WISCONSIN HOSPITAL ASSOCIATION

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June 24, 2019

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–1716–P: 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 2020 Rates; Proposed Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Promoting Interoperability Programs Proposed Requirements for Eligible Hospitals and Critical Access Hospitals

Dear Administrator Verma:

On behalf of our more than 150 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 2020 rule related to the Medicare Program Hospital Inpatient Prospective Payment Systems.

WHA was established in 1920 and is a voluntary membership association. We are proud to say we represent all of Wisconsin's hospitals, including small Critical Access Hospitals, mid, and large-sized 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.

Area Wage Index

The area wage index is designed to adjust payments based on local differences in labor costs. 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."

WHA applauds CMS for exploring ways to restore fairness to the wage index in this and other rules. In this proposed rule, CMS would make two changes that have the potential to increase equity in the wage index calculation:

1. CMS proposes to increase wage index values for low-wage hospitals in the bottom 25th percentile. To do this, it would adjust downward the wage index for hospitals in the top 25th percentile.
2. CMS proposes to modify the rural floor calculation as it relates to budget neutrality. Specifically, CMS would not take into consideration urban hospitals that reclassify as rural hospitals when calculating each state's rural floor.

WHA supports CMS's efforts to restore fairness but believe CMS should focus more narrowly on areas that have most gamed the system, rather than applying a broad-brush solution. For instance, Wisconsin has a small number of hospitals that are currently in expensive labor markets which fall inside the top 25th percentile. To our knowledge, these are naturally expensive labor markets, and are not inflated markets that occurred as a result of gaming the rural floor. In contrast, the Bay State Boondoggle refers to areas of the country where hospitals have intentionally reclassified to inflate the state's rural floor, which artificially increases the entire state's labor market at the expense of other states. We believe a fairer approach would be for CMS to focus more narrowly on the outliers while protecting states like Wisconsin that overall lose millions from the Bay State Boondoggle, but then stand to lose more by this downward adjustment of naturally occurring expensive labor markets.

WHA is more supportive of CMS's efforts to modify the rural floor calculation when considering budget neutrality. We believe this policy change will further limit the ability of hospitals to game the system and supports the overall goal of making the wage index more based on its original intended goal of reflecting variances in labor markets. We support CMS making this policy change which will bring us one step closer to a fairer wage index.

Even with this change, however, we believe CMS needs to do more to bring fairness to the wage index calculation. As CMS has previously stated, the impact of the Bay State Boondoggle, that changed budget neutrality from a statewide calculation to a nationwide calculation, is significantly inflated wage indexes across particular states. This has come at the expense of other states and in a manner not intended by Congress when the wage index was originally created.

This distortion undercuts states like Wisconsin that have continued to pursue high quality, high value health care and who are already reimbursed below the national average for Medicare. For instance, Wisconsin hospitals receive only 75% of costs from Medicare while the national average is closer to 87% of cost. While Medicare should be focusing on incentivizing and rewarding states like Wisconsin, its payment policies all too often create perverse disincentives to provide such care.

WHA certainly appreciate CMS recognizing these imbalances and proposing some of the incremental changes in this and previous rules. At the same time, we urge CMS to continue its efforts in this arena and use its regulatory authority to continue unraveling the impacts of the Bay State Boondoggle.

Graduate Medical Education

The proposed rule would allow hospitals that utilize CAHs as part of their residency programs to count nonprovider settings like a physician clinic as part of their GME FTE costs so long as the hospital bears the costs of residents' stipends and fringe benefits. WHA supports efforts to allow Medicare to more fully account for costs associated with graduate medical education (GME). Wisconsin, like many other states, is projecting a workforce shortage particularly in the physician field. By 2030, the number of people age 65 and older is projected to double in every county in our state. This demographic change means many baby-boomers will be leaving the medical field and we will need new physicians to replenish them. While WHA has worked with the Wisconsin Legislature to create a successful GME grant program at the state level, Medicare should be shouldering more of the GME costs at the federal level, particularly when considering that Medicare significantly under-reimburses hospitals for their cost of care.

