WISCONSIN HOSPITAL ASSOCIATION, INC.

September 24, 2018

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

Re: Comments on Proposed Rule CMS–1695–P: Calendar Year 2019 Medicare Program Proposed Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs

Dear Administrator Verma:

On behalf of our more than 135 member hospitals and integrated health systems, the Wisconsin Hospital Association (WHA) appreciates the opportunity to provide comments on the Centers for Medicare & Medicaid Services' (CMS) proposed FY 2019 rule related to Medicare Program Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs.

WHA was established in 1920 and is a voluntary membership association. We are proud to say that we represent all of Wisconsin's hospitals. Our members include small, mid, and large-sized hospitals, including many Critical Access Hospitals and several large academic medical centers. We have hospitals in every part of the state—from very rural locations to larger, urban centers like Milwaukee. In addition, we count close to two dozen psychiatric, long-term acute care, rehabilitation and veterans' hospitals among our members.

Proposal to Extend Site-Neutral Payment Reductions to Clinic Visits for Excepted Off-campus Provider Based Departments

WHA and our members have strong concerns about CMS's proposal to reduce clinic visit payments for excepted off-campus provider-based departments (PBDs). We understand CMS is citing authority under SSA 1833(t)(2)(F) to propose "a method for controlling unnecessary increases in volume of covered OPD services." However, we believe this is in clear conflict with Congressional intent in two separate acts of Congress that specifically excepted or grandfathered these facilities from receiving these payment cuts. We do not believe Congress intended for the authority CMS sites to be used in a way that conflicts with other specific directives of Congress.

As CMS knows, the 2015 Bipartisan Budget Act reduced payments to *new* off-campus provider-based departments (PBDs). However, recognizing that many hospitals had already built their budget projections and made community investments under current payment rules, Congress grandfathered PBDs in existence as of November 2nd, 2015. One thing Congress did not

immediately take into account was the fact that there were also hospital outpatient departments in the mid-build phase that were not be grandfathered. To correct for this omission, Congress included language in the 21st Century Cures Act signed into law in December of 2016 that grandfathered HOPDs in mid-build, excepting them from these cuts. Clearly, this proposal is in direct conflict with these two specific acts of Congress.

Furthermore, there are legitimate reasons why Medicare pays higher rates for these services. As healthcare has improved, more care has gone from the inpatient setting to the outpatient setting. The Medicare payment system, which was largely designed to reimburse hospitals for inpatient care, has recognized that hospitals bear higher costs ***due to specific Medicare requirements*** and that Medicare reimbursements should reflect such costs associated with those requirements. CMS has stated itself in previous proposed changes to the Physician Fee Schedule,

> *"When services are furnished in the facility setting, such as a hospital outpatient department (OPD) or an ambulatory surgical center (ASC), the total Medicare payment (made to the facility and the professional combined) typically exceeds the Medicare payment made for the same service when furnished in the physician office or other nonfacility setting**. We believe that this payment difference generally reflects the greater costs that facilities incur than those incurred by practitioners furnishing services in offices and other non-facility settings.** For example, hospitals incur higher overhead costs because they maintain the capability to furnish services 24 hours a day and 7 days per week, furnish services to higher acuity patients than those who receive services in physician offices, and have additional legal obligations such as complying with the Emergency Medical Treatment and Active Labor Act (EMTALA). Additionally, hospitals and ASCs must meet Medicare conditions of participation and conditions for coverage, respectively."*[1]

It seems disingenuous for CMS to previously recognize this fact, but attempt to now reverse course and go around Congress to implement such cuts.

Lastly, it is unfair to propose such sweeping payment changes with such little time for hospitals to adjust. CMS projects these policy changes would reduce payments to hospitals by $760 million in 2019. We estimate the Wisconsin impact will be to reduce payments to about 40 Wisconsin hospitals by about $30 million in 2019 alone, and about $440 million over the next ten years. If CMS were to finalize this proposal, many of our hospitals will have only a few months' notice to fill budget holes that could be in the millions of dollars. It is simply unfair to change the rules mid-game for these hospitals and unjust to give such little time for them to prepare for such significant budget holes.

