

July 10, 2020

Administrator Seema Verma
Centers for Medicare and Medicaid Services (CMS)
Department of Health and Human Services
Attention: CMS-1735-P
P.O. Box 8013
Baltimore, MD 21244-1850

RE: **CMS-1735-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 2021 Rates; Quality Reporting and Medicare and Medicaid Promoting Interoperability Programs Requirements for Eligible Hospitals and Critical Access Hospitals; published at Vol. 85, No. 104 Federal Register 32460-32975 on May 29, 2020.

Submitted electronically via <http://www.regulations.gov>

Dear Administrator Verma,

UnityPoint Health (“UPH”) appreciates the opportunity to provide comment on this proposed rule related to hospital inpatient rates. UPH is one of the nation’s most integrated healthcare systems. Through more than 32,000 employees and our relationships with more than 310 physician clinics, 39 hospitals in metropolitan and rural communities and 19 home health agencies throughout our 9 regions, UPH provides care throughout Iowa, central Illinois and southern Wisconsin. On an annual basis, UPH hospitals, clinics and home health provide a full range of coordinated care to patients and families through more than 6.2 million patient visits.

In addition, UPH is committed to payment reform and is actively engaged in numerous initiatives which support population health and value-based care. UnityPoint Accountable Care (UAC) is the ACO affiliated with UPH and has value-based contracts with multiple payers, including Medicare. UAC is a current Next Generation ACO. UnityPoint Health also participates in a Medicare Advantage provider-sponsored health plan through HealthPartners UnityPoint Health.

UPH appreciates the time and effort of CMS in developing this proposed Inpatient Prospective Payment System (IPPS) rule and respectfully offers the following comments.

MARKET-BASED MS-DRG RELATIVE WEIGHT DATA COLLECTION AND RELATIVE WEIGHTS

CMS proposes that hospitals report on the Medicare cost report: (1) The median payer-specific negotiated charge that the hospital has negotiated with all of its Medicare Advantage (MA) organizations (also referred to as MA organizations) payers, by MS-DRG; and (2) the median payer-specific negotiated charge the hospital has negotiated with all of its third-party payers, which would include MA organizations, by MS-DRG. Beginning in FY 2024, CMS is considering a potential change to the methodology for calculating

the IPPS MS-DRG relative weights to incorporate this market-based rate information.

Comment: Generally, ***UPH is committed to price transparency efforts that are meaningful to consumers and enable consumers to make informed health care decisions in conjunction with other factors such as quality, experience and other patient satisfiers.*** CMS requires hospitals to make available a list of current standard charges via the internet in a machine-readable format. Although hospital standard charges is a relatively easy price point to post, we do not believe it provides meaningful information for consumers. Hospital standard charges data represents an incomplete picture at best and is limited in that it reflects only inpatient and outpatient stays and procedures and is based on historical charges. A key omission is the physician component, which adds costs especially when services or procedures involve multiple physicians.

Out-of-pocket costs are the costs that are most meaningful to consumers, as it is the amount for which consumers are responsible. ***Out-of-pocket costs are most readily available from a consumer's health plan and may be obtained by contacting the health plan directly.*** In this proposed rule, CMS continues its misguided approach of requiring hospitals to be the centralized resource for vital pricing information. Hospitals do not employ all providers, which often results in incomplete cost estimates. As opposed to a hospital, the health plan does have access to the consumer's contract rates and specific benefits, such as deductibles, co-pays or co-insurances. The health plan also has the ability to give the consumer the full out-of-pocket costs that would include the hospital, physician and any other normal services for the episode of care. Health plans currently provide cost/liability information in a pre-authorization process as well as in an explanation of benefits document. Health plans have the infrastructure in place to illustrate the suite of available health care services across provider type and are ideally suited to assist with bending the cost curve by providing consumers with a full and timely picture of out-of-pocket costs.

