, for example, each with their own bill and potential out-of-pocket payment requirements. Finally, we must work to ensure patients understand that new clinical information may be present during treatment that may impact the initial cost estimate. Below, we identify the best source for this information depending on the patient’s insurance status.

Providers have a shared responsibility with others for improving the service-specific out-of-pocket information electronically available to patients on a timely basis.

* + Hospitals and other providers should be the principal source of patient-specific out-of-pocket amounts for patients who are uninsured. They are best positioned to determine if patients qualify for charity care or other discounts. Hospitals can best enable patients to use charge information in their decision-making by posting charges on their websites with the following notations:
    - Uninsured patients should contact the hospital to determine if they qualify for a discount from posted charges.
    - Insured patients should contact their insurer to determine their out-of-pocket amount.
  + Medicare, Medicare Advantage, Medicaid, Medicaid managed care, and commercial insurers should be the principal source of patient-specific out-of-pocket amounts for their members as they have the most accurate information on patient deductibles and remaining balances. While they may not have information for outstanding claims, it is still more complete than what individual providers have. Insurers also have provider payment rates to calculate the patient’s share of approved amount.

Michigan-based health plans have developed robust cost estimator tools that provide information based on member-specific copayment, coinsurance and deductible balances for various procedures and providers. Many health plans nationally have created similar tools for their members. The MHA encourages the CMS to establish a workgroup of health plans and hospitals to determine how to most accurately and efficiently provide patient-specific out-of-pocket amounts to their patients.

* **CMS Request**: Should health care providers be required to inform patients how much their out-of- pocket costs for a service will be before those patients are furnished that service? What changes would be needed to support greater transparency around patient obligations for their out-of-pocket costs? What can be done to better inform patients of these obligations? Should health care providers play any role in helping to inform patients of what their out-of- pocket obligations will be?

**MHA Response**: Providers have a shared responsibility with others for providing out-of-pocket information to patients who desire this information prior to receiving non-emergent services. For uninsured patients, providers should make available the out-of-pocket cost estimate. This includes working with patients to determine eligibility for financial discounts, providing information regarding other providers that may bill separately, and explaining that unforeseen circumstances may result in changes from the initial estimate. Providers should refer insured patients to their insurer as they have the most accurate information on deductible balances and provider payment rates to calculate the patient’s share of approved amount.

Through this proposed rule, the CMS is taking action to require that hospitals post standard charges to promote greater healthcare transparency. The MHA encourages the CMS to also work with insurers.

* **CMS Request**: Should we require health care providers to provide patients with information on what Medicare pays for a particular service performed by a health care provider? If CMS were to finalize a requirement that this information be made available to beneficiaries by health care providers, what changes would need to be made by health care providers? What corresponding regulatory changes would be necessary?

**MHA Response**: The CMS should not require providers to make available the amount Medicare pays for a particular service. As previously mentioned, the out-of-pocket amount is what patients desire. Adding a Medicare payment amount requirement would confuse many Medicare patients since it is not what they would pay for the service. In addition, in Michigan, as a result of our Medicaid expansion law, hospitals must already accept as payment in full 115 percent of Medicare rates from any uninsured individual whose income is at or below 250 percent of the federal poverty level. Instead, the MHA encourages the CMS to work with Medicare fee-for-service and Medicare Advantage plans provide patients with pre-service, patient-specific out-of-pocket estimates. No changes are required by providers if this mandate is not pursued.

Regulatory changes to increase healthcare transparency should result in outcomes that meet the needs of patients to make informed healthcare purchasing decisions while not adding unnecessary burden and cost to healthcare providers. Requiring organizations that do not have patient-specific information to provide patients with cost estimates will add unnecessary cost to the system while not meeting the needs of patients. In its comments, the MHA has made several recommendations to improve healthcare transparency.

We must continue to work collectively to educate patients about how to use price and quality information together to make better informed healthcare decisions. The CMS is focusing its efforts in this proposal on price transparency. The MHA recommends the CMS also take action to promote the use of information about healthcare quality and patient safety. The CMS provides this information to the public on its “provider compare” websites. This and similar sites such as the MHA’s transparency site, [www.verifymicare.org](http://www.verifymicare.org), should also be promoted.

Finally, patients should also have information about total cost of care across the full continuum, professional, acute, and post-acute, to allow for a greater understanding of healthcare cost beyond an individual service.

