



AMERICA'S ESSENTIAL HOSPITALS

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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; 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:

Thank you for the opportunity to submit comments on the above-captioned proposed rule. America's Essential Hospitals appreciates and supports the Centers for Medicare & Medicaid Services' (CMS') work to improve the delivery of high-quality health care across the health care continuum. We applaud the agency's proposals to streamline hospital quality measurement, as the rapid growth in measure reporting requirements has limited the effectiveness of quality improvement efforts and caused confusion for the public. However, the structure of certain programs to encourage the use of electronic health records (EHRs) has a disproportionately negative financial effect on essential hospitals, which provide stability and choice for people who face financial barriers to care. With that in mind, America's Essential Hospitals asks CMS to consider the challenges inherent in caring for our members' complex patient populations when finalizing this rule.

America's Essential Hospitals is the leading association and champion for hospitals and health systems dedicated to providing high-quality care to all people. Filling a vital role in their communities, our more than 325 member hospitals provide a disproportionate share of the nation's uncompensated care and devote approximately half of their inpatient and outpatient care to Medicaid or uninsured patients. Our members provide

state-of-the-art, patient-centered care while operating on margins substantially lower than other hospitals—4 percent on average compared with 7.8 percent for all hospitals nationwide.¹ Through their integrated health systems, members of America’s Essential Hospitals offer a full range of primary through quaternary care, including trauma care, outpatient care in their ambulatory clinics, public health services, mental health services, substance abuse services, and wraparound services.

Our members also offer specialized inpatient and emergency services not available elsewhere in their communities. The high cost of providing complex care to struggling Americans leaves our hospitals with limited resources, driving them to find increasingly innovative strategies for high-quality care. But improving care coordination and quality while staying true to a mission of helping those in need can be a delicate balance. This balance is threatened by payment cuts to hospitals—especially the inequities built into the Affordable Care Act’s (ACA’s) payment reductions for quality improvement programs.

Members of America’s Essential Hospitals constantly engage in robust quality improvement initiatives, ranging from preventing falls to reducing readmissions, patient harm events, and blood stream infections. They have created programs to break down language barriers and engage patients and families to improve quality of care. To ensure our members have sufficient resources to continue these activities and are not unfairly disadvantaged for providing comprehensive care to complex patients, CMS should adopt the following recommendations when finalizing the above-mentioned proposed rule.

- 1. CMS should ensure that data used to implement the ACA’s Medicare disproportionate share hospital (DSH) payment methodology accurately capture the full range of uncompensated care costs hospitals sustain when caring for the disadvantaged.**

The Medicare DSH program provides crucial funding for the care provided by essential hospitals, including uncompensated care. In 2016, our members provided \$5.5 billion in uncompensated care, representing 14.4 percent of all uncompensated care nationwide.²

As mandated by section 3133 of the ACA, a large portion of Medicare DSH payments now is distributed based on a hospital’s uncompensated care level relative to all other Medicare DSH hospitals. While DSH hospitals continue to receive 25 percent of their otherwise payable Medicare DSH payments, the remaining 75 percent is decreased to reflect the change in the national uninsurance rate and distributed based on uncompensated care burden (referred to as uncompensated care–based Medicare DSH payments). This change was in line with the Medicare Payment Advisory Commission’s (MedPAC’s) long-standing recommendation to incorporate uncompensated care into the Medicare DSH formula to better target dollars to hospitals with the greatest need. We agree with MedPAC’s assessment that CMS should better target DSH funds.

¹ Clark D, Roberson B, Ramiah K. Essential Data: Our Hospitals, Our Patients—Results of America’s Essential Hospitals 2016 Annual Member Characteristics Survey. America’s Essential Hospitals. June 2018.

² Ibid.

However, while effective targeting is important, we are concerned about the reductions to the aggregate uncompensated care–based DSH payments that occurred as coverage initially expanded. From fiscal years (FYs) 2014 to 2017, aggregate uncompensated care–based payments decreased rapidly, from \$9 billion in FY 2014 to less than \$6 billion in FY 2017—constituting a 33 percent cut in payments. Partly due to a change in the data source used to calculate the national uninsurance rate, aggregate uncompensated care–based DSH payments in FY 2018 increased for the first time since the Medicare DSH cuts went into effect. CMS projects another increase in FY 2019, driven by the increase in the uninsurance rate. As the number of uninsured individuals increases across the country due to policy changes, it is imperative that essential hospitals, which bear the burden of treating disproportionate numbers of uninsured and underinsured patients, receive adequate Medicare DSH payments to cover these costs.

Although the ACA has increased access to coverage nationally, essential hospitals still provide high levels of uncompensated care as part of their mission. Further, hospitals in states that have not expanded Medicaid are not experiencing the drop in uncompensated care that hospitals in expansion states have seen. While targeting DSH payments based on a hospital’s uncompensated care levels might mitigate this issue somewhat, the overall cuts have been severe, such that the magnitude of cuts in the uncompensated care pool often outweighs any redistributive benefit. As a result, steep cuts to Medicare DSH payments are detrimental and unjustifiable for essential hospitals.

Acknowledging that statute largely dictates the size of the uncompensated care pool, CMS should consider how its policy choices will affect hospitals that are essential to the communities they serve. In particular, the agency should consider how it defines uncompensated care for purposes of allocating uncompensated care–based Medicare DSH payments among eligible hospitals. CMS should continue efforts to accurately capturing all uncompensated care costs as data sources evolve and coverage patterns change. CMS should clarify the Medicare cost report and other guidance to ensure Medicare DSH payments target the hospitals that need them most.

The comments below are of particular importance to ensure essential hospitals receive adequate Medicare DSH payments to provide vital care to vulnerable populations.

- a. CMS should continue its work to accurately capture hospital uncompensated care costs in its calculation of Medicare DSH allocations.

Given the importance of uncompensated care to the Medicare DSH program, we urge CMS to continue to refine its methodology to accurately capture uncompensated care costs. Under existing Medicare DSH methodology, CMS determines a hospital’s qualifying uncompensated care burden by estimating its percentage of the total uncompensated care costs incurred by all DSH hospitals. CMS had been using a low-income insured days proxy, which is a hospital’s Medicaid days plus Medicare supplemental security income (SSI) days as a percentage of all hospitals’ low-income insured days. But beginning in FY 2017, CMS began using three years of data to determine a hospital’s share of the uncompensated care burden (Factor 3), instead of the one year of data the agency previously used.

Hospitals are required to report their uncompensated care costs and other indigent patient care costs on worksheet S-10 of the Medicare hospital cost report form. In FY 2018, CMS began phasing in the use of one year of FY 2014 uncompensated care data from the S-10, and proposes to use two years of S-10 data in FY 2019. As CMS transitions to the worksheet S-10, we urge the agency to incorporate the below recommendations to ensure a more accurate representation of each hospital's total uncompensated care costs.

- z. CMS should implement a stop-loss policy to insulate hospitals from large decreases in Medicare DSH payments that result from a change in the methodology for calculating uncompensated care costs.*

CMS' transition to using the S-10 will have a negative impact on hospitals with a certain payer mix—namely, those that treat high levels of Medicaid and low-income Medicare patients. These hospitals, including hospitals in expansion states that have seen an increase in Medicaid patients, should not be penalized for treating low-income patients in a changing coverage landscape. While their uncompensated care costs might be relatively lower as defined using the S-10, their commitment to serving the most vulnerable is manifested in other ways, such as their high numbers of Medicaid and patients dually eligible for Medicare and Medicaid.

Limiting the losses of hospitals that see a large percentage decrease in their DSH payments due to the S-10 transition will ensure that hospitals treating Medicaid patients and low-income Medicare dual-eligible beneficiaries can continue to fulfill their mission to treat the vulnerable. Dual-eligible beneficiaries are more likely to experience chronic illness and typically are costlier to treat.³ By reducing payments for these hospitals during the S-10 transition, CMS would overlook the important role of certain hospitals that treat disproportionate numbers of dually eligible beneficiaries. Because of the high cost of treating these patients and the underpayment associated with Medicaid, limiting these hospitals' losses will minimize disruption in their commitment to providing uncompensated care and serving the most vulnerable.

The different nature of hospitals' uncompensated care underscores the need to protect these hospitals from large decreases in DSH payments. Some of these hospitals are in states that expanded Medicaid, while other are not; Hospitals' uncompensated care costs for treating these previously uninsured patients might decrease slightly as the Medicaid population grows. Yet, these hospitals continue to serve the most vulnerable patients in their communities and still incur losses when the costs of treating these patients far outweighs the reimbursement received from public programs.

Implementing a stop-loss policy will help mitigate the sudden adverse financial impact on hospitals treating dual-eligible patients and incurring large underpayments for these patients (which are not captured in CMS' metric for uncompensated care costs).

³ Kasper J, O'Malley M, Lyons B. Chronic Disease and Co-Morbidity Among Dual Eligibles: Implications for Patterns of Medicaid and Medicare Service Use and Spending. Kaiser Commission on Medicaid and the Uninsured. July 2010.

- ii. CMS should provide clear guidelines on its audit processes and be transparent in its methodology for adjusting payments for hospitals with high uncompensated care costs.*

In the FY 2018 Inpatient Prospective Payment System (IPPS) proposed and final rules, CMS indicated that it would instruct Medicare Administrative Contractors (MACs) to conduct audits of S-10 data beginning with FY 2017 cost report data. CMS has so far not made public its audit protocols, but it is imperative that the agency do so to be transparent with stakeholders about which factors it will use to determine the need to audit a hospital. **We urge the agency to disclose the criteria it uses to identify hospitals to be audited, as well as provide more details about the procedural aspects of the audit, such as opportunities for hospitals to resolve or contest issues identified in the audit.** This is important to ensure that audits are conducted consistently and equitably.

CMS also states in the rule that it has instructed MACs to identify hospitals with “extremely high” ratios of uncompensated care costs to total operating costs for FY 2014 and 2015 cost reports. CMS proposes to reduce uncompensated care costs for these hospitals for the year in question by applying the next year’s ratio (uncompensated care costs to total operating costs) to the hospital’s uncompensated care costs. It is unclear if this is part of the audit process or separate from the audit process. CMS also does not provide any detail about how it defines hospitals with an “extremely high” ratio, although it does reference the 50 percent threshold from the FY 2018 rule. In addition to the lack of clarity on how these hospitals are identified, CMS does not account for situations in which a hospital might legitimately have high uncompensated care costs due to their payer mix. We agree with the need for data integrity and for accurate reporting of uncompensated care costs. However, CMS should discern erroneous data from legitimate instances in which a hospital might incur very high uncompensated care costs. Essential hospitals serve as the primary health care safety net in their communities, especially in heavily populated metropolitan areas, and have very high volumes of uninsured and low-income patients that drive up their uncompensated care costs. **We call on CMS to ensure MACs are working collaboratively with hospitals to distinguish inaccurate uncompensated care values from legitimately high values. In the latter case, if a hospital can justify its high uncompensated care costs, these costs should not be reduced by another year’s ratio of uncompensated care costs to total operating costs.**

- iii. CMS should include all patient care costs when using the worksheet S-10 to determine uncompensated care costs.*

The worksheet S-10 does not account for all patient care costs when converting charges to costs. Most important, the current worksheet ignores substantial costs hospitals incur in training medical residents, supporting physician and professional services, and paying provider taxes associated with Medicaid revenue. As CMS begins using the S-10 as the data source for measuring uncompensated care costs, the agency should refine the worksheet to incorporate all patient care costs—including those for teaching—into the CCR. In particular, CMS should:

- use the total of worksheet A, column 3, lines 1 through 117, reduced by the amount on worksheet A-8, line 10, as the cost component; and
- use worksheet C, column 8, line 200, as the charge component.

The line items above are not limited to Medicare-allowable costs and include additional patient care costs, such as the cost of graduate medical education (GME). Because of this, the result would more accurately reflect the true cost of hospital services, compared with the CCR currently used in worksheet S-10.

CMS should include GME costs when calculating a hospital's CCR. The decision not to include these costs will disproportionately affect teaching hospitals by reducing their share of the uncompensated care pool in relation to other hospitals. Essential hospitals are committed to training the next generation of health professionals. In 2016, the average member hospital trained 223 physicians, nearly three times as many as other U.S. teaching hospitals.⁴ Further, our members trained an average of 41 physicians above their GME funding cap, versus eight at other teaching hospitals.⁵ So, the costs associated with direct graduate medical education constitute a significant portion of overall costs at essential hospitals. Leaving out these costs in the CCR understates teaching hospitals' uncompensated care costs when it converts those hospitals' uncompensated care costs to charges. Incorporating GME costs into the CCR would reflect the full range of costs incurred by teaching hospitals. By excluding these costs, CMS' proposed CCR for determining uncompensated care costs will penalize hospitals, such as academic medical centers, which tend to provide high levels of uncompensated care. **We strongly urge CMS to include teaching costs when converting charges to ensure accurate distribution of the uncompensated care pool funds to hospitals with the highest levels of uncompensated care.**

CMS also should include the cost of providing physician and other professional services when calculating uncompensated care. In addition to employing physicians and paying community specialists directly for providing care to patients, many essential hospitals subsidize the cost of physician services to ensure vulnerable patients continue to have access to necessary care. Because hospitals regularly incur these costs when providing charity care and other uncompensated care, CMS should recognize these costs when determining uncompensated care. **By refining the worksheet S-10 to reflect these issues, CMS will accurately measure the uncompensated care costs hospitals incur to serve low-income and uninsured patients.**

ii. CMS should issue clarifying guidance as soon as possible to improve the consistency and accuracy of worksheet S-10 data and, in particular, the accuracy of uncompensated care amounts listed on the S-10.

