Texas Hospital Association

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*Via electronic submission*

**PUBLIC COMMENT LETTER**

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

Re: CMS–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; Proposed Rule (Vol. 83, No. 88), May 7, 2018.

Dear Ms. Verma:

On behalf of our more than 465 member hospitals and health systems, including rural, urban, children's, teaching and specialty hospitals, the Texas Hospital Association appreciates the opportunity to provide comments on the above-referenced proposed rule for the hospital inpatient and long-term care hospital prospective payment systems. The proposed rule would revise the hospital inpatient prospective payment system, the long-term care hospital payment system and quality reporting requirements for specific providers. In this letter, THA submits comments on the following issues:

- Use of Worksheet S-10 Data for Uncompensated Care Payments
- Pricing Transparency
- Wage Index Disparities/Rural Floor
- Burden Reduction
- GME Flexibility
- Measure Reporting
- Electronic Prescribing Measures – Query the Prescription Drug Monitoring Program
- Hospital Readmission Reductions Program
- Request for Information on Interoperability

**Use of Worksheet S-10 Data For Uncompensated Care Payments**

Unlike other states, in Texas, both Medicare and Medicaid Uncompensated Care payments will be based on data derived from the Worksheet S-10. Texas' recently renewed Medicaid 1115 waiver requires the use of hospitals' Medicare cost reports beginning in CY 2018 for determining FY 2020 Medicaid UC payments. With the increased reliance on Worksheet S-10 data for payment purposes, as well as the recent CMS guidelines regarding the inclusion of uninsured discounts, many Texas hospitals have updated their Worksheet S-10 data at least once.

For several years, CMS has discussed using the cost report's Worksheet S-10 data (charity care and bad debt) to determine the amount of uncompensated care each hospital provides, and in FY 2018, CMS began incorporating the cost report Worksheet S-10 data to determine Medicare UC payments for hospitals. For FY 2019, CMS proposes to continue phasing in the Worksheet S-10 data and using data from a rolling three-year period to estimate uncompensated care payments. The intent of the transition to Worksheet S-10 was to create more balance between Medicaid expansion and non-expansion states.

Initially, CMS questioned the accuracy and consistency of the Worksheet S-10 data. **If this is still considered a substantive issue, selective auditing of cost reports submitted by hospitals reporting the highest levels of uncompensated care will lead to increased confidence in the data**. If the accuracy of the data continues to be perceived as an issue, the various Medicare Administrative Contractors (for Texas, Novitas Solutions) should be directed to work directly with hospitals to better understand their data and to provide additional educational and training opportunities.

**Pricing Transparency**

In health care, there are many different sources of price and quality information, many different benefit designs for insured patients, and an increasing variety of payment models and quality indicators. There also are many unknowns and individual variables in the clinical delivery of health care that make pricing of care in advance particularly challenging. The path to diagnosis and treatment can vary significantly based on the underlying health issue, the appropriate care pathway for a given individual, and the physician's treatment plan.

The Patient Protection and Affordable Care Act contains a provision that requires each hospital to publish, update and make public a list of its standard charges for items and services provided by the hospital including for diagnosis related groups. In the August 22, 2014 *Federal Register*, CMS encouraged hospitals to undertake efforts to engage in consumer friendly communication of their charges to help patients understand what their financial liability might be for services they obtain at the hospital and to enable patients to compare charges for similar services across hospitals.

However, in the proposed rule, CMS is creating more specific guidelines. Effective Jan. 1, 2019, hospitals will be required 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. The posting of a hospital's charge master is unreasonable, as it contains hundreds of pages with several thousands of line items and is not intended or designed for a layperson.

As patients have more responsibility for health care costs, access to meaningful and transparent price information is paramount. However, because patients are unable to compare prices during emergency situations, the posting of charges is useful only for those admissions that are considered elective, and even in those situations may not be illustrative as

patients have different underlying conditions and health statuses. THA and its member hospitals are committed to providing price, quality and other information that patients need to make informed health care decisions. THA believes that price transparency information must be provided in a manner that is clear, readily accessible to the patient and in a format that offers an opportunity to make **meaningful comparisons** among providers. Price transparency information must also be coupled with other information that defines the value of services for the patient. Price alone is not sufficient to enable patients and others to make an informed choice of providers. Information on quality also is needed to ensure that a provider offers the desired level of value.

**THA recommends that CMS give hospitals the flexibility to publish charge data in service groupings, such as MS-DRG, APC or other basic groupings**. Some states have passed laws and provided regulatory guidance for the type of information hospitals should make available to the public. **THA also recommends that CMS defer to state directives as to what is required to be posted by hospitals** in order to minimize contradictory federal and state standards.

For the past 20 years, Texas law has required hospitals to submit their inpatient bills to the state. Since March 2007, THA has purchased these hospital data files from the state and has publicly posted hospital-specific summary information on Texas PricePoint (www.txpricepoint.org) in a consumer-friendly format. Texas is not alone in publishing hospital charges. There are at least 15 other state hospital associations that provide a similar website on behalf of their hospitals.

