July 7, 2020

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1735–P
Submitted electronically to: http://www.regulations.gov

Re: CMS–1735–P Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Proposed Policy Changes and Fiscal Year 2021 Rates

Dear Administrator Verma:

On behalf of the Premier healthcare alliance serving approximately 4,000 leading hospitals and health systems, hundreds of thousands of clinicians and 175,000 other provider organizations, we appreciate the opportunity to submit comments on the Centers for Medicare & Medicaid Services (CMS) FY 2021 proposed rule for the Medicare Inpatient Prospective Payment System (IPPS). Premier healthcare alliance, a 2006 Malcolm Baldrige National Quality Award recipient, maintains the nation's most comprehensive repository of hospital clinical, financial and operational information and operates one of the leading healthcare purchasing networks. Premier healthcare alliance, plays a critical role in the rapidly evolving healthcare industry, collaborating with members to co-develop long-term innovations that reinvent and improve the way care is delivered to patients nationwide. Our comments primarily reflect the concerns of our owner and member hospitals and health systems which have a vested interest in the effective operation of the IPPS. Below, the Premier healthcare alliance provides detailed comments with suggested modifications to the policies proposed by CMS.

PRICE TRANSPARENCY AND MARKET-BASED MS-DRGS

The Administration has expressed continued interest in increasing consumer choice and promoting competition in the healthcare market. Last fall, CMS finalized a Hospital Price Transparency Rule (84 FR 65538), which would require hospitals to make certain information publicly available beginning January 1, 2021. Under this policy, hospitals must make public a consumer-friendly list of negotiated rates for at least 300 shoppable services and must publish all payer-negotiated rates for all items and services in a machine-readable file.

CMS proposes to build on this policy by requiring hospitals to submit information through their cost reports on median-negotiated rates by both Medicare Advantage (MA) plans and all third-party payers. CMS notes it may utilize this information in the future to reform how it establishes the MS-DRG weights. CMS believes this policy will reduce reliance on hospital chargemasters and inject more market pricing into Medicare payment rates.

While the Premier healthcare alliance supports improving the efficiency of care and ensuring payments are set appropriately, using negotiated rates for the MS-DRG relative weights has several significant flaws. The policy will not result in market-based rates, but instead will introduce new distortions and inaccuracies into how MS-DRG rates are set. Additionally, reporting median negotiated rates will place

significant burden on hospitals, which CMS grossly underestimates in the proposed rule. We have provided additional information on these points below.

We strongly urge CMS to not finalize its proposal to require hospitals to report median negotiated rates on cost reports. Instead, CMS should develop a multi-payer voluntary demonstration that would allow providers to work with CMS to explore ways to rebase and reset relative costs based on market data.

Hospital Price Transparency Policy

Premier continues to strongly oppose the Hospital Price Transparency policy. While we support price transparency and believe CMS should work to help consumers understand price information, providing negotiated rates via the internet will not address CMS' concerns with price transparency and will not provide meaningful information to consumers. The policy will force hospitals to violate contracts and could actually discourage competition and ultimately drive up costs.

Additionally, standard charges and negotiated rates are also not useful to patients in that they do not consider contractual allowances, plan coinsurance structures, charity care policies and mission driven expenses, such as teaching programs. Most consumers also only bear a fraction of the cost of their care because of cost-sharing. As a result, posting standard charges or negotiated rates will do little to help consumers make more informed decisions about their healthcare. Moreover, it is difficult to identify the actual costs associated with care because the components, such as staffing, overhead, and materials costs, are accounted for inconsistently across the healthcare systems. Consumers ultimately need information on their financial responsibility for co-payments or coinsurance, as well as progress toward meeting relevant deductible and/or out-of-pocket maximums.

CMS has cited its belief that the price transparency policy will promote competition in the healthcare marketplace and lead to lower healthcare costs for consumers. While these are goals that Premier supports, we believe that the policy will not achieve either of them. Rather, the policy instead interferes with ongoing efforts in the private sector to leverage the benefits of private sector competition to advance both quality of care and value of healthcare services.