**Chimeric Antigen Receptor (CAR) T-Cell Therapy**

(*Federal Register* pages 20,377-20,381)

CAR T-cell therapy is a cell-based gene therapy in which a patient’s own T-cells are genetically engineered in a lab and administered to the patient by infusion to assist in treatment to attack certain cancerous cells. Procedures involving the CAR T-cells therapy drugs are currently identified with ICD-10-PCD procedure codes XW033C3 and XW043C3. Two CAR T-cell therapy drugs, KYMRIAH and YESCARTA, received approval by the Food and Drug Administration in 2017, with both manufacturers submitting applications for new technology add-on payments for FY 2019.

After examination, the CMS clinical advisors believe that patients receiving CAR T-cell therapy services would have similar clinical characteristics and comorbidities to patients receiving treatment for other hematopoietic carcinomas treated with autologous bone marrow transplant.

In the proposed rule, the CMS:

* proposes to assign CAR-T therapy procedures to Medicare Severity Diagnosis Related Group (MS-DRG) 016, “Autologous Bone Marrow Transplant with CC/MCC or T-cell Immunotherapy” which has a proposed relative weight of 6.529.
* discusses these technologies in the context of new technology add-on payments since these two technologies submitted new technology add-on payment applications for FY 2019. In the IPPS, new technology add-on payments provide additional payments (at a rate of 50 percent of the marginal cost) for cases with relatively high costs involving eligible new medical services or technologies. New technology add-on payments are not subject to budget neutrality which means they do not reduce payments for other IPPS services.
* invites comments on alternative payment approaches for these two technologies. Based on feedback that hospitals would be unlikely to set charges different from cost for these services, estimated at $400,000 to $500,000 per therapy, the CMS discusses a suggestion to allow hospitals to use a cost-to-charge ratio of 1.0 for charges associated with these technologies for determining outlier payments and for 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.

**Given the extremely high cost and unique nature of these services which are provided by a limited number of hospitals, the MHA believes that the CMS should pay for these items through a new technology add-on payment. Utilizing this payment option will ensure that the CMS pays only when these technologies are used and will not reduce payments for other core services which would result from establishing a new MS-DRG.**

**RESTORATION OF ATRA DOCUMENTATION AND CODING OFFSET**

***(****Federal Register* pages 20,176-20177)

In FY 2018, the CMS began a six-year process required by statute to restore the negative adjustments removed from the IPPS base operating rates to recoup $11 billion in payments for documentation and coding adjustments mandated by the American Taxpayer Relief Act of 2012 (ATRA). The CMS implemented a 0.8 percent cut to the annual market basket update in FYs 2014-2016 to recoup the effect of documentation and coding changes that the CMS believes do not reflect real changes in patient acuity. For FY 2017, the CMS increased this cut from 0.8 percentage points to 1.5 percentage points to achieve the $11 billion targeted through the ATRA.

In the FY 2018 IPPS proposed rule, the CMS indicated that the agency had anticipated making a single positive adjustment in FY 2018 to offset the reductions, which would have been 3.2 percent if the CMS had made four adjustments of -0.8 percent as originally planned. However, two pieces of legislation modified this plan.

Section 414 of the Medicare Access and CHIP Reauthorization Act (MACRA) was enacted in April 2015, and replaced the single positive adjustment that the CMS had intended to make in FY 2018. The CMS replaced the one-time positive adjustment with a 0.5 percentage point positive adjustment for each year, FYs 2018- 2023, which equates to a total positive adjustment of 3.0 percent instead of the 3.9 percent cumulative adjustment that the CMS indicated was required by ATRA.

More recently, the 21st Century Cures Act was enacted in December 2016 and required the CMS to reduce the positive adjustment for FY 2018 from 0.5 percentage points to 0.4588 percentage points which results in a cumulative restoration adjustment for documentation and coding of 2.9588 percent rather than the 3.9 percent removed from the rates to complete the recoupment. **The MHA believes, despite current law, that the CMS should ensure that the full 3.9 percent withheld is returned to hospitals.**

**REDUCTIONS IN MS-DRG RELATIVE WEIGHTS**

(*Federal Register* pages 20,176-20,353)