The Texas PricePoint site provides hospital-specific comparative data that includes all inpatient DRGs (not just the top 25) for all patients (not just Medicare patients) as well as the posting of median and average charges. The data are updated on a quarterly basis and comparisons are provided to other similar hospitals in the county and the state. These inpatient bills only include the hospital charges and do not include any physician charges. It is unfortunate that physician data is still not reported and made available to the public.

**For patients, the relevant charge information is their potential out-of-pocket costs for a given service or course of treatment – not standard charges.** More than 75 percent of Texans have health coverage, and their payer – whether Medicare, Medicaid or a private insurance plan – establishes their cost-sharing obligations. This includes whether the plan covers the service, whether the provider is in the plan's network, the plan's cost-sharing requirements and, if applicable, whether the individual has met his or her deductible. Nationally, hospitals contract with thousands of payers, with the vast majority offering multiple health plans with different benefit structures. Efforts should be taken to increase patients' health care literacy, especially around their health plan benefit design.

**Because payers have access to both hospital and physician charges and payments, payers are the best source of information on what a covered individual's out-of-pocket costs may be for a given service.**

**Wage Index Disparities and Rural Floor**

THA applauds CMS for requesting comments on wage index disparities. Although some geographical variation in payment rates needs to exist, the current wage index system is broken. Symptoms include the amount of reclassifications into adjoining geographic areas, the volatility induced by the national rural floor budget neutrality adjustment and the downward financial spiral experienced by hospitals in states with low wage index values.

The Department of Health and Human Services also shared concerns about the national rural floor adjustment by stating, "Only urban hospitals can benefit from the rural floor provision. Because the provision is budget neutral, all other hospitals

(that is, all rural hospitals and those urban hospitals to which the adjustment is not made) experience a decrease in payments due to the budget neutrality adjustment applied nationally to their wage index."

The flaws in using a national rural floor budget neutrality adjustment are highlighted in a March 2017 Office of Inspector General report. A single hospital over-reported cost data and under-reported hours, driving up the average hourly wage. The OIG estimated this error resulted in more than $133 million in Medicare payments being redirected to Massachusetts hospitals.

In addition to these examples, the FY 2019 proposed rule includes a significant payout to hospitals in Connecticut. As published in the latest correction notices for FY 2017 and FY 2018, Connecticut benefitted by $4 million in FY 2017 and by $2 million in FY 2018. In the FY 2019 proposed rule table, Connecticut is estimated to realize a $90 million windfall, a 4,400 percent increase from the prior year. The average wage index (AWI) for Connecticut hospitals also increased from 1.2530 to 1.3836, a 10.4 percent increase. Connecticut's rural wage index increased from 1.1563 to 1.3836, a 19.7 percent increase. This change appears to be driven by merger activity rather than significant changes to wages. This type of volatility needs to end.

An MSA with a high AWI (e.g. 1.9046) that experiences a 5 percent increase receives significantly more payments than an MSA with a low AWI (e.g. 0.6701) that experiences a 5 percent increase. Hospitals subject to this low wage index must increase their average hourly wages faster than the increase in national average wages in order to improve their positions. When compounded over time, it becomes quite difficult for the hospitals in the MSA with the lower AWI to recover.

The disparities in the various proposed FY 2019 AWIs are stark, with significant financial implications:

- All 26 MSAs in Texas, as well as the Texas rural category, have an AWI below 1.0
- The highest AWI in Texas is 0.9754 (Houston-The Woodlands-Sugarland) and the lowest AWI in Texas is 0.8050 (Texas Rural, El Paso, Tyler).
- Nationwide the highest AWI is 1.9046 (Santa Cruz-Watsonville, CA) and the lowest AWI is 0.3711 (Puerto Rico). The lowest AWI for the continental U.S. is 0.6701 (Rural Alabama).
- Nationwide:
    - 130 MSAs/regions have an AWI greater than 1.0
    - 77 MSAs/regions have an AWI greater than 1.1
    - 54 MSAs/regions have an AWI greater than 1.2
    - 23 MSAs/regions have an AWI greater than 1.3
    - 12 MSAs/regions have an AWI greater than 1.4
    - 10 MSAs/regions have an AWI greater than 1.5
    - 8 MSAs/regions have an AWI greater than 1.6
    - 5 MSAs/regions have an AWI greater than 1.7
    - 1 MSA/region has an AWI greater than 1.9
- Nationwide there are 8 rural AWIs greater than 1.0. The highest rural AWI is 1.3836 (Connecticut).

**THA recommends the following:**

- **Establish a national AWI floor at 0.91. In order to maintain budget neutrality (using FY 2018 AWIs), the payments necessary to fund this recommendation would be achieved by reducing the maximum AWI to 1.254. This would positively impact 261 MSAs/regions.**
- **Adjust AWI on a state-specific basis. In order to maintain budget-neutrality, AWI adjustments are currently done on a national basis.**
- **Establish parameters (e.g. 35 mile limit) whereby strategic reclassifications are not allowed. This would prevent any future re-occurrences similar to what has already transpired in Massachusetts and Connecticut. This will help restore integrity and stability to the hospital wage index system.**
- **Adjust individual state-specific funds based on changes in population. Those states that see an increase in population should receive additional payments. The payments should follow the work/patient.**

Reforming the Medicare wage index will be a monumental task. THA recommends that CMS collaborate closely with the hospital industry and their member associations to craft needed reforms.

