AHPA
ADVENTIST HEALTH
POLICY ASSOCIATION

June 25, 2018

VIA ELECTRONIC MAIL
regulations.gov

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244-8013

Re: CMS-1694-P, FY 2019 Hospital Inpatient Prospective Payment System (IPPS) Notice of Proposed Rulemaking

Dear Ms. Verma:

On behalf of the Adventist Health Policy Association (AHPA), we appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) Fiscal Year (FY) 2019 Hospital Inpatient Prospective Payment System (IPPS) proposed rule. Our organization is the policy voice of five Seventh-day Adventist affiliated health systems that include 83 hospitals and more than 300 other health facilities in 17 states and the District of Columbia.

AHPA represents a major segment of the U.S. hospital sector. Our member hospitals operate in a variety of settings, ranging from rural Appalachia to urban areas of California. With such diverse facilities, populations served and geographical locations, we strive to provide an objective and sound policy voice that works across health care providers.

We have read the proposed IPPS rule for acute care hospitals and appreciate the opportunity to provide comments. Below, please find AHPA's comments and recommendations on CMS' proposed policies. Specifically, we comment on the following eight issue areas:

- Transparency
- Disproportionate Share Hospital and Uncompensated Care Payments
- Inpatient Orders
- Long-Term Care Hospitals 25 Percent Threshold Policy
- Inpatient Quality Reporting Program
- Hospital-Acquired Condition Reduction Program
- Value-Based Purchasing Program
- Promoting Interoperability Program

Transparency

AHPA applauds CMS for tackling the complexity surrounding price transparency. As we partner with CMS and other health care providers to achieve price transparency, we believe that the patient should be at the center of our efforts. With that in mind, we must help provide meaningful information to patients to help them make educated health care decisions. As CMS continues to explore and make strides toward health care price transparency, we urge the Agency to consider the principles outlined below:

- Provide Meaningful Price Information
- Provide Education on Health Literacy
- Engage all Health Care Providers and Payers
- Address Barriers to Providing Price Information

Provide Meaningful Price Information

For price information to be meaningful to patients, it must be shared in a way that can be easily understood by patients. Under CMS' proposal, hospitals would be required to make available a list of their current standard charges via the internet in a *machine-readable format* and update this information at least annually. This means that a hospital would only have to post its Chargemaster online to fulfill this requirement. While we commend CMS for seeking price transparency, we believe this proposal fails to achieve that goal. The Chargemaster is not meaningful to patients. It uses terms difficult for the average consumer to understand, lacks important contextual information, such as quality metrics, and the charges listed are rarely what is negotiated by insurers and paid by consumers. Moreover, not-for profit hospitals must provide reduced rates or charity care based on patient household income. Therefore, a hospital's charges are not as relevant to a patient because the patient's bill may be significantly discounted or the services provided at no charge under the hospital's charity policy. A patient's financial responsibility, as opposed to price information, often is what is most meaningful to the patient.

Instead of using the Chargemaster to promote price transparency, AHPA urges the Agency to focus its efforts on "shoppable" health care services. These are services that can typically be scheduled in advance, such as a caesarean section or a colonoscopy. Based on a 2011 study by the Health Care Cost Institute (HCCI), 42.5 percent of total spending from employer-sponsored insurance on individuals younger than age 65 was for medical services that can be considered shoppable.[1] Because consumers facing a medical emergency are unable to shop for health services, CMS' efforts should focus on those services where patients have the time to compare prices. We believe this is a more strategic and targeted approach to achieving price transparency. Focusing efforts on what is likely to be utilized by the consumer will also help reduce administrative burden.

Additionally, the main goal of price transparency should be to empower patients to make educated health care decisions. Providing price information alone does not achieve this goal. For example, a minimally

[1] Frost, A., et. Al. Health Care Consumerism: Can The Tail Wag The Dog?

invasive robotic surgery may be costlier than a regular surgery, but a patient will encounter less blood loss and have a faster recovery. On the other hand, the most expensive care does not necessarily translate into the best care. Services provided in one hospital may be costlier than another, however the costlier hospital may have higher readmission and mortality rates. Without quality information, individuals are most likely to assume that higher prices mean better care.[2] While cost information about health care services matters to patients, so does quality related information. **Therefore, we recommend that CMS use both price and quality information to help consumers choose high-quality care.** This quality information should be risk adjusted so that hospitals serving more vulnerable populations are not penalized. As recognized by the Office of the Assistant Secretary for Planning and Evaluation (ASPE), providers that disproportionately serve beneficiaries with social risk factors tend to have worse performance on quality measures, even after accounting for their beneficiary mix. These providers are more likely to face financial penalties across all five Medicare value-based purchasing programs in which penalties are assessed.[3] Without appropriate risk-adjustment for socio-economic factors, consumers will be unable to get an accurate picture of a hospital's quality.

AHPA also recommends that the Agency conduct further research on best methods to share price information with patients. The way price information is shared with consumers can significantly impact how that information is interpreted and used. For example, CMS should list health care services in layman's terms that patients can understand instead of just providing the Diagnosis Related Group (DRG). Both providers and insurers have previously made attempts at creating price estimation tools. However, these tools are not widely utilized by consumers despite the growing financial pressure on consumers from increasing health insurance deductibles. Studies have shown that price estimation tools are not widely used. For example, UnitedHealthcare's tool was only used by 10 percent of their commercial members.[4] Another national study found that only half of Americans tried to find price information before seeking care.[5] CMS should engage consumers through focus groups, to identify what price transparency means to consumers and what method for implementation would be most meaningful. This would allow the Agency to gain a better understanding of patient's needs and provide recommendations for further consideration.