Promoting Interoperability Program

Because regulatory burden creates additional healthcare costs and limits provider productivity, reducing EHR-related burden on hospitals and clinicians in the Medicare Promoting Interoperability ("PI") Program and in the PI performance category of the Merit-Based Incentive Payment System ("MIPS") is a priority for WHA. We believe that in its regulations for these programs that mandate specific uses of EHR technology, CMS should minimize EHR-related regulatory burdens and ensure that any additional EHR investments, additional time spent using EHR technology, or adjustments to workflow that are necessary to comply with regulatory requirements are outweighed by healthcare cost-savings and improvements in patient outcomes.

In our comments on the Office of the National Coordinator for Health Information Technology's ("ONC") recent draft "Strategy on Reducing Regulatory & Administrative Burden Relating to the Use of Health IT & EHRs" ("Strategy"), WHA encouraged the federal Department of Health and Human Services ("HHS") to identify additional regulatory reforms to reduce EHR-related provider regulatory burden when such regulations do not meaningfully improve healthcare quality, safety, and efficiency. And in our comments on the 2019 Inpatient Prospective Payment System and Physician Fees Schedule proposed rules, WHA supported CMS's decision to reduce regulatory burden by simplifying EHR reporting requirements in the PI Program and in the PI performance category of MIPS.

We understand that HHS likewise is committed to reducing EHR-related provider burden. On March 5, 2018, in remarks to the Federation of American Hospitals, HHS Secretary Azar identified the following as a "key engine for transformation" of healthcare: "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."[1] Further, in ONC's draft Strategy, CMS Administrator Verma said that "we believe that providers should be able to focus on delivering care to patients instead of spending far too much time on burdensome and often mindless administrative tasks."[2] Also in ONC's draft Strategy, ONC identified as significant source of EHR-related burden the misalignment between EHR and clinical workflows and says that "[a]s EHRs continue to evolve, it is imperative that they support the workflows that have been established in clinical practice so as not to add to clinician burden."[3]

Even in this proposed rule, CMS says that one of the goals of its proposals relating to the PI Program is "reducing administrative burden."[4] CMS also says that "[w]e believe in the value of EHRs in today's health care environment and understand the way forward must include reductions in persistent sources of technology-related burden, and more effective use of technology to achieve true efficiency gains."[5]

WHA's comments below on CMS's proposals for the PI Program align with HHS's stated policy of reducing EHR-related regulatory burden.

EHR Reporting Periods

CMS proposes that the 2021 EHR reporting period for all participants in the Medicare PI Program be any

[1] Azar, Alex, Remarks on Value-Based Transformation to the Fed'n of Am. Hosps. (March 5, 2018), https://www.hhs.gov/about/leadership/secretary/speeches/2018-speeches/remarks-on-value-based-transformation-to-the-federation-of-american-hospitals.html.
[2] Office of the Nat'l Coordinator for Health Info. Tech., Strategy on Reducing Regulatory & Admin. Burden Relating to the Use of Health IT & EHRs (2018) 7, available at: https://www.healthit.gov/sites/default/files/page/2018-11/Draft%20Strategy%20on%20Reducing%20Regulatory%20and%20Administrative%20Burden%20Relating.pdf.
[3] *Id.* at 31.
[4] 84 Fed. Reg. 19,158, 19,554.
[5] *Id.* at 19,565.

continuous 90-day period in CY 2021.[6] Under current law, the 2020 EHR reporting period for all PI Program participants (*i.e.*, for eligible professionals, eligible hospitals, and critical access hospitals ("CAHs") attesting under the Medicaid PI Program and for eligible hospitals and CAHs attesting under the Medicare PI Program) is any continuous 90-day period in CY 2020. Further, under current law, the 2021 EHR reporting period for eligible professionals attesting under the Medicaid PI Program is any continuous 90-day period in CY 2021, but the 2021 EHR reporting period for other PI Program participants is not defined.

WHA supports this proposal as providing flexibility for hospitals seeking to attest to meaningful use of certified EHR technology. In WHA's comments to CMS over the years on the PI Programs and on the EHR Incentive Programs, we continually have encouraged CMS to create reporting period flexibilities for hospitals and providers attesting to meaningful use of certified EHR technology. A flexible reporting period allows hospitals and providers to demonstrate advanced use of health IT while limiting the administrative burden associated with CMS regulatory reporting requirements.