The Federal Trade Commission (FTC) has reacted negatively to efforts at the state level that require public disclosure of competitively sensitive information, especially with respect to price and costs negotiated between providers and insurers.[1] ***According to the FTC, the public disclosure of privately negotiated rates and other similar competitively sensitive information could restrict competition***; this is due in part to the increased likelihood of collusion among the parties.[2] The FTC believes there is a substantial risk of anticompetitive behavior where competitively sensitive information becomes available to competing healthcare providers. The problem is exacerbated in healthcare markets that are highly concentrated and where provider competition is already limited. Further, this type of mandate also undermines the effectiveness of selective contracting by health plans; the FTC believes that selective contracting reduces healthcare costs and improves overall value in the delivery of healthcare services.[3]

[1] https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-regarding-amendments-minnesota-government-data-practices-act-regarding-health-care/150702minnhealthcare.pdf.
[2] Ibid.
[3] Ibid.

Making proprietary information on negotiated rates publicly available will undermine competition and inevitably lead to higher prices for healthcare services. This will not help beneficiaries, and it will not achieve the goals the agency seeks to advance.

CMS' price transparency policy will also require hospitals to violate their existing contracts. While each insurance company, group health plan, employer plan and other payor has their own set of terms and conditions when contracting with hospitals for the delivery of healthcare services to their enrollees, it is common for those contracts to prohibit disclosure by the hospital of the rates the parties have agreed to in negotiations. There are consequences for violating those contractual terms or conditions.

Additionally, the Medicare statute currently prohibits the disclosure of certain rate information, in this case by the agency itself. For example, section 1834A(a) of the Act requires certain laboratories, including hospital laboratories, to report to CMS private payor rates for laboratory services. The Secretary may not disclose those rates in a way that would permit the identification of a specific payor or laboratory or the prices charged or payment made to the laboratory. Yet the agency's transparency proposal would force hospitals to disclose the very information that CMS is prohibiting from disclosing.

CMS should take steps to ensure patients have the price information they need. However, as noted above, the information that CMS is requiring hospitals to submit will not be useful to patients. Ultimately, payers have the best access to this information and providers do not consistently have ready access to this information. ***Accordingly, CMS should work with payers to ensure providers have consistent access to real-time beneficiary cost estimate tools. We urge CMS to utilize its other regulatory authorities to help hospitals gain access to MA claims information from payers. This will enable providers to better manage and reduce the costs of the patients they serve.***

Market-Based MS-DRGs

In order to reduce the Medicare program's reliance on hospital chargemasters and to advance the Administration's goals of market competition, CMS proposes to require hospitals to report certain market-based information on their Medicare cost reports. Under this proposal hospitals would be required to report the median rate the hospital negotiated with MA organizations and the median rate the hospital negotiated with all third-party payers (including MA organizations) for each MS-DRG for cost reporting periods ending on or after January 1, 2021. CMS may use this information to revise how it calculates the IPPS MS-DRG relative weights in the future. CMS also seeks comment on a methodology that would incorporate the median MA rates into setting MS-DRG relative weights.

CMS' proposal builds on many of the same policies finalized in the Hospital Price Transparency rule. As a result, many of the same concerns noted above persist with this new proposal. Cost report data is ultimately made public and could ultimately have a detrimental effect on competition and require hospitals to violate contracts and report proprietary information.

Median negotiated rates do not reflect true market-based pricing. In the proposed rule, CMS highlights its concerns that hospital chargemasters do not reflect true market costs. CMS presumes that MA and commercial rates reflect competitive negotiations between hospitals and commercial plans, including MA. While this may be the case for some markets and individual hospitals, other factors may contribute to the rates paid by MA plans and private insurers , including whether rates are set based on Medicare fee-for-service or the level of competition (between either hospitals or payors) in the individual hospital's market.