Provide Education on Health Literacy

AHPA recommends that CMS launch outreach efforts, in collaboration with other health care stakeholders, on health literacy. Patients frequently ask hospitals for an explanation of cost information. Without appropriate health literacy, this information can often be very difficult to understand. We find that patients lack knowledge surrounding their own health plans and what contributes to their out-of-

[2] Associated Press-NORC Center for Public Affairs Research. Finding Quality Doctors: How Americans Evaluate Provider Quality in the United States.
[3] Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation (ASPE). Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs.
[4] Modern Healthcare. Achieving Transparency in Healthcare.
[5] Public Agenda. Still Searching: How People Use Health Care Price Information in the United States.

pocket costs. Hospitals see this as an opportunity to educate patients but more must be done to provide the average American with basic health care literacy. To promote health literacy, AHPA recommends that CMS create standard health care definitions and patient-friendly vocabulary that could be used across the nation to help share price information.

Engage all Health Care Providers and Payers

AHPA believes that price transparency cannot be achieved without the engagement of all health care stakeholders: hospitals, post-acute care providers, physicians, insurers, and drug and medical supply manufacturers. While hospitals play a key role in providing price estimates, every stakeholder in health care contributes to costs. For example, the cost of a service depends on the costs of medications and medical supplies set by manufacturers, and what physicians may charge for their services. Insurers also play a key role, as they hold information about a patient's benefits and out-of-pocket costs.

While much emphasis has been placed on hospitals' price transparency, *all* stakeholders should play a role in educating patients about prices. Efforts should not disproportionately target one stakeholder or focus mainly on one area of the health care continuum. To achieve price transparency, the Agency must broaden the discussion by ensuring that all health care stakeholders are brought to the table.

Address Barriers to Providing Price Information.

Achieving price transparency is a complex issue because price information is not held solely by hospitals. Information impacting costs, such as a patient's co-payments and deductibles, are held by payers. For example, the cost of a health care service may significantly increase if the patient has not met his or her deductible or if the plan's benefit does not cover the specific procedure. Unfortunately, this information is not always readily available to hospitals. Although the 270/271 Health Plan Eligibility Benefit and Response transactions implemented by the Affordable Care Act (ACA) require insurers to share a plan's benefit information with hospitals, this mandate is rarely enforced.[6] Given the rise of high-deductible plans, having access to a patient's co-payments and deductibles is crucial to providing accurate price estimates. Without addressing this barrier, true price transparency cannot be achieved.

Additionally, the ability to share patient financial liability information is influenced by a variety of factors, such as limitations within a contract to share an insurer's negotiated rates. Doctors and payers generally do not want their negotiated rates to be publicized and it is difficult to provide accurate estimates without doing so. In contracts, there are often clauses that prohibit hospitals from revealing these rates and the violation of such clauses could result in litigation. Due to these contractual restrictions, providers cannot share price information on behalf of other parties. We ask for CMS to consider these limitations when engaging in efforts to promote price transparency.

[6] Department of Health and Human Services. 270/271 Companion Guide for NGHP Entities

Questions on Price Transparency

In the rule, CMS poses several questions in regard to price transparency. CMS' questions, followed by our responses, are included below.

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?

We do not believe that the Chargemaster is an appropriate tool to promote price transparency. Hospital billed charges rarely equal the amount reported in the Chargemaster. Billed charges are determined by a variety of factors, including a hospital's negotiated rates with insurance companies and a patient's comorbidities. Today, Medicare Inpatient payments are not based on the Chargemaster but on the DRG. Additionally, most Outpatient services are based on Medicare's fee schedules. Regardless of what a hospital charges or the actual costs incurred, Medicare pays a relatively uniform fee for the same service nationwide. In contrast, insurance companies negotiate payment methods directly with hospitals. Some insurers pay a discount off charges, some pay on a per-day basis and others pay DRG-type set rates. Hospitals contract with many different insurers, all with different cost-sharing and benefit structures that are completely unrelated to a hospital's Chargemaster. Therefore, the Chargemaster would not provide patients with an accurate price estimate. Due to its complexity and the nomenclature included, it would also be difficult for patients to understand.

Instead of using the Chargemaster, AHPA recommends that "standard charges" be defined as the average median payment rate for a shoppable service. Shoppable services should be non-emergent or elective procedures that patients will most likely use. As mentioned earlier, this policy would help reduce administrative burden while also being more meaningful to patients.

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?

AHPA believes that consumers would benefit from knowing the following: 1) their co-payments and deductibles, 2) the price of services deemed shoppable and 3) a provider's performance in quality metrics. However, there are many barriers to providing this information. A patient's financial liability will depend on the patient's insurance coverage and whether they have reached their deductible. Unfortunately, this information is held solely by the payer. Hospitals can only provide accurate price estimates before a service is provided if insurers provide patient benefit and eligibility information in advance of patient visits. In our experience, collecting this information directly from the consumer leads to inaccuracies. We find that information on co-payments and deductibles must come from the payer.