The CMS updates the MS-DRG classifications and relative weights annually to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources. A review of the CMS Table 5 indicates that the proposed relative weights for four MS-DRGs would decrease by 20 percent or more in FY 2019 as reflected below:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **MS-DRG** | **MS-DRG Title** | **FY 2018 Final Weights** | **FY 2019 Proposed Weights** | **% Increase (Decrease)** |
| 295 | DEEP VEIN THROMBOPHLEBITIS W/O CC/MCC | 0.7855 | 0.5507 | -29.9% |
| 661 | KIDNEY & URETER PROCEDURES FOR NON-NEOPLASM W/O CC/MCC | 1.4540 | 1.0727 | -26.2% |
| 215 | OTHER HEART ASSIST SYSTEM IMPLANT | 12.8861 | 9.6416 | -25.2% |
| 659 | KIDNEY & URETER PROCEDURES FOR NON-NEOPLASM W MCC | 3.4129 | 2.7051 | -20.7% |

Hospitals that provide services assigned to these MS-DRGs need time to adjust their expenses given the significant payment cut. These weight decreases would have a significant negative financial impact on hospitals that provide care for patients assigned to these MS-DRGs. **The MHA urges the CMS to phase-in substantial reductions of MS-DRG relative weights to allow hospitals additional time to modify their operations to manage these significant payment cuts.**

**LOW VOLUME PAYMENT ADJUSTMENT**

(*Federal Register* pages 20,384 – 20,386)

The recent Bipartisan Budget Act extended the low volume adjustment through FY 2022 and modified the adjustment for FY 2019-2022 to require that hospitals have less than 3,800 total discharges rather than 1,600 Medicare discharges required for the FY 2011-2018 payment adjustment. On *Federal Register* page 20,385, the CMS indicated that the new payment formula for FY 2019 for hospitals with between 500 and 3,800 total discharges will be:

***Low-Volume Hospital Payment Adjustment = 95/330 \* Total Discharges/13,200***

Review of this formula indicates an error in the sign reflected and that the correct formula should be:

***95/330 minus (-) Total Discharges/13,200***

**The MHA urges the CMS to correct this formula in the final rule.**

As a result of the Bipartisan Budget Act, the low-volume adjustment is retroactive to Oct. 1, 2017. **The MHA urges the CMS to provide instructions to the Medicare Administrative Contractors for making the retroactive low volume adjustment for FY 2018 as soon as possible since the agency has not provided instructions as of June 8.**

**Worksheet S-10 Data for Allocating Uncompensated Care Pool Payments**

(*Federal Register* pages 20,386 – 20,401)

The CMS proposes to proceed with year two of the three-year transition to use data reported on worksheet S-10 of the Medicare cost report for allocating payments from the uncompensated care pool, which totals $8.25 billion for FY 2019. These payments get allocated to approximately 2,500 hospitals nationally based on data reported on Medicare cost report worksheet S-10, specifically Line 30, Cost of Non-Medicare Uncompensated Care comprised of:

* + Line 23 – Cost of Charity Care
  + Line 29 – Cost of Non-Medicare Bad Debt Expense

As indicated in our comments regarding the FY 2018 proposed rule, we have concerns regarding the integrity of the data reported on Worksheet S-10. We appreciate that the CMS provided hospitals with an opportunity to revise data reported on FY 2014 and 2015 cost reports during the period September 2017 through Jan. 2, 2018, but a review indicates that only roughly 60 percent of hospitals nationally revised their FY 2014 cost reports while approximately 67 percent revised their FY 2015 cost reports. The CMS proposes to use data from the FY 2014 and FY 2015 worksheet S-10 to allocate the FY 2019 UCC payments.

A key change since release of the FY 2018 final rule was the release of cost report Transmittal 11 by the CMS in September 2017, after hospitals had filed their initial FY 2014 and FY 2015 cost reports and after some hospital had filed amended cost reports to update S-10 data. This transmittal includes a significant change in that Charity Care coinsurance and deductibles reported on line 20 column 2 (Insured Patients) are no longer converted to cost using the hospital’s cost-to-charge ratio. Previously, under Transmittal 10, these amounts were converted to cost on Worksheet S-10. We believe that this change is creating a significant inconsistency in the data reported on line 20, column 2. Due to these major inconsistencies in reporting among hospitals, we urge the CMS to delay moving forward with the transition. Instead, **we encourage the CMS to continue using one year of worksheet S-10 data and two years of “proxy” data as it used for the FY 2018 UCC payment allocations. We urge the CMS to continue working with the Medicare Administrative Contractors (MACs) and hospitals to develop clear and concise instructions for completing Worksheet S-10 data to help ensure consistency among hospitals.** The CMS should delay the transition to Worksheet S-10 data until all relevant data has been audited to ensure that data for all hospitals is consistently reported. It is inappropriate for CMS to use what we believe to be flawed data to distribute $8.25 billion among hospitals. In addition, **we urge the CMS to give hospitals an additional opportunity to amend data reported on worksheet S-10 of FY 2014, 2015 an d2016 cost reports, prior to proceeding with the transition.** We believe it is critical that hospitals are aware of the major changes between transmittals 10 and 11.