Using median negotiated MA rates for the IPPS relative weights is based on the false premise that MA rates are freely negotiated and reflect competitive market forces. However, many MA-specific rates are

set based on Medicare fee-for-service, and therefore are reflective of the existing MS-DRGs. In the preamble of the regulation, CMS notes that its "research suggests that payer-specific charges negotiated between hospitals and MA organizations are generally well-correlated with Medicare IPPS payment rates." If that is the case, there would be no point in adopting MA rates in place of the current relative weight system as it would lead to little or no change in the final rates but would impose significant burden on hospitals. Even for those plans that do set rates independent of the IPPS rates, the plans are still limited by Medicare fee-for-service regulations and MA-specific policies set by the government. CMS seeks comment on a potential proposal that would base MS-DRGs weights on median negotiated rate by MA organizations. However, for the reasons noted above, it is unlikely that setting rates based on rates negotiated by MA plans would result in true market-based rates.

Without insight into whether commercial rates are reflective of true market-based negotiations, CMS is committing itself to a new metric that could be less accurate than its current methodology. Section 1886(d)(4)(B) requires that the Secretary establish MS-DRG weights that reflect the relative hospital resources within a DRG relative to the average across all DRGs. As detailed below, we are concerned that use of median negotiated MA or third-party payor rates may introduce new distortions into the MS-DRG methodology that will result in weights that no longer reflect the resources required to furnish care to the Medicare population.

CMS acknowledges that not all payer-specific rates will be based on MS-DRGs. For example, some hospitals may negotiate rates on a per diem basis. As a result, hospitals will have to use their own discretion to crosswalk these other rate-setting mechanisms to MS-DRGs, which may not always be feasible. In doing so, hospitals may apply different methodologies, which may not reflect the true cost of care in these hospitals and may introduce new distortions into the rate-setting process.

Additionally, since non-MA commercial plans typically serve a different demographic than the general Medicare population, commercial rates may not be truly reflective of the resource utilization needed to care for Medicare beneficiaries, who often have higher complications and comorbidities than the general population. Given that MS-DRG weights are set in a budget neutral manner, this proposal may have the effect of shifting payments in a less informed and less precise manner.

Proposal will create significant burden for hospitals. Finally, CMS states that it expects its proposal will pose minimal burden because hospitals could utilize data they are required to report under the Hospital Price Transparency rule to calculate the median negotiated charges. CMS estimates that this proposal will create an average annual burden of 15 hours per hospital. ***CMS grossly underestimates the amount of time it will take hospitals calculate and report median rates by MS-DRG.***

The current proposal requires hospitals to report median negotiated rates based on MS-DRG, whereas hospitals are required to publicly report charges for each item and service under the Hospital Price Transparency regulation. Hospitals do not typically negotiate rates at the individual item or service level. As a result, hospitals will likely need to calculate the median based on additional information or to go through a manual process of calculating MS-DRGs based on the price transparency data.

The regulation cites a simplified example where a hospital negotiates payments with four different MA organizations and the process whereby a hospital would calculate the median for seven discharges for a certain MS-DRG. This example grossly oversimplifies the process that most hospitals will undertake. For example, a health system operating in numerous states will have multiple contracts for each individual hospital, within each state, and with each payer. This could result in the system needing to array the rates for hundreds of discharges for a given MS-DRG across more than 300 different payor contracts in order to determine the median.

Additionally, as CMS notes in the preamble, some third-party payers do not pay based on MS-DRGs. As a result, hospitals will need to calculate an MS-DRG based on the same or similar package of services. This process becomes even more complicated if commercial plans do not pay the hospital based on fee-for-service rates. ***As a result, this proposal places significantly higher burden on hospitals than what is reported in the proposed rule***. We urge CMS to revise this estimate and to take this into consideration when assessing this proposal.

Given there is limited information on whether hospital payments by third-party payers are truly based on competitive market-based negotiations, we recommend that CMS ***establish a multi-payer voluntary demonstration that would allow providers to rebase and reset relative costs within their chargemasters***. Private payers would need to develop a hold harmless to ensure provider payments do not drop significantly by reducing charges. CMS would need to waive cost reporting rules and make adjustments to the payment systems that rely on cost to charge ratios for rate setting. Recognizing this would require significant effort, CMS should provide technical assistance as well as funds to providers during a transition period when participants would need to submit cost reports under the old system and a new system. Demonstration participants would provide ongoing feedback to CMS regarding the initiative.

