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Seema Verma, Administrator

Centers for Medicare & Medicaid Services

Department of Health and Human Services

Attention: CMS–1694–P

P.O. Box 8011

Baltimore, MD 21244–1850

*Delivered via online form:* [*http://www.regulations.gov*](http://www.regulations.gov)

Subject: CMS-1694-P, Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2019 Rates; Proposed Quality Reporting Requirements for Specific Providers; Proposed Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs (Promoting Interoperability Programs) Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Medicare Cost Reporting Requirements; and Physician Certification and Recertification of Claims; (Vol. 83, No. 88), May 7, 2018

Dear Administrator Verma:

The Rural Wisconsin Health Cooperative (RWHC) is pleased to offer our comments on the previously referenced Centers for Medicare & Medicaid Services (CMS) proposed rule for the fiscal year (FY) 2019 Hospital Inpatient Prospective Payment System (IPPS). We appreciate your continued commitment to the needs of rural patients.

Established in 1979, RWHC is owned and operated by forty rural acute, general medical-surgical hospitals. RWHC works to achieve the vision that rural Wisconsin communities will be the healthiest  
in America.

Critical Access Hospital Location/Mileage Standards

Before we offer comments to items in the proposed rule, it is important to address a major concern related to Critical Access Hospital (CAH) location/mileage standards. On the May 17th CMS Rural Health Open Door Forum, participants were informed during the call to a radically new interpretation on the location/mileage regulations from a CAHs provider-based clinics to another hospital and or their provider based clinics. They proceeded to say that a PPS provider-based clinic opening up within the mileage standards (35 miles on primary roads/15 miles on secondary roads) of a non-necessary provider deemed CAH hospital would jeopardize their CAH status.

The case example seems to be Curry General Hospital in Gold Beach, OR, and their off-campus provider-based location in Brookings, OR is less than 35 miles from Sutter Coast Hospital in Crescent City, CA, yet the distance between each of their inpatient facilities is 55 miles and would still meet CAH certification for Curry General Hospital. **CAH distance standards should be only from other like inpatient facilities; otherwise, health care access to inpatient services will be jeopardized and limited to rural populations.**

Wisconsin only has four non-necessary provider deemed CAH hospitals; however, if this interpretation is to stand, they could be at risk of losing status through current non-inpatient, provider-based facilities or the potential of a malicious competitor opening a provider-based clinic that could jeopardize their CAH status. **This radically new interpretation on the location/mileage regulations must be changed back to the interpretation that had existed for two decades that judged mileage from like inpatient facilities.** This new interpretation seems even stranger given CMS’ new Rural Health Strategy, which seeks to “inform CMS’ work as it relates to rural health and thereby helps CMS achieve its vision for equitable rural health and health care.” As CMS further states this “strategy applies a rural lens to new and ongoing activities of the Agency and informs the pathway by which CMS can achieve its rural health vision through intra-agency collaboration, stakeholder engagement, and the elevation of programs and policies that will advance the state of rural health care in America.”

Price Transparency

Wisconsin did not wait to be dragged into price transparency. The Wisconsin Hospital Association Information Center (WHAIC) began collecting data in January 2004 under a contract with the Wisconsin Department of Administration. WHAIC has collected and disseminated complete, accurate, and timely data about charges and services provided by Wisconsin hospitals and ambulatory surgery centers since 2004. Further, pursuant to Wisconsin Statutes Chapter 153, all Wisconsin hospital and surgery centers are required to submit inpatient and outpatient data to WHAIC each quarter. PricePoint uses this data to provide health care consumers with hospital-specific information about health care services and charges in Wisconsin, allowing them to learn more about the services that go into your care and how those services contribute to the charges you might see on your bill or in a report from your insurance company. **RWHC believes that price transparency should be done at the state level, as not to complicate or undercut efforts and success like Wisconsin has already had. We believe that CMS should focus on states not as advanced in price transparency as Wisconsin and could provide grant dollars for states to initiate and improve their own programs.**

RWHC does remain concerned that price transparency is not the same as out of pocket transparency. It is a concern that we have had with WHAIC’s PricePoint, as it shows the average charge at each hospital, but it does not take into consideration contractual discounts, copays, coinsurance, deductibles, or any other variables that impact a patient’s out-of-pocket expense. Unless CMS is considering how they level the playing field if their intent is to inform patients, simply publishing charge masters does nothing to inform patients. The best process is for patients to request pricing which gives their local hospital the opportunity to get insurance information and try to help them understand their out-of-pocket. A published chargemaster takes away our ability to truly guide the patient and could have unintended consequences.