In order to improve the accuracy of hospitals' price estimates, AHPA recommends that CMS better enforce the 270/271 Health Plan Eligibility Benefit and Response real-time eligibility transactions under the Health Insurance Portability and Accountability Act (HIPAA). This 270/271 rule requires that insurance companies update and electronically transmit their health care eligibility benefit information in a timely fashion. An electronic eligibility system can determine the patient's financial liability before a service is performed, but it can only be accurate if payers provide that information in a timely fashion. CMS should require that all payers, including Medicare secondary insurance payers, provide timely electronic eligibility and benefit information to health providers. This would allow providers to share accurate price estimates in a timely manner.

AHPA also recommends that initiatives to provide price estimates be tied to quality metrics. As explained earlier, having quality metrics readily available beside price information would empower patients to make an informed choice. It would also serve as an incentive for providers to improve on their quality metrics. Currently, there are many different sources of quality information, including Leapfrog, the Joint Commission and the Hospital Overall Star Ratings. We believe that health providers, payers and patients should work together to determine what quality information consumers need the most to make informed decisions. Moreover, the quality metrics included need to capture the socio-economic factors of the populations served by a hospital. Otherwise, a hospital serving a high population of dual-eligible beneficiaries or underserved communities may appear as being a low-quality provider.

Lastly, we believe that CMS should develop a technical expert panel composed of stakeholder groups to help inform the development of patient-friendly price interfaces. Ensuring that the price and quality scores tied to a service are provided in a way that is easily understandable will enable patients to utilize this information.

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?

AHPA believes that price transparency should be driven by the market. Forcing hospitals to post prices and potentially imposing penalties will unfairly harm hospitals because critical information (e.g. co-payments and deductibles) is held by payers. However, we do believe there are steps that CMS should take to promote price transparency. AHPA recommends that CMS develop a list of "shoppable" services for hospitals to use as a guide when creating price estimation tools. As mentioned earlier, the Agency should also better enforce the 270/271 transactions that provide the eligibility and benefit information needed for providers to estimate a patient's out-of-pocket costs.

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?

Again, the focus for price transparency should be on a patient's financial liability. Medicare Inpatient payments are determined by the DRG selected in a course of treatment, and Medicare Outpatient payments are determined by the Medicare fee schedule and other add-ons and modifiers. This information can be confusing to patients. AHPA recommends that CMS provide a list of payment rates by facility on the Agency's website so that patients can compare a hospital's standard charges to Medicare's remittance advice.

What is the most appropriate mechanism for CMS to enforce price transparency requirements? Should CMS require hospitals to attest to meeting requirements in the provider agreement or elsewhere?

If CMS implements the proposed price transparency requirement, AHPA recommends that hospitals attest to meeting the requirement as part of their cost report filing. While charges for health care services can change throughout the year, hospitals should only be required to submit price information once a year to attest that the information is available.

How should CMS assess hospital compliance? Should CMS publicize complaints regarding access to price information or review hospital compliance and post results? What is the most effective way for CMS to publicize information regarding hospitals that fail to comply?

AHPA recommends that hospital compliance for providing charges be included in CMS' Monitoring and Auditing Plan. For patient complaints, providers should be responsible for addressing these as they do today. If patients' complaints are not addressed by the facility, the patient can file a complaint with CMS. If the Agency would like to publicize these complaints, we recommend posting the volume of complaints per facility instead of the individual details of each complaint online. This would provide patients with a broader picture of the hospital's compliance with this policy.

Should CMS impose civil monetary penalties on hospitals that fail to make standard charges publicly available as required by section 2718(e) of the Public Health Service Act? Should CMS use a framework similar to the Federal civil penalties under 45 CFR 158.601, et.seq. that apply to issuers that fail to report information, or would a different framework be more appropriate?

AHPA strongly opposes imposing civil monetary penalties on hospitals failing to make standard charges public. Imposing such penalties for non-compliance could drive hospitals to focus on checking the box for complying with this regulation rather than looking for solutions that are more meaningful to patients. For example, hospitals that merely post their Chargemaster online could fulfill the price transparency requirement even though consumers may not understand the information provided. Moreover, as mentioned earlier, hospitals may not have all the information necessary to provide patients with accurate price estimates.

How does Medigap coverage affect patients' understanding of their out-of-pocket costs before they receive care? What challenges do providers face in providing information about out-of-pocket costs to patients with Medigap? What changes would be needed to support providers sharing out-of-pocket cost information with patients that reflects the patient's Medigap coverage?

AHPA recommends that CMS require Medigap payers to comply with the electronic 270/271 eligibility and benefit transactions. Without this information, hospitals will not be able to inform Medigap patients of their out-of-pocket costs.

Disproportionate Share Hospital (DSH) and Uncompensated Care Payments

CMS proposes to continue its transition to using Worksheet S-10 of the Medicare cost report to determine a hospital's uncompensated care payments. In combination with proxy data, hospital payments would be distributed based on one year of low-income patient days and two years of uncompensated care costs (derived from 2014 and 2015 Worksheet S-10 data). This appears to indicate an intent by CMS to base future uncompensated care disbursements solely on Worksheet S-10 data for FY 2020 and beyond.

As recognized in the rule, uncompensated care costs reported on Worksheet S-10 have often been erroneous due to lack of clarity about how the information should be reported. We commend CMS on acknowledging this ambiguity, releasing clarifying instructions and permitting a four-month resubmission period. Despite this allowance, many hospitals find this four-month window insufficient to address the corrections needed. **To maximize data validity, AHPA recommends that CMS provide hospitals with additional time for correction.** We also encourage the Agency to provide further educational resources to ensure that hospital data is consistently reported for use in calculating uncompensated care payments.