A review of worksheet S-10 data indicates an inconsistency in how hospitals categorize and report charity care versus bad debt. While CMS can overcome this data limitation using the sum of charity care and bad debt, the agency still should issue clarifying

⁴ Clark D, Roberson B, Ramiah K. Essential Data: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2016 Annual Member Characteristics Survey. America's Essential Hospitals. June 2018.

⁵ Ibid.

guidance so there is consistency across the hospital field in how charity care and bad debt are reported.

CMS should treat the unreimbursed portion of state or local indigent care programs as charity care. Many state or local indigent care programs are not insurance programs, but rather sources of funding to help subsidize hospitals' overall uncompensated care costs. The populations supported through these programs are typically the same populations that qualify for hospital charity care policies. Just as the unreimbursed costs for charity care patients is recognized in the S-10, so should the unreimbursed portion (i.e., the shortfall) of state or local indigent care programs.

Moreover, the agency must revise the worksheet S-10 so data on Medicaid shortfalls better resemble actual shortfalls incurred by hospitals. CMS is not proposing to include Medicaid shortfalls from the S-10 in the calculation of uncompensated care costs. We agree that Medicaid shortfalls, as currently reported on the S-10, should not be included in the calculation of uncompensated care at this time. But data on Medicaid shortfalls increasingly will be useful for informational purposes as previously uninsured low-income individuals gain access to health coverage through Medicaid. Data on the unreimbursed costs of providing care to Medicaid patients (many of whom formerly were uninsured) will provide valuable information on Medicaid underpayment and, thus, should be measured accurately. Current data underestimate the amount of Medicaid shortfalls. First, GME-related costs are excluded, while GME-related reimbursements are included. Without the necessary revision to the CCR mentioned above, counting payments but not costs is an inaccurate way to measure shortfall. Second, the worksheet should be consistent in allowing hospitals to reduce their Medicaid revenues by the amount of any Medicaid nonfederal share funding they provide, whether through provider taxes, intergovernmental transfers (IGTs) or certified public expenditures (CPEs). Like provider taxes and assessments, provider-funded IGTs and CPEs are contributions to the nonfederal share of Medicaid payments and often are critical to a state's ability to make such payments. Allowing offsets for one such type of contribution—for example, provider taxes and assessments—and not others distorts shortfall amounts and might create inequities among hospitals. **Because of this discrepancy in the instructions and the different types of financing mechanisms used by states, the S-10 in its current form provides an incomplete picture of Medicaid shortfalls and should be revised to allow hospitals to deduct IGTs, CPEs, and provider taxes from their Medicaid revenues.**

CMS also should clarify the instructions on line 29 regarding non-Medicare bad debt for insured patients. The agency should allow coinsurance and deductibles to be included on the S-10 without multiplying them by the CCR. Currently, CMS' cost report instructions and guidance as revised last year dictate that hospitals do not have to multiply non-reimbursed Medicare bad debt by the hospital CCR, since these amounts are coinsurance and deductibles, which are actual amounts expected from the patient (as opposed to charges, which are not the actual amounts a patient is expected to pay). However, CMS' transmittal last year states that hospitals still should multiply their non-Medicare bad debt by the CCR. The different treatment of non-reimbursed Medicare bad debt and non-Medicare bad debt is inconsistent, and the agency provides no justification for the inconsistency. Coinsurance and deductible amounts for patients

other than Medicare fee-for-service (FFS) patients, such as Medicare Advantage (MA) patients, are actual amounts the hospital expects the patients to pay. Therefore, co-insurance and deductible amounts not paid should be listed as bad debt in their entirety and not reduced by the CCR. Making this change would be consistent with the way CMS treats charity care amounts for insured patients. CMS has clarified that charity care amounts for insured patients—that is, coinsurance and deductible amounts that patients do not have the ability to pay—do not have to be reduced by the CCR. **CMS should clarify the instructions for bad debt expenses to treat all coinsurance and deductibles for non-Medicare bad debt the same by not requiring they be multiplied by the hospital CCR.**

- vi. CMS should clearly communicate changes to the S-10 to stakeholders and continue to provide stakeholder education on revisions to the worksheet S-10.*

America's Essential Hospitals urges CMS to provide ample opportunities for stakeholder feedback and education before issuing substantive revisions to the worksheet S-10. Last September, CMS issued a transmittal revising the instructions on the S-10 pertaining to charity care and bad debt charges. These changes clarified CMS' policy on which lines of the cost report should be multiplied by the CCR and provided additional instructions on which types of costs can be included in charity care. However, these changes were more than merely clarifying instructions. The changes in the definition of charity care charges to include uninsured discounts, as well as the clarification that insured charity care charges do not have to be multiplied by the CCR, are essentially new policy that will affect the distribution of DSH payments. CMS at first provided hospitals a month to make these revisions. Subsequently, CMS extended the deadline to January 2, 2018. The information about the extended deadline was communicated inconsistently through hospitals' MACs; it was not communicated widely by the agency until a later date. Due to the scope of the changes made through the transmittal, as well as the importance of ensuring the accuracy of S-10 data, hospitals require substantial lead time to comply with revised instructions. CMS notes in the rule that about half of DSH-eligible hospitals revised their FY 2014 and 2015 cost reports. This indicates that the remainder of DSH-eligible hospitals were not able to take advantage of the additional time to revise their cost reports. **For this reason, we urge the agency to clearly communicate any revisions to stakeholders, as well as information about extended deadlines. We also urge the agency to allow stakeholders who already submitted their FY 2016 cost reports to reopen them to make revisions in accordance with the September 2017 transmittal.**

CMS also should conduct additional educational outreach to hospitals as the agency transitions to using data from the S-10. The S-10 will assume increased importance if it becomes the sole basis for uncompensated care-based Medicare DSH payments; as such, it is critical that CMS provide necessary guidance to hospital staff tasked with completing Medicare cost reports. Hospitals report that the S-10 and its corresponding instructions are ambiguous in certain respects, including directions on how hospitals should report non-Medicare bad debt. CMS should provide educational resources to hospitals in the form of agency conference calls, webinars, frequently asked questions documents, and examples illustrating how to report values on the S-10. Because the data entered on the S-10 will significantly affect hospital reimbursement,

CMS should work with hospitals to ensure they have appropriate and thorough direction when completing the worksheet.

2. CMS should examine ways to account for social risk factors in Medicare programs and continuously engage stakeholders to ensure transparency and reduced administrative burden.

While the health of the U.S. population overall has improved, socioeconomically disadvantaged populations continue to experience a disproportionate share of many diseases and adverse health conditions. Essential hospitals fulfill the complex clinical and social needs of all patients that come through their doors. Our members treat a high proportion of patients with social risk factors—factors outside the control of the hospital, such as lack of transportation for follow-up care or limited access to nutritious food—which can affect health outcomes.

Essential hospitals support quality and accountability. What they want—and what their patients and communities deserve—is to be on equal footing with other hospitals for purposes of evaluating quality. When calculating quality measures, Medicare programs should account for the socioeconomic and sociodemographic complexities of vulnerable populations to ensure hospitals are assessed on their work, rather than on the patients they serve. Differences in patients’ backgrounds might affect complication rates and other outcome measures; by ignoring these differences, CMS will skew quality scores against hospitals that provide essential care to the most complex patients, including those with sociodemographic challenges and the uninsured.

It is important to strive for quality and performance improvement, and essential hospitals show they are doing that every day in innovative ways and with limited resources. But these penalties might be counterproductive for essential hospitals that treat patients who often are sicker and higher utilizers than those at other hospitals. One recent study found that some programs—like the Hospital Readmissions Reduction Program (HRRP)—lead to persistent penalization for certain hospitals and limited capacity to reduce penalty burden. Alternative structures might prevent persistent penalization, while motivating hospitals to reduce hospital readmissions.⁶

As required by the Improving Medicare Post-Acute Care Transformation (IMPACT) Act, the Department of Health and Human Services’ (HHS’) Office of the Assistant Secretary for Planning and Evaluation (ASPE) in December 2016 released the first of two reports in which the connection between social risk factors and health care outcomes was clearly shown.⁷ The report provides evidence-based confirmation of what essential hospitals and other providers have long known: Patients’ sociodemographic and other social risk factors matter greatly when assessing the quality of health care providers.

⁶ Thompson M, et al. Most Hospitals Received Annual Penalties For Excess Readmissions, But Some Fared Better Than Others. *Health Affairs*. 2017;36(5):893–901.

⁷ Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation. Report to Congress: Social Risk Factors and Performance Under Medicare’s Value-Based Purchasing Programs. December 2016. <https://aspe.hhs.gov/system/files/pdf/253971/ASPESESRTCfull.pdf>. Accessed June 4, 2018.

The ASPE report illustrates that hospitals and other providers caring for large numbers of low-income patients are more likely to receive penalties under the HRRP and several other pay-for-performance programs. Unfortunately, failing to adjust measures for sociodemographic factors when necessary and appropriate can adversely affect patients and worsen health care disparities, because penalties divert resources away from hospitals and other providers treating vulnerable populations. Failing to appropriately risk adjust also can mislead and confuse patients, payers, and policymakers by not accounting for the effect of community factors that contribute to worse outcomes.

Policies aiming to improve quality of care should be expanded to include a specific focus on improving population health for the most vulnerable and underserved. **We urge CMS to further examine the recommendations in the ASPE report for future incorporation in Medicare programs.**

As noted by the National Academies of Sciences, Engineering, and Medicine (NAM), in its series of reports on accounting for social risk factors in Medicare programs, “achieving good outcomes (or improving outcomes over time) may be more difficult for providers caring for patients with social risk factors precisely because the influence of some social risk factors on health care outcomes is beyond provider control.”⁸ We urge CMS to closely examine NAM’s considerations for risk adjustment in federal programs. Among them, the ad-hoc group’s reports recommend four domains of risk indicators:

- income, education, and dual eligibility;
- race, ethnicity, language, and nativity;
- marital/partnership status and living alone; and
- neighborhood deprivation, urbanicity, and housing.

Like the growing body of research on socioeconomic risk adjustment, NAM found community-level elements providers are unable to change can indicate risk unrelated to quality of care.⁹ We urge CMS to examine these criteria, as identified by NAM, for choosing the risk factors for an adjustment methodology:

- conceptual relationship with the outcome of interest;
- empirical association with the outcome of interest;
- risk factor presence at the start of care;
- risk factor is not modifiable through the provider’s actions; and
- risk factor resistance to manipulation or gaming.

We urge CMS to examine NAM’s report for examples of currently available data that could be included in measure risk adjustment. The agency also should develop

⁸ National Academies of Sciences, Engineering, and Medicine. *Accounting for Social Risk Factors in Medicare Payment*. Washington, D.C.: The National Academies Press; January 2017. <http://nationalacademies.org/hmd/Reports/2017/accounting-for-social-risk-factors-in-medicare-payment-5.aspx>. Accessed June 4, 2018.

⁹ America’s Essential Hospitals. *Sociodemographic Factors Affect Health Outcomes*. April 18, 2016. <http://essentialhospitals.org/institute/sociodemographic-factors-and-socioeconomic-status-ses-affect-health-outcomes/>. Accessed June 4, 2018.

analytic methods for integrating patient data with information about contextual factors that influence health outcomes at the community or population level.

Identifying which social risk factors, such as readmissions, might drive outcomes and how to best measure and incorporate those factors into payment systems is a complex task, but doing so is necessary to ensure better outcomes, healthier populations, and lower costs. We look forward to working with CMS to account for social risk factors and reducing health disparities across Medicare programs.

3. CMS should continue to refine the HRRP risk-adjustment methodology, mandated by law, to mitigate unintended consequences, including disproportionate penalties against essential hospitals.

Reducing preventable readmissions is of paramount concern to America's Essential Hospitals and its members. We believe that any program directed at reducing readmissions must target readmissions that are preventable and include appropriate risk-adjustment methodology. America's Essential Hospitals previously expressed concern that the HRRP unduly penalizes hospitals that serve the nation's most vulnerable populations because it fails to account for external factors that explain higher readmission rates. Accurately measuring readmissions, when appropriately risk adjusted, supports essential hospitals' ability to provide care to all patients, including the vulnerable.

- a. CMS should improve inadequacies in the risk-adjustment methodology for the HRRP by examining methods beyond payment adjustment and accounting for social and community-level factors at the measure level.