Another concern of ours in the price transparency debate is that the insurance companies do not seem to have any “skin in this game,” yet they drive the patient’s out-of-pocket in most cases. There are times that even with all the needed information, a patient’s out-of-pocket expense may change after the bill is sent out. An example of this is with MultiPlan and their non-exclusive network. Since insurance companies using the MultiPlan network are not bound to its participation, they can choose to process the claim outside the terms of the network agreement. This results often in underpaid claims where the patient must be billed the balance. Even with pre-authorized services this can happen and results in higher than anticipated out-of-pocket expenses. How would CMS propose we handle those situations if the insurances are not involved in the process?

Part A Certification Statements and Physician Orders

RWHC appreciates CMS proposing to remove the requirement for stating where in a medical record required information can be found. Further, we appreciate CMS also proposing to remove the requirement that a written inpatient order be present in the medical record as a condition of Part A payment. RWHC believes that this was an unnecessary regulatory burden.

Hospital Specific Rates

**RWHC is concerned that the Sole Community Hospital (SCH) and Medicare Dependent Hospital (MDH) hospital-specific rates for FY 2019 were not calculated correctly and urge CMS’ further review.** Specifically, we believe that CMS may have omitted certain factors when updating the rates and, as a result, they are much lower than they should be.

Following an American Hospital Association (AHA) review, these hospital-specific rates, the AHA found that over the past few years, the annual recalibration of the MS-DRG weights has had a substantially negative impact on rural hospitals. For example, over the past eight years, there has been an impact of negative 2.5 percent on SCHs – a sizeable cut for small, and often vulnerable, rural hospitals. Indeed, it is well documented that many rural communities are facing challenges accessing health care with more than 80 rural hospitals closing since 2010. **As such, and in light of CMS’s recently released *Rural Health Strategy* that aims to make health care in rural America accessible, affordable and accountable, RWHC asks the agency to consider ways to ameliorate these cuts. One such possibility is to re-evaluate the agency’s decision to apply documentation and coding cuts totaling 5.4 percent to the SCH and MDH hospital-specific rates in FYs 2011 through 2013, which were not required by law.**

Proposed Changes to Medicare GME Affiliated Groups for New Urban Teaching Hospitals

CMS proposes to provide more flexibility for new urban teaching hospitals to enter into Medicare GME affiliation agreements, which allow hospitals to share FTE cap slots to accommodate the cross training of residents, hopefully in rural areas. **RWHC support this changes.**

Request for Information on Promoting Interoperability and Electronic Healthcare Information Exchange

RWHC believes that while interoperability is a goal and excellent vision for the future of the electronic medical record, it does not appear that our technology is there yet. Currently, there are issues with the documentation and “finding of information” in the electronic medical records in facilities and with providers. We would suggest that **standards to improve the use and efficiency of the electronic medical records be made and put on the companies of these products rather than burden providers at this time.**

Patients are getting more availability to their medical records which is very good and this should continue to grow and expand with demand. Pushing incentives before technology has caught up may not achieve the intended results. An example is the discharge information that is given to patients which is complete but is very lengthy and difficult to find specific information or what key points are most important. The same may happen with making the current electronic medical records available to patients before we have made improvements that are needed.

Remove Unnecessary, Redundant, and Process-Driven Quality Measures From a Number of Quality Reporting and Pay-For-Performance Programs

RWHC supports removing the redundancy in measures and simplify measures. We would also support increased overview and communication within Medicare and Medicaid to ensure duplication does not occur in the future. It would also be helpful if the Medicare Beneficiary Quality Improvement Project (MBQIP) program came out of the IPPS rule to improve alignment in removal and addition of measures and have requirements for CAH available in one place.

