North Carolina Healthcare Association

Uniting hospitals, health systems and care providers for healthier communities

June 25, 2018

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services Hubert H. Humphrey Building, Room 445-G 200 Independence Avenue SW
Washington, DC 20201

Ref: CMS-1694-P: Medicare Program: Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2019 Rates; Proposed Quality Reporting Requirements for Specific Providers; Proposed Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs (Promoting Interoperability Programs) Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Medicare Cost Reporting Requirements; and Physician Certification and Recertification of Claims

Dear Ms. Verma:

On behalf of our 130-member hospitals and health systems, the North Carolina Healthcare Association (NCHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) hospital inpatient prospective payment system (IPPS) proposed rule for fiscal year (FY) 2019.

Reducing Regulatory Barriers

NCHA commends CMS's efforts to ease regulatory barriers by proposing (1) a streamlined approach to quality measurement across the hospital quality reporting and value programs that can help ensure programs are focused on the core issues that are most critical to providing high-quality care and improving patient outcomes, (2) a more flexible performance-based approach to determine whether a hospital has met meaningful use requirements, (3) a 90-day reporting period in 2019 and 2020 and (4) reducing documentation requirements (e.g., eliminating the requirement that providers record a written inpatient admission order in the medical record to receive Part A payment).

Transparency

Under current law, hospitals are required to establish and make public a list of their standard charges. However, CMS is creating more specific guidelines, effective January 1, 2019, that would require hospitals to make available a list of their current standard charges via the internet in a machine-readable format and to update this information at least annually, or more often, as appropriate. This could be in the form of the charge master itself or another form of the hospital's choice, as long as the information is in machine-readable format.

CMS also is considering potential actions that would further their objective of hospitals undertaking efforts to engage in consumer-friendly communication of their charges to help patients understand what their potential financial liability might be for services they obtain at the hospital. These actions also would enable patients to compare charges for similar services across hospitals. Therefore, it is seeking information regarding barriers that prevent providers from informing patients of their out-of-pocket costs; changes that are 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; and what role

providers should play in this initiative. It also is considering making information regarding hospital non-compliance with the requirements public and intends to consider additional enforcement mechanisms in future rulemaking.

Consumers/patients encounter numerous decisions as they address their health care needs including but not limited to selecting a health insurance plan, choosing providers, determining a course of treatment, and understanding in advance what costs they will face from undergoing treatment or how their provider choice will affect total costs, out-of-pocket costs or the quality of the outcomes. Patients are assuming greater financial responsibility for their healthcare needs and thus, need enhanced information that will allow them to make informed healthcare decisions. NCHA and its members support providing high-quality information to patients through well-designed tools, as well as other resources to help them understand and interpret that information and believe that this approach will enable patients to make better choices.

Price transparency and quality ratings are critical if patients are to be empowered to make meaningful decisions prior to receiving care. Patients want and need cost, quality, and treatment information that is highly personalized to their situations and preferences, and delivered at the point of decision-making. Patients want to know the total price of the service, the provider's network status, and their estimated out-of-pocket responsibility, along with other available provider and service-specific information such as quality ratings, clinical outcomes, patient safety, satisfaction scores, etc. In addition, patients want to know the total price and out-of-pocket costs for a given episode of care, not just the price for a discrete procedure. For example, a patient undergoing a total knee replacement would like to understand the costs of the entire episode, from preparation for surgery through rehabilitation, rather than just the costs of the surgery. Ideally, the price would reflect the negotiated reimbursement rates between the insurance carrier and the providers as well as the patient's specific out-of-pocket responsibility. Thus, we do not believe that requiring hospitals to make available and update a list of their current standard charges via the internet in a machine-readable format would provide patients with the information needed to make informed decisions. This could be confusing since patients generally do not know all the services that they will receive prior to a given encounter, and the standard charge amounts are not the amounts that the insurance carrier will reimburse the provider on the patient's behalf.

The healthcare payment system is very complex and these complexities create numerous challenges when addressing price transparency and quality ratings as illustrated below:

- There are many different sources of price and quality information, many different benefit designs for patients with insurance coverage, and an increasing variety of payment models and quality indicators.

- Patients may receive services from numerous independent providers as part of their treatment for a specific condition. They may also need to pay separately for pharmaceuticals or medical devices. As a result, it can be difficult for patients to obtain price estimates for everything that will be needed as part of the treatment or procedure.

- Patients may receive additional services not included in the initial estimate or providers may render, code and bill for a service different from the service for which the patient sought an estimate. Thus, price information will likely take the form of an estimate or price range, given that unexpected complications may affect the price of care.

- The rates negotiated between in-network providers and insurance companies are subject to the confidentiality clauses included in managed care contracts and in most cases, cannot be shared with patients and others without breaching the terms of the contract. This reality suggests that transparency in the private insurance market should either emphasize out-of-pocket costs instead of full transparency based on negotiated rates or mask provider-specific negotiated rates by reporting total episodic costs.

- Patients may also receive services from out-of-network providers, making it virtually impossible to obtain the total price of the service and the patient's out-of-pocket cost until after the insurance carrier processes the claim.