**Burden Reduction**

THA appreciates CMS' acknowledgment of the administrative burden and associated costs that many technical requirements impose on hospitals. THA supports the removal of the requirement that Medicare Part A certification statements describe where required information can be found within the medical record, and that CMS will now look at the record as a whole. THA also supports the removal of the requirement for an inpatient admission order as a condition of Medicare Part A payment. Consistent with the previous change, CMS proposes to examine the medical record as a whole to determine whether it supports coverage criteria, including the medical necessity of an inpatient admission. THA believes the relaxation of these requirements will reduce the administrative burden on hospitals without an adverse impact patient on patient safety.

**GME Flexibility**

CMS proposes to provide more GME flexibility for urban teaching hospitals that established residency programs on or after Jan. 1, 1995 (referred to as "new" urban teaching hospitals) by allowing these hospitals to form Medicare GME-affiliated groups to share full time equivalent GME cap slots. THA supports this proposal. However, THA believes CMS could do more to advance GME flexibility, particularly in rural areas and areas with physician shortages.

During the current five-year cap-building window, new teaching institutions are allowed to add as many residents as their program accreditations allow. However, once the cap-building window closes, Medicare funding to that particular hospital for all future years is limited to the number of residency slots the hospital was able to fill during the cap-building window. For health care institutions to establish a post-medical school, GME residency program requires immense investment of human capital, infrastructure, institutional capacity, as well as community and financial support. Programs located in regions experiencing physician shortages as well as rural and underserved areas could greatly benefit from additional time to secure the necessary resources and to foster the development of residency programs that can meet the increasing demand for physicians.

THA has previously expressed its support for the concept of "Cap Flexibility," which allows CMS to use its existing authority to supplement the current broad-based GME cap-building policy with a strategic, directed approach to provide incentives and additional assistance for GME programs to develop in select areas of need across the country. Specifically, under Cap Flexibility, new GME teaching hospitals in areas of need would have up to an additional five years beyond the current five-year window (for a total of up to ten years) to add residents to their training programs. THA encourages CMS to allow new teaching hospitals in areas of need additional time under "Cap Flexibility" in order to help alleviate regional physician shortages.

**Measure Reporting**

THA applauds CMS' commitment to use a smaller set of more meaningful measures in the quality and value-based purchasing programs by removing measures that are duplicative, easy to comply with or excessively burdensome to report. In addition, THA supports CMS' proposal to eliminate overlap between the Hospital Acquired Conditions Reduction Program and the Value Based Purchasing Program.

**Electronic Prescribing Measures – Query the Prescription Drug Monitoring Program**

THA supports CMS' encouragement of the adoption and use of the Prescription Drug Monitoring Program concurrent with the issuance of a prescription for opioids. Texas has already taken significant steps towards widespread use of the PDMP. Effective Sept. 1, 2019, under Texas law, physicians, pharmacists, health care providers, and individuals acting under their direction must access individual prescription information prior to prescribing or dispending opioids, benzodiazepines, barbiturates, and carisoprodol, unless the patient has been diagnosed with cancer, the patient is receiving hospice care, or after a good faith effort, cannot access prescription history information. THA hopes that CMS will align the reporting period consistent with the timing under Texas law and encourages CMS to adopt clear, easy to understand standards for compliance with this measures that accommodate state legislation. THA's primary concern associated with this measure is the unfunded implementation cost – as much as $200 per user per year – charged to electronically access the PDMP gateway.

**Hospital Readmission Reductions Program**

THA is concerned that the proposed FY 2019 Hospital Readmission Reductions Program performance period continues to combine data collected under both ICD-9 and ICD-10. THA encourages CMS to provide analysis demonstrating that measure reliability and validity are not compromised by using these two different coding systems. THA also urges CMS to ensure that the ICD-10-only versions of the measures in the HRRP are endorsed by the National Quality Forum as soon as practicable.

**Request for Information on Interoperability**

CMS seeks input regarding the opportunity to further advance interoperability of health information through the creation of Conditions of Participation (CoPs) for hospitals and critical access hospitals (CAHs) and conditions for coverage (CfCs) for other providers. THA recognizes the importance of a robust infrastructure for health information exchange, but placing the burden only on hospitals and providers through COPs or CfCs is not an appropriate strategy. Moreover, this strategy would impose additional cost on already struggling rural hospitals. CMS has already placed significant incentives on EHR adoption and use through the Meaningful Use Program (now Promoting Interoperability Program). THA believes that CMS should focus on infrastructure that includes other participants in health information exchange, such as requiring common

standards for and placing incentives on EHR and other IT vendors, rather than placing the impetus and cost of compliance solely on the end users of the programs.

Thank you for your consideration of these comments. We look forward to working with you on these issues. Should you have any questions, please email us at rschirmer@tha.org or cduncan@tha.org.

Sincerely,

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