Proposal does not promote movement to value-based care. We also note that CMS' proposal is fee-for-service centric and conflicts with the Administration's commitment to value-based healthcare. Last fall, CMS committed to the Healthcare Payment Learning and Action Network's goal that 50 percent of Medicare payments would be tied to quality and value by 2022 and 100 percent of payments would be tied to these metrics by 2025. Many commercial payers have also committed to moving from fee-for-service and have introduced their own alternative payment structures.

As hospitals and other entities move to value-based care, it will be difficult for providers to crosswalk alternative payment arrangements for purposes of reporting under this proposal. For example, it will be challenging, if not impossible, for a hospital to calculate a MS-DRG based on its global budget or the capitated payments it receives to manage a certain population. As a result, the policy would place significant burden on those entities participating in advanced alternative payment models and could further distort any calculations that use these rates.

Establishing a policy that ignores value-based arrangements stymies the progression to value. Additionally, the proposed policy will become less meaningful as more hospitals move toward value-based care. The Administration should be focused solely on policies that move providers from fee-for-service to value. ***We encourage CMS to focus on reforms that move the entire healthcare system away from fee-for-service toward greater value.***

DISPROPORTIONATE SHARE HOSPITAL (DSH) AND UNCOMPENSATED CARE

CMS estimates that approximately $7.8 billion will be available in uncompensated care payments for qualifying IPPS hospitals in FY 2021, which is a 6.4 percent decrease from FY 2020. Since FY 2014, CMS has calculated uncompensated care payments as the product of three factors:

- *Factor 1:* 75 percent of the aggregate DSH payments that would be made in the absence of the Affordable Care Act (ACA)
- Factor 2: The ratio of the percentage of the population insured in the most recent year to the percentage of the population insured prior to ACA implementation; and

- Factor 3: A hospital's uncompensated care costs for a given time period relative to uncompensated care costs for that same time period for all hospitals that receive Medicare DSH payments.

Factor 1

CMS Office of the Actuary estimates Factor 1 based on the most recent available data and adjusts this estimate to account for inflation and changes in utilization and case-mix. Since the FY 2020 IPPS Final Rule, CMS has updated several of its assumptions, which have led to a nearly $1 billion decrease (or -7.4%) in Factor 1 in FY 2021 as compared to FY 2020.

The primary driver of this decrease is changes in CMS assumptions around the "Other Factor," which includes various adjustments to payment rates not accounted for by the update, case-mix, or discharge factors. The Other Factor also includes a factor for Medicaid expansion due to the ACA. To-date, CMS has provided minimal transparency of how the Other Factor is calculated. Given the significant change in Factor 1 since FY 2020, ***we encourage CMS to provide additional information on the calculation of Factor 1***, including the parameters around any assumptions CMS made in this calculation.

More importantly, CMS' estimate of Factor 1 does not appear to take into account how Medicaid enrollment will be affected by the COVID-19 public emergency. The Other Factor that includes Medicaid enrollment has a small reduction for FY 2020 and a small increase for FY 2021. However, job loss from the COVID-19 public health emergency is certain to have increased Medicaid enrollment beginning in March of 2020. The Urban Institute estimates that between 12 and 21 million people will gain Medicaid coverage as a result of losing employer sponsored insurance (ESI) due to the economic dislocation of the COVID-19 public health emergency.[4] Kaiser Family Foundation estimates that of the 27 million people losing ESI as of May 2, 2020, nearly half (12.7 million) are eligible for Medicaid.[5] If the economy does not recover in FY 2021, these increases in Medicaid enrollment can be expected to continue.

Factor 2

Factor 2 is used to adjust Factor 1 based on the change in uninsured since implementation of the ACA. Since FY 2018, CMS uses uninsured estimate from the National Health Expenditures Accounts (NHEA). With the ongoing COVID-19 pandemic, there has been an unexpected spike in unemployment, which has unfortunately led to a rise in the uninsured. ***We encourage CMS OACT to build in the effects of the COVID-19 public health emergency into its model to estimate the percent of uninsured for FY 2021.***

Factor 3

CMS proposes to continue its policy of using one-year of audited Worksheet S-10 data for use in Factor 3 in determining the distribution of uncompensated care. If finalized, CMS would use data from the FY 2017 cost report for determining uncompensated care distributions in FY 2021. CMS also proposes that for subsequent years that it would use the most recent single year of cost report data that has been audited.