For consumers without insurance, we agree that hospitals are the best source of pricing information related to inpatient stays and employed providers. Instead of a generic website posting pricing relative to standard charges and shoppable services, which are not standardized and do not promote comparison shopping, ***a better approach is for consumers to contact the hospitals to directly obtain estimated pricing information from billing offices for specific procedures or services.*** Our health system provides estimated pricing information to consumers for scheduled procedures and also has a phone line to provide price estimates for consumers who are planning or shopping for a service. These estimates are individualized and are developed by trained personnel in response to distinct inquiries. Additionally, when consumers contact us directly, we can assist them in obtaining resources that may include filing for Title XIX or Financial Assistance. Without these services and resources, individuals may delay urgently needed medical care. It should be noted that while we strive to provide accurate and timely information, health care procedures and services are unlike a merchandise purchase in that complications may occur which may alter the original estimates. It is a false comparison to equate the purchase of a toaster or car to obtaining a knee replacement or a value repair. Alternatively, ***if an electronic approach is still desired, we believe it should focus on out-of-pocket costs and involve patient cost-estimator tools and resources.*** To promote a standard approach, we encourage CMS to convene stakeholders to identify best practices, recommend standards for common features of cost-estimator tools and develop solutions to common technical barriers. We urge stakeholder input in this proposed process from consumers, providers and

health plans.

Legal Deficiencies: *UPH agrees with the American Hospital Association and its position that this proposal raises legal issues and should not be pursued.* Specifically:

- *Information Collection is Unauthorized:* CMS cites no authority to require hospitals to furnish median payer-specific negotiated charge information by MS-DRG. Instead, CMS relies exclusively on a rule the agency promulgated in 2019, denominated by CMS as the “Hospital Price Transparency Final Rule,”¹ to require disclosure of negotiated charge information by MS-DRG. CMS explains that “[t]he payer specific negotiated charges used by hospitals to calculate these medians would be the payer-specific negotiated charges for service packages that hospitals are required to make public under the requirements we finalized in the Hospital Price Transparency Final Rule (84 FR 65524) that can be crosswalked to an MS–DRG. We believe that because hospitals are already required to publicly report payer-specific negotiated charges, in accordance with the Hospital Price Transparency Final Rule, that the additional calculation and reporting of the median payer-specific negotiated charge will be less burdensome for hospitals.”²

The Hospital Price Transparency Final Rule is scheduled to go into effect on Jan. 1, 2021, but it has been challenged by the AHA and other hospitals on statutory, procedural and constitutional grounds. Although the district court denied hospitals’ motion for summary judgment,³ the hospitals have appealed that decision to the United States Court of Appeals for the District of Columbia Circuit. The appeal will be fully briefed by the end of August, and the parties are requesting oral argument as soon after that as possible. Because the information to be furnished under the proposed rule would be derived from information collected under the Hospital Price Transparency Final Rule, the new information collection requirement suffers from the same legal infirmities: It is not authorized by statute and violates both the Constitution and Administrative Procedure Act. Moreover, if the hospital price transparency final rule is found unlawful, then CMS’s requirement for disclosure of median payer-specific charge information by MS-DRG would similarly be unlawful.

- *MS–DRG Relative Weight Calculation is Unauthorized:* The same is true as to the potential approach to change the method of calculation for MS-DRG relative weights beginning in FY 2024. CMS says that it is considering adopting in the FY 2021 IPPS final rule a “change to the methodology for calculating the IPPS MS–DRG relative weights to incorporate this market-based rate information, beginning in FY 2024. . . .”⁴ But if it is unlawful to require disclosure of median payer-specific negotiated charge information by MS-DRG, then CMS could not use that information to change relative weights.

In addition, it would be arbitrary and capricious to use median payer-specific negotiated charge

¹ 84 Fed. Reg. 65,524 (Nov. 27, 2019).

² 85 Fed. Reg. 32,460, 32,465 (May 29, 2020). We note that, because there is no comparator in the statement, it is not clear what CMS means when it says that reporting median payer-specific negotiated charges is “less burdensome for hospitals.”

³ *American Hospital Assn, et al. v. Azar*, No. 19-CV-3619 (D.D.C. June 23, 2020).