Lastly, AHPA recommends for the data reported to be audited by Medicare Administrative Contractors in a consistent manner. In a white paper produced by the California Hospital Association, Worksheet S-10 data was found to still contain egregious errors and inaccuracies. For example, unclear instructions on charity care line items resulted in hospitals accidentally "double-counting" uncompensated care costs.[7] These inaccuracies could lead to inappropriate uncompensated care payments. Therefore, we urge the Agency to standardize and audit the reporting of the data before continuing its transition to using Worksheet S-10 data.

Inpatient Admission Orders

CMS proposes to eliminate the requirement that hospitals include an Inpatient admission order in the medical record. The Agency believes this is necessary to eliminate denials due to technical deficiencies in the Inpatient order. Specifically, CMS explains that "it has come to our attention that some otherwise medically necessary inpatient admissions are being denied payment due to technical discrepancies with

[7] California Hospital Association. Technical Whitepaper Regarding Improvements to S-10.

the documentation of inpatient admission orders such as missing co-signatures or authentication signatures, and signatures occurring after discharge."

We commend CMS for its efforts to address inappropriate payment denials resulting from technical issues in the Inpatient admission order. **However, we are concerned that removing the requirement for a written Inpatient admission order may have the unwanted consequence of increasing patient risk of delayed care or inappropriate care.** We agree that a focus on medically reasonableness and necessary care by the Medicare Administrative Contract (MAC) requiring consideration of all documentation should be addressed or clarified. Denying payment should not rest on a technicality when it is clear that Inpatient care was needed and provided. We also agree that unnecessary administrative burdens deriving from redundant documentation should be avoided if possible. There should be a balance between burdensome documentation and good communication resulting in efficient clinical care. We believe CMS' proposal fails to reach this balance because the omission of a complete Inpatient admission order will likely result in less efficient and delayed care. Furthermore, in the absence of such order, the determination of whether it was the intent of the physician to admit a patient would *always* fall to the discretion of the MAC. Because intent can be highly subjective and open to different interpretations, this will likely lead to increased denial rates.

Eliminating the need for an Inpatient admission order will affect the implementation of other Medicare regulations such as the Two-Midnight rule, the three-day Inpatient rule for Skilled Nursing Facilities (SNF), the Medicare Outpatient Observation Notice (MOON) and Condition Code 44. Below we explain the reason for this belief.

Two-Midnight Rule

The Two-Midnight rule amended the Medicare Conditions of Participation (CoPs) to require an Inpatient admission order. If CMS proceeds with its proposal, the Agency would have to revise the CoPs to clarify that an order is no longer a condition for Medicare Part A payment. At a minimum, the Inpatient admission order should be able to be signed after the patient's discharge since in many cases the physician provides a verbal order, but the admitting physician may not get to the record to sign the admission order until the patient is discharged. This is especially common on short stays where the hospitalist or other physicians are managing the patient's care.

Three-Day SNF Rule

Under this rule, a beneficiary is eligible for SNF coverage only when the beneficiary has been admitted to the hospital as an Inpatient for no fewer than three consecutive days. Without an Inpatient admission order, Medicare coverage of SNF services would be at risk due to issues such as lack of clarity in the medical record or a MAC's misinterpretation of physician intent. Denial of such needed services would negatively impact patients' health.

MOON Form

Hospitals must use the MOON form to comply with the Notice of Observation Treatment and Implication for Care Eligibility (NOTICE) Act. The form is provided to patients receiving Outpatient Observation services to inform them of their status and the financial implications of such status. Without an order

clearly stating the patient's status, the parties responsible for providing the MOON form may misinterpret the physician's intent and omit providing such crucial information to the patient. This would put the hospital in violation of the NOTICE Act and cause confusion among patients.

Use of Condition Code 44: Inpatient Admission changed to Outpatient

Condition code 44 is used when an Inpatient admission is changed to Outpatient status prior to the patient being discharged from the hospital. According to Chapter 1 of Medicare's Claims Processing Manual, condition code 44 should only be used when the physician *orders* Inpatient services but upon internal utilization review, determines that the services do not meet Inpatient criteria. We seek clarification on whether condition code 44 could still be used by hospitals without the presence of an Inpatient admission order. The inability of hospitals to use such code could result in inappropriate payments.

Due to the issues presented above, we ask that CMS *not* eliminate the requirement of having an Inpatient admission order in the medical record. **Instead, we recommend that CMS change the audit requirements for contractors so that claims are not denied solely on technical issues found in the Inpatient admission order.** The Agency could amend its Medicare Manual to clarify that if an Inpatient admission order is deemed defective, the contractor should look at the *entire* medical record to make a determination regarding the physician's intent to admit the patient. We believe that this solution would more effectively address inappropriate denials due to errors found in an Inpatient admission order.

Long-Term Care Hospital (LTCH) 25 Percent Threshold Policy

CMS proposes to rescind the 25 percent threshold policy that applies to LTCHs. Under this 25 percent threshold policy, certain LTCHs cannot have more than 25 percent of their discharges come from a single referring hospital. For LTCHs exceeding the 25 percent patient threshold, CMS reimburses the LTCH at the lower payment rate for general acute care hospitals. This policy seeks to limit incentives for acute care hospitals and LTCHs to join and split a single episode of care into separate acute hospital and LTCH stays.