[4] Bowen Garrett and Anuj Gangopadhyaya, How the COVID-19 Recession Could Affect Health Insurance Coverage, Urban Institute, May 2020.
[5] Rachel Garfield, Gary Claxton, Anthony Damico and Larry Levitt, *Eligibility for ACA Health Coverage Following Job Loss,* Kaiser Family Foundation, May 13, 2020.

As stated in the past, ***the Premier healthcare alliance prefers the Worksheet S-10 data as the source for calculating uncompensated care payments*** and commends CMS for actions it has taken to improve the quality of this data through audits and revisions to the Worksheet S-10 instructions. However, we continue to be concerned about the stability of the allocation from year-to-year. As a result, we continue to encourage CMS to use an average of three years of data when calculating Factor 3. Once the distribution of uncompensated care payments stabilizes from year-to-year as a result of improved cost reporting instructions and multiple years of audits, CMS could consider whether to drop from three years of data to two or one year of data.

While our recommendation to continue using three years of data in the uncompensated care distribution will smooth out the variation in uncompensated care values, it may not be sufficient. If after auditing the data, applying trim points and using a three-year rolling average of data there is still a significant negative impact at the hospital level, CMS should consider additional transition policies. Medicare has a longstanding history of transitioning in policies with significant impacts on providers. For example, inclusion of MS-DRGs and the decennial census data used a three-year transition period. CMS should consider a series of transition polices such that no hospital experiences more than a 5 percent decrease in overall uncompensated care payment in any given year.

Auditing Worksheet S-10

As a fixed pool of uncompensated care payments is available to distribute to eligible hospitals, Premier healthcare alliance believes it is essential that CMS audit all hospitals receiving these payments so that a consistent set of rules and protocols applies uniformly nationwide. Nevertheless, if CMS' audit resources are limited, we commend CMS for focusing its limited audit resources on those hospitals that receive that highest amount of uncompensated care payments.

We appreciate the effort CMS has put forth to ensure Worksheet S-10 instructions are clear. CMS should continue to revise the instructions associated with the Worksheet S-10 to ensure additional clarity. For example, some stakeholders have expressed concern with the lack of consistency that the Medicare Administrative Contractors (MAC) apply to audits – both across MAC jurisdiction and across auditors within the same MAC. This has resulted in auditors requesting hospitals to resubmit information in completely different formats than what is required by their usual MAC or hospitals having to submit different information depending on the individual auditing them. ***We urge CMS to work with their MACs to establish consistent auditing practices and to provide greater transparency on auditing protocols, such as making audit instructions publicly available.*** Additionally, CMS should consider implementing a fatal edit to ensure the S-10 is complete and internally consistent and instruct the MACs to audit negative, missing or suspicious values.

Definition of Uncompensated Care

For purposes of calculating Factor 3 and uncompensated care costs, CMS defines "uncompensated care" as the amount on line 30 of Worksheet S-10, which is the cost of charity care and the cost of non-Medicare bad debt. CMS continues to exclude Medicaid shortfalls reported on Worksheet S-10 from the definition of uncompensated care for purposes of calculating Factor 3. As we have previously commented, the Premier healthcare alliance believes that CMS should capture the fact that many of the states do not fully cover the costs associated with the newly insured Medicaid recipients.

Among other reasons, CMS notes that including Medicaid shortfalls in the calculation would represent a form of cross-subsidization from Medicare to cover Medicaid costs, a general policy that CMS and the

Medicare Payment Advisory Commission have not supported. However, as the policy stands, Medicare will be significantly subsidizing those states with Medicaid payment rates that cover the cost of care relative to those with lower Medicaid payment rates that do not cover the cost of care. This problem is further compounded if a state has higher Medicaid enrollment if its payment rates do not cover the cost of care and the state has high Medicaid enrollment either because it has expanded under the ACA, has more permissive Medicaid eligibility criteria, or simply has a high proportion of its citizens that qualify for Medicaid. ***The Premier healthcare alliance again urges CMS to include Medicaid shortfalls in the definition of uncompensated care.***

Effects of the COVID-19 Public Health Emergency

The COVID-19 pandemic will likely result in significant anomalies in the FY 2020 (and possibly FY 2021) cost reports, which will impact future uncompensated care distributions. We encourage CMS to explore mechanisms to minimize any negative effect that these anomalies may have on future distributions. As part of this process, CMS should seek stakeholder input.