We are pleased that CMS finalized the provisions of the 21st Century Cures Act related to risk adjustment in the HRRP rulemaking process.¹⁰ Specifically, section 15002 of the recently enacted 21st Century Cures Act directs the HHS secretary to "assign hospitals to groups ... and apply the applicable provisions of this subsection using a methodology that allows for separate comparison of hospitals within each such group" for the HRRP.¹¹ The legislation further specifies that the groups are to be "based on their overall proportion, of the inpatients who are entitled to, or enrolled for, benefits under Part A, and who are full-benefit dual eligibles." But this is only the first step toward true risk adjustment for hospitals treating patients with social and economic challenges. **The agency must go a step further and adjust measures so that quality comparisons are accurate and fair.**

CMS should ensure the methodology for calculating a hospital's excess readmissions includes adequate risk adjustment for the program's six applicable conditions: acute myocardial infarction; heart failure; pneumonia; acute exacerbations of chronic obstructive pulmonary disease; elective total hip arthroplasty and total knee arthroplasty (or hip and knee replacement, respectively); and hospital-level, 30-day, all-cause, unplanned readmission following coronary artery bypass graft. Currently, the methodology used to calculate the readmission measures does not incorporate risk

¹⁰ 21st Century Cures Act, P.L. 114-255 (H.R. 34, section 15002), 114th Cong. (2016).

¹¹ Ibid.

adjustment for sociodemographic status, language, postdischarge support structure, or other factors that reflect the challenges involved in caring for disadvantaged populations.¹²

Race, homelessness, cultural and linguistic barriers, low literacy, and other socioeconomic factors can skew results on certain quality measures, such as those for readmissions. It is well known that patients who lack reliable support systems after discharge are more likely to be readmitted to a hospital or other institutional setting. These readmissions result from factors beyond the control of providers and health systems and do not reflect the quality of care.¹³ Risk adjusting measures for these factors will ensure that patients receive accurate information about a hospital's performance. Without proper risk adjustment, providers—many of them essential hospitals—could be forced to absorb a greater proportion of readmissions penalties, leaving them with even fewer resources to treat disadvantaged populations.

Essential hospitals go above and beyond medical treatment to provide for vulnerable patients every day; for example, one hospital in Florida introduced a program that ensures discharged patients have nutritious food—something vital to their recovery. The program combines a team of clinicians, social workers, and other health care professionals to determine whether patients are malnourished or at risk for malnutrition after discharge. At-risk patients then are provided nutritional counseling during their hospital stay and are eligible to receive nutritionally balanced meals after discharge.

By not considering all the differences in patients' backgrounds that might affect readmission rates inevitably will skew readmission measure calculations against hospitals providing essential care to low-income individuals, including the uninsured. The failure to risk adjust could cause hospitals treating a large proportion of complex patients to face penalties at an increased rate, further diminishing resources at hospitals that often operate at a loss.¹⁴ **America's Essential Hospitals urges CMS to include factors related to a patient's background—including sociodemographic status, language, and postdischarge support structure—in measure development and risk-adjustment methodology.**

- b. CMS should closely monitor the implementation of risk-adjustment methodology, as mandated by law, for unintended consequences to certain types of hospitals.

In the FY 2018 IPPS final rule, CMS finalized a payment-adjustment methodology for inclusion of dually eligible patients in the HRRP beginning in FY 2019. The payment-

¹² Nagasko EM, et al. Adding Socioeconomic Data to Hospital Readmissions Calculations May Produce More Useful Results. *Health Affairs*. 2014;33(5):786–791.

¹³ See, e.g., National Quality Forum Technical Report. Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors. August 2014. http://www.qualityforum.org/Publications/2014/08/Risk_Adjustment_for_Socioeconomic_Status_or_Other_Sociodemographic_Factors.aspx. Accessed June 4, 2018.

¹⁴ Reiter KL, Jiang HJ, Wang J. Facing the Recession: How Did Safety-Net Hospitals Fare Financially Compared with Their Peers? *Health Services Research*. 2014;49(6):1747–1766.

adjustment methodology assesses hospitals relative to their performance within the same peer group. CMS proposes to codify the previously adopted definitions of dual-eligible patients, the proportion of dual eligibles, and the applicable period for dual eligibility. Specifically, hospitals are stratified into five peer groups, or quintiles, based on proportion of dual-eligible stays. CMS identifies full-benefit dual status using dual-eligibility status data from the Medicare Modernization Act file, which states submit monthly to CMS. CMS then defines a hospital's proportion of dual-eligible patients as the number of such patients among all Medicare FFS and MA stays. **We support CMS' use of quintiles, but we urge CMS to closely monitor the effect of this peer grouping approach, continuously evaluate it, and make adjustments as necessary to avoid unintended consequences for essential hospitals.**

Further, we recognize CMS' approach to include managed care patients with FFS patients is an attempt to account for states with high managed care penetration rates. However, the HRRP payment adjustment ultimately is applied only to Medicare FFS payments and is based on excess readmissions among only Medicare FFS patients. **We ask the agency to closely monitor its definition of proportion of dual eligibles for unintended consequences among hospitals in states with high managed care penetration, compared with those that have low penetration, and modify the methodology to adjust for future growth in managed care.**

4. CMS should implement policies that reduce burden on hospitals in the Medicare and Medicaid Promoting Interoperability Programs (PIPs) and provide flexibility as they transition to more difficult Stage 3 requirements.

CMS proposes changes to the Medicare and Medicaid PIPs for calendar years (CYs) 2019 and 2020 that will require hospitals to transition to more stringent program requirements. Specifically, CMS proposes that beginning in CY 2019, hospitals must exclusively use the 2015 version of certified EHR technology (CEHRT) and report on Stage 3 measures, both of which are optional in CY 2018. In addition, CMS proposes to restructure Stage 3 by changing the scoring methodology for hospitals and reconfiguring the objectives and measures in the program. The proposed scoring methodology and measure reconfiguration apply only to hospitals participating in the Medicare PIP and to those participating in both the Medicare and Medicaid PIPs. States have the option to adopt these changes for Medicaid-only hospitals.

While hospitals work toward the overarching goals of Stage 3—to promote interoperability and ensure patient access—the reality of provider EHR usage does not yet match CMS' timeline. We applaud CMS for acknowledging some of these difficulties, such as by proposing to remove measures dependent on patient action and by providing additional flexibility in the proposed new scoring approach. Through these proposals, CMS acknowledges that eligible hospitals still face obstacles to the meaningful use of health information technology (IT). In many respects, however, CMS leaves some of the underlying difficulties with Stage 3 unchanged, such as the heavy reliance on information exchange with outside providers. CMS should take additional steps to reduce provider burden and enable hospitals to deliver high-quality, patient-centered care. Below, we provide recommendations specific to CMS' proposals in the

rule that will ensure providers are afforded sufficient time and flexibility to attain true interoperability and extend the benefits of EHRs to their patients.

- a. CMS should remove measures contingent on patient action outside of hospitals' control.

America's Essential Hospitals is encouraged that CMS has proposed to remove measures dependent on patient action, and we strongly urge the agency to finalize its proposal to remove these measures in Stage 3. In the rule, CMS proposes to remove four measures in Stage 3 related to patient-specific education; secure messaging; view, download, or transmit; and patient-generated health data. Hospitals have struggled with reporting these measures because successfully doing so requires patient action. These challenges are even more pronounced for essential hospitals, whose vulnerable patient populations often have less access to and knowledge of how to use IT. Providers should not be penalized for failing to meet thresholds when performance on a measure is outside of their control. We are pleased that CMS has proposed the removal of these measures; reducing this burden will enable providers to dedicate their resources and staff time to measures more relevant to hospitals and their patients.

- b. CMS should delay Stage 3 for an additional year and allow providers another year to implement 2015 CEHRT.

CMS should delay Stage 3 until at least CY 2020. In the meantime, the agency can take steps to ensure all stakeholders are prepared for the complex requirements of this stage. We are concerned that some aspects of Stage 3 impose unnecessary burdens on providers instead of incorporating meaningful metrics that facilitate the provision of health care and improve the provider-patient relationship. In some respects, Stage 3 requirements merely build on many flawed elements of the existing program, simply raising thresholds for measures already demonstrated to be unfeasible. The requirements of the PIPs so far have proved quite onerous for some providers, particularly essential hospitals with scarce resources and diverse patient populations. CMS should not rush providers into Stage 3 without requisite advances, such as truly interoperable products; standards that ensure the seamless exchange and use of health information; and adequate testing of such standards and of electronic clinical quality measures (eCQMs). Regarding interoperability, hospitals have experience exchanging health information with other providers, but obstacles remain to seamless information exchange. The Office of the National Coordinator for Health Information Technology (ONC) is leading efforts to facilitate information exchange, such as through its work on the Trusted Exchange Framework and Common Agreement (TEFCA).

Stage 3 contains new requirements, including the use of application programming interfaces (APIs) that can give patients access to their health information through mobile applications. However, much work remains for ONC to develop certification criteria that ensure these APIs meet program requirements and have mature standards. There also are serious privacy and security concerns about the use of APIs and third-party applications. Recent cybersecurity threats to providers, including in the form of ransomware attacks, are a reminder of the need to ensure the security of new

capabilities before rushing into their implementation. CMS must thoroughly vet these issues before APIs are ready for Stage 3.

In addition to the issues on Stage 3, vendors still are preparing compliant EHRs. Given the shortage of EHR products, there are significant doubts about vendors' ability to deliver the systems in time for providers to successfully test and deploy them by January 1, 2019. Without these systems, providers face rushed implementation, which might jeopardize patient safety and result in substantial financial penalties.

CMS can alleviate this concern by offering flexibility regarding the edition of CEHRT a provider must use in CY 2019. **Specifically, CMS should give providers the option of using 2014 edition CEHRT, 2015 edition CEHRT, or a combination of both for the CY 2019 reporting period.** The 2015 certification criteria are tailored to enable new capabilities in EHR products in Stage 3, such as the use of APIs and the electronic exchange of information. However, vendors have not made sufficient progress in making 2015 edition products available. A recent search of the Certified Health IT Product List shows that there are 338 products currently certified to the 2015 requirements. Of these, only a subset are complete hospital EHR platforms that can be used to meet the Stage 3 requirements—the remainder are limited modules for other types of providers and specialties or are limited to specific functionalities, such as a patient portal. In comparison, there are more than 2,400 EHR products still certified to the 2014 criteria.

Aside from the paucity of available products, the upgrade process to a new edition involves many different parties—both within and outside the hospital—and requires a substantial investment of time and staff resources. When providers begin upgrading their EHRs, they inevitably will have issues that need to be resolved with the provider's IT staff and vendor. Fully implementing a new EHR platform and ensuring it is ready to use involves a substantial investment of financial resources, staff training, updating workflows, and testing the technology.

Providing additional flexibility would not be without precedent. In 2014, some providers faced significant obstacles in upgrading EHRs to the 2014 edition; in response, CMS allowed hospitals to use the 2011 edition. CMS also provided flexibility in 2018, recognizing the low availability of 2015 certified products. Similar flexibility in 2019 is critical as providers transition to Stage 3.

- c. CMS should finalize a 90-day reporting period for CYs 2019 and 2020.

CMS should finalize its proposal to shorten the 2019 and 2020 PIPs reporting periods to 90 days, which will offer much-needed relief as providers transition to a new version of CEHRT and to more demanding Stage 3 measures. While we continue to push for a one-year delay of Stage 3, the flexibility of a 90-day reporting period will be critical in 2019 and 2020 for providers to begin preparing for Stage 3 requirements. Many of the Stage 3 objectives—such as those requiring the use of APIs and health information exchange—differ from Stage 2 measures for hospitals, so hospitals will benefit from additional preparation time resulting from a shorter reporting period. The shorter reporting period will give hospitals time to adjust to Stage

3 and make system changes necessitated by new measures and the new scoring methodology. Accordingly, CMS should finalize the 90-day reporting period for CYs 2019 and 2020.

- d. CMS should not finalize the inclusion of the two opioid-related measures until there are adequate standards and specifications for these measures.

CMS should not finalize the inclusion of two opioid-related measures, due to the lack of uniformity across states in the adoption of these practices, as well as a lack of standards and certification criteria. CMS proposes two opioid-related measures for the electronic prescribing (e-prescribing) objective, which would be optional in 2019 and required in 2020:

- Query of Prescription Drug Monitoring Program: For at least one Schedule II opioid e-prescribed using CEHRT during the EHR reporting period, the eligible hospital or critical access hospital (CAH) uses data from CEHRT to conduct a query of a prescription drug monitoring program (PDMP) for prescription drug history, except where prohibited and in accordance with applicable law; and
- Verify Opioid Treatment Agreement: For at least one unique patient for whom a Schedule II opioid was e-prescribed by the eligible hospital or CAH using CEHRT during the EHR reporting period, if the total duration of the patient's Schedule II opioid prescriptions is at least 30 cumulative days within a six-month look-back period, the eligible hospital or CAH seeks to identify the existence of a signed opioid treatment agreement and incorporates it into the patient's EHR using CEHRT.

Essential hospitals are on the front lines of treating patients most affected by the opioid crisis and have implemented innovative strategies to reduce opioid dependence. As leaders in population health, essential hospitals continue to develop programs that prevent opioid misuse among the most vulnerable populations. They partner with pharmacies, public health departments, law enforcement, emergency medical services, and other community providers to combat the crisis. As key stakeholders in combating the opioid crisis, essential hospitals stand ready to implement practices that have been proved effective in reducing opioid dependence. While the intent behind using EHRs to fight the opioid crisis is commendable, the measures CMS proposes are not ready for inclusion in the PIPs.