**Inpatient Quality Reporting Program Changes**

(*Federal Register* pages 20,469 – 20,500)

The CMS proposes to remove 39 measures from the hospital inpatient quality reporting program, many of which are currently included in multiple programs such as the hospital acquired conditions (HAC) reduction, value based purchasing (VBP) or hospital readmissions reduction programs. Many of the measures proposed for removal will be retained in those programs. The MHA is supportive of the CMS’ proposed streamlining of measures and historically have objected to the use of the same measure, or a variation of it, in multiple programs.

The proposal also includes removing the survey on patient safety culture which the agency does not propose to retain in another program. The MHA believes that the patient safety culture survey component should remain in the IQR program to support improving quality and safety outcomes. We recommend that the survey be conducted bi-annually rather than annually since culture change moves at a slower rate. There is a strong, and continually growing, body of evidence that links safety culture to improved clinical outcomes. While patient safety culture surveys may not directly impact outcomes, it is a vital tool for the measurement of cultural factors that do have a direct bearing on the delivery of safe, high-quality care.

Unlike many quality measures that are collected for the sole purpose of reporting to entities outside of the hospital, patient safety culture surveys have become part of the routine operational assessments. Additionally, it is important to note that there are a variety of methods to survey and report data that allow hospitals to use a mechanism that minimizes burden while generating important information to manage patient safety culture. Most organizations will continue to conduct this survey regardless of requirement from the CMS. However, through inclusion in the IPPS, the CMS recognizes the value and importance of this survey process.

Data collected from a patient safety culture survey provides information to organizational leaders, as well as those working directly to improve quality of care. While most organizations regularly measure their patient safety culture, removal of the survey requirement may reduce the imperative for some to deploy this important tool, in-turn decreasing their ability to more effectively manage quality and safety improvements.

**Request for Information on Interoperability**

(*Federal Register* pages 20,550 – 20,553)

With this proposed rule, the CMS is issuing a Request for Information (RFI) on “Promoting Interoperability and Electronic Health Information Exchange through Possible Revisions to the CMS Patient Health and Safety Requirements for Hospitals and Other Medicare- and Medicaid-Participating Providers and Suppliers”.

We support the CMS’ change of focus for the EHR Incentive Program to reflect the continued importance of interoperability. Michigan has been a leader in statewide information sharing and the growth of Health Information Exchanges (HIEs) such as Great Lakes Health Connect ([www.GLHC.org](http://www.GLHC.org)) and the Upper Peninsula Health Information Exchange ([www.uphie.org](http://www.uphie.org)) is a reflection of that leadership.  Along with these HIEs, the Michigan Health Information Network ([www.mihin.org](http://www.mihin.org)) allows providers to “connect once” to gain access to patient information across the state. This network of networks facilitates interoperability and the exchange of electronic health information to build technical and collaborative partnerships between healthcare providers throughout the state; from hospitals and physicians to pharmacies and payers. MiHIN offers shared technology services that help ensure the electronic health records of Michigan citizens are available for all who deliver care services. More than 17 million secure patient information passes through MiHIN’s statewide network weekly.

In addition, the CMS seeks input regarding whether the agency should promote interoperability by including electronic sharing of health information as a Medicare condition of participation for hospitals, skilled-nursing facilities, inpatient rehabilitation facilities, and other post-acute care settings.

