



A Passionate Voice for Compassionate Care

July 10, 2020

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Room 445-G Herbert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

REF: CMS-1735-P

Re: Medicare Program; Hospital Inpatient Prospective Payment Systems (IPPS) for Acute Care Hospitals and the Long- Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year (FY) 2021 Rates; Quality Reporting and Medicare and Medicaid Promoting Interoperability Programs Requirements for Eligible Hospitals and Critical Access Hospitals

Dear Ms. Verma:

The Catholic Health Association of the United States (CHA) is pleased to submit these comments on the referenced Centers for Medicare & Medicaid Services' (CMS) proposed rule published in the Federal Register on May 29, 2020. (85 Federal Register 32460). We appreciate the ongoing efforts of CMS to administer and improve the payment systems for acute inpatient hospital services, especially considering the agency's many competing demands and limited resources. CHA offers the following comments on the proposed rule.

- **Price Transparency and Market-Based Medicare-Severity Diagnosis-Related Group (MS-DRG) Relative Weights**

In the FY 2021 IPPS proposed rule, CMS proposes that hospitals would be required to report:

1. the median payer-specific negotiated charge that the hospital has negotiated with all of its Medicare Advantage (MA) plans, 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 plans, by MS-DRG.

Hospitals would be required to report this information on their Medicare cost report for cost reporting periods ending on or after January 1, 2021, for potential use in setting the IPPS MS-DRG relative weights beginning in FY 2024.

In the FY 2020 outpatient prospective payment system rule, CMS adopted a policy that requires hospitals to report gross charges and payer-specific negotiated charges for all items and services and for 300 shoppable services to be posted on hospital websites in a consumer-friendly manner. CMS finalized this policy over the universal objections from the hospital community. Now CMS proposes to add to hospital burdens by requiring the reporting of additional information—ostensibly to set the IPPS relative weights based on negotiated rates instead of hospital reported cost and charge data beginning in FY 2024.

Price Transparency

CHA continues to oppose CMS' price transparency policy. While we agree that consumers should have access to information about the cost of their care, we reiterate our objections that the policy is burdensome, of questionable legality and utility and potentially in conflict with other federal policies. Furthermore, it fails to provide consumers with useful information.

Patients are most concerned with the amounts that they will be paying out-of-pocket when they need health care services. They are not interested in the negotiated rate between hospitals and private insurers, nor is that information useful to them. Hospitals spend considerable time and effort working to inform patients about how much a hospital stay will cost them. These efforts give patients a reasonable expectation of their planned out-of-pocket expenses based on their insurance plan and minimize the potential for surprise bills. Patients should also be able to obtain information on their out-of-pocket costs from their health plans.

As noted in our letter responding to the price transparency proposal, the Department of Justice (DOJ) and the Federal Trade Commission (FTC) have antitrust concerns with revealing proprietary confidential information¹ and the policy requires hospitals to make information public that the statute prohibits CMS itself from disclosing.²

CHA and its members are committed to making sure everyone has access to affordable health care and believe that patients should know what their out-of-pocket costs will be when making health care decisions. **CHA reiterates its opposition to the current price transparency policy and urges CMS to instead work with health plans, patients, providers and other stakeholders to find reasonable and effective ways to get patients information they need and can use.**

¹ <https://www.justice.gov/atr/page/file/1197731/download>; page 43.

² Section 1834A(a)(10) of the Act explicitly prohibits the Secretary from disclosing private payer rates reported by “applicable laboratories,” which (effective January 1, 2019) includes hospital outreach laboratories that receive a referred specimen.

Market-based MS-DRGs

In the proposed rule, CMS seeks to reduce the Medicare programs' reliance on hospital chargemasters, which it is concerned do not reflect true market costs and whose use in setting rates it believes overstates Medicare payments. The CMS proposal presumes that MA and commercial rates reflect competitive negotiations between hospitals and commercial plans, including MA. While this may be the case for some markets and individual hospitals, other factors may contribute to the rates that hospitals set, including whether rates are set based on Medicare fee-for-service or the level of competition (between either hospitals or payers) in the individual hospital's market.

CMS bases its proposal on the mistaken premise that MA rates reflect competitive market forces because they are freely negotiated. In fact, many MA-specific rates are set based on Medicare fee-for-service and therefore reflect existing MS-DRGs.