The PDMP and opioid treatment agreement measures are not ready for inclusion in the PIPs because they lack uniformity of adoption across states and providers. PDMPs are state-level databases that can be used to increase provider awareness of at-risk patients and thus reduce prescription drug abuse. Due to varying state requirements governing PDMPs, their use is uneven across the country. Not all states require the use of PDMPs and one—Missouri—does not even have a PDMP. Additionally, platforms differ by state, creating a lack of uniformity in accessing PDMP data and difficulty in establishing standards for the use of EHRs to access PDMP data. There are no standards or certification criteria governing the use of PDMPs, so hospitals have no guarantee that their CEHRT will include the functionality to query a PDMP.

Like the difficulties associated with the use of PDMPs, opioid treatment agreements are not integrated into CEHRT by all providers. Aside from the technological challenges with the opioid treatment agreement measure, there is a difference of opinion among providers, as well as patients, about the usefulness of these agreements. There also is wide variation in what constitutes an opioid treatment agreement, with no uniform definition of what elements are required for such an agreement for the purposes of the proposed measure. Both this measure and the PDMP measure would require significant changes in provider workflows, as well. Due to these issues, it would be premature for CMS to add these measures to the PIPs. **We urge the agency to continue to evaluate provider and EHR vendor readiness for these measures and not finalize the measures at this time.**

- e. CMS should lower the required minimum total score and provide more flexibility in the scoring methodology.

CMS should reduce the minimum total score to satisfy the requirements of the PIPs and allow hospitals to attest to the measures that are most useful to their practices and patient populations. Under the current structure of the program, CMS assesses hospitals on a measure-by-measure basis, with required minimum percentage thresholds that a hospital must achieve to meet the requirements of the program and avoid a penalty. A hospital that meets all but one measure under a single objective is not deemed a meaningful user and is penalized under this approach. Penalizing a hospital that is willing and able to meet the thresholds, but misses the threshold for one or two measures, is a disincentive to program participation. These rigid requirements often are an obstacle to fulfilling the true promise of EHRs to empower providers to offer the most appropriate care.

CMS' proposed scoring methodology is a step in the right direction, because it removes minimum individual thresholds for measures in favor of a weighted-average scoring approach. CMS' proposal is to assign a weight to each measure in the program and calculate a score based on the hospital's performance rate for each measure. For example, a hospital reporting a 60 percent performance rate for the e-prescribing measure in 2019 would receive a score of 6 for that measure (10 maximum possible points multiplied by 0.6). A hospital can receive a maximum of 100 points (plus potential bonus points for the opioid measures in 2019) across all measures, but must receive a minimum total score of 50 to meet PIPs requirements and avoid a penalty.

In some respects, this approach is still all-or-nothing in that a hospital must report on every single measure in the program, even though there is not a minimum threshold for each measure. Further, a hospital would have to receive on average a score of 50 percent on each measure to receive a total passing score of 50. A hospital can compensate for low scores on individual measures by scoring exceptionally high on other measures. However, the scoring methodology is skewed in favor of more highly-weighted measures, such as the health information exchange measures and the measure requiring hospitals to provide patients electronic access to their health information. In practice, a hospital must receive high performance rates on both health information exchange measures to reach the minimum required score. Expecting high rates of performance on these measures in the first year of Stage 3 is unrealistic. In the currently finalized

version of Stage 3 measures with individual measure thresholds, CMS established a minimum threshold of 10 percent for these measures, acknowledging the barriers providers face to exchanging health information. By lowering the minimum required total score, CMS will allow providers to focus on measures of importance to them, instead of dedicating resources to measures that might be difficult for reasons outside of their control, such as the inability of outside providers to send or receive a summary of care document.

Additionally, CMS can provide more flexibility in the PIP scoring methodology by awarding hospitals a base score for reporting on all the required measures. This would be in addition to any performance points awarded for a hospital's performance rate on specific measures. This approach would be in alignment with the methodology for clinicians in the Merit-based Incentive Payment System of the Quality Payment Program (QPP). For example, hospitals could receive 20 of their total required points through a base score, which would be awarded to hospitals if they report a numerator and denominator for the required measures in the PIPs.

- f. CMS should adopt its alternative scoring methodology, which would award points on the objective level, instead of the measure level.

CMS also seeks comment on whether hospitals should be assessed at the objective level, rather than requiring reporting and scoring at the measure level. Instead of the required six measures, hospitals would be scored on only one measure in each objective, with the potential to receive bonus points for reporting on additional measures within each objective. **We urge CMS to adopt this alternative approach, as it allows providers the necessary flexibility to choose which measures on which to report. While CMS does not provide additional details on this approach, we urge the agency to allow hospitals to choose any measure from each objective and receive bonus points for any additional measures on which they can report.**

- g. CMS should revise Stage 3 measures while the agency and other stakeholders resolve barriers to health information exchange and patient access to health records.

As providers prepare for the transition to Stage 3, CMS should refine certain Stage 3 measures while it works to correct known issues on health information exchange that are outside of the hospital's control. Stage 3 includes more exacting requirements for health information exchange, such as requiring that providers both send and receive summary of care documents for patients referred or transitioned to and from outside providers. This measure also includes the requirement to reconcile information received from outside providers for new patients. The Stage 3 patient access measure includes a new requirement to provide patients access to their health information using any application of their choice through an API enabled as part of the EHR. The public health and clinical data exchange objective also requires active engagement with public health agencies to share various types of data, including on syndromic surveillance, immunizations, clinical data, and laboratory results. We are in support of the seamless exchange of information with other providers, patients, and public health agencies. However, as we outline below, there are many unresolved issues

related to health information exchange that must be identified and fixed before CMS can expect hospitals to fully meet the requirements of these measures. Until those issues are resolved, CMS can revise certain measures to ease the burden on hospitals.

- i. CMS should provide hospitals with the option to report on any two public health and clinical data exchange measures and award bonus points for additional public health measures.*

For the public health and clinical data exchange objective, which has a total of six measures, CMS propose requiring hospitals to report on the syndromic surveillance measure and a choice of any one of the five remaining measures. **Instead of requiring the syndromic surveillance measure, CMS should give hospitals the option to report on any two public health measures and receive bonus points for any additional measures.** While hospitals are capable of actively engaging with their public health agencies, many continue to have trouble with public health measures because of implementation delays on the part of those agencies. For example, an essential hospital reports that their state public health agency is not ready for the bidirectional exchange required for certain measures in Stage 3, including the immunization registry measure. Other essential hospitals have reported concerns that agencies continue to face challenges with the syndromic surveillance measure. By providing hospitals with the option to choose any two public health measures, CMS will accommodate hospitals in states where public health agencies are not yet able to support all the Stage 3 public health measures. The potential to earn bonus points for any public health measures reported beyond the two required measures also will encourage hospitals to exchange additional categories of information with their public health agencies.

- ii. CMS should facilitate efforts to improve health information exchange and revise the support electronic referral loops measure to reduce provider burden associated with clinical information reconciliation.*

Members of America's Essential Hospitals have experienced various obstacles to meeting the measure requiring electronic exchange of a summary of care record for transitions or referrals. As large, integrated health systems, essential hospitals can provide a variety of services within their system without referring a patient to a provider outside of the system. Because of this, many essential hospitals lack a sufficient number of transitions or referrals outside of the system to meet the required threshold for this measure. Even in cases for which an outside referral is necessary, the providers receiving the referral often do not have the capability to receive an electronic summary of care. Essential hospitals might refer patients to providers who are able to offer the most linguistically and culturally competent care to their diverse patients, even if these providers do not have EHRs capable of receiving a document for this measure. Providers in settings that do not take part in the PIPs, such as post-acute care providers, also frequently are not equipped with the technology to electronically accept a summary of care document. As a result, providers either are forced to change existing referral patterns solely to meet the measure or suffer the risk of not meeting the measure threshold due to factors unrelated to their own ability to exchange data.

CMS and ONC should lift barriers to exchanging information through the Direct Project standard. Direct exchange is a standard for secure transmission between providers and is one method through which providers can exchange information for the purposes of the electronic exchange measure. Vendor EHRs must be certified to enable the use of Direct exchange. However, while vendor software is required to be Direct certified, many vendors have specific requirements for sending and receiving Direct messages that are incompatible with other vendor EHRs. Additionally, each provider has a Direct address for transmitting data, but there is no centralized list that providers can use to locate a receiving provider's Direct address. Providers invest significant time in contacting other providers to determine and verify their Direct address—time that could be spent on other patient care activities. **ONC should create standards necessary for the development of a centralized, accurate directory that would enable providers to easily locate other providers' Direct addresses before sending a document.** This is one step that CMS and ONC can—and should—take in facilitating interoperability and information exchange.

Hospitals receive large amounts of data from other sources, including external providers. CMS proposes to require that hospitals conduct clinical information reconciliation for three types of data received from other providers—medication, medication allergies, and problem lists. Vendors' EHR products often are unreliable at automatically reconciling information from external providers. EHR systems might be able to identify if information received from another provider is an exact match with an existing record, but the structure of underlying data can be altered slightly as data is transferred across providers and between different types of EHRs. For example, an existing condition on a problem list, such as diabetes, might appear in slightly varied terminology in two different EHRs. This makes automatic reconciliation through the EHR impractical, and in turn requires substantial staff time to conduct reconciliation. Hospitals also face the challenge of matching patients using existing algorithms, which are not sufficiently robust to identify if an incoming record is for a patient previously seen by the hospital. This also requires manual identification by staff to open an inbound document and compare it with potential matching patients to determine if there is a match. **Because of the significant amount of time required for information reconciliation, as well as the lack of automated processes to conduct reconciliation, CMS should require hospitals to perform only reconciliation for one of the three types of data, as opposed to all three.**

iii. CMS should revise the patient access measure to increase opportunities for providers to share health information with patients.

The Stage 3 measure to provide patients access to their health information also includes a requirement that hospitals give patients access to such information through any application of their choice, provided it is configured to meet the specifications of an API that meets ONC certification criteria. Providers can use APIs to give patients access to their health information through third-party applications—such as smart phone applications—instead of being limited to a vendor's patient portal. The use of APIs in Stage 3 is promising because it potentially offers providers and patients a variety of options through which to access health information, instead of limiting them to a single portal. The availability of the API functionality will provide an alternative option for

hospitals that have not implemented a patient portal because it is financially prohibitive or because the portal does not meet the organization's needs. However, instead of requiring that a hospital provide access to view, download, and transmit patient information *and* do so through an application, CMS should allow hospitals to provide timely access through an existing mechanism such as a portal *or* through an application.

America's Essential Hospitals supports the concept of leveraging APIs to satisfy the patient access requirement, in addition to allowing for the current method of meeting this objective. CMS must thoroughly vet privacy and security issues related to APIs before they are required in Stage 3. **While providers, vendors, and application developers gain more experience and address privacy and security issues associated with APIs, CMS can change the PIP requirement to allow the API as an option, instead of a requirement, for facilitating patient access.**

To mitigate privacy and security concerns, CMS can allow hospitals to meet the API requirement by providing access through a single application, instead of *any* application of the patient's choice. Requiring a hospital to enable access through any application that a patient chooses could introduce security threats if the provider is unable to maintain some control over the applications through which it is sharing patient information. Due to the proliferation of mobile applications, a patient could request access through any application that has not been thoroughly vetted and is new to the market; This could lead to privacy and security concerns.

- h. CMS should finalize its proposal to require four eCQMs for one self-selected calendar quarter reporting period.

CMS should finalize its proposal that hospitals electronically reporting eCQMs in the Inpatient Quality Reporting (IQR) Program and PIPs should choose four measures to report for one self-selected quarter. A shorter eCQM reporting period and fewer required measures will help hospitals that are experiencing vendor issues as they upgrade their CEHRT. As hospitals make the transition to 2015 edition CEHRT, many will face delays as they work with their vendor to ensure the seamless operation of the 2015 edition CEHRT across their hospital (as was the case during the last required upgrade to the 2014 edition). The upgrade process will make it even more difficult for hospitals to electronically report eCQMs for more than one calendar quarter, especially if they are not able to complete the upgrade to the new CEHRT until the end of the year.

The additional flexibility CMS provides also will give the agency more time to verify that these measures are reliable and valid and have accurate specifications. CMS should work with EHR vendors to make electronic reporting of measures a viable option for all hospitals. The extracted EHR data differ from data obtained from chart-abstracted measures and, therefore, are not reliable for display in a publicly reported program. These issues also have been highlighted by the Government Accountability Office (GAO), which noted that "HHS has not yet developed a comprehensive strategy to address concerns with the reliability of eCQMs collected using certified EHRs."¹⁵ Due to

¹⁵ Government Accountability Office. Electronic Health Record Programs: Participation has Increased, but Action Needed To Achieve Goals, Including Improved Quality of Care. March 2014. <http://www.gao.gov/assets/670/661399.pdf>. Accessed June 3, 2018.

the differences between data extracted from eCQMs and chart-abstracted quality measures, CMS should adopt a validation process and conduct robust testing to ensure data extracted from eCQMs are accurate and comparable to chart-abstracted information.

Further, it would be premature for CMS to require electronic reporting before all measures are fully electronically specified and field tested. In general, electronic measures have specific requirements about what type of information should be documented; they require more standardization than non-electronic measures. Without detailed electronic specifications available far in advance, many providers will not have enough time to bring their reporting systems up to date. Providers are adapting their workflows to ensure meticulous entry of standardized data into their EHRs. However, it is a process that requires extensive training and resources. Often, the data produced by chart-abstracted measures and eCQMs vary widely. Therefore, it is unwise to finalize any electronic measure until there is enough evidence of its validity in the field to justify its inclusion as a truly meaningful measure.