Hybrid Hospital-Wide Mortality Measure with Electronic Health Record Data

The Hospital-Wide All-Cause Risk Standardized Mortality Measure is claims-based that estimate hospital-level, risk-standardized mortality rate (RSMR) for Medicare Fee For Service patients between the ages of 65 and 94. Mortality is defined as death from any cause within 30 days after the index admission date, including in-hospital deaths. The hybrid version will use Medicare FFS administrative claims to derive the cohort and outcome, and claims and clinical EHR data for risk adjustment. Mortality rates will be separately calculated and risk adjusted for cases in 13 mutually exclusive service lines, as well as aggregated into a hospital wide rate. The measure is conditionally supported by the National Quality Forum (NQF) Measures Application Partnership (MAP) Workgroup, pending NQF review and endorsement. The MAP recommended the hybrid version undergo a voluntary reporting period before mandatory implementation.

CMS is proposing to include 10 clinical data elements meant to reflect a patient’s clinical status upon arrival to the hospital. RWHC believes the 10 clinical criteria with timeframes proposed for this Electronic Clinical Quality Measure (eCQM) would be problematic and complex from a vendor perspective and we would not support this measure. Erroneous data measurements (such as BP, temperature, heart rate) can be difficult to not include in the medical record or discrete data field capture which could alter the impact of the clinical data elements. Additionally, consideration of the patient’s baseline for some of the clinical data elements is not part of the measure, and also not commonly captured in discrete data fields. **Rural areas will also have different contributing factors too, for example, often social isolation, common among older rural people, is a driver of poor health outcomes and increases the risk of falls, dementia, depression, re-hospitalization, and all-cause mortality.** Further, the CDC Morbidity and Mortality Weekly Report (MMWR) has found that “Americans living in **rural** communities are **more likely to die prematurely from the top five causes of death** (heart disease, accidents, stroke, cancer, and respiratory disease), than are their urban counterparts.”

Potential Future Inclusion of the Hospital Harm—Opioid-Related Adverse Events eCQM

CMS is proposing to assess, by hospital, the proportion of patients who had an opioid-related adverse event. RWHC has been actively involved in several state-focused initiatives related to opioids and other substance abuse disorders, but believes this measure could also produce unintended consequences such as undertreating pain. The larger issues seem to be with prescribing opioids in the outpatient setting.

**RWHC would also not support this as a mandatory measure because for many facilities naloxone is rarely used and the measure would not be meaningful.** We would not support this as an eCQM because the timeframes within the measure could make the data difficult to retrieve and the data would not be meaningful for many facilities. While the wide discrepancy in utilization of this measure is noted, it may be more beneficial to increase education of the issue or target facilities that may have issues with utilization of this drug.

Potential Future Development and Adoption of eCQMs Generally

As CMS states, stakeholders continue to identify areas for improvement in the implementation of eCQMs under a variety of CMS programs, including the Hospital IQR Program and the Medicare and Medicaid Promoting Interoperability Programs (previously known as the Medicare and Medicaid EHR Incentive Programs). RWHC agrees that effective utilization of eCQMs promises greater efficiency and more timely access to data to support quality improvement activities and various types of costs associated with these measurement approaches detract from these benefits. CMS is asking for stakeholder feedback on ways to address these and other challenges related to eCQM use. We have attempted to provide feedback on the specific questions asked:

1. **What aspects of the use of eCQMs are most costly to hospitals and health IT vendors?**
   * Developing the needed documentation and ability to pull the data to reportable formats is costly in terms of the time of staff education, IT changes to the EHR to capture the data, and IT report development/data collection. In addition, needed improvements add cost for the corrections and changes to the ability to collect the data.
   * Smaller hospitals that merge into a single instance form of the EHR with a larger system is challenging to manage the information and keep eCQMs documentation requirements available to report.
   * Changes in reporting from year to year is costly and difficult. One facility merged with a system EHR and is having difficulty getting the files in the required QRDA format when last year the data could be submitted themselves. CY2018 requirement for 2015 certification was removed in autumn of 2017. If some vendors had known this would not be required, they could have waited a year to get this certification with fewer eCQMs (many removed in the 2017 IPPS final rule) which would have been less costly as well. In summary, more advance notice to changes to allow vendors and providers time to adequately budget and implement the changes needed.
2. **What program and policy changes, such as improved regulatory alignment, would have the greatest impact on addressing eCQM costs?**
   * Alignment of definitions, calculations, and populations with eCQMs and the Core Measures would be helpful and more efficient. Including verbiage for clinicians to understand in the eCQM specifications rather than the current verbiage directed to IT specialists would improve communication between IT and clinicians and create a more efficient electronic medical record as well as consistency in reporting between facilities.
   * Changing previously finalized requirements adds cost for vendors and providers. The CY2017 hospital eCQM requirement at the beginning of the year was 8 eCQMs for the calendar year and was changed at the end of July to 1 quarter and 4 eCQMs.
   * We would support a slower introduction of eCQMs reporting requirements and in lower volumes to ensure that CMS technology can accept and calculate the data timely. This would also allow providers to work on internal process improvements with their EMRs.
   * eCQM measure selections are limited especially for small hospitals. We would support broader eCQM measure selections for more meaningful measures with easy data fields to capture the information and evolve to more difficult measures with time.
   * Having eCQM selections with common data fields is most helpful rather than data codes (such as SNOMED) that are not/had not commonly been utilized
3. **What specifically would stakeholders like to see us do to reduce costs and maximize the benefits of eCQMs?**
   * Provide changes and the detail of changes in a timely manner.
   * Test measures and measure data capture before rolling out in finalized rules.
   * Do not finalize measure requirements that are burdensome and then suspend or repeal the requirement during the reporting period or within months of the reporting period.
   * Ensure the CMS data collection and support systems have the capability to receive data and provide feedback reports timely and accurately.
   * Provide specifications to the eCQMs that define the data fields to ensure data is submitted consistently between providers. Provide verbiage on the logic of the eCQMs that is understandable to clinicians and IT personal (translate the IT logic into clinician terms) and ensure the specifications to the eCQMs will capture the desired data.
   * Have eCQM selections with discrete data fields commonly used rather than more difficult data capture such as SNOMED codes.
4. **How could we encourage hospitals and health IT vendors to engage in improvements to existing eCQMs?**
   * Improve the feedback loop system. Currently, there are a number of places to ask questions on the eCQMs only to find out that the question was not submitted to the correct area. If there can be one place for eCQM questions that can filter where or who addresses the question that would be most helpful. Also, more timely responses to questions would be greatly helpful. A review of the questions by CMS could provide much feedback on where improvements with eCQMs is needed.
   * Provide a feedback area for hospitals and IT vendors to submit where there are issues and where improvements can be made.
   * There are very few eCQM measures with volume and meaning for smaller hospitals. Having measure selections of a broader scope and that provide meaningful data may encourage more engagement. Many smaller hospitals don’t do OB, have an ICU, nor admit stroke patients. eCQM selections for these hospitals are very limited.
5. **How could we encourage hospitals and health IT vendors to engage in testing new eCQMs?**
   * Supplement or reimburse for the costs to trial eCQMs and provide feedback.
   * Provide eCQMs that provide meaningful data that would be helpful to the quality improvements needed within an organization.
6. **Would hospitals and health IT vendors be interested in or willing to participate in pilots or models of alternative approaches to quality measurement that would explore less burdensome ways of approaching quality measurement, such as sharing data with third parties that use machine learning and natural language processing to classify quality of care or other approaches?**
   * Now may not be the best time for this initiative given the number of measures impacting reimbursement, the multiple changes within the measure requirements, and the uncertainty of changes that may occur within the healthcare system with the uninsured.
   * It may be beneficial to ensure information is secure before moving toward sharing data with a third party. Given the number of data breaches in recent years and the sensitivity of healthcare data, technology may not yet be ready for this move at this time.
   * Providing more granular data results to the data currently collected may be helpful and would not require any additional burden on providers or vendors. For example, of the 30-day readmission, what percent of these are within 7 days which is usually more within the control of a hospital (rather than those readmitted within the 21-30 day period from discharge). Is there another factor within this data that would be of interest such as the percent readmitted that were discharged to home?
7. **What ways could we incentivize or reward innovative uses of health IT that could reduce costs for hospitals?**
   * Supplement or reimburse for the costs to trial eCQMs and provide feedback.
   * Provide standards (and perhaps incentives) for EMR vendors (such as EPIC, Cerner, etc.) Currently, there are many differences between the EMR vendors that can make finding information in the medical record difficult, make documentation difficult, and be potentially harmful to patient care due to these inadequacies. Also require (incentivize) that standardized reports commonly used for quality data and internal quality review be within the package of all medical records. Currently, every hospital (or hospital system) has to pay extra and wait for reports to be developed for their   
     EMR. Examples include reports for the core measure cases, readmissions, mortality.
   * Making a patient’s date of death available to import into the EMR would be very helpful for hospitals to track the 30-day mortality measures. Currently, we have not seen an efficient way for hospitals to retrieve this data if the death occurs outside of their facility.
8. **What additional resources or tools would hospitals and health IT vendors like to have publicly available to support testing, implementation, and reporting of eCQMs?**
   * There are multiple places to go for information and to ask questions and we often find we have submitted a question to the wrong place or called the wrong help desk. Simplifying this structure and “searches” would be very time saving.
   * Availability and ability to find in “plain-non-IT language” the requirements and specifications for providers for the different eCQMs. The algorithms for core measures were most helpful. Defining data fields as with the Core Measures Data Dictionary would improve the consistency of measure reporting between hospitals.
   * Including the “performance period” in addition to the FY impact would be most helpful when referencing all measures as well as standardizing timeframes. (CY quarter rather than 90 days; changes beginning January 1 for all measures, etc.)