HIP AND KNEE JOINT REPLACEMENTS

Based on claims data analysis and input from its clinical advisors, CMS proposes to create two new MS-DRGs (MS-DRGs 521 and 522) for hip replacements with a principal diagnosis of hip fracture. CMS specifically seeks comment on what effect this would have on the Comprehensive Care for Joint Replacement (CJR) model, an ongoing Innovation Center model that tests the effectiveness of establishing target prices for an episode of care centered around lower extremity joint replacements. CMS recently proposed to extend the model an additional three years through December 31, 2023.

Given that CMS has waived the 60-day delayed effective date of the IPPS final rule and does not anticipate finalizing these policies until late August or early September, we are concerned that CMS may not have enough time to adopt corresponding changes to the CJR model. If these MS-DRGs are finalized for adoption in FY 2021, CMS would need to modify the CJR model through notice-and-comment rulemaking to include target prices for these new MS-DRGs as of October 1, 2020.

Additionally, under the model, hospitals manage their programs based on prospectively established target prices that are provided prior to the start of a performance year. Model participants are currently in Performance Year 5, which started January 1, 2020 and was recently extended through March 31, 2021 due to the ongoing public health emergency. We are concerned that introducing these new MS-DRGs at the end of Performance Year 5 would potentially impact any target prices that were previously established for Performance Year 5. ***To ensure that these target prices continue to be reliable, CMS should not retrospectively adjust previously published target prices for existing joint replacement MS-DRGs.***

PAYMENTS FOR INDIRECT AND DIRECT GRADUATE MEDICAL EDUCATION COSTS

CMS proposes to expand how hospitals can temporarily count displaced medical residents when their residency program or teaching hospital closes. Currently, a resident must be physically present on the day prior to or the day the hospital or program closes, which can create issues if the resident left the program after the closure had been announced, is on a planned rotation, or had been matched with the

closing program but had not started. Challenges with these requirements have been highlighted by recent high-profile teaching hospital closures.

CMS proposes to rectify these issues by changing the requirements so that a displaced resident would only need to be present on the day the program or hospital announces its closure. Secondly, CMS proposes to allow funding to be transferred temporarily when the resident had intended to train at or return to training at the closing program or hospital. **We applaud CMS for modifying these program requirements, which will help ensure continued funding for residents who have been displaced by teaching hospital and residency program closures.**

NEW TECHNOLOGY ADD-ON PAYMENTS (NTAP)

As part of last year's rulemaking, CMS established a new alternative NTAP pathway for technologies that have received certain designations from the Food and Drug Administration (FDA), including medical products that are designated as a Qualified Infection Disease Product (QIDP). These efforts align with the Administration's goals to address issues related to antimicrobial resistance and to secure access to antibiotics. Under this pathway, technologies would automatically be considered new and would not need to meet the substantial clinical improvement requirements.

CMS proposes to extend this alternative pathway to include products approved under the FDA's Limited Population Pathway for Antibacterial and Antifungal Drugs (LPAD) pathway. Drugs approved under this pathway are used to treat serious or life-threatening infections in a limited population with unmet needs. CMS also proposes to provide conditional approval for antimicrobial products that would meet the criterion for the NTAP alternative pathway but have not been approved by FDA as of July 1.