⁴ 85 Fed. Reg. 32,460, 32,465 (May 29, 2020).

information by MS-DRG to change relative weights. As set forth in section 1886(d)(4)(A) of the Act, relative weights are intended to reflect “the relative hospital resources used with respect to discharges classified within that group” and not the relative price paid. CMS currently uses “a cost-based methodology to estimate an appropriate weight for each MS-DRG.”⁵ In proposing to use median payer-specific negotiated charges to set MS-DRG relative weights, CMS has not adequately explained why it thinks market price rather than costs is a better measure of hospital resources used. Instead, the agency appears to conflate market price with cost.

The rationales CMS uses for basing MS-DRG relative weights on price (e.g., promoting transparency, bringing down the cost of health care, wanting to move beyond the chargemaster, etc.) have nothing to do with whether median payer-specific negotiated charges are a measure of “hospital resources used” as the Medicare statute requires. Rather, CMS proposes to use this information to “advanc-[e] the critical goals of [Executive Orders] 13813 and 13890, and to support the development of a market-based approach to payment under the Medicare FFS system.”⁶ But that is not the statutory test. Simply put, we believe CMS has not adequately explained why basing IPPS MS-DRG relative weights on market price would result in relative weights being based on hospital resources used. As such, it would be arbitrary and capricious to adopt this proposal. *See Motor Veh. Mfrs. Ass'n v. State Farm Ins.*, 463 U.S. 29 (1983).

We implore CMS to delay finalizing this proposal unless and until (1) the court upholds the hospital price transparency final rule upon appeal, (2) CMS has adequately explained the basis for concluding that payer-specific negotiated charges by MS-DRG reflect resources used, and (3) stakeholders have had another opportunity to comment on the proposal.

Operational Concerns: In addition to the legal arguments, the proposal raises implementation issues.

- Negotiated Charge Reporting on the Cost Report - Medicare cost report will contain a new form (Worksheet S-12) for the collection and reporting of the median of the payer-specific negotiated charges for every MS-DRG that the hospital has negotiated with MA organizations and third-party health plans. **A median calculation will establish an apples-to-oranges comparison.** Median calculations will not be standard across hospitals – median calculations are easily skewed by outliers, fail to account for size of health plans (e.g. number of covered lives), and will vary due to the number of health plans contracts included as well as the fact that all health plans do not use MS-DRGs. As an integrated health system, we complete cost reports for multiple hospitals within our three state service area and these calculations will encompass between 10 – 12 contracted financial classes and 70 - 200 contracts depending upon the hospital.
- Administrative Burden - CMS estimates the average annual burden per hospital of 15 hours (5 hours for recordkeeping and 10 hours for reporting) for the new Worksheet S-12 and states that the burden is minimized because the median payer-specific negotiated charge data to be collected is based on payer-specific data maintained by the hospital. This time and effort burden does not appear to take into account training and workflow changes. **We will also reiterate the**

⁵ *Id.* at 32,791.

⁶ *Id.*

cumulative burden being mandated by CMS upon hospitals as the result of this rule and the FY 2020 IPPS final rule, which is at least 150 hours per hospital license. To decrease this burden, we request that CMS consider capturing pricing information on the top eight health plans by covered lives – for UPH, this would represent over 80% of contracts.