Instead of going forward with this proposal that goes counter to two specific Acts of Congress, we suggest CMS take an approach similar to its Patients over Paperwork initiative. In this initiative, CMS has been working with hospitals and health system leaders to identify unnecessary, expensive, and burdensome rules and regulations that do not improve patient care. We are genuinely appreciative of the great work CMS has been doing on this initiative and are

[1] CMS-1600-P, Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2014; Proposed Rule (Vol. 78, No. 139), July 19, 2013, p. 43296.

carefully reviewing the proposed rule CMS released on September 17th, of which we believe we will have many supportive comments. We strongly encourage CMS to utilize a similar approach in working with hospital, health system, and healthcare leaders to find ways to reduce unnecessary costs for Medicare and its beneficiaries.

For instance, Wisconsin has a national reputation as being one of the top quality states for healthcare according to the federal Agency for Healthcare Research and Quality (AHRQ), ranking first in 2017 and being in the top ten every year in the last decade. At the same time, Wisconsin ranks in the bottom fifteen states when it comes to average spending per Medicare beneficiary. We believe this is clear evidence that Medicare's payment system is not currently designed to incentivize or reward high quality, high value healthcare. CMS should abandon this proposal and focus its efforts on reforming Medicare's antiquated payment system to one that rewards providers in states like Wisconsin that provide high-quality, high-value healthcare.

Extending Site-Neutral Payment Reductions to New "Families of Services."

In addition to CMS proposing to reduce the payment for clinic visits to hospital outpatient departments (HOPDs) previously excepted or grandfathered under two separate acts of Congress, CMS is proposing to extend site-neutral payment cuts to new families of services for these HOPDs. We believe this also runs counter to Congressional intent and urge CMS to reverse course on this as well for the same reasons mentioned above. As previously stated, there are legitimate reasons that off-campus HOPDs receive today's higher payment structure and this policy would penalize HOPDs that have previously planned to offer new kinds of services to meet the needs of their communities.

Expanding 340B Cuts to Non-Excepted Off-campus Provider-based Departments

CMS proposes in this rule to expand the current policy of reducing payments for most 340B acquired drugs to non-excepted off-campus PBDs, to make the policy implemented in the 2018 OPPS rule more consistent. While we are unaware of how this would impact Wisconsin's hospitals, we take issue with these continued efforts to undermine the success of the 340B program. These continued cuts serve only to reduce the effectiveness of a program designed to stretch scarce federal resources. In Wisconsin alone, our hospitals are approaching a $2 billion annual deficit between what Medicare pays and the costs hospitals bear to provide Medicare services. Much of these costs get passed onto the private sector in a hidden healthcare tax that also acts to drive up the cost of private health insurance premiums. Programs like 340B help hospitals offset some of these costs, and also expand important services to local communities they serve.

Area Wage Index

WHA has often noted concerns about manipulation of the Medicare Area Wage Index in the prospective payment system. CMS has echoed these concerns in recent proposed rules, noting that results of making the rural floor budget neutral on a national basis, as required by the Patient Protection and Affordable Care Act Section 3141, is that all hospitals in some states receive an artificial wage index that is higher than the what the single highest urban hospital wage index would otherwise be. WHA has previously joined with associations in other states to garner

support from Congress to address this patently unfair payment manipulation, which has specifically benefited hospitals in states on the east and west coasts and has been commonly referred to as the "Bay State Boondoggle."

CMS has previously stated it believes it has the legal authority to "decouple" the OPPS wage index from the IPPS wage index. Section 1833(t)(2)(D) of the Social Security Act requires the wage index for outpatient services be applied in a budget neutral manner, but does not specify how to apply budget neutrality. WHA agrees with CMS that it has the authority to decouple the OPPS area wage index from the IPPS and encourages CMS to explore how to implement budget neutrality in a manner that restores accuracy and fairness to the calculation.

Measure Removal Factors

As previously stated, WHA is appreciative of the work CMS is doing to reduce unnecessary burdens on hospitals. WHA thanks CMS for its continued focus on the appropriateness of the measures included in the various pay-for-performance programs. WHA appreciates CMS' efforts to align the definitions and criteria for removing measures, and supports the change of Measure Factor 7 to align with the ASCQR program. WHA further supports the adoption and finalization of Measure Factor 8 to allow for a measure to be removed when the burden of collecting and reporting the data outweighs any benefit to either the patient or provider community. The measures that are proposed for removal using Factor 8 are perfect examples of measures that are time-consuming, of little value for improvement, and are often duplicated in other programs. We encourage CMS to allow providers to focus on improving care through innovation, and eliminate disruption through meaningful measurement.