There is no analogous independent analysis or recommendation supporting the current proposal to use payer-specific negotiated rates in determining cost-based relative weights. Without insight into whether commercial rates are in fact the result of true market-based negotiations, CMS is committing itself to a new metric that could be less accurate than its current methodology. Section 1886(d)(4)(B) requires that the Secretary establish MS-DRG weights that reflect the relative hospital resources within a DRG relative to the average across all DRGs. This proposal may introduce new distortions into the MS-DRG methodology that will result in weights that no longer reflect the resources required to furnish care to the Medicare population. For example, CMS acknowledges that not all payer-specific charges will be based on MS-DRGs - some hospitals may negotiate charges based on a per diem basis. Hospitals will have to crosswalk these other rate-setting mechanisms to MS-DRGs, which may not always be feasible. In doing so, hospitals may apply different methodologies, and may introduce new distortions into the rate-setting process.

Furthermore, non-MA commercial plans typically serve a different demographic than the general Medicare population so commercial rates may not be truly reflective of the resource utilization needed to care for Medicare beneficiaries, who often have higher complications and comorbidities than the general population. Given that MS-DRG weights are set in a budget neutral manner, this proposal may have the effect of shuffling payments in a less informed and less precise manner.

CMS also grossly underestimates the burden the proposal will place on hospitals. Hospitals are currently required to publicly report standard charges. This proposal would require them to report something different: median negotiated rates based on MS-DRG. As a result, hospitals will likely need to calculate the median based on additional information or go through a manual process of calculating MS-DRGs based on the price transparency data. Because not all third-party payers based their rates on MS-DRGs, hospitals will have to calculate an MS-DRG based

on the same or similar package of services. The proposal will impose a significantly greater burden than CMS acknowledges.

As the CMS proposal will only add reporting burdens for hospitals without leading to any improvement in how Medicare's IPPS rates are determined, CHA opposes CMS' proposal and asks that it be withdrawn.

- **FY 2021 MS-DRG Documentation and Coding Adjustment**

The proposed rule would make an adjustment to IPPS payment rates of +0.5 percentage points as the fourth step in a six-year process of restoring prior year downward adjustments to IPPS payment rates required by the American Taxpayer Relief Act of 2012 (ATRA). The ATRA adjustments were intended to recoup prior year spending increases attributed by CMS to documentation and coding changes which CMS believed did not reflect real changes in case-mix.

As acknowledged in prior rulemaking, CMS made recoupment adjustments totaling 3.9 percentage points. CMS indicates in the propose rule its intent to return only 2.96 percentage points of those adjustments to IPPS rates by FY 2024. Approximately 70 percent of the difference is the result of a change in CMS' estimates of the adjustment necessary in FY 2017 to complete recoupment of the \$11 billion required by ATRA.

CHA continues to assert that CMS' failure to restore IPPS payment rates fully within its authority is unfair and detrimental to hospitals. CMS' failure to accept hospitals' repeated requests for this change has given rise to ligation over the issue. **CHA again respectfully requests CMS to indicate in the FY 2021 IPPS final rule that it will restore the additional 0.7 percentage point reduction it made to IPPS rates in FY 2017 by FY 2024.**

- **FY 2021 Outlier Threshold**

CMS proposes an FY 2021 outlier threshold of \$30,006, a 13 percent increase over the FY 2020 outlier threshold of \$26,552. CHA remains concerned about the high level of the outlier threshold and the rate at which CMS proposes to increase it in FY 2021 compared to FY 2020. We understand that a small proportion of exceptionally costly cases may be resulting in increases to the outlier threshold.

The Department of Health and Human Services' Office of the Inspector General (OIG) indicated in a 2013 report that 16 MS-DRGs accounted for over 41 percent of outlier payments.³ The OIG recommended that CMS examine whether MS-DRGs associated with high rates of outlier payments warrant coding changes or other adjustments. Consistent with the OIG's findings, **CHA requests that CMS examine the reasons for the continuing rise in the outlier**

³ Daniel R. Levinson, *Medicare Hospital Outlier Payments Warrant Increased Scrutiny*, Office of the Inspector General, OEI-06-10-00520, November 2013.

threshold and whether there are any interventions it can take to ensure that outlier payments remain equitable and continue to protect hospitals from high cost cases where Medicare's IPPS payments are insufficient to adequately compensate the hospital.

- **Chimeric Antigen Receptor (CAR) T-Cell Therapy**

CMS proposes to create a new MS-DRG 018 (CAR T-cell Immunotherapy) for cases involving CAR-T therapy for FY 2021. To determine the relative weight for MS-DRG 018, CMS proposes to exclude clinical trial cases where the CAR-T product is furnished to the hospital at no cost. Further, CMS proposes to pay hospitals for clinical trial cases where the hospital does not have a cost for the CAR-T product at 15 percent of the full payment.