Due to the unresolved issues with electronic reporting for providers, vendors, and the agency, we support CMS' proposal to require four eCQMs and allow hospitals to choose any one calendar quarter for electronic reporting.

5. CMS should continue to refine the IQR Program measure set so it contains only reliable and valid measures that provide an accurate representation of quality of care.

CMS should continue to tailor the IQR Program measure set so it helps hospitals improve care quality and benefits the public by accurately reflecting the care hospitals offer. America's Essential Hospitals supports the creation and implementation of measures that lead to quality improvement. However, before including measures in the IQR Program, CMS must verify that the measures are properly constructed and do not lead to unintended consequences.

CMS proposes to remove or de-duplicate 39 measures across the FY 2020, 2021, 2022, and 2023 payment determinations. CMS also proposes to adopt an additional factor, related to the costs and benefits of measures, to consider when evaluating measures for removal from the IQR Program. We applaud CMS' recognition that providers are overwhelmed and burdened by the number of measures for which they are required to collect, report, and analyze data. Measures found in two quality programs often lead to duplicative efforts and increased costs associated with tracking reports. For essential hospitals, which already face resource demands, there is a real need to not only remove measures, but also ensure that remaining measures are accurate and meaningful and do not unfairly penalize certain groups of hospitals.

CMS also proposes two measures for future inclusion in the program—a hospitalwide mortality measure and a hospital harm opioid-related adverse events measure. Additionally, CMS seeks input from stakeholders about the provision of confidential feedback reports, for the pneumonia readmission measure, beginning fall 2018, with results stratified by patient dual-eligibility status.

The following comments provide specific recommendations to ensure the IQR Program provides accurate information on hospital quality of care and does not unfairly penalize certain hospitals.

- a. We support CMS' Meaningful Measures Initiative and encourage the agency to continue to refine the IQR Program measure set.

Essential hospitals have long supported quality measurement and pay-for-performance initiatives as vitally important tools for improving value. However, the rapid growth in measures and measure reporting requirements has jeopardized the effectiveness of efforts to make meaningful quality improvements. Although some measures provide useful information, their sheer number—as well as lack of focus, consistency, and organization—limits their overall effectiveness in improving health system performance. Further, the proliferation of measures combined with a lack of consistency often leads to inaccurate comparisons of providers and confusion for consumers.

As highlighted by the Institute of Medicine's Committee on Core Metrics for Better Health at Lower Cost, there is a need to reduce the burden of unnecessary and unproductive reporting by requiring fewer, more focused measures that improve comparability.¹⁶ The committee set forth a measure set of “vital signs” for tracking progress toward improved health and health care in the United States. While this starting set might be imperfect, it emphasizes the importance of streamlining measures to promote greater alignment and harmonization and to reduce redundancies and inefficiencies in health system measurement.

Last year, CMS launched its Meaningful Measures Initiative to identify high-priority areas for quality measurement and improvement. In the IPPS proposed rule, CMS outlines changes across the quality programs to meet the objectives of the Meaningful Measures Initiative. Specifically, the agency references 19 meaningful measure areas identified as high impact. These measure areas can be categorized into six overarching priorities:

- making care safer by reducing harm caused in the delivery of care;
- strengthening person and family engagement as partners in care;
- promoting effective communication and coordination of care;
- promoting effective prevention and treatment of chronic disease;
- working with communities to promote best practices of healthy living;
- and
- making care affordable.

Beyond these goals, CMS has stated that the hospital value-based programs “should not add unnecessary complexity or costs associated with duplicative measures across programs.” **We applaud CMS' efforts to increase measure alignment across programs and reduce provider reporting burden. We encourage the agency to**

¹⁶ Blumenthal D, Malphrus E, McGinnis JM. Vital Signs: Core Metrics for Health and Health Care Progress. Institute of Medicine Committee on Core Metrics for Better Health at Lower Cost. Washington, D.C.: *The National Academies Press*; 2015.

continue this work, with input from all stakeholders, to promote improved outcomes while minimizing costs.

- b. CMS should provide flexibility in the application of the proposed additional factor—i.e., the costs and benefits of a measure—the agency will consider when evaluating measures for removal from the IQR Program measure set.

CMS previously removed measures from its quality programs for a variety of reasons, including that measures were topped out, measures did not align with current clinical guidelines, or a more applicable measure became available. CMS currently uses seven factors to decide whether to remove measures in the IQR Program; these factors are considerations, not firm requirements. Beginning in FY 2019, CMS proposes to adopt an eighth factor: whether the costs associated with a measure outweigh the benefit of its continued use in the program. Further, the agency has stated that it would remove measures based on this new factor on a case-by-case basis. **We support the addition of this factor and encourage CMS to provide flexibility in its application as stakeholders might define costs and benefits in various ways.**

In proposing the additional removal factor, CMS has identified different types of costs, including, but not limited to, provider collection burden, CMS program oversight, and costs associated with participating in multiple programs. **We urge CMS to consider a broad variety of costs, both direct and indirect, associated with a measure, as they might create significant burden on essential hospitals and outweigh the benefit of its continued use.** For example, CMS might examine whether data is collected from a single or limited number of data sources, as opposed to multiple different sources (charts, EHR, claims, disease registries, etc.) to calculate the measure. Similarly, a burden or cost could be that hospitals must contract with (and pay for) external vendors to collect and report data. For essential hospitals already operating on low margins, these costs have significant implications. Additionally, CMS should examine the indirect benefits of a measure, such as whether the data collected in the course of reporting a measure can inform multiple measures. Conversely, if a measure does *not* inform other measures, perhaps it should be removed from the program.

Additionally, we urge CMS to seek input from hospitals, physicians, and other stakeholders when evaluating costs and benefits. Recently, CMS requested participation by clinicians in a study related to the QPP. Specifically, the agency will study the burdens associated with reporting quality measures in the QPP, by asking clinicians about their clinical workflows and data collection methods using different submission systems, as well as challenges they have in collection and reporting of quality data. We encourage CMS to promote this type of information sharing across its programs so that the day-to-day “costs” of quality reporting are captured and incorporated into the agency’s considerations for removal of measures.

- c. CMS should finalize the removal and de-duplication of measures in the IQR Program and continue to refine the measure set for future program years.

CMS proposes to remove 39 measures across the FY 2020, 2021, 2022, and 2023 payment determinations. However, CMS will only remove 18 measures entirely, while

21 measures will be de-duplicated—i.e., these measures will remain in one of the other four hospital quality programs. **We applaud CMS’ efforts to streamline measures across its programs.** This is a step in the right direction for quality measurement, and we look forward to working with the agency to further its initiative to come to a consensus on a set of meaningful measures across providers, patients, and payers.

However, some measures that CMS has determined are no longer good indicators of quality in one program would remain in another program. **We urge CMS to remove entirely measures that the agency has determined are inappropriate for use in one program.** For example, CMS proposed to remove the elective delivery (PC-01) measure from the Value-based Purchasing (VBP) Program, but this measure would remain in the IQR Program. CMS said the measure should be removed from the VBP Program because as “overall performance on the PC-01 measure has improved over time ... the measure will have little meaningful effect on the [total performance score] for most hospitals.” It is confounding that this measure would remain in any program based on CMS’ reasoning for its removal in one program. **We urge the agency to seek consistency in the removal of measures across programs to truly streamline reporting and avoid confusion by providers and patients.**

- d. CMS should provide clarification and guidance to hospitals about the implications on overall hospital star ratings of its proposed removal of measures from the IQR Program.

The overall star rating for hospitals includes a select group of quality measures taken from all measures reported on Hospital Compare, divided into seven measure groups or categories: mortality, safety of care, readmission, patient experience, effectiveness of care, timelines of care, and efficient use of medical imaging. CMS uses certain criteria to exclude measures from the overall star rating calculation. Among the exclusion criteria is that CMS will not include a measure in the star rating calculation if the measure is not required for the IQR Program.

CMS proposes removal from the IQR Program of certain National Healthcare Safety Network (NHSN) measures, including *Clostridium difficile* infection (CDI), catheter-associated urinary tract infection (CAUTI), central line-associated bloodstream infection (CLABSI), and methicillin-resistant *Staphylococcus Aureus* (MRSA) bacteremia, as well as the patient safety and adverse events composite (PSI 90) measure. These measures currently are included in the overall star ratings measure set. If a factor for measure exclusion from the star ratings methodology is that a measure is not required for the IQR Program, then it follows that the NHSN measures proposed for removal would not be included in a star rating calculation. **We seek clarification from CMS as to star rating implications in the event CMS’ proposals for measure removal from the IQR Program are finalized.**

- e. CMS should only include measures in the IQR Program that are evidence-based, National Quality Forum (NQF)-endorsed, supported by NQF’s Measure Applications Partnership (MAP), and include appropriate risk adjustment for sociodemographic and other related factors.

CMS proposes two measures for future inclusion in the IQR Program: a hospitalwide mortality measure and an opioid-related adverse events eCQM. **We caution CMS not to publicly report measures that have yet to be fully vetted through the NQF processes.** NQF endorsement and approval by the MAP—a multi-stakeholder partnership that guides HHS’ selection of performance measures for federal health programs—are imperative to ensure measure validity and reliability. Through these processes, measures are fully vetted and approved through a consensus-building approach that involves the public and interested stakeholders. Additionally, **CMS should not add any proposed measure until it is appropriately risk adjusted and should suspend or remove other outcome measures until they incorporate appropriate risk-adjustment methodology.**

- i. CMS should not include the hospital harm opioid-related adverse event eCQM in public reporting until the measure is more fully developed and tested, including attaining NQF endorsement.*

The hospital harm opioid-related adverse event measure is under development and aims to advance the safe use of opioids in hospitals and prevent serious opioid-related adverse drug events. The measure uses naloxone administration as a proxy to calculate the proportion of patients who experience an opioid-related adverse event. Naloxone is an overdose-reversal drug used for severe opioid-related adverse events.

We seek clarification from CMS and its developers as to whether this measure is the most appropriate to identify instances of in-hospital opioid-related adverse events. As cited by the developers in their measure rationale, nearly half of the adverse drug events reported to the Joint Commission’s Sentinel Event database were due to a wrong medication dose. That being the case, it is unclear whether this hospital harm measure, as currently specified, would directly improve this issue. **Before including this measure in public reporting programs, we encourage CMS to continue development and field testing, with input from stakeholders, to ensure the information collected accurately reflects quality of care.**

Additionally, it is necessary to balance the usefulness of information reported through EHRs with the challenges of extracting such data and the accuracy of captured information. CMS notes that the measure is currently being tested in multiple hospitals and the agency plans to submit it for NQF endorsement in November. **We urge CMS to work with EHR vendors to ensure electronic reporting of the measure is a viable option for all hospitals, not only those included in field testing.** Further, it would be premature for CMS to require electronic reporting before the measure is fully electronically specified. Electronic measures have specific requirements for the type of information that should be documented; they require more standardization than non-electronic measures. If detailed specifications are not provided far enough in advance, many providers will not have enough time to update their reporting systems. Providers are adapting their workflows to ensure meticulous entry of standardized data into their EHRs. However, essential hospitals still face obstacles to the meaningful use of health IT, and adoption requires extensive training and resources. **We urge CMS to ensure the hospital harm eCQM is administratively simple to collect and report.**

Finally, due to the sensitive nature of opioid use in hospitals, **we encourage CMS to limit the use of this measure, once fully vetted, to public reporting and quality improvement programs**, rather than value-based purchasing programs. CMS recognized the unintended consequences, related to influence on opioid prescribing practices, that could arise from the pain management dimension questions in the hospital VBP Program. The agency removed such questions for payment purposes under the hospital VBP Program in FY 2018. Similarly, **we urge CMS to avoid any linkage to payment in the context of its development of the hospital harm eCQM for opioid-related adverse events**. In doing so, hospitals and physicians can monitor the administration of opioids and promote their evidence-based use, unrelated to financial incentives.

ii. CMS should not include the hospitalwide mortality measure in the IQR Program measure set until NQF endorses the measure and it is risk adjusted for factors outside the control of the hospital.

CMS proposes for future inclusion in the IQR Program two versions of a hospitalwide measure of mortality. One measure is calculated using only claims data, and a hybrid version would use a combination of data from EHRs and claims. Currently, the program includes condition-specific mortality measures that support quality improvement work targeted toward patients with a set of common medical conditions, such as heart failure, pneumonia, or stroke. In contrast, the hospitalwide measure is a relatively imprecise and crude measure of quality, which could be misleading and cause erroneous evaluation of hospitals, leading to patient confusion and loss of public confidence. Further, the MAP is on record suggesting that condition-specific mortality measures might be more actionable for providers and informative for consumers.¹⁷ **We seek clarification from CMS as to how the proposed hospitalwide approach would enhance or further quality improvement efforts beyond information reported through existing condition-specific mortality measures.**

As with other outcome measures, mortality measures must include appropriate risk adjustment. The current mortality measures are not risk adjusted for sociodemographic factors, including socioeconomic status. A growing body of literature shows that race, homelessness, cultural and linguistic barriers, low literacy, and other socioeconomic factors can skew performance on certain quality measures, including those for mortality.¹⁸ For example, patients lacking reliable support systems after discharge—factors unrelated to the quality of care received at a hospital—are more likely to be readmitted. Despite best efforts to homogenize patient populations for quality measurement, the hospitalwide measure's risk-adjustment methodology requires further development. In fact, CMS agreed with MAP concerns regarding the need for the NQF endorsement process to ensure mortality measures do not disproportionately

¹⁷ Measure Applications Partnership. MAP 2018 Considerations for Implementing Measures in Federal Programs: Hospitals. 2018.

https://www.qualityforum.org/Publications/2018/02/2018_Considerations_for_Implementing_Measures_Final_Report_-_Hospitals.aspx. Accessed June 1, 2018.