Removal of Quality Measures from the Hospital OQR Measure Set

WHA supports the removal of OP-27: Influenza Vaccination Coverage Among Healthcare Personnel from the OQR measure set from the CY2020 payment determination. WHA agrees that immunization is a critical component of preventing influenza transmission, and CMS is correct in identifying other measurement programs and employer-based requirements that already promote vaccination.

WHA supports the removal of OP-5: Median Time to ECG, OP-29: Endoscopy/Polyp Surveillance Follow Interval for Normal Colonoscopy, OP-30: Endoscopy/Polyp Surveillance for Patients with History of Adenomatous Polyps, and OP-31: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery from the OQR Measure Set, but recommend that CMS reconsider and remove these measures from the CY2020 payment determination, rather than the proposed CY2021. CMS notes the costs and burdens to both facilities and CMS related to these measures. Despite facilities and CMS having dedicated resources to operationalize these measures for CY2020, there would be benefit to both to be able to shift these resources sooner.

WHA supports the removal of OP-9: Mammography Follow-up Rates, but recommends CMS reconsider and remove this measure from the CY2020 payment determination, rather that the proposed CY2021 payment determination year. CMS notes the costs and burdens to both facilities and CMS related to these measures. Despite facilities and CMS having dedicated

resources to operationalize these measures for CY2020, there would be benefit to both to be able to shift these resources sooner. This is even more true when a measurement includes misalignment with current clinical practice. If CMS intends to re-specify and include this measure in future rule-making, WHA encourages CMS to also consider whether a measure of this type should more appropriately belong in the MIPS program, as physicians are more likely to influence the ordering of Digital Breast Tomosynthesis (DBT) to meet clinical guidelines.

WHA supports the removal of OP-11: Thorax CT Use of Contrast Material and OP-14: Simultaneous Use of Brain-Computed Tomography (CT) and Sinus CT, but recommend CMS reconsider and remove these measures from the CY2020 payment determination, rather than the proposed CY2021 payment determination year. When performance levels are statistically indistinguishable, and the measure no longer is considered valuable, it should be removed as soon as feasibly possible. WHA recognizes the resources that have been allocated by CMS to operationalize this measure since its inception, and recognizes the efforts by facilities to track the submission and display of these rates to ensure their payment determination. Quicker reallocation of these resources by facilities and CMS would be a cost savings to the healthcare system.

WHA supports the proposed removal of the Notice of Participation form effective with CY2020 payment determination year for the reasons CMS stated in the proposed rule. Not only is the form of no informational benefit for CMS, but the process to submit the form is burdensome for facilities.

Ambulatory Surgical Center Quality Reporting Program (ASCQR)

Measure Removal Factors

WHA thanks CMS for its continued focus on the appropriateness of the measures included in the various pay-for-performance programs. WHA supports the re-design of Factor 2 to align with the OQR program and de-duplicate the intent of Measure Factor 6. WHA further supports the adoption and finalization of Measure Factor 8 to allow for a measure to be removed when the burden of collecting and reporting the data outweighs any benefit to either the patient or provider community. The measures that are proposed for removal using Factor 8 are perfect examples of measures that are time-consuming, of little value for improvement, and are often duplicated in other programs. We encourage CMS to allow providers to focus on improving care through innovation and eliminate disruption through meaningful measurement.

Removal of Quality Measures from the Hospital ASCQR Measure Set

WHA supports the removal of OP-27: Influenza Vaccination Coverage Among Healthcare Personnel from the ASCQR measure set from the CY2020 payment determination. WHA agrees that immunization is a critical component of preventing influenza transmission, and CMS is correct in identifying other measurement programs and employer-based requirements that already promote vaccination.

WHA supports the removal of ASC-1: Patient Burn, ASC-2: Patient Fall, ASC-3: Wrong Site, Wrong Side, Wrong Patient, Wrong Implant, ASC-4: All-Cause Hospital Transfer/Admission,

ASC-9: Endoscopy/Polyp Surveillance Follow Interval for Normal Colonoscopy in Average Risk Patients, ASC-10: Endoscopy/Polyp Surveillance for Patients with History of Adenomatous Polyps, and ASC-11: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery.

We encourage CMS to reconsider and remove these measures from the CY2020 payment determination, rather than the proposed CY2021. CMS notes the costs and burdens to both facilities and CMS related to these measures. Despite facilities and CMS having dedicated resources to operationalize these measures for CY2020, there would be benefit to both to be able to shift these resources sooner.