- Negotiated Charges as Rate Setting Basis – ***Rate setting should be rooted in resource intensity rather than contracted rates.*** The latter is a fundamentally flawed approach which will create an expectation of lower costs over access to care and quality care. Lower reimbursement without reference to resources will result in employment cuts and ultimately a reduction in access to care, including service line and hospital closures. Rate setting based on negotiated charges fails to recognize economies of scales or that some service lines subsidize other negative margin but needed service lines.
- Provider-Based Arrangements – Some hospitals include ambulatory settings within provider-based arrangements. ***CMS does not describe how posting of charges and development of median rates will account for these arrangements.***
- Value-Based Arrangements – UPH is an early adopter of Medicare valued-based arrangements – portions of our health system have participated in the Pioneer ACO Model, Medicare Shared Savings Program, Next Generation ACO Model, Bundled Payment Care Initiative, Medicare Care Choices Model, and Home Health Value-Based Purchasing Model. ***CMS does not describe how posting of charges and development of median rates will account for episodes of care and risk arrangements, which often contain claw back provisions.*** In addition, bundling is defined differently among payers and is not easily conducive to comparison pricing. These rules intended for Fee-For-Service providers do not align with a transition to value and raise challenges that underscore the importance of health plans as the nexus for pricing information.
- Patient Privacy - ***We are concerned that the format of pricing information may not align with the prohibition on information blocking.*** For instance, there are situations when a patient has a covered procedure but then elects an additional self-pay procedure during the same stay. Some costs during the procedure are not easily divided (infeasible). In addition, the patient may not want the health plan to know about the elective procedure (privacy of electronic health information). We are concerned that these well-intended exceptions may overlap, will require every health care provider to create new information blocking policies and procedures, and also entail significant documentation to justify use of the exceptions in the absence of such policies.

OTHER DECISIONS AND PROPOSED CHANGES TO THE IPPS FOR OPERATING COSTS

FY2021 IPPS rates increase by a net of 3.1%, factoring in the market-basket update, the productivity cut and the ATRA recoupment. The proposed market basket rate increase for FY2021 is 3.0 percent. Other select provisions include methodology for determining the distribution of Disproportionate Share Hospital (DSH) uncompensated care payments, and instructions for low-volume hospitals to receive enhanced payments.

Comment:

DSH Factor 3 Calculations: We continue to remain concerned with the calculation of DSH uncompensated care payments. Foremost is the use of a single year's cost report (Worksheet S-10 data) as well as the use of 2017 data, which has not been universally audited and brings into question data integrity issues. We reiterate our position from last year – we do not support calculations that rely on one year of data and eliminate use of the three-year average, which aids in normalizing fluctuations. **We request that CMS reinstate the three-year average and only use years that have audited data to encourage standardization in reporting among providers.** While it appears that all 2017 cost reports will be audited for use in future rulemaking, this does not diminish our concerns for 2021 DSH calculations.

We also request that CMS revisit the 15-business-day timeframe from the date of public display of the FY 2021 IPPS/LTCH PPS final rule to review and submit comments on the accuracy of the table and supplemental data file published in conjunction with the final rule. We respectfully disagree that hospitals are afforded sufficient time to offer comment. Over time, CMS has consistently delayed the release of the IPPS/LTCH PPS, which increasingly puts additional time constraints on providers to perform analyses and make operational adjustments prior to the start of the federal fiscal year. With the unexpected financial impact of the COVID-19 pandemic, we request that CMS release the proposed rule for FY 2022 and future years earlier and engage stakeholders throughout the year to provide a head's up on how DSH will be calculated and reimbursed.

Rural Community Hospital (RCH) Demonstration Program: The purpose of RCH Demonstration Program is to better reimburse Prospective Payment System (PPS) hospitals for Medicare's portion of their Inpatient Acute and Swing Bed services. UnityPoint Health has two Iowa hospitals (Grinnell Regional Medical Center in Grinnell; and Trinity Regional Medical Center in Fort Dodge) participating in the RCH Demonstration Program. ***We support the continuation of this program but, as a demonstration, this program does not offer long-term financial sustainability needed to maintain health care access in rural areas.***

HOSPITAL INPATIENT QUALITY REPORTING (IQR) PROGRAM

eCQM reporting submission and public display requirements are revised and include a progressive increase in the numbers of quarters of eCQM data reported, from one self-selected quarter of data to four quarters of data over a 3-year period as well as a public display of eCQM data beginning with data reported by hospitals for the Calendar Year 2021 reporting period. The use EHR technology certified to the 2015 Edition for submitting data is required for all hybrid measures in the Hospital IQR Program. The validation processes are streamlined to require the use of electronic file submissions via a CMS-approved secure file transmission process, a combined validation processes for chart-abstracted measures and eCQMs, and a formalize process for conducting educational reviews.