We appreciate the Administration's commitment to antibiotic stewardship and improving Medicare access to life-saving products. **CMS should also look to adopt certain clinical decision support (CDS) technologies that use artificial intelligence and are embedded directly in EHRs to provide real-time, patient-specific best practices at the point of care.** CDS provides clinical support best practices content for enhanced patient safety including safe prescribing practices and antibiotic stewardship. CDS can also leverage and pull data from evidence-based practice guidelines to provide patient-specific recommendations to ensure patients are on the most clinically appropriate and cost-effective treatment regimen. In addition, CDS can serve as a solution for electronic prior authorization (ePA) and minimize the time between prescribing and a coverage decision, thereby expediting patient access to necessary treatments to further combat antimicrobial resistance. **We encourage the Administration to take additional actions to improve access.**

Finally, many hospitals have noted that the existing NTAP process is extremely cumbersome, which results in some hospitals choosing to forego submitting NTAP because of the laborious process involved. **We encourage CMS to explore using CDS and ePA as vehicles to help streamline and automate the NTAP submission process to ensure hospitals are receiving adequate reimbursement for the use of novel antibiotics when clinically appropriate**.

QUALITY REPORTING PROGRAMS

Hospital Star Ratings

CMS had previously announced that it would update the Overall Hospital Quality Star Rating methodology in the FY 2021 IPPS proposed rule. However, given the ongoing public health emergency CMS has decided to delay changes until future rulemaking.

Premier healthcare alliance urges CMS to not conduct its annual refresh of the Hospital Star Rating data in January until methodological changes have been put into place. We also encourage CMS to move forward with seeking input on changes to the Star Ratings and to consider other avenues for adoption, such as through a sub-regulatory process that takes into consideration stakeholder input. For example, in developing the existing star rating methodology, CMS used a subregulatory process. We also continue to recommend that CMS develop a simplified methodology that is transparent and replicable and that takes into account social risk factors.

CMS should create a transparent model for star ratings that is reliable and can be effectively replicated. An effective quality measurement program enables hospitals to clearly understand where to focus and drive improvement. ***Premier believes the program would benefit from a simplified methodology using an explicit approach to enable hospital and patient understanding.*** CMS could consider modeling the star rating after a program such as the Hospital Value Based Purchasing (HVBP) program that incorporates both achievement and improvement, allowing low performers to rise rather than stagnate at the bottom. HVBP has proved to be an effective vehicle because it is a well understood, tested method that addresses many of the flaws in the other programs. Converting HVBP performance to a star rating could ensure comprehension for hospitals and patients.

It is important to understand the numerous and variable risks associated with socio-demographic factors that are outside of the control of the provider that can affect outcomes. **Any star rating should account for social risk factors in the methodology.** Aa a first step, Premier supports peer grouping by percentage of dual-eligible beneficiaries as used in the Hospital Readmission Reduction Program; however, we urge the agency to consider a broader set of social risk factors**.** Should CMS move forward with the incorporation of peer groups, the agency must also consider how to display such information to the public. Inclusion of a secondary peer-based five-star metric could add confusion to a program that is already difficult to interpret for the average consumer of this data. ***As such, the agency should continue to seek stakeholder feedback to evaluate how peer grouping could be implemented as well as the usefulness to the patient in having this information.***

Reporting and Submission Requirements for eCQMs

CMS proposes to increase the number of quarters of electronic clinical quality measure (eCQM) data that a hospital must submit for the Inpatient Quality Reporting (IQR) and Medicare Promoting Interoperability Programs. Currently, hospitals must submit one self-selected quarter of data. Under the proposal, CMS would gradually increase the number of quarters that hospitals must submit, with hospitals needing to submit all four calendar quarters by CY 2023 reporting (which effects FY 2025 payment). CMS notes that it believes this proposal will produce more comprehensive and reliable quality data since one quarter of data is not enough to capture trends in performance over time. CMS also proposes to begin public reporting of eCQM data with data reported in 2021 for the FY 2023 payment determination. CMS could post this data as early as the fall of 2022.

Premier opposes public reporting of the eCQM meaures at this time. Most measures require a full-year of data to be reliable. We are concerned that many of the measures may not be reliable with just one self-selected quarter of data. Additionally, as CMS acknowledges in the preamble, additional quarters of data are needed to capture meaningful trends in performance overtime. Publishing the existing data will be of limited use and may cause greater confusion for stakeholders. We recommend that CMS delay public reporting of eCQM data until hospitals are required to report one full calendar year of data.