Cases where CAR-T cell therapy is furnished are currently included in MS-DRG 016 with bone marrow transplants. CMS indicates that CAR-T cell therapy patients are clinically distinct from bone marrow transplant cases and nearly five times as expensive. While there are not many CAR-T cases, CMS believes their unique clinical characteristics and high costs merit creation of a separate MS-DRG. **CHA agrees that these findings warrant creation of a separate MS-DRG for CAR-T cell therapy cases and supports CMS' proposal to do so.**

CMS further indicates that the cost of the CAR-T product itself averages \$373,000 and that hospitals participating in clinical trials are furnished with the CAR-T product at no cost as part of participating in a clinical trial. Consistent with our recommendation on the FY 2020 IPPS proposed rule, **CMS proposes to exclude clinical trial cases where the hospital does not have a cost for the very expensive CAR-T product from the relative weight determination.** This proposal will avoid determining an IPPS payment that averages very high cost cases outside of a clinical trial with clinical trial cases that do not have a \$373,000 cost and result in a more accurate payment. **CHA supports this proposal.**

- **Allogeneic Hematopoietic Stem Cell Acquisition Costs**

For cost reporting periods beginning on or after October 1, 2020, as required by Medicare statute, CMS proposes that allogeneic hematopoietic stem cell acquisition costs be paid on the basis of reasonable costs rather than through the IPPS. CHA understands that hospitals have historically been underpaid for stem cell acquisition costs under the IPPS resulting in access problem to this potentially life-saving service for patients. **CHA supports reasonable cost payment for allogeneic hematopoietic stem cell transplants.**

- **Disproportionate Share Hospitals (DSH)**

Determining the Aggregate Pool of Uncompensated Care Payments

Since FY 2014, hospitals that qualify for Medicare DSH payments receive two separately calculated payments. The first payment equals 25 percent of the amount they would have

received under the Medicare DSH formula prior to the Affordable Care Act. The second payment is based on the remaining 75 percent of the total Medicare DSH payments that would have been paid under the old formula (Factor 1), adjusted by the change in the number of uninsured individuals since FY 2013 (Factor 2). The amount received by a given hospital from this aggregate pool of uncompensated dollars is based upon that hospital's share of national uncompensated care costs using Worksheet S-10 of the Medicare cost report (Factor 3).

CMS estimates that the amount available to distribute as uncompensated care will decrease from \$8.35 billion in FY 2020 to \$7.82 billion in FY 2021, a decrease of 6.4 percent or nearly \$534 million. To arrive at its estimate CMS uses two data sources that do not take into account the impact of the COVID-19 public health emergency (PHE). The calculation of funds available to distribute as uncompensated care, once determined, is not changed to reflect subsequent updates to the data sources. For this reason, it is critical that CMS' estimates accurately reflect the latest information available, including loss of employment based insurance coverage; increases in the number of uninsured; and increases in Medicaid eligibility due to the pandemic.

Factor 1 is determined by taking Medicare DSH payments from FY 2017, adjusting that amount to estimate FY 2021 DSH payments and multiplying the result by 0.75. The adjustment reflects changes in areas such as utilization and case mix, and an "Other Factor" which includes changes in Medicaid enrollment. The "Other Factor" proposed by CMS would fall slightly for FY2020 and increase slightly for FY 2021.

Medicaid enrollment in FY 2020 and FY 2021 will certainly increase due to the PHE. Unemployment began increasing in March of 2020 as businesses closed to mitigate the spread of COVID-19. Economic dislocation is expected to continue into FY 2021.⁴ The Urban Institute estimates that between 12 and 21 million people will gain Medicaid coverage as a result of losing employer sponsored insurance (ESI) due to the economic dislocation of the COVID-19 public health emergency.⁵ Kaiser Family Foundation estimates that of the 27 million people losing ESI as of May 2, 2020, nearly half (12.7 million) are eligible for Medicaid.⁶

The proposed rule indicates, "OACT [the Office of the Actuary] intends to use more recent data that may become available for purposes of projecting the final Factor 1 estimates for the FY 2021 IPPS/LTCH PPS final rule." (85 FR 32748). When updating its estimate for the final rule, **CHA strongly urges that OACT use data that accurately reflects the impact of the COVID-19 PHE on Medicaid enrollment for determining Factor 1 of the uncompensated care determination.**

⁴ Federal Reserve Chairman Jerome Powell, *60 Minutes Interview*, May 17, 2020.