**Although the MHA is supportive of the CMS’ promoting interoperability, we object to the CMS requiring interoperability as a Medicare condition of participation since this would likely result in some hospitals and post-acute providers no longer being eligible to participate in the Medicare program and therefore would be ineligible for Medicare payments for services to Medicare beneficiaries, potentially resulting in hospital closures. Hospital closures or exclusion from Medicare would reduce access to essential services for Medicare patients. The MHA recommends that the CMS provide additional incentive payments to help ensure that hospitals and post-acute care facilities have the resources necessary for investing in technologies that promote interoperability.**

**Value-Based Purchasing (VBP) Program**

(*Federal Register* pages 20,407 – 20,426)

Currently, the VBP program includes four domains each weighted at 25 percent in determining a hospital’s total performance score (TPS):

* + Clinical Care
  + Safety of Care
  + Person and Community Engagement
  + Efficiency and Cost Reduction

The CMS proposes to remove 10 measures from the VBP program for future years, with most of these retained in the HAC reduction program. Other measures are proposed for removal due to their similarity to other existing efficiency measures. The MHA is supportive of the proposed removal of the 10 measures. As previously indicated, historically, the MHA has objected to the use of the same or similar measure in multiple programs.

However, because the CMS has proposed to remove all the safety measures from the VBP, the CMS proposes to revise the VBP measure domain weights by removing the safety domain altogether and increasing the weight of the “clinical outcomes” domain to 50 percent with the remaining two domains weighted at 25 percent each. As a result, the CMS proposes to reweight the program domains for FY 2021 as follows:

* Clinical Outcomes – 50 percent
* Person and Community Engagement – 25 percent
* Efficiency and Cost Reduction – 25 percent

**The MHA is supportive of the proposed re-weighting for the VBP program domains.**

**Hospital Readmission Reduction Program (HRRP)**

*(Federal Register* pages 20,403 – 20,407)

The CMS proposes to continue using a three-year performance period for the HRRP for FY 2019. Specifically, the CMS would use data from July 1, 2014 through June 30, 2017 to evaluate hospital performance for the FY 2019 HRRP. **The MHA urges the CMS to examine the impact of using data for the proposed period which includes both ICD-9 and ICD-10 data since ICD-10 replaced the ICD-9 effective Oct. 1, 2015, to ensure that there are no unintended negative consequences of using data from two unique systems.**

**Hospital-Acquired Conditions (HAC) Reduction Program**

*(Federal Register* pages 20,426 – 20,437)

We support the CMS’ proposed removal of the PSI-90 and infection measures from the VBP program since as previously stated we believe it is inappropriate for the CMS to use the same measure or variation of it in multiple programs. **We encourage the CMS to eliminate the use of the PSI-90 composite measure, which is comprised of 10 individual measures, from the HAC reduction program since we continue to believe that this measure lacks reliability and should not be used in any of the quality-based programs. Our specific concerns relate to the:**

* Individual component measures such as the PSI-12 that includes post-operative pulmonary embolism (PE) or deep vein thrombosis (DVT rate), which we believe are susceptible to survelliance bias; and
* The administrative data used to determine the measures in the PSI-90 lack clinical precision for accurately identifying patient safety issues such as accidental punctures or lacerations

**Medicare Cost Report Submission Requirements**

*(Federal Register pages 20,544 – 20,548)*

For Medicare disproportionate share hospital (DSH) payment purposes, the CMS proposes to require that hospitals provide a listing of Medicaid-eligible patient days to the MAC when the cost report is filed, generally five months after the hospital’s fiscal year end. This data is used to determine both the traditional Medicare DSH and each hospital’s share of uncompensated care pool payments. Currently, hospitals provide this detail to the MAC upon audit, typically several years after their fiscal year end.

Based on current practice, hospitals estimate the number of Medicaid-eligible patient days when filing their cost report since Medicaid eligibility is pending for many patients. Hospitals are then given an opportunity to submit a revised listing prior to the beginning of the desk review or audit which will be used by the MAC to update the Medicaid-eligible patient days. Generally, compared to the filed cost report, hospitals see an increase in the number of Medicaid-eligible days when the listing is provided to the MAC prior to the desk review or audit.

We believe that Medicare DSH payment should be determined using the most accurate data, which is not available when the cost report is filed due to delays in verifying Medicaid eligibility for patients. **The MHA urges the CMS to modify this proposal to allow hospitals to provide an updated listing when the MAC begins the desk review or audit without requiring hospitals to amend their cost reports.**

**SUMMARY**

The MHA appreciates this opportunity to provide comments to the CMS regarding this proposed inpatient rule. We believe our suggested modifications will result in positive changes for hospitals and the Medicare beneficiaries they serve. If you have questions regarding this comment letter, please contact Vickie Kunz at (517) 703-8608 or vkunz@mha.org.

Sincerely,

Marilyn Litka-Klein

Vice President, Health Finance

Policy and Health Delivery