AHPA supports the elimination of the 25 percent threshold rule as this policy conflicts with the current legislative and regulatory environment. For example, the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) requires that hospitals assist patients and their representatives to select Post-Acute Care (PAC) providers by sharing data on quality and resource use measures during the discharge planning process. If, based on that data, a greater number of patients choose a LTCH that provides higher quality of care, then the LTCH would be financially penalized for those patient choices if it exceeds the 25 percent threshold. Health care providers should not be placed in a position of telling patients and their families that they must go to a lesser quality facility because the better one already reached its cap. Therefore, AHPA strongly supports eliminating the 25 percent threshold rule.

Inpatient Quality Reporting (IQR) Program

New Measure Removal Factor

Beginning in FY 2019, CMS proposes the adoption of an additional measure removal factor to the IQR program. If finalized, the new factor would remove measures in which it is determined that the costs associated with the measure outweigh the benefit of its continued use in the program.

AHPA supports the adoption of this new removal factor as it will reduce administrative burden and promote efficiency within the IQR program.

Measures Proposed for Removal

As part of its Meaningful Measure Initiative, CMS proposes to remove 39 measures from the IQR program over a period of four fiscal years beginning in the FY 2020 payment determination. The proposed measures for removal include:

Measures Proposed for Removal in FY 2020

- Safe Surgery Checklist Use
- Hospital Survey on Patient Safety Culture
- Patient Safety and Adverse Event Composite (PSI 90) (NQF# 0531)
- Hospital 30-Day, All-Cause, Readmission Rate Following Acute Myocardial Infarction (AMI) Hospitalization (NQF# 0505)
- Hospital 30-Day, All-Cause, Readmission Rate Following Coronary Artery Bypass Graft (CABG) Surgery (NQF# 2515)
- Hospital 30-Day, All-Cause Readmission Rate (RSRR) Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization (NQF# 1891)
- Hospital 30-Day, All-Cause, Readmission Rate Following Heart Failure (HF) Hospitalization (NQF #0330)
- Hospital 30-Day, All-Cause, Readmission Rate Following Pneumonia Hospitalization (NQF# 0506)
- Hospital-Level 30-Day, All-Cause, Readmission Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (NQF# 1551)
- 30-Day Readmission Rate Following Stroke Hospitalization (READM-30-STK)
- Medicare Spending Per Beneficiary (MSPB) (NQF# 2158)

Measures Proposed for Removal in FY 2021

- National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) (NQF #1717)
- NHSN Catheter-Associated Urinary Tract Infection (CAUTI) (NQF #0138)
- NHSN Central Line-Associated Bloodstream Infection (CLABSI) (NQF #0139)

- NHSN Facility-wide Inpatient Hospital-onset Methicillin-Resistant Staphylococcus Aureus Bacteremia (MRSA) (NQF #1716)
- American College of Surgeons – Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure (NQF #0753) (Colon and Abdominal Hysterectomy SSIs)
- IMM-2: Influenza Immunization (NQF# 1659)
- VTE-6: Incidence of Potentially Preventable Venous Thromboembolism Measure (VTE)
- Emergency Department (ED) -1: Median Time from ED Arrival to ED Departure
- ED-2: Admit Decision Time to ED Departure Time from Admitted Patients

Measures Proposed for Removal in FY 2022

- Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following CABG Surgery (NQF# 2558)

Measures Proposed for Removal in FY 2023

- Hospital-Level Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) Hip/Knee Complications (NQF#1550)

AHPA applauds the Agency for launching the Meaningful Measure Initiative to reduce regulatory burden through the de-duplication of measures. Therefore, we support the removal of the proposed measures from the IQR program whether or not removal factor 8 is finalized. As recognized by CMS, the removal of duplicative measures will eliminate the complexity of tracking performance on a measure that is included in multiple quality programs. Moreover, the de-duplication of measures will avoid instances in which a hospital is penalized multiple times for the same measure. While we support the proposed removals, we ask that CMS clarify how removing these measures will affect the Hospital Overall Star Ratings.

As part of the Meaningful Measure Initiative, AHPA also urges the Agency to consider *not* penalizing hospitals participating in an Alternative Payment Model (APM) for measures included in both the APM and a pay-for-performance program. We believe that if a hospital's payments are already being adjusted based on the hospital's performance on a measure in the APM, then the hospital shouldn't be penalized twice if that measure is also in a pay-for-performance program.

Electronic Clinical Quality Measures

Beginning in the FY 2022 payment determination period, CMS proposes to remove seven Electronic Clinical Quality Measures (eCQMs) from the IQR program. According to CMS, the cost of the measures below outweigh the benefit of their use.

- Primary Percutaneous Intervention (PCI) Received Within 90 Minutes of Hospital Arrival (AMI-8a)

- Home Management Plan of Care Document Given to Patient/Caregiver (CAC-3)
- Median Time from ED Arrival to ED Departure for Admitted ED Patients (NQF #0495)
- Hearing Screening Prior to Hospital Discharge (NQF #1354) (EHDI-1a)
- Elective Delivery (NQF #0469) (PC-01)
- Stroke Education (STK-08)
- Assessed for Rehabilitation (NQF #0441) (STK-10)

AHPA supports the removals of the aforementioned measures. We believe that the measures reported to CMS should be meaningful indicators, parsimonious and promote hospital quality improvement.

CMS also proposes the potential inclusion of two new eCQMs in the IQR program. Those measure are:

- The Hospital-Wide, All Cause, Risk-Standardization Mortality measure.
- The Opioid Adverse Events Measures.