Premier supports gradually increasing the number of quarters that must be reported. This allows hospitals to continue gaining experience with measure reporting while moving towards eCQMs that produce meaningful data. **During the transition to reporting one full calendar year, Premier urges CMS to actively solicit feedback from hospitals and to monitor for challenges with reporting eCQMs.** While challenges with eCQMs have eased over time, we must ensure that the measure can be reliably and validly be captured across multiple EHRs. Additionally, the recent ONC interoperability rules place requirements on certified EHRs to allow application programming interfaces (APIs), this may ease eCQM collection and lead to novel eCQMs. CMS should monitor how the interoperability rules may enable enhanced measurement.

COVID-19 Public Health Emergency

We appreciate the flexibilities that CMS has granted to date regarding the ongoing public health emergency, including providing blanket extraordinary circumstances policies and excepting hospitals from reporting certain quality measures. Most of these exceptions were in place for the first two quarters of this calendar year. We urge CMS to extend these flexibilities through the end of the emergency.

Additionally, we encourage CMS to conduct rigorous reliability testing when evaluating measures affected by data collected during the public health emergency. Most measures require at least one full year of data to be valid. However, as the public health emergency continues, it becomes increasingly likely that large amounts of data will be missing when it comes time to calculate measures. **We urge CMS to continue to collect data where possible; however, this data should not be publicly reported. CMS should also consider not scoring these measures and to temporarily modify its pay-for-performance programs to pay-for-reporting.**

PROMOTING INTEROPERABILITY PROGRAM

Under MACRA, CMS established and codified attestation requirements to support the prevention of information blocking, which consist of three statements containing specific representations about a healthcare provider's implementation and use of CEHRT. CMS will publicly report information about clinicians, hospitals, and critical access hospitals (CAHs) that have submitted a "no" response to any of the three attestation statements about information blocking starting in late 2020.

In addition to CMS regulations, healthcare providers are subject to the separate information blocking regulations finalized by ONC since section 4004 of the Cures Act defines conduct by healthcare providers, health IT developers, and health information exchanges and networks that constitutes information blocking.

ONC's final rules include significant changes to the information blocking provisions and established a November 2, 2020 compliance date for information blocking. While all stakeholders (actors) need time to plan and prepare for adherence to ONC's information blocking final rules, ONC has decided to use

enforcement discretion related to their information blocking requirements for health IT developers. At the same time, CMS has not proposed a period of non-enforcement (postponing posting of providers' information publicly), resulting in significant discrepancies and inequities between what is required of EHR vendors compared to providers.

Furthermore, since healthcare providers depend on the practices of health IT (EHR) vendors to comply with CMS and ONC information blocking requirements, it is unreasonable to expect providers to meet CMS information blocking attestation requirements when certified EHR vendors are not required to comply with similar ONC (assurance and attestation) requirements. **Premier urges CMS to harmonize its compliance and enforcement dates with those of ONC.**

Query of Prescription Drug Monitoring Program (PDMP) measure

Premier supports CMS' proposal to continue the Query of PDMP measure as a voluntary measure instead of moving forward with mandatory reporting. As we have previously commented, at this point the measure requires burdensome manual data collection activities, and mandatory reporting is not appropriate given the variation in state PDMPs. If CMS wants to promote routine electronic queries of PDMPs, it should work with ONC to support development of data and interoperability standards that would enable this type of electronic exchange. CMS should work with ONC to include data elements within the USCDI and functionality within CEHRT to enable better monitoring and reporting of opioid-related care, treatment and outcomes. Additionally, given the ongoing criticality of addressing issues regarding opioid use, we once again urge CMS and ONC to identify and prioritize the need for revised or new CEHRT criteria as well as the potential need for development, adoption and support for additional data, interoperability and transmission standards.

CONCLUSION

In closing, the Premier healthcare alliance appreciates the opportunity to submit these comments on the IPPS proposed rule. If you have any questions regarding our comments or need more information, please contact Aisha Pittman, vice president, policy, at aisha_pittman@premierinc.com or 202.879.8013.

Sincerely,

Blair Childs
Senior Vice President, Public Affairs
Premier healthcare alliance