¹⁸ America's Essential Hospitals. Sociodemographic Factors Affect Health Outcomes. April 18, 2016. <http://essentialhospitals.org/institute/sociodemographic-factors-and-socioeconomic-status-ses-affect-health-outcomes/>. Accessed June 1, 2018.

penalize facilities that treat more complex patients. MAP emphasized that risk adjustment models should include appropriate clinical and social risk factors and address necessary exclusions.¹⁹ **The hospitalwide measure should be submitted for NQF endorsement, aligned with existing measures, and risk adjusted for sociodemographic factors to accurately represent the quality of care essential hospitals provide and ensure they are not unfairly penalized.**

America's Essential Hospitals supports hospital quality improvement efforts through public reporting. We caution that CMS must undertake thorough public testing, vetting for accuracy and usability, and adjustment for social risk factors when appropriate before making data publicly available. CMS also should provide hospital-specific, confidential reports to hospitals to facilitate quality improvement efforts, without the measures' inclusion in the IQR Program and public reporting.

- f. CMS should provide confidential preview reports to hospitals and seek further input from stakeholders before publicly reporting stratified quality data.

CMS seeks comments on potential options for confidential and public reporting of certain quality measures—specifically, the pneumonia readmission measure—stratified by patient dual-eligibility status. By providing confidential reports to hospitals, CMS hopes to illuminate differences in outcome rates among patient groups within a hospital and allow for comparison of those differences across hospitals.

America's Essential Hospitals supports the stratification of quality measurement data to encourage active improvement and identify gaps in outcomes for different groups of patients. We have long supported the collection of race, ethnicity, and language data to allow health care organizations to monitor and improve the quality of care for diverse populations. As proposed, CMS initially would report stratified data for the pneumonia readmission measure—beginning in fall 2018—using two methodological approaches. The first method would calculate differences in outcome rates among patient groups within a hospital. A second, complementary method would assess hospitals' outcome rates for subgroups of patients, such as dual-eligible patients, across hospitals. We applaud CMS for the direction it is taking to develop stratified performance rates by social risk, which is supported by recommendations contained in the ASPE report to Congress. **These results should be provided to hospitals, confidentially, and we urge CMS to seek further input from stakeholders before publicly reporting stratified data.**

Further, we urge CMS to expand social risk beyond dual eligibility as a marker of poverty. CMS should consider all the differences in patients' backgrounds that might affect outcomes, such as readmission rates. In reporting stratified data, CMS notes that the measures would remain unchanged. If CMS' stated goal of stratification is to drive consumer choice, then the risk-adjustment methodology of these measures must reflect a complete and accurate picture of care. In the absence of appropriate risk adjustment,

¹⁹ Measure Applications Partnership. MAP 2018 Considerations for Implementing Measures in Federal Programs: Hospitals. 2018.

https://www.qualityforum.org/Publications/2018/02/2018_Considerations_for_Implementing_Measures_Final_Report_-_Hospitals.aspx Accessed June 1, 2018.

there is a very real chance that the consumer will be misled about the quality of care provided. **America’s Essential Hospitals urges CMS to incorporate factors related to a patient’s background—sociodemographic status, language, and postdischarge support structure, for example—in its risk-adjustment methodology.**

6. CMS should only include measures in the hospital VBP Program that have improved patient outcomes, do not overlap with existing measures, and adjust for social risk factors.

The VBP Program, authorized by the ACA, continues CMS’ efforts to link Medicare payments to improved quality of care in inpatient hospital settings. The program evaluates hospital performance on quality measures and provides incentives to encourage hospitals to improve the quality and safety of care for all patients. The incentive payments are funded through a reduction in diagnosis-related group base operating payments for each hospital discharge. Hospitals will have a chance to earn back the reduction, plus additional incentives, based on their performance relative to other hospitals. As the program evolves, CMS should ensure the measures by which hospitals are evaluated actually improve patient outcomes and increase quality for all patients.

CMS proposes the removal of 10 measures from the VBP Program, including all seven health care–associated infection (HAI) and patient safety measures from the safety domain and three condition-specific payment measures from the efficiency and cost reduction domain. Additionally, CMS proposes removing the safety domain under the VBP Program and reweighting the remaining three domains.

- a. CMS should finalize its proposed removal of the elective delivery, HAI measures—CAUTI, CLABSI, colon and hysterectomy surgical site infections (Colon and Hysterectomy SSI), MRSA, and CDI—and PSI 90 composite measure from the VBP Program, and the agency should continue to refine the measure set to ensure the program more accurately reflects hospitals’ quality of care.

In the FY 2018 IPPS final rule, CMS finalized the removal of the PSI 90 measure beginning with the FY 2019 program year, and adoption of a modified version of the PSI 90 in the FY 2023 program year. CMS now proposes not to adopt the modified PSI 90 measure in any program year for the VBP Program.

America’s Essential Hospitals continues to be concerned that both the current and modified PSI 90 composite measure remain an unreliable indicator of quality of care. The events in this claims-based measure occur infrequently; are susceptible to surveillance bias; lack appropriate and necessary exclusions; might not be preventable through evidence-based practices; and are based on administrative claims data that cannot capture the full scope of patient-level risk factors.^{20,21} Placing excessive emphasis

²⁰ Rajaram R, et al. Concerns About Using the Patient Safety Indicator-90 Composite in Pay-for-Performance Programs. *JAMA*. 2015;313(9):897–898.

on claims-based data unreliably represents a hospital's actual progress in improving quality. **We support and praise CMS for its proposed removal of the PSI 90 measure, as well as the removal of the elective delivery measure and five HAI measures from the VBP Program.**

- b. CMS should remove the three condition-specific payment measures; examine the appropriateness of the Medicare spending per beneficiary (MSPB) measure and account for the effect of social risk factors on the measure; and continue to adapt the domains and weights in the VBP Program.

To better understand the service utilization and costs associated with certain conditions, CMS previously proposed the adoption of condition-specific payment measures to the efficiency and cost-reduction domain related to pneumonia (PN), acute myocardial infarction (AMI), and heart failure (HF). CMS now proposes to remove these three measures because their associated costs outweigh the benefit of their continued use in the VBP Program.

America's Essential Hospitals supports the evolution of value-based purchasing as it shifts the health care market from volume to value. However, improving care coordination and quality while maintaining a mission to serve the most vulnerable is a delicate balance. It is important for policymakers to seek guidance from organizations with measurement expertise, such as NQF and the MAP. Through the NQF endorsement and MAP approval processes, CMS, the public, and other stakeholders can fully vet and approve measures through an unbiased, consensus-building approach. For example, the pneumonia episode-based payment measure did not receive MAP support. Further, MAP members expressed concern that condition-specific payment measures might overlap and double count services already captured in the MSPB measure. **We support CMS' proposed removal of the three condition-specific payment measures (PN, AMI, and HF) from the VBP Program.**

CMS also proposes to remove the safety domain from the VBP Program, beginning with the FY 2021 program year, because there no longer would be any measures in that domain if the agency's proposals for removal of the safety domain measures, outlined above, are finalized. As such, CMS proposes this domain and weight structure for the VBP Program for FY 2021:

- clinical outcomes (formerly, clinical care), 50 percent;
- efficiency and cost reduction, 25 percent; and
- person and community engagement, 25 percent.

Currently, the four domains in the VBP Program carry equal weighting, at 25 percent each. With the proposed removal of the safety domain, CMS would increase the weight to 50 percent for the clinical outcomes domain (proposed name change; currently referred to as the clinical care domain) to reflect the fact that this domain would now include the greatest number of measures. **If measures are added to or removed from**

²¹ Cassidy A. Medicare's Hospital-Acquired Condition Reduction Program. *Health Affairs: Health Policy Briefs*. August 6, 2015. http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=142. Accessed June 4, 2018.

these domains, CMS should examine the weighting and make appropriate adjustments.

Additionally, if CMS' proposal to remove the condition-specific measures is finalized, the efficiency and cost reduction domain will consist of only the MSPB measure. Having a domain with only one measure effectively gives that single measure much more weight—and, therefore, more importance—than any other measure in the VBP Program. The VBP Program was created to improve quality and patient outcomes. The MSPB measure does not lead to quality improvements because it solely reflects Medicare payments for services provided. Efficiency is an important component of overall hospital performance improvement; however, this measure does not truly address hospital efficiency because Medicare payments are more reflective of the services a hospital provides and the patients it cares for, rather than its efficiency. Further, the MSPB lacks risk adjustment for factors outside the control of the hospital and might unfairly penalize essential hospitals that serve a disproportionate share of patients with complex and costly needs—both clinically and socially. **We urge CMS to ensure the validity and value of the MSPB measure, including risk adjustment for factors outside the control of the hospital, and reduce the weight of the efficiency and cost reduction domain to improve quality of care while not unduly penalizing essential hospitals.**

7. CMS should ensure the methodology and quality measures in the HAC Reduction Program are tailored to accurately measure hospitals' improvements on HACs and do not disproportionately penalize certain types of hospitals.

CMS should continue to examine its methodology for determining whether a hospital is penalized under the HAC Reduction Program because the methodology is skewed against large hospitals and teaching hospitals, which provide essential care to vulnerable populations. The ACA requires HHS to adjust payments to hospitals with high rates of HACs. Specifically, for hospitals that rank in the top quartile nationally for HACs during the applicable period, CMS will adjust payments to 99 percent of what they otherwise would have been. The ACA also requires the secretary to provide confidential HAC reports to applicable hospitals so they can review and correct the information. CMS subsequently will post to the Hospital Compare website information pertaining to hospitals' performance on HAC measures.

America's Essential Hospitals supports the reduction of HACs, which create serious adverse outcomes for patients and can lead to death or disability. Essential hospitals are committed to improving quality by eliminating HACs and are at the forefront of using evidence-based guidelines to prevent HACs and improve the overall patient experience. However, the nature and volume of care essential hospitals provide to vulnerable populations make our members likely to be disproportionately included in the top quartile of hospitals, based on the total HAC score. As highlighted in an association research brief, patient acuity and status as an essential hospital are associated with a

higher proportion of penalties under the HAC Reduction Program.²² Our analysis found that even though mortality rates among essential hospitals either were lower or not statistically different than those of other hospitals, essential hospitals were nearly 8 percentage points more likely than all hospitals nationwide to be penalized under the HAC Reduction Program.

Further analysis shows that the HAC Reduction Program in its current form has severely affected DSH hospitals, teaching hospitals, and urban hospitals. Many of the measures in the HAC Reduction Program occur disproportionately in teaching hospitals and hospitals providing highly specialized services and should not be measured as a true difference in performance when compared with other types of hospitals. For example, many essential hospitals provide high-risk procedures—such as cancer surgery—that involve a higher risk of acquiring an accidental puncture, laceration, or other condition; these procedures often are not performed at the facilities against which our members are measured.²³ In these cases, the higher risk of infection does not reflect poor quality of care at the hospital, but rather reflects the types of procedures performed. Thus, essential hospitals might report higher infection rates than other hospitals. Even a minimal increase in the number of infections could place a hospital in the top quartile for these measures. **To provide the most accurate assessment of care quality, CMS should only include measures in the HAC Reduction Program that accurately gauge quality, include appropriate risk-adjustment, and are not inherently skewed against teaching hospitals, large hospitals, and hospitals that provide care to vulnerable populations.**

The following comments provide specific recommendations for ensuring the HAC Reduction Program accurately measures hospitals' performance and does not unfairly penalize certain hospitals.

- a. CMS should remove the PSI 90 measure from the HAC Reduction Program and include additional risk-adjustment factors for the quality measures in the program.

As noted in our comments above, we support CMS' proposed removal of the flawed PSI 90 measure from the VBP and IQR programs. It is CMS' intent to remove the measure from these programs while retaining it in the HAC Reduction Program. **We urge the agency to remove the PSI 90 measure from all programs**, as the measure is a poor indicator of quality and disproportionately penalizes teaching hospitals and hospitals providing highly specialized services. The frequency of infections at these facilities is not necessarily a result of poor quality of care, but instead a reflection of the large number of high-risk procedures essential hospitals perform, including their emergency trauma and burn units.

²² Essential Hospitals Institute. HAC Reduction Program Penalties: An Undue Burden on Essential Hospitals? December 2014. <http://essentialhospitals.org/wp-content/uploads/2014/12/HAC-research-brief-12-18.pdf>. Accessed June 13, 2017.