⁵ Bowen Garrett and Anuj Gangopadhyaya, *How the COVID-19 Recession Could Affect Health Insurance Coverage*, Urban Institute, May 2020.

⁶ Rachel Garfield, Gary Claxton, Anthony Damico and Larry Levitt, *Eligibility for ACA Health Coverage Following Job Loss*, Kaiser Family Foundation, May 13, 2020.

Factor 2 is determined by comparing estimates of the number of uninsured for FY 2021 to the number of uninsured in calendar year 2013, before the Affordable Care Act went into effect. OACT uses estimates of the uninsured from the National Health Expenditure Accounts (NHEA) based on the latest historical data through 2018 (85 FR 32751). In an explanatory document on CMS' website dated March 24, 2020, OACT indicates:

The models used to project trends in health care spending are estimated based on *historical* relationships within the health sector, and between the health sector and macroeconomic variables. Accordingly, the spending projections assume that these relationships will remain consistent with history, except in those cases in which adjustments are explicitly specified.⁷ (Emphasis added).

CHA believes that such relationships in FY 2020 and FY 2021 will not be consistent with recent historical relationships. Prior years included consistent economic growth from the end of the great recession in 2009 through February of 2020. As stated previously, the COVID-19 PHE has resulted in a sudden and severe economic dislocation beginning midway through FY 2020 that is expected to continue through FY 2021.

In selecting use of the NHEA to determine Factor 2, OACT states:

Timeliness and continuity are important considerations because of our need to be able to update this estimate annually. Accuracy is also a very important consideration and, all things being equal, we would choose the most accurate data source that sufficiently meets our other criteria.” (85 FR 32751)

Further, OACT states “we may also consider the use of more recent data that may become available for purposes of estimating the rates of uninsurance used in the calculation of the final Factor 2 for FY 2021.” (85 FR 32751) **CHS urges OACT to update Factor 2 with more timely and accurate data to reflect an increase in FY 2020 and FY 2021 in uninsured patients due to the PHE.**

Distributing Uncompensated Care Payments

For FY 2021, CMS proposes to use one year of audited Worksheet S-10 data from FY 2017 for distributing uncompensated care payments. CHA has previously commented that CMS should only use audited cost report data in the distribution of uncompensated care payments and we thank CMS for being responsive to our concerns regarding auditing Worksheet S-10 data. CHA supports the use of audited FY 2017 Worksheet S-10 data in the uncompensated care distribution.

⁷ Office of the Actuary, Projections of National Health Expenditures and Health Insurance Enrollment: Methodology and Model Specification, page 1.

CHA has concerns, however, with the proposal to use only one year of data to distribute uncompensated care payments. In the past, CMS used three years of data, which lessens instability and mitigates wide swings in hospital payments from year to year. While CMS believes its proposal would give providers greater predictability for planning purposes, we are concerned that the use of a single year of cost report data could result in significant year-to-year volatility in uncompensated care payments for hospitals. **CHA requests that CMS transition back to using three years of S-10 data, basing the uncompensated care distribution on two years of Worksheet S-10 data in FY 2022 and three years of Worksheet S-10 data in FY 2023 to mitigate large year-to-year changes in a hospital's uncompensated care payments.**

Definition of Uncompensated Care

CMS does not propose any changes to its definition of uncompensated care from prior years. Under this definition, CMS would recognize non-Medicare bad debt and charity care. However, CMS would not recognize payment shortfalls from public health programs like Medicaid, the Children's Health Insurance Program and state and local indigent care programs. **CHA believes that uncompensated care should also include the unreimbursed costs of public health care programs, including Medicaid, the Children's Health Insurance Program and state and local indigent care programs.** This approach would be a fairer way to allocate uncompensated care dollars to hospitals, especially given that analyses we have reviewed suggest that hospitals located in states that opted out of Medicaid expansion do significantly better under the CMS proposed approach than hospitals located in states that have expanded Medicaid. Broadening the definition to include Medicaid shortfalls and other forms of unreimbursed costs of other public health care programs would help make the allocation more equitable.