Hospital-Wide, All Cause, Risk-Standardization Mortality Measure

This measure would capture mortality within 30 days of hospital admission for each hospitalized Medicare Fee-For-Service (FFS) beneficiary over the age of 65 years. This measure would include the mortality rates from 13 different service-line divisions as outlined below:

- Eight Non-Surgical: cancer; cardiac; gastrointestinal; infectious disease; neurology; orthopedics; pulmonary and renal.
- Five Surgical: cancer; cardiothoracic; general; neurosurgery and orthopedics.

CMS is considering two different measurement approaches for implementation of the Hospital-Wide Mortality measure. The first approach is the claims-only assessment. The second approach is the hybrid assessment, which would include the claims detail as well as core clinical data from the Electronic Health Record (EHR) of the patient. **If CMS finalizes this measure, AHPA recommends that CMS use the hybrid instead of the claims-only assessment approach.** Implementing the claims-only measure is analogous to the condition specific mortality measures and therefore redundant and ineffectual.

Furthermore, AHPA recommends that before implementing the measure, CMS address concerns raised by the National Quality Forum's (NQF) Measure Applications Partnership (MAP) committee. The MAP stated that the committee would support the hospital wide mortality measure but only after review and endorsement of the measure by the NQF. The NQF is responsible for reviewing the validity, reliability and feasibility of measures. The MAP also expressed concerns regarding the suitability of the clinical and social risk factors in the risk adjustment models. They noted that the measure as it currently stands may disproportionately penalize facilities who care for more medically complex patients, specifically academic medical centers and safety net providers. Therefore, AHPA recommends using a voluntary reporting period before mandatory implementation.

Hospital Harm Opioid-Related Adverse Events

The proposed measure would track how many patients are receiving opioids during their Inpatient stay. It would be calculated by using the number of patients who received naloxone outside of the operating room as a numerator. Then, counting all patients over the age of 18 who are discharged from an Inpatient encounter as a denominator to give the proportion of patients that experienced an adverse event. According to CMS, the measure could decrease the number of patients that incur harmful side effects resulting from opioids, such a respiratory depression. CMS is looking to choose one of two conditions outlined below for the calculation of the numerator.

- Numerator: the number of patients who received naloxone outside of the operating room either:
    - After 24 hours from hospital arrival.
    - During the first 24 hours after hospital arrival with evidence of hospital opioid administration prior to the naloxone administration.

AHPA supports the adoption of the Opioid-Related Adverse Events measures and commends CMS for taking a leading role in combatting the current opioid epidemic. However, AHPA recommends that the proposed measure be submitted to the NQF for review and endorsement prior to its inclusion in the IQR program. Upon review, the MAP committee raised concerns that the measure had not been tested in enough facilities to ensure reliability across hospitals. AHPA urges the Agency to further test the measure and resubmit it for consideration by the MAP. AHPA supports the committee's mission of demonstrating the reliability and validity of measures prior to implementation in the IPPS.

Potential Future Development and Adoption of eCQMs Generally

CMS requests ideas on ways to address challenges related to eCQM use. Specifically, the Agency poses the following questions:

- What aspects of eCQMs are most costly to hospitals and health IT vendors?
- What are the most significant barriers to the availability and use of new eCQMs today?
- What specifically would stakeholders like CMS do to reduce costs and maximize the benefits of eCQMs?
- How could CMS encourage hospitals and health IT vendors to engage in testing new eCQMs?

AHPA recommends that CMS improve existing partnerships with third-party health IT vendors and encourage these vendors to proactively formulate processes to capture the information required for new eCQMs. Currently, hospitals may be prevented from participating in the voluntary reporting of eCQMs because their health IT vendors are unable to extract the data needed for eCQM reporting. This would allow hospitals to preview their performance and correct reporting deficiencies prior to submitting the information to CMS.

Hospital-Acquired Condition (HAC) Reduction Program

Proposed Changes to the HAC Reduction Program Scoring Methodology

CMS proposes two alternative scoring options to improve the fairness of the HAC Program. In considering these new methodologies, CMS hopes to mitigate the disproportionately large weight applied to Domain 2 for hospitals reporting between one and four measures. The Equal Measure Weights policy, which is preferred by CMS, removes domains and applies an equal weight for each measure reported. Another option under consideration is the Variable Domain Weights approach, which would retain the current dual-domain structure and assign a different weight to each measure contingent upon the number of measures reported.

AHPA supports the adjustment of the scoring methodology to improve fairness across hospital types. We believe that the reweighting better supports the stated goal of the HAC Program to weight each measure similarly. While the Equal Measure Weights approach appears to be the most beneficial for Low-Volume Hospitals, AHPA believes that either proposal would result in a more equitable and useful scoring methodology for all hospitals.