²³ Kin C, et al. Accidental Puncture of Laceration in Colorectal Surgery: A Quality Indicator or a Complexity Measure? *Diseases of the Colon & Rectum*. 2013;56(2):219–225.

To more precisely gauge a hospital's performance on HAC measures, CMS should consider sociodemographic factors, such as the patient's location before admission or after discharge, primary language, and income. The risk adjustment used for the HAC measures is insufficient to account for the many variables outside hospitals' control that can affect rates of infection and complications. For example, a patient's residence can determine their condition before coming to the hospital and primary language can affect their ability to communicate with hospital staff and follow discharge instructions—and both factors can contribute to a higher risk of infection or other complications. Having a lower income also can greatly affect a patient's chance of developing a complication after high-risk procedures. For instance, studies have shown that lack of resources, both financial and educational, are associated with worse pressure ulcer outcomes following care for a spinal cord injury.²⁴

The populations essential hospitals serve are among the most complex and vulnerable. For them, even common conditions—such as high blood pressure, diabetes, and asthma—often become worse because of social risk factors (e.g., having no place to properly store medications or syringes). **The HAC Reduction Program's risk-adjustment methodology should include sociodemographic factors to ensure measures accurately reflect quality outcomes within hospitals' control.**

- b. CMS should closely examine the unintended consequences of the removal of domains and proposed equal weighting of measures.

The current HAC Reduction Program scoring methodology ranks hospitals by calculating a total HAC score based on hospitals' performance on two domains: patient safety (Domain 1) and NHSN HAIs (Domain 2). Domain 1 includes the PSI 90 measure, and Domain 2 includes the CLABSI, CAUTI, Colon and Hysterectomy SSI, MRSA, and CDI measures. Total HAC scores are calculated as a weighted average of Domain 1 (15 percent) and Domain 2 (85 percent). In the proposed rule, CMS sets forth an alternative scoring methodology that would remove domains from the program and assign equal weight to each measure for which a hospital has a measure score.

Under the equal measure weights approach, CMS projects that the percentage of hospitals in the worst-performing quartile (i.e., hospitals that would receive a penalty) decreases by 1.8 percent among small hospitals, as compared with the current methodology. However, for large urban hospitals and large teaching hospitals, the same approach results in an *increase* of 2.2 percent and 2.4 percent, respectively. We are concerned that the agency's attempt to reduce the effect of the program on low-volume hospitals will end up greatly increasing the potential costs on other hospital groups, including essential hospitals. **We urge CMS to further examine the unintended consequences of its proposed changes to the HAC Reduction Program methodology to mitigate any negative impact on essential hospitals.**

- c. CMS should clearly communicate any administrative policies adopted for the HAC Reduction Program related to the collection, validation, and public

²⁴ Saunders LL, et al. The Relationship of Pressure Ulcers, Race, and Socioeconomic Conditions After Spinal Cord Injury. *Journal of Spinal Cord Medicine*. 2010;33(4):387–395.

reporting of quality measure data and provide education to stakeholders on any changes to existing processes.

In the event CMS' proposals for the IQR Program are finalized—namely, the removal of the NHSN HAI measures—the agency proposes to adopt the HAI data collection process established in the IQR Program for those measures. In other words, hospitals would continue to submit data through the CDC NHSN portal and the HAC Reduction Program would receive the NHSN data directly from the CDC, instead of using the IQR Program as an intermediary. Beginning in FY 2019, the HAC Reduction Program would provide the same quarterly reports of NHSN HAI measures that stakeholders are accustomed to under the IQR Program. These reports provide hospitals with their facility's quarterly measure data as well as facility-, state-, and national-level results for the measures. **We urge CMS to provide education to stakeholders before the implementation of finalized administrative policies to ensure a seamless, uninterrupted transition.**

- d. CMS should use its exceptions and adjustment authority to ensure payment reductions under the HAC Reduction Program are applied only to base operating diagnosis-related group (DRG) payments—not to indirect medical education (IME) and DSH payments.

As noted above, the ACA states that the payment penalty for hospitals that rank in the top quartile nationally for HACs should be “equal to 99 percent of the amount of payment that otherwise would apply to such discharges under this section or section 1814(b)(3).”²⁵ The unspecified section referred to is section 1886 of the Social Security Act, which includes not only the base operating DRG payment, but also add-on payments critical to essential hospitals, including IME and DSH payments. Due to the high volume of low-income patients our member hospitals treat, as well as the fact that many of our members are teaching hospitals, cuts to IME and DSH payments in addition to base operating DRG payments would be unsustainable.

Essential hospitals already operate on significantly lower margins than other hospitals nationally. Without IME and DSH payments, essential hospitals face difficult financial decisions that could affect their ability to maintain vulnerable patients' access to care. The HHS secretary has authority under section 1886(d)(5)(I)(i) of the Social Security Act to make exceptions and adjustments to payments for inpatient hospital services. The secretary should use this authority to apply the HAC reduction only to base operating DRG payments. Doing so would maintain the purpose of these add-on payments—which is to help account for the increased resources needed to care for complex patients and train future physicians—and minimize the disproportionate effect of the HAC Reduction Program on essential hospitals.

8. CMS should reduce administrative burden related to supporting documentation requirements during submission of cost reports.

²⁵ Social Security Act § 1886(p)(1).

CMS should not finalize its proposal to require hospitals to include various types of detailed supporting documentation at the time of cost report submission. CMS proposes that at the time of cost report submission, a hospital also must submit this supporting documentation:

- a detailed listing of the hospital’s Medicaid eligible days that matches the Medicaid eligible days claimed on the hospital’s cost report;
- a detailed listing of the hospital’s charity care and uninsured discounts, including patient name, dates of service, insurer, and the amount of charity care or uninsured discounts provided. The total amount of charity care and uninsured discounts on the listing should match the amount reported on the cost report;
- a detailed listing of bad debt that matches the amount of bad debt claimed in the cost report; and
- intern and resident information system data on total unweighted and weighted full-time equivalent (FTE) counts that equals the FTE numbers submitted on Worksheet E-4 and Worksheet E, part A.

If a hospital fails to submit any of this documentation at the time of its initial cost report submission, CMS proposes that the cost report will be considered incomplete and should be rejected by the MAC. Hospitals already submit detailed financial information in their cost reports and maintain comprehensive supporting documentation. As CMS notes, hospitals produce listings of charity care and Medicaid days if the MAC requests this data when reviewing the hospital’s cost report. Requiring this information at the time of initial cost report submission, however, would increase administrative burden on hospitals by requiring them to prepare this information on a much shorter time frame (i.e., the initial five-month cost report submission window). The patient-level charity care detail CMS proposes to require would be time and resource-intensive for hospitals. **CMS should not require hospitals to submit this information for the cost report to be considered complete because the consequence of being unable to prepare this information at the time of submission—i.e., rejection of the cost report—is so severe.**

9. CMS should continue its imputed floor policy for all-urban states that do not have a rural floor.

In the proposed rule, CMS aims to discontinue the imputed floor policy for calculating the hospital wage index in all-urban states. Under the rural floor policy, hospitals in urban areas of a state cannot be assigned a wage index lower than the wage index assigned to hospitals in rural areas in the state. Because all-urban states do not benefit from the protection of a rural floor, CMS since 2005 has used its statutory authority to apply an imputed floor policy. Realizing the necessity of this policy to treat all-urban states equitably compared with states that have rural areas, CMS repeatedly has extended the imputed floor policy. This year, however, CMS proposes to discontinue the policy. **Absent any alternative policies that could replace the imputed floor policy, we urge the agency to leave the imputed floor policy in place.** This policy is vital to protect hospitals in all-urban states from low wage index values, which will have adverse

effects on reimbursement, compared with hospitals in other states that would benefit from the rural floor.

10. CMS should ensure any efforts to improve transparency account for existing reporting requirements, as well as sociodemographic variation among patients served by essential hospitals, and do not add administrative burden to providers.

America's Essential Hospitals appreciates the opportunity to respond to CMS' request for information about price transparency. We support CMS' efforts to improve transparency and ensure patients have access to vital information to make informed decisions about their care. However, we are concerned that CMS' proposal to require that hospitals make available a list of standard charges (either in the form of the chargemaster itself or another form of the hospital's choice) via the internet in a machine-readable format might be misleading to patients and cause excess administrative burden on essential hospitals.

We urge CMS to consider the unique role essential hospitals play in serving patients who face social, linguistic, and economic obstacles, as well as the high costs associated with tackling these challenges, when discussing price transparency initiatives or policies. The following are specific recommendations to ensure transparency measures provide patients with appropriate and usable information, without duplication or additional administrative burden.

- a. CMS should ensure information shared publicly on cost is meaningful and accurate, avoids consumer confusion, and reflects vulnerable patients' socioeconomic and demographic circumstances.

America's Essential Hospitals supports patient empowerment to foster shared decision-making and engage beneficiaries in their health care choices. Each patient's out-of-pocket costs must be communicated to the patient individually. Providers must work in partnership with insurers to communicate to patients about their financial responsibilities. This individualized communication should be done in a timely manner, in the language the patient prefers, and in a format the patient can understand.

It also is important to ensure that information provided to patients is relevant as they navigate their care decisions and does not create additional uncertainty. What hospitals charge and what they receive from payers can—and often does—vary significantly. Medicare and Medicaid, for example, pay administratively determined rates that often fall well short of a hospital's true cost of care. Despite this, the law requires hospitals to maintain uniform charges for all patients, regardless of their economic or insurance status—the rate represented on their charge description master (CDM). This means that the price in the hospital CDM rarely reflects the amount for which a patient, or their insurer, is responsible. Further, hospital CDMs are complicated documents, filled with technical terms and codes that most consumers would find difficult to interpret without having specialized knowledge.

Hospital pricing is complex. The final amount paid by patients often is dependent on insurance benefit design, including deductibles, coinsurance, copayments, out-of-pocket maximum amounts, and how the payer has negotiated a contract with the provider. Prices listed in the CDM are no more useful for patients without insurance, as they are often eligible for hospital charity care policies or other significant discounts. No single list at an institution can capture this information. Posting gross prices will have the effect of creating more confusion for patients and ultimately will generate more administrative costs and burden on hospitals.

Patients should receive adequate and clear information and support regarding financial assistance for the cost of their care so that the fear of responsibility for all or part of a health care bill does not cause a patient to forgo necessary care. While essential hospitals strive to connect eligible individuals to coverage, they acknowledge some individuals will be ineligible or slip through coverage cracks. Essential hospitals are proud of their mission to provide access to quality care for all. They recognize that interacting with the health care system can be daunting to some individuals, and they strive to implement not only robust charity care policies, but also financial navigation assistance to patients who need it.

Essential hospitals strive to ensure that their patients receive the most timely and accurate information regarding the cost of their care, including through their charity care programs. For example, an essential hospital in Missouri employs more than 30 financial counselors to help patients navigate the billing process and understand cost assistance for which they qualify. They guide patients that are eligible for their charity program and even post the application for the program online to provide easier access. The hospital provides a steep discount for patients who do not qualify for the charity program and works with patients to ensure they can access care without an excessive financial burden.

Based on the populations they serve, essential hospitals are likely to need more resources for providing meaningful education related to prices, costs, and quality of care. For example, beneficiary communication about such complex subjects will require resources to overcome language barriers and low health literacy. This requires staff time dedicated to oral explanation and the use of interpreters, as needed. It is important that transparency policies fully capture these factors, minimize their effect, and provide additional support to essential hospitals, which already operate with limited resources.

The growing number of patients with limited English proficiency (LEP) experience significant communication barriers when they enter the health care system.²⁶ Communication to beneficiaries about prices and costs must be developed and administered in a manner that ensures comprehension by all beneficiaries and, in particular, those with LEP. Further, essential hospitals treat a population that often has a combination of low educational completion along with a language barrier, which

²⁶ Hasnain-Wynia R, Yonek J, Pierce D, et al. Hospital language services for patients with limited English proficiency: Results from a national survey. Health Research & Educational Trust and National Health Law Program; 2006.

places many LEP patients at double the risk of not understanding critical information. It is important that communications—both in text and oral explanations—be carried out in a language understood by the patient or the patient’s representative. Further, terminology used should be crafted in a way that enhances comprehension by all patients.

An essential hospital in Illinois provides a plain-language summary of its financial assistance program to patients at several stages of their care, including through the intake process of the emergency department (ED). This summary, printed in both English and Spanish, also is posted to the hospital’s website. The hospital employs bilingual financial counselors, who assist patients in either accessing coverage or applying for financial assistance. In addition, hospital staff communicate information on copayments and high deductibles to patients.

Any information made publicly available must explain how and why the cost of patient care varies among hospitals. Essential hospitals that take on the provision of services that are vital to the community, such as trauma or behavioral health care, will have higher costs. These hospitals provide services not typically provided to the same extent by other hospitals, including, but not limited to, community clinics; neonatal services; wraparound services, such as social services and interpretation; and coordination of access to food and shelter for patients who otherwise would not have these necessities. Much of this care is provided to vulnerable populations, who often are uninsured. This leaves essential hospitals to shoulder the costs of the uncompensated care provided to these patients. In addition, essential hospitals are committed to teaching and training the next generation of physicians, further increasing the cost of care. Information provided to patients should include the unique cost challenges essential hospital face in their mission of caring for vulnerable people.