"Query of PDMP" Measure

CMS proposes to make the "Query of PDMP" measure optional for 2019 and 2020 and worth up to 5 bonus points in 2019 and 2020. In addition, CMS proposes making the measure a "yes/no" attestation beginning with the EHR reporting period in 2019. Under current law, for the "Query of PDMP" measure, for at least one Schedule II opioid electronically prescribed using certified EHR technology, the eligible hospital or CAH must use data from certified EHR technology to conduct a query of a PDMP for prescription drug history. Further, under current law, this measure is optional for 2019 only and worth 5 points starting in 2020.

WHA supports this proposal to remove the "Query of PDMP" measure as a required measure under the PI Program. In our comments on the 2019 IPPS proposed rule, we recommended that CMS not include this measure in the PI Program. We stated that while Wisconsin hospitals rely on the dispensing data collected by Wisconsin's PDMP to provide efficient and high-quality care, and while the ability to access such data helps to prevent the abuse of opioids and other prescription drugs, Wisconsin hospitals have encountered significant problems with integrating the PDMP into their EHRs. Because of this lack of widespread integration between PDMPs and certified EHR products, WHA told CMS that the measure would create significant provider EHR task burden by necessitating manual data entry into the EHR to document completion of the PDMP query and by necessitating manual calculation of the measure.

We are pleased to see CMS recognize concerns with the "Query of PDMP" measure that WHA and others raised last year. In this proposed rule, CMS acknowledges that "[b]ecause currently there are not standards-based interfaces between [certified EHR technology] and the PDMPs, health care providers must manually track the number of times that they query the PDMP outside of [certified EHR technology]."[7] CMS says it is proposing eliminating the "Query of PDMP" measure as a required measure "to reduce the burden on health care providers of having to manually keep track of information related to the measure."[8]

"Verify Opioid Treatment Agreement" Measure

CMS proposes to remove the "Verify Opioid Treatment Agreement" measure. Under current law, for the "Verify Opioid Treatment Agreement" measure, for at least one unique patient for whom a Schedule II opioid was electronically prescribed by the eligible hospital or CAH using certified EHR technology, if the total duration of the patient's Schedule II opioid prescriptions is at least 30 cumulative days within a six-month lookback period, the eligible hospital or CAH must seek to identify the existence of a signed opioid treatment

[6] CMS is not proposing to adjust the 2021 EHR reporting period for hospitals and CAHs attesting under the Medicaid PI Program because it does not believe there are any hospitals that remain eligible for a Medicaid PI Program incentive payment in 2021.
[7] 84 Fed. Reg. at 19,558.
[8] *Id.*

agreement and incorporate it into the patient's EHR using certified EHR technology. Further, under current law, this measure is optional for 2019 and 2020 only and worth 5 points starting in 2021.

WHA supports this proposal to remove the "Verify Opioid Treatment Agreement" measure from the PI Program. In our comments on the 2019 IPPS proposed rule, we recommended that CMS not include this measure in the PI Program. We stated that the lack of a definition of "opioid treatment agreement" and the lack of a description of what actions a hospital must take to identify the existence of a signed opioid treatment agreement likely would cause confusion as to how to attest to this measure. Further, WHA told CMS that because the measure would require hospitals not only to incorporate opioid treatment agreements into the patient's EHR but also first to take non-health-IT actions to identify the existence of such agreements, the measure would create additional regulatory burden on hospitals and did not align with CMS's new stated goals of promoting interoperability and improving patient access to health information.

We are pleased to see CMS recognize concerns with the "Verify Opioid Treatment Agreement" measure that WHA and others raised last year. In this proposed rule, CMS acknowledges that it has heard concern from stakeholders about this measure, including "concern regarding the lack of defined data elements, structure, standards and criteria for the electronic exchange of opioid treatment agreements and how this impacts verifying whether there is an opioid treatment agreement to meet this measure."[9]

WHA appreciates the opportunity to provide comment on this proposed rule.

Sincerely,

Eric Borgerding
President & CEO

[9] *Id.* at 19,559.