Given these complexities, payers, providers, and patients will need to work together to define and provide the price and quality information that patients need to make informed decisions. In today's healthcare environment, health plans have the most comprehensive understanding of their benefit designs, networks, and negotiated prices and thus, are in the best position to provide this information to their members. Providers must also be highly engaged in helping patients weigh treatment options, understanding total costs of treatment, and evaluating options to address their out-of-pocket liability.

Many health plans as well as the North Carolina Department of Health and Human Services have already developed or are in the process of developing web-based transparency tools. In 2013, the North Carolina Legislature passed a "Transparency in Health Care Cost" law. The complexities of reporting the required data categories in a logical format that is also acceptable to payers are enormous, and the result is an annual report that is costly to produce and of little benefit to patients. Public awareness and use of these tools are low, in part because these tools are difficult to use and sometimes the information lacks relevance. Quality ranking tools are also not being used as the information is not presented in a consumer-friendly manner. For example, very few tools provide quality data on providers at the procedure level and some pricing tools only present charge data. These existing tools must be improved by providing information that is tailored to a patient's specific conditions, needs, and insurance coverage, that is easy to understand and is made available at the point of decision-making. Providers, insurance carriers and other stakeholders must work to improve the accuracy, ease of use, and accessibility of information and must increase patient awareness of the new tools and resources. Transparency tools must be flexible to adapt to changing healthcare payment and delivery models. Public policy should support these goals by providing financial resources for development and implementation of new tools and resources.

Alternative Payment Approaches for New Technology

CMS invited public comments on alternative payment approaches, including in the context of the proposed rule's discussion of the pending KYMRIAHTM and YESCARTATM new technology add-on payment applications, and the most appropriate way to establish payment for FY 2019 under any alternative approaches. CMS stated that it is concerned about redistributive effects away from core hospital services toward specialized services and the impact it may have on payment for core services. NCHA is also concerned about the redistributive effects and is concerned about the effect this technology will have on the rates of other services reimbursed through the inpatient prospective payment system given that it is administered in a budget neutral manner.

Hospital Inpatient Quality Report (IQR) Program

CMS is proposing to remove 39 measures from the IQR program for FYs 2020 through FY 2023. Of the 39 measures proposed for removal, 18 measures would be removed from hospital quality programs altogether because they are "topped out" in performance, do not lead to better care or have costs that outweigh their value. The remaining 21 measures would be "de-duplicated." That is, the measures would be removed from the IQR program, but retained in one of the other hospital measurement programs. Hospitals would still be required to report measure data, and measure results would continue to be publicly reported on *Hospital Compare.* The NCHA supports the removal of 18 measures from the IQR program. We also believe "de-duplicating" measures should lead to reduced administrative burden but are concerned that this approach might have unintended consequences in other programs.

Hospital Readmissions Reduction Program (HRRP)

CMS has proposed no major changes to the HRRP for FY 2019. However, as finalized in the FY 2018 inpatient PPS final rule, CMS will implement the socioeconomic adjustment approach mandated by the

21st Century Cures Act. CMS is also proposing to continue using the three-year performance period for the HRRP (e.g., July 1, 2014 – June 30, 2017). NCHA continues to have concerns that CMS is combining data collected under both ICD-9 and ICD-10 and urge the agency to examine this impact before moving forward with this approach.

Rural Floor Budget Neutrality Adjustment

NCHA continues to oppose the continued application of the nationwide rural floor budget neutrality adjustment as described in the proposed rule. NCHA recognizes that the impetus for the policy is a federal statute, not regulation. A one-sentence section of law enacted in the Patient Protection and Affordable Care Act of 2010 established a policy of national budget neutrality for Medicare wage index changes. Coupled with the orchestrated conversion of a single facility in Massachusetts – Nantucket Cottage Hospital – from a critical access hospital to an IPPS hospital, this law unfairly manipulates the Medicare payment system to reward hospitals in Massachusetts and a few other states at the expense of most other hospitals across the nation.

The adverse consequences of nationwide rural floor budget neutrality have been recognized and commented upon by CMS, the Medicare Payment Advisory Commission (MedPAC) and many others over the past several years, but the continuity of the policy is disconcerting at best. Until this policy is corrected, the Medicare wage index system cannot possibly accomplish its objective of ensuring that payments for the wage component of labor accurately reflect actual wage costs.

Transition to S-10

In FY 2018, CMS began incorporating the cost report Worksheet S-10 data on hospital charity care and bad debt to determine the amount of uncompensated care each hospital provides. For FY 2019, CMS is proposing to continue phasing in the S-10 data and using data from a rolling three-year period to estimate uncompensated care payments. Specifically, for FY 2019, CMS would use FY 2014 and 2015 Worksheet S-10 data in combination with FY 2013 Medicaid days and SSI ratios to determine the distribution of uncompensated care payments. NCHA supports CMS's proposal to continue using Worksheet S-10 of the Medicare cost report to determine the amount of uncompensated care provided by hospitals.

Thank you for your consideration of our comments. If you have any questions, please contact me (slawler@ncha.org, 919–677-4229), Jeff Weegar, Vice President Financial Policy (jweegar@ncha.org, 919-677-4231) or Ronnie Cook, Finance and Managed Care Consultant (rcook@ncha.org, 919-677-4225).

Sincerely,

Stephen J. Lawler
President
North Carolina Healthcare Association