Comment:

Progressive Increase in Timeframe for eCQM Data Reporting: UPH understands the intent of extended quality data measure reporting and agrees that full year data reporting provides a more complete view of the reporting quality measures. However, ***we request that CMS extend the implementation timeframe, given the uncertainty of COVID-19 pandemic needs this fall (specifically as laid out in Table 1 below).*** We are concerned that CMS did not fully recognize resource allocation required for increased data submission. Time and effort considerations should include:

- QRDA file structure validation – this process takes approximately 10 hours, but may be longer if structure issues occur. This process is triggered every time an update to the QRDA I file structure occurs as well as a general validation test prior to file creation for submission.
- CCN file creation – for submission of one quarter of data, this process has historically taken anywhere from 10 minutes to 5 hours, depending on the size of the hospital, patient volumes, and number of cases needing to be pulled for each measure. Resources are then required to review these data files again to ensure the electronic file creation process did not encounter any technological glitches that may cause missing or interrupted data and lead to false reporting. It should be noted that this estimate of file creation time does not take into consideration the decision making process that must be completed prior to file submission.

Taking into account resource allocation, the relative speed of the proposed implementation and the uncertainty of COVID-19 pandemic generally, we suggest the following implementation timeframe:

Table 1. Suggested eCQM Implementation Timeframe

Calendar Year	Fiscal Year	# of Reporting Quarters	# of eCQMs	Safe Use of Opioid eCQM
2021	2023	1 quarter	4 self-selected eCQMs	N/A
2022	2024	2 quarters	3 self-selected eCQMs	Mandated reporting
2023	2025	2 quarters	3 self-selected eCQMs	Mandated reporting
2024	2026	3 quarters	3 self-selected eCQMs	Mandated reporting
2025	2027	3 quarters	3 self-selected eCQMs	Mandated reporting
2026 and Beyond	2028 and Beyond	4 quarters	3 self-selected eCQMs	Mandated reporting

We request that Calendar Year 2020 reporting be maintained for the Calendar Year 2021 reporting period. While Table 1 represents an elongated implementation period to balance uncertainties, we recognize the fluidity of our environment and encourage CMS to actively engage with stakeholders throughout this implementation process. We urge CMS to gather feedback throughout the year to evaluate operational barriers (if any), time and effort burdens and competing regulatory and reporting mandates. This evaluation can guide whether to further extend or shorten timeframes suggested in Table 1.

eCQM Measures: CMS is continuing its mandated reporting of three self-selected eCQMs and the Safe Use of Opioids eCQM. To monitor and address the ongoing opioid crisis, ***UPH supports the mandated inclusion of the Safe Use of Opioids eCQM*** and believe this measure enables further review of the overuse of opioid drugs and adherent prescribing patterns.

eCQM Validation Process: Currently hospitals report one self-selected quarter of eCQM data, and the corresponding validation process involves the submission of eight cases. With the increase in reporting to four quarters, our possible chart abstraction increases from eight eCQM charts to 32 charts throughout the year. While we support the changes to align the request period for both chart-abstracted and eCQM

data, we urge CMS to institute a longer return period to return validation data. Specifically, ***we request that the validation timeframe be extended time from 30 days to 60 days*** due to the heightened number of data requests and the fact that hospitals use the same resources to complete the process for both chart-abstracted measures and eCQM data. The validation process requires substantial resourcing – additional time for data pull and for review of the required chart documentation to validate our eCQM submission. For a chart-abstracted measure, a single chart for data validation may take up to 10 hours to find all data sources required to be pulled. Because a single case may include multiple measures, this time allotment per case may increase exponentially. As we approach up to 40 cases for a single hospital to validate both chart-abstracted measures and eCQM data, the amount of resourcing could be quite cumbersome.

For the FY 2023 payment determination, we appreciate the transition window and support a two-quarter collection period for chart-abstracted measures. ***We also support the use of electronic file submission of for chart-abstracted measures starting with the FY 2024 payment determination.*** The ability to supply PDF copies of medical records and upload to QualityNet via a secure file transfer process should not be an issue for hospitals using CEHRT software. This capability further facilitates record sharing and aligns with other federal requirements, such as the CMS Interoperability and Patient Access final rule (CMS-9115-F) and the ONC 21st Century Cures Act final rule (RIN 0955-AA01).