Retain and Modify the Exception for Limited Access to Broadband

CMS proposes to remove the exclusion criterion related to broadband availability, which was set at 4 Mbps of broadband availability within the county in which the facility is located (as opposed to availability for the provider). **RWHC recommends that CMS retain the exception and examine whether it will need to be modified over time, as the use of telehealth and other modalities dependent on Internet access increases.** According to the Federal Communication Commission’s most recent “Broadband Progress Report”, the existing community speed benchmark is 25 Mbps download/3 Mbps upload (25 Mbps/3 Mbps) for what it considers as fixed broadband. **Over 24 million Americans still lack fixed terrestrial broadband at speeds of 25 Mbps/3 Mbps, with deployment in rural areas and Tribal lands lagging behind that of urban areas** (*see* https://apps.fcc.gov/edocs\_public/attachmatch/FCC-18-10A1.pdf).

With respect to health care providers specifically, the FCC’s 2012 *Healthcare Connect Fund* included a needs assessment of “health care provider (HCP) needs for broadband capability in light of the current and future state of telemedicine, telehealth, and health care information technology (Health IT).” RWHC ITN became one of the first networks in the country to be designated as a Healthcare Connect Fund (HCF) Consortium, helping 29 hospitals and nearly 70 sites apply for broadband funding through the new FCC HCF subsidy program. That assessment found that the optimal bandwidth needs for the transmission of HD video consultation averages 22 Mbps. The report also notes that a minimum speed of 10 Mbps symmetrical is necessary to support the majority of telehealth applications, but emphasizes that larger facilities utilizing multiple concurrent technologies and connections may require upwards of 100 Mbps (s*ee* https://apps.fcc.gov/edocs\_public/attachmatch/FCC-12-150A1.pdf at §§ 6-12). Thus, in the future, CMS may need to deploy an exception based on the bandwidth available to the health care provider, at higher speeds. **RWHC recommends maintaining the existing exception.**

Thank you for your consideration of these comments on CMS-1694-P. We urge your review and reconsideration. We look forward to continuing our work together to achieve mutual goals of improving access and quality of health care for all rural Americans.

Sincerely,



Tim Size

Executive Director