Hospital Value-Based Purchasing (VBP) Program

Measures Proposed for Removal

CMS proposes to eliminate ten measures from the VBP program beginning in FY 2019. The intent of the proposed removals is to avoid the duplication of measures across Medicare quality programs. The measures proposed for removal are outlined below:

Measures Proposed for Removal in FY 2019

- Elective Delivery (NQF#0469) (PC-01)
- Central-line associated bloodstream infection (CLABSI)
- Surgical site infection (SSI): Colon surgery; abdominal hysterectomy
- Catheter-associated urinary tract infection (CAUTI)
- Methicillin-resistant staphylococcus aureus (MRSA) Bacteremia
- Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI)
- Patient Safety and Adverse Events Composite (NQF #0531) (PSI-90)

Measures Proposed for Removal in FY 2021

- Hospital-Level, Risk-Standardization Payment Associated with a 30-Day Episode of Care for Acute Myocardial Infarction (AMI payment)
- Hospital-Level, Risk-Standardization Payment Associated with a 30-Day Episode of Care for Heart Failure (HF payment)
- Hospital-Level, Risk-Standardization Payment Associated with a 30-Day Episode of Care for Pneumonia (PN payment)

AHPA supports the removal of the proposed measures as their removal will result in the elimination of duplicative penalties that hospital face when one measure is assessed in more than one pay-for-performance program. The removal of the measures will also help narrow the scope of the VBP program.

Removal of the Safety Domain

CMS proposes to remove the Safety domain from the Hospital VBP Program beginning in FY 2021 and redistribute the weight of the remaining three domains as follows:

- Clinical Outcomes: 50%
- Person and Community Engagement: 25%
- Efficiency and Cost Reduction: 25%

AHPA supports the removal of the Safety domain from the VBP program and the increased weight of the Clinical Outcomes domain. However, AHPA recommends that CMS reevaluate the measures in the program so that they better reflect the meaning of high quality care. While mortality, patient experience and cost are important measures of quality, they are not necessarily equivalent to high quality care. Under the current VBP program, the measures provide a limited picture of quality, failing to capture the value of improving a patient's quality of life, including the ability to perform activities of daily living. Accordingly, we recommend that CMS explore including measures that encompass a more holistic view of quality.

Promoting Interoperability (PI) Program

CMS proposes an overhaul of the Medicare and Medicaid EHR Incentive Program to focus on interoperability and improving the accessibility of patient health information. To better reflect this focus, the program would be renamed the Promoting Interoperability (PI) Program. Additional proposed changes include an updated scoring methodology and the introduction of new measures. Finally, CMS is considering requiring hospitals to electronically transfer patient information to providers and third-party applications upon patient request.

PI Program Proposed Scoring Methodology

CMS proposes to convert the scoring methodology for eligible hospitals to be performance-based, rather than threshold-based. The number of required measures under this new methodology would be decreased from 16 to 6 and each measure would contribute to the total PI score. CMS' intent is to reduce burden and provide greater flexibility to hospitals while maintaining the intent of the program. If the new scoring methodology is *not* adopted, CMS proposes maintaining the current Stage 3 methodology, incorporating the new opioid-related measures.

AHPA strongly supports the proposal that moves the PI Program to a performance-based measure program and away from thresholds. Interoperability efforts are currently the cornerstone of many

health organizations' IT roadmaps. We believe that CMS is on the right track in shifting the focus from measure compliance on data points in EHRs, to more interconnected provider-patient relationships.

If the PI is not finalized as proposed for 2019, we believe participants in the program should have the option to continue with Modified Stage 2 measures for one more year in 2019. EHR vendors are currently struggling to finalize coding for Stage 3 measures midway through 2018. It will likely be difficult for vendors to have all functionality and reporting capabilities ready for their clients in another six months, given the many regulatory programs for which they code and build functionality. This will impact hospitals' ability to attest to the program. The continuation of Modified Stage 2 measures for one more year will allow program participants to comply with the program requirements while continuing to work with vendors and within their organizations to move towards interoperability. This also achieves CMS' goal of reducing administrative burden and achieving greater flexibility.

PI Program Proposed New Measures

CMS proposes the introduction of new measures to improve prescribing practices for controlled substances. These new e-Prescribing measures would be optional for 2019 and become mandatory beginning in 2020. Below are the proposed measures:

- Query of Prescription Drug Monitoring Program (PDMP)
- Verify Opioid Treatment Agreement

New e-Prescribing Measure: Query of the PDMP

This measure would assess the number of Schedule II opioid prescriptions for which Certified EHR Technology (CEHRT) data are used to conduct a query of a PDMP for prescription drug history as a percentage of the number of all Schedule II opioids electronically prescribed using CEHRT.

AHPA believes that this requirement should remain at the state level to avoid creating duplicative or conflicting data collection or reporting requirements. Currently, there are 49 states that have PDMPs that are accessed via a web interface. We recognize that the benefits of querying the PDMP outweigh the burden of changed workflow; however, it may take significant time and resources from both hospitals and vendors to implement such measure.

We urge the Agency to make this measure voluntary and eligible for bonus points in 2019. This would allow for further development of the PDMP program at both the state and national level. An exclusion should also be available for providers who operate in states that may not be ready to have incoming PDMP queries and allow for the potential points for this measure to be shifted to another reported measure.

We also recommend that the PDMP be accessible via the CEHRT. Accessing the PDMP through this method will increment the numerator and capture at least one unique patient. **If CMS proceeds to implement this measure, we recommend that the Agency limit the denominator for this measure to**

unique patients and not to individual medication prescribed. This would help reduce administrative burden.

Additionally, AHPA opposes using a manual numerator and denominator for this measure. As currently proposed, the measure requires manual data collection activities, which would be significantly burdensome for hospitals to conduct. Manual entry and calculation of any measure is always risky. The validity of the data collected and reported in this manner can generally be considered suspect and records can be difficult to produce. **Instead of using manual data collection, we recommend that CMS use a Yes/No reporting feature similar to previous Clinical Data Support or Public Health attestation.** In subsequent years, EHR vendors should be required to have a reporting functionality in place to gather and calculate this data similar to current reporting practices used for e-Prescribe.