Weighted Scoring: Starting with the FY 2024 payment determination, a single score will be instituted to reflect a weighted combination of a hospital's validation performance for chart-abstracted measures and eCQMs. As proposed, the eCQM portion will be weighted at zero percent and chart-abstracted measures will be weighted at 100 percent. ***We recognize the combining these processes will entail a weighting process and support the delay in heightened eCQM weighting.*** We urge CMS to maintain a zero weight for eCQMs until organizations adjust to this validation process and develop processes that address the progressive eCQM reporting timeline.

Educational Review Process: We appreciate the proposed educational review process for eCQMs, which is also available for chart-abstracted measures. As UPH develops workflows to request educational reviews, we appreciate being able to use the same workflow for multiple purposes.

Hybrid Hospital Wide Readmission (HWR): There were no further changes to the Hybrid HWR measure from the FY 2020 Final Rule. We reiterate our position from last year – ***although we support the concept, we have substantive and process concerns with this measure as proposed and encourage CMS to delay mandatory reporting until the measure has been certified as valid and reliable.*** We believe that a FY2023 mandatory reporting deadline is too aggressive for this unproven measure. We oppose establishing a timeframe for mandatory reporting until the Hybrid HWR measure is further defined, tested and proven, and we likewise disagree with the removal of the current HWR metric until a reliable replacement measure is established. Our hospitals have invested significant time, capital and infrastructure into readmissions initiatives and need to be assured that efforts are accurately measured.

Among our process concerns are reporting timeframe variances and the interplay of IQR and Promoting Interoperability submissions. ***While UPH appreciates the two years of volunteer measure reporting prior to the mandatory reporting to begin July 1, 2023, we have concerns with the misalignment of data capture years compared to the other quality reporting measures.*** First, we recommend that mandatory

reporting start at the beginning of a calendar year, and not a July start date. Second, we request that CMS verify that a single submission for the Hybrid HWR measure would count towards both IQR and Promoting Interoperability programs, akin to how a single submission of eCQM data is treated today. As proposed, we anticipate confusion with the timeline of reported and validated data for this measure and difficulties with software collection of this data and other eCQM data in the QRDA file format. We encourage CMS to clarify (1) the measure validation process as it pertains to the Hybrid HWR measure reporting period, and (2) when this measure data is expected to be submitted, including whether calendar year eCQM data will be submitted at the same time as the Hybrid HWR measure data (e.g. the first two months following the calendar year in which data collection occurred).

OTHER HOSPITAL QUALITY MEASUREMENT

This proposal does not contain any changes to the submission process to Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) or hospital acquired infection (HAI) measures.

Comment: Thank you.

PROMOTING INTEROPERABILITY PROGRAM

The Support Electronic Referral Loops by Receiving and Incorporating Health Information measure is renamed as the Support Electronic Referral Loops by Receiving and Reconciling Health Information measure. Consistent with the Hospital IQR Program proposal, the CQM reporting period in Calendar Year 2021 under the Medicare and Medicaid Promoting Interoperability Programs requires eligible hospitals and critical access hospitals to report two self-selected calendar quarters of eCQM data for four self-selected eCQMs.

Comment: UPH supports renaming the measure to promote better understanding of the measure's intent to send and incorporate electronically shared data. As stated in our Hospital IQR Program comments related to eCQM data submission, we understand and agree that longer reporting windows provide a more complete depiction of patient quality care; however, ***we echo our previous request to extend the implementation timeline due to associated burden and required resources.***

We are pleased to provide input on this proposed rule and its impact on our integrated health system and the individuals and communities we serve. To discuss our comments or for additional information on any of the addressed topics, please contact Cathy Simmons, Government & External Affairs at Cathy.Simmons@unitypoint.org or 319-361-2336.

Sincerely,



Cathy Simmons, JD, MPP
Executive Director, Regulatory Affairs