WHA does not support consideration of data validation of ASCQR program measures in future CMS rulemaking. Understanding the need for valid data versus the cost and burden for both providers and CMS to operationalize data validation requirements seems a poor return on investment for CMS and resources for providers. Rather, CMS should continue to seek and invest in ways to receive timelier data that is meaningful related to patient quality and safe care.

Communication about Pain Questions

WHA agrees with the President's Commission on Combating Drug Addiction and the Opioid Crisis' recommendation to remove the HCAHPs Communication about Pain (CAP) questions from the survey. WHA urges CMS to reconsider its proposed update timeline, stating operational constraints and further analysis opportunities as reasons to delay the effective removal date until January 2022 inpatient discharges. It seems plausible that in a year's time (January 2020 discharges) CMS can alert vendors and its own warehouse to omit the questions from the survey, stop public reporting of the CAP questions, and develop a statement on Hospital Compare to alert consumers. The pace of these tasks would certainly correspond to the administration's urgency to address this population health issue.

Request for Information on Price Transparency

CMS's request feedback in this rule is similar to its request in the 2019 IPPS rule in regard to pricing transparency. In response to the IPPS rule, WHA cited the usefulness of PricePoint, a website that includes charge information on top inpatient and outpatient procedures for all Wisconsin hospitals. One of the strengths of PricePoint is how simple it is for members of the public to use. One simply selects the area of the body and condition, and can directly compare prices for multiple hospitals. The site also includes an insurance checklist which directs patients to contact their health insurer to help determine their out-of-pocket costs. The checklist even includes reminders to ask about particular practitioners, such as radiologists and anesthesiologists, so as to avoid potential surprise billing issues in the event those practitioners are not covered by their particular insurance plan.

WHA commissioned a transparency taskforce shortly after the ACA was passed in order to determine if PricePoint meets the requirements under section 2718(e) of the Public Health Service Act. The taskforce recommended that displaying a prominent link to PricePoint along

with a contact number for additional questions would be a reasonable way to comply with the ACA. WHA urges CMS to consider PricePoint and other similar transparency efforts other states have implemented before adding additional regulations that might unnecessarily increase hospitals' administrative burden. This aligns with CMS's Patients over Paperwork initiative, with the goal of increasing transparency without adding unnecessary administrative burden.

We believe these tools are far superior to a chargemaster, which consumers would not understand. In comparison to a chargemaster, which is simply a data dump of thousands of hospital charges, PricePoint groups the charges for procedures together so that patients have a reasonable expectation of what the overall charges they will see on their bill. It also provides a checklist for patients to contact their insurance company to know what their negotiated rate is likely to be, and what copays the patient will be responsible for. This is all useful information for consumers, much more so than a complicated, nonintuitive chargemaster.

Request for Information on Promoting Interoperability and Electronic Healthcare Information Exchange

On January 30, 2017, President Trump issued an Executive Order, "Reducing Regulation & Controlling Regulatory Costs," which stated "it is essential to manage the costs associated with the governmental imposition of private expenditures required to comply with Federal regulations" and "it is important that for every one new regulation issued, at least two prior regulations be identified for elimination." On March 5, 2018, in remarks to the Federation of American Hospitals, Secretary Alex Azar identified the following as a "key engine for transformation" of health care: "addressing any government burdens that may be getting in the way of integrated, collaborative, and holistic care for the patient, and of structures that may create new value more generally."

Unfortunately, physician and other provider time spent using EHR continues to be significant. In a recent study of University of Wisconsin family medicine physicians, researchers found that clinical FTEs spent an average time of 5.9 hours per day on EHR and that physicians spent 44.2 percent of their total EHR time doing clerical tasks.

WHA recommends that CMS not proceed with future rulemaking so to revise the hospital Conditions of Participation (CoP) related to interoperability, as it would go against the previously stated goal of reducing government burdens. Any new requirements within the hospital CoP would be duplicative with what hospitals would already have to report under Medicare PI Program to avoid receiving Medicare reimbursement penalties. Further, all requirements in the hospital CoP must be met as a condition of receiving Medicare funding, and unlike CMS's recently finalized requirements for the Medicare PI Program, hospital CoP requirements do not involve "performance-based scoring." Accordingly, by including these requirements in the hospital CoP, CMS would be acting inconsistently with its recent efforts to move the Medicare PI Program incrementally away from a wholly "pass/fail" or "all-or-nothing" approach.

WHA appreciates the opportunity to provide CMS with our comments.

Sincerely,

Eric Borgerding
President & CEO