New e-Prescribing Measure: Verify Opioid Treatment Agreement

This measure would assess the percentage of patients who were prescribed a Schedule II opioid during the EHR reporting period and for whom the hospital obtained a signed opioid treatment agreement and incorporated it into the CEHRT.

AHPA strongly opposes the adoption of this measure. While we agree that there needs to be additional measures in place to prevent opioids' misuse, standardized formats for treatment agreements that can be tracked electronically through an e-Prescribing method are currently lacking. This makes the transmission of treatment agreements via a health information exchange or other secure electronic method difficult. While the proposal references various pilots that may facilitate the identification of opioid treatment agreements, these pilots only capture behavioral health patients. Therefore, we do not believe the pilots are a truly viable blueprint for increasing the availability of these documents. We urge CMS to remove this measure from consideration until such time as a standardized electronic format for opioid treatment agreements can be developed.

AHPA is also concerned that the proposed measure is not being required in a standardized language, content or electronic format. We believe that further clarification about the measure is needed before including it as part of the PI program. CMS should define the content structure and minimal requirements for an opioid treatment agreement. We recommend that an opioid treatment agreement include the most recent refill information, amount filled/refilled and diagnoses for treatment. The agreement should also be provided in a Consolidated Clinical Document Architecture (CCDA) template format.

PI Program Proposed Measures for Removal

Removal of the View, Download or Transmit (VDT) Measure

AHPA does not support the removal of this measure. We believe that VDT plays an important role in encouraging and enabling patients to access their health records. In addition, the measure promotes patient engagement in the continuum of care through the use of patient portals and the services that can be provided within them. Instead, we propose that CMS consider allowing VDT to remain in the PI program

as a bonus measure. This would allow providers who have invested enormous human and financial resources engaging patients in novel ways to reap the benefits of those efforts.

CMS argues that it is removing this measure based on concerns raised by stakeholders about measures that require patient actions for successful provider attestation. Although this could be true for this measure, we see the proliferation of new media and digital solutions as not only a regulatory requirement but also as part of the industry's shift to providing consumer-centric care. **Therefore, we recommend that CMS continue to include this measure in the PI program as a bonus measure worth five points.**

Removal of Patient Generated Health Data

AHPA supports the removal of the Patient Generated Health Data. While data related to home monitoring, such as blood pressure and glucose readings, may assist clinicians in the treatment of chronic conditions, the appropriateness of this measure to an Inpatient setting has been difficult to operationalize. The types of data CMS prescribed for the Stage 3 measure are generally regarded as useful for ambulatory rather than Inpatient settings. Therefore, we urge the Agency to remove this measure.

Electronic Referral Loops by Receiving and Incorporating Health Information

CMS proposes to remove the Request/Accept Summary of Care Measure and the Clinical Information Reconciliation Measure and replace these two measures with the Support Electronic Referral Loops by Receiving and Incorporating Health Information measure. CMS also proposes to adopt an exclusion for this measure so that any eligible hospital that is unable to implement the measure for a reporting period in 2019 would be excluded from having to report this measure.

AHPA conditionally supports the proposed new measure based on EHR vendors' capability to provide automated tools that remove duplicates and provide meaningful information for clinicians to reconcile. Without this capability, clinicians would be left to do significant manual reconciliation work that can be administratively burdensome. Once this issue is addressed, we believe the measure would be beneficial. Reconciling clinical information can decrease the amount of duplicative medications, clean up problem lists and generally allow Inpatient clinicians to have a better understanding of the patient's overall health. We also support the numerator and denominator used for this measure.

Public Health and Clinical Data Registry Reporting Objective Measures

CMS proposes requiring hospitals to attest to the Syndromic Surveillance Reporting measure and at least one additional measure from the following options: Immunization Registry Reporting; Clinical Data Registry Reporting; Electronic Case Reporting; Public Health Registry Reporting; and Electronic Reportable Laboratory Result Reporting.

AHPA supports the requirement of the Syndromic Surveillance Reporting measure and encourages the inclusion of state immunization registry reporting in this objective. Immunization registries with required bidirectional capabilities help provide accurate records across the continuum of care and reduce the potential for duplicative therapies. If CMS chooses not to include immunization registry reporting as a

required measure, we suggest awarding a five-point bonus for having bidirectional capabilities and accessing/querying state registries via the HL7 interface.

Maintaining eCQM Reporting Requirements

AHPA recommends that CMS align the eCQMs and the PI program so that they share the same reporting framework. This is critical to reducing the complexity of the programs, a goal stated by CMS in this rule. Aligning both eCQM and PI to one consecutive 90-day reporting period would eliminate confusion among providers. It would also reduce the administrative burden currently experienced within organizations to coordinate with both vendors and internal teams to report on separate timeframes. Additionally, aligning the reporting requirements of these programs would allow health systems to focus more on patient care and less on the coordination of regulatory compliance activities.

Conclusion

AHPA welcomes the opportunity to further discuss any of the recommendations provided above. If you have any questions or would like further information, please do not hesitate to contact Julie Zaiback-Aldinger, Director of Public Policy and Community Benefit, at Julie.Zaiback@ahss.org.

Sincerely,

Jeff Bromme
President
Adventist Health Policy Association