- b. Transparency requirements should not increase administrative or regulatory burden on essential hospitals.

America’s Essential Hospitals commends the current administration for their attempts to reduce regulatory and administrative burden. Last year, CMS announced its Patients over Paperwork initiative to increase efficiency in the delivery system by allowing providers to focus their time and resources on patient care. We urge CMS to consider the administrative burden that its policies on transparency would impose on essential hospitals.

A variety of hospital regulatory requirements increase the demand on resources to deliver care, and ultimately the cost of care, without necessarily improving quality. Information reported by hospitals and other stakeholders should be limited to content that has been proved meaningful to consumers and providers and will lead to increased quality of care for all. Efforts should be taken to examine the usefulness of data already reported. If stakeholders are required to report specific data beyond what is currently reported, we urge CMS to mitigate the administrative burden associated with additional reporting requirements.

The requirement to post hospital CDM charges will require significant investment of time and resources from essential hospitals—time and resources that otherwise could be spent providing care to patients. The CDM is a massive document, and uploading it in a machine-readable format annually would require extensive staff time, perhaps even new full-time employees. Hospitals might have to purchase new systems, such as price estimating systems, to comply with these new requirements. The CDM also would be cumbersome and confusing for patients, requiring dedicated staff and resources to adequately respond to patient questions. **Sharing patient-specific information on their own out-of-pocket costs is a more accurate and less burdensome use of hospital resources and will lead to less confusion among patients, especially those with complex needs and low health literacy or LEP.**

- c. CMS should ensure that any efforts to comply with transparency requirements are not in conflict with existing laws and regulations that could result in inappropriate sanctions on hospitals.

The Emergency Medical Treatment and Active Labor Act (EMTALA) is a federal statute that specifically outlines the requirements for hospitals to provide emergency medical services. According to EMTALA, hospitals must provide emergency medical services to all individuals that come to the hospital with an emergency medical condition. If the hospital determines the patient has an emergency condition, it must provide examination and stabilization of the patient or transfer the individual to another medical facility for treatment.²⁷

Essential hospitals take seriously the obligation under law for their ED to stabilize and treat patients regardless of their insurance status or ability to pay. The idea of having cost conversations in this setting is a complicated one for providers and patients alike. **If transparency policies require that hospitals post prices for services, we urge CMS to examine the unintended consequences and potential conflicts that would arise in the ED.** While we encourage policies that ensure patients have information to make better decisions, it is difficult in this care setting to have clear-headed conversations as patients often are in dire circumstances. Requirements to post pricing would only further confuse the patient as to costs attributed to their care and could expose a hospital to liability under EMTALA. For example, hospitals that are in violation of EMTALA might not receive accreditation from the Joint Commission and/or could receive civil monetary penalties under the statute against the hospital and physician.

- d. CMS should encourage transparency, while recognizing that essential hospitals already comply with multiple transparency requirements on both the state and federal level.

Essential hospitals, many of which are fully or partially governed by state or local governments, are, by definition, more transparent than most other hospitals. Public hospitals often are subject to more stringent requirements under state and/or local laws

²⁷ Examination and Treatment for Emergency Medical Conditions and Women in Labor. 42 U.S. Code § 1395dd

intended to increase accountability to the public. For example, public hospitals often must periodically report to local government entities and government audits; conform to open meeting and open records laws; take part in competitive bidding before entering contracts; and follow stringent procurement requirements to ensure appropriate spending of public dollars.

In addition, other essential hospitals (including some public hospitals) are nonprofit organizations under section 501(c)(3) of the Internal Revenue Code. In 2009, Congress and the IRS implemented reforms on nonprofit hospitals to ensure greater transparency in their activities. These transparency requirements include the creation of the IRS Form 990, Schedule H, which requires that nonprofit hospitals disclose financial assistance and means-tested government program information and other benefits to their communities. Section 501(r) also requires nonprofit hospitals to publicize their financial assistance policies and limit the amount they charge patients who are eligible for financial assistance. Nonprofit hospitals face the very real threat of losing their tax-exempt status if they do not comply with these requirements.

In addition to federal regulations, hospitals face transparency requirements from their state and local governments. In some states, data on hospital prices for common procedures are posted online to allow consumers to compare potential charges at hospitals in their area. Any new reporting requirements, including the posting of the CDM or a similar list of charges, should not be duplicative of other efforts to increase transparency.

Hospitals also face a multitude of quality reporting standards intended to improve quality and reduce costs. While America's Essential Hospitals supports these efforts, many quality reporting standards serve only to increase administrative burden without necessarily meeting their goals. Hospital cost reports, filed annually by all hospitals, also collect detailed records and create significant burden. **Before implementing new price transparency guidelines, CMS should consider the full scope of reporting requirements with which hospitals already comply.**

11. CMS should encourage improved communication between providers and patients, as well as improved care transitions, without putting further burden on essential hospitals by requiring additional information exchange through Conditions of Participation (CoPs).

America's Essential Hospitals appreciates the opportunity to respond to CMS' request for information on the potential use of Medicare and Medicaid CoPs to further advance the electronic exchange of information. We support the agency's efforts to improve interoperability amongst providers and the use of EHR technology to improve the flow of information between providers and patients. However, the proposed changes do not account for the unique patient population served by essential hospitals or the challenges to interoperability and information exchange that have yet to be addressed. Further, these changes would create administrative burden and duplicative reporting requirements.

We support CMS' goal of promoting communication between providers and improving care transitions and outcomes by highlighting the importance of discharge planning. Essential hospitals understand the need for providers across the care continuum to have ready access to patients' health information. However, there are obstacles—many of which are outside of the control of hospitals—that inhibit their ability to seamlessly exchange information. The GAO pointed to the many remaining challenges to attaining a truly interoperable nationwide health IT infrastructure.²⁸ There are multiple private- and public-sector initiatives to improve the interoperability landscape, but there still is much work to be done to allow providers to easily exchange information. Requiring such information exchange through CoPs—for which noncompliance might result in the inability to participate in the Medicare and Medicaid programs—would hold providers to an exacting standard for health information exchange that is not in line with the reality of nationwide progress with this technology.

In regard to the discharge planning process, we urge CMS to consider the special challenges essential hospitals face in caring for those who require a more extensive discharge planning process—one that accounts for complex needs, such as socioeconomic and literacy barriers, limited access to medications, and little availability of non-health care services—and to not add administrative burden.

- a. CMS should encourage patient-centered care and care transitions while recognizing the challenges essential hospitals face in caring for vulnerable patients with complex postdischarge needs and in implementing CEHRT.

In 2015, CMS proposed revisions to discharge planning requirements for hospitals. In response, America's Essential Hospitals urged CMS to consider the additional challenges faced by essential hospitals and their patients in the discharge planning process. The patients treated at essential hospitals are among the most vulnerable and require extensive time and resources to ensure the discharge planning process is tailored to their clinical needs. Discharge planning for this population also requires consideration of social risk factors outside the control of the hospital, such as homelessness, cultural and linguistic barriers, and low literacy.

Members of America's Essential Hospitals understand the critical contribution non-health care social services make to achieving effective care transitions and improved outcomes, including reduced readmissions. One member in Missouri developed a care transitions program that reduced hospital admissions, ED visits, and costs. This essential hospital identified the need for a multidisciplinary team, bringing together licensed clinical social workers, client-community liaisons, and advanced-practice registered nurses, among other staff, to address both the clinical and social issues affecting their patient population.

In caring for vulnerable populations, essential hospitals face special challenges, such as identifying a patient's or caregiver's capability and availability to provide necessary postdischarge care, as well as the availability of community-based support, including

²⁸ U.S. Government Accountability Office. Nonfederal Efforts to Help Achieve Health Information Interoperability. GAO-15-817. September 2015. <http://www.gao.gov/assets/680/672585.pdf>. Accessed May 24, 2018.

transportation, meals, housing, and other non–health care services. For example, the successful transfer of patients from one level of care to another, or from one setting to another, requires careful attention to patient care goals and treatment preferences, in combination with consideration of the availability of postdischarge services. Further, patients served by essential hospitals might have language-related access barriers. As such, **identifying language needs is important in accurately capturing the patient’s care goals and treatment preferences, which form the core of the discharge planning process.**

CMS’ discharge planning proposed rule was never finalized, and yet the agency’s current proposals under consideration for this RFI seek to go beyond the proposed rule by requiring electronic sharing of discharge planning information. This introduces additional complexity and resource allocation for essential hospitals. Existing EHR technology remains a challenge for essential hospitals as they adapt to the PIPs. While many essential hospitals are leaders in implementing CEHRT, the health care field in general has not reached a point where CMS can reasonably expect the seamless sharing of information, particularly between hospitals and community providers.

- b. To avoid duplicative reporting requirements, CMS should not require the electronic exchange of information through CoPs.

CMS has listed relieving administrative and regulatory burden from providers as an agency priority. As part of the Patients over Paperwork initiative, the agency issued an RFI on ways to reduce regulatory burden on providers. Further, as part of CMS’ Meaningful Measures Initiative, the agency proposed in this rule the elimination or de-duplication of a significant number of measures across its quality programs. We applaud the administration’s efforts to allow essential hospitals to focus more of their time and resources on patient care instead of onerous administratively burdensome actions. However, **the addition of new CoPs would be a step backward and represent a new administrative challenge for essential hospitals.**

As major providers of care to Medicaid and Medicare patients, essential hospitals adhere to the regulatory requirements and CoPs they must meet to participate in these programs. CoPs are process-oriented and cover every hospital service and department. These requirements were put in place to protect the health and safety of patients. However, compliance with frequently changing CoPs can place administrative burden on some hospitals, as well as financial stress to invest funds into compliance efforts.

CMS already requires hospitals to electronically exchange information with other providers and to provide patients access to their health records as part of the PIPs. If they fail to meet these requirements, they face financial penalties. CMS now is considering adding CoPs for hospitals to ensure a patient’s right and ability to electronically access his or her medical information without undue burden. Imposing duplicative requirements through CoPs would force essential hospitals to use resources to report the same information twice and would not benefit patients. **The addition of CoPs to improve the electronic exchange of information is overly burdensome to hospitals and an inappropriate means to improve patient access to health records.**

Moreover, adding requirements for health information exchange and patient access through CoPs is premature, given that hospitals currently are focused on updating their systems and training their staff to meet Stage 3 requirements. In Stage 3, CMS has added new requirements for health information exchange and patient access, including the use of APIs for enabling patient access to their records. Stage 3 also includes requirements for hospitals to both send and receive health information from other providers. Hospitals are focusing their resources on ensuring they have implemented the appropriate version CEHRT and that they can successfully report on these measures. As such, **CMS should not impose similar requirements through CoPs while hospitals work to ensure readiness for Stage 3 and have yet to gain familiarity with reporting more challenging Stage 3 measures.**

- c. CMS should recognize and mitigate the barriers that prevent health information exchange before imposing new requirements.

The commitment essential hospitals make to serve all people, regardless of income or insurance status, and their diverse patient mix pose unique challenges. A disproportionate number of their patients face sociodemographic challenges to accessing electronic patient information, including poverty, homelessness, language barriers, and low health literacy. Many patients served at essential hospitals struggle to access technology that would enable them to access discharge planning documents electronically. Members of America's Essential Hospitals predominantly serve a diverse mix of patients who face significant socioeconomic challenges and who are uninsured or covered by public programs. Some of these patients are homeless and seek care at programs designed for their needs, including respite programs at essential hospitals. In addition to homelessness, patients' ability to access the technology is affected by a variety of other sociodemographic factors, including income, education, and primary language. Many of our members' patients do not have electronic access to their health information outside of the hospital. While internet service might be readily available in most urban areas, many families do not have a computer at home or cannot afford the monthly cost of internet access. **We urge CMS to recognize the patient challenges that make sharing information even more difficult for essential hospitals serving this population.**

In addition to the challenges they face due to their unique patient populations, essential hospitals struggle with difficult measures in the PIPs, such as the measure requiring electronic exchange of a summary of care document and the measure requiring a certain percentage of patients to electronically access their health information. The consequences for failing to report or meet benchmarks through CoPs would be even more damaging to hospitals. The result of noncompliance with CoPs is far more punitive when compared with the PIPs, and could result in hospitals losing the ability to participate in the Medicare program. With the multitude of challenges essential hospitals still face in ensuring their EHR technology is properly implemented, the use of CoPs in this area could be devastating to the communities these hospitals serve.

ONC has conducted important work in promoting new technology for providers and encouraging increased interoperability. As directed in the 21st Century Cures Act, ONC in January 2018 released the TEFCA, which outlines a set of principles for trusted

exchange and is intended to enable interoperability.²⁹ ONC should be allowed to continue its work of promoting interoperability. However, a great deal of progress needs to be made before seamless health information exchange is possible.

America's Essential Hospitals appreciates the opportunity to submit these comments. If you have questions, please contact Senior Director of Policy Erin O'Malley at 202-585-0127 or eomalley@essentialhospitals.org.

Sincerely,

Bruce Siegel, MD, MPH
President and CEO

²⁹ Office of the National Coordinator for Health Information Technology. Draft Trusted Exchange Framework. January 2018. <https://www.healthit.gov/sites/default/files/draft-trusted-exchange-framework.pdf>. Accessed June 1, 2018.