Puerto Rico, Tribal and Indian Health Service Hospitals

For Puerto Rico, Tribal and Indian Health Service (IHS) hospitals, CMS is not using Worksheet S-10 to determine their uncompensated care payments. Rather, because of special reporting issues that make Worksheet S-10 inaccurate for these hospitals, **CMS proposes to continue to using low-income patient days as a proxy for uncompensated care in FY 2021 for these hospitals. CHA supports this proposal.**

CMS also discusses potentially removing Tribal and IHS hospitals from the uncompensated care distribution beginning FY 2022. Instead of paying Tribal and IHS hospitals 25 percent of Medicare DSH and uncompensated care, **Medicare would pay Tribal and IHS hospitals 100 percent of Medicare DSH. Given the unique nature of IHS and Tribal hospitals in serving a vulnerable Native American community with special health care needs, CHA supports CMS adopting this idea beginning in FY 2022.**

- **Changes to the Wage Index**

In FY 2020 CMS began increasing the wage index values for hospitals with a wage index in the lowest quartile by one-half the difference between a low wage index hospital's wage index and the 25th percentile. CMS applies a budget neutrality adjustment that lowers payments to all hospitals nationwide. CMS proposes to continue this policy for the second of four years. CHA believes that CMS is correct to consider revisions to the wage index as concerns about its equity and accuracy have long been documented. **While we support increasing the wage index values of low-wage hospitals, we again urge CMS to do so in a non-budget-neutral manner.**

In addition, CMS is proposing to make significant changes to labor market areas based on Office of Management and Budget changes to core-based statistical area (CBSA) delineations. Generally, changes to CBSA delineations between decennial censuses are very minor and do not significantly change hospital wage indexes. However, the changes CMS is proposing for FY 2021 may result in significant wage index changes for some hospitals.

In the past, CMS adopted changes to the wage index based on revised CBSA delineations over a two-year period by determining 50 percent of the wage index based on the current delineations and 50 percent of the wage index based on the revised delineations. (85 FR 32706). In this year's proposed rule, CMS proposes to apply a five percent limit on reductions in a hospital's wage index from FY 2020 to FY 2021. **CHA urges CMS to adopt a transition policy that minimizes annual reductions to the wage index.**

- **Payments for Indirect and Direct Graduate Medical Education Costs**

Hospitals receive Medicare payment for direct graduate medical education (GME) and indirect medical education (IME) based on the number of full time equivalent (FTE) residents in training. The number of FTEs for determining GME and IME payment has been capped since 1997. When a hospital or a specialty program closes, the regulations provide for temporarily modifying the caps of other hospitals to allow these hospitals to receive payment for training displaced residents until the residents can finish training. For a hospital to receive a temporary cap adjustment in order to accept a displaced resident the resident must have been in training at the closing hospital on the day the program or the hospital closed. This policy failed to accommodate for instances where a resident left the program after the closure was announced but before it occurred, had been matched with a program but had not begun training, or had been on a rotation when the hospital closed.

To address such situations, CMS proposes to amend the policy to require that the resident be present on the day the hospital or program announces it will be closing. It also proposes to allow funding to be transferred temporarily in the case of residents who have been matched with a program but not yet started training or are temporarily training in another hospital on a rotation. **CHA supports this proposal and appreciates the flexibility CMS is offering to ensure that displaced residents can complete their post-medical school training.**

- **Medicare Bad Debt Policy**

Medicare bad debt is uncollectible deductible and coinsurance amounts owed but not paid by Medicare beneficiaries. Under specific circumstances, Medicare bad debt can be partially reimbursed to hospitals. Section 413.89(e) of the regulation provides CMS general policy on when Medicare bad debt is reimbursable. The Medicare Provider Reimbursement Manual (PRM), Chapter 3, section 308 provides more detailed guidance on Medicare bad debt policy.

CMS is proposing to codify many of the PRM policies in the Code of Federal Regulations, clarifying or modifying some of the policies, proposing new requirements and making a number of the proposals apply retroactively. CMS claims that without a retroactive effective date confusion could arise with some providers believing they need to resubmit cost reports. In fact, retroactive adoption of such policies may have the effect that CMS is intending to avoid, as hospitals may feel obliged to resubmit cost reports previously submitted pursuant to the sub-regulatory guidance.

Several of the bad debt proposals would transform recommended activities into mandated actions. Retroactively changing hospital bad debt practices from recommended to required would affect the standard to which prior actions are held and could render providers out of compliance even if they had been following applicable conventions of an earlier time period. In some instances, subtle changes in the wording of the codified policies could have significant effect. **CHA believes that retroactive implementation is neither warranted nor appropriate and strongly urges CMS not to impose retroactive implementation in its rulemaking.**

Determining Indigence

CHA is also concerned about the change to the policy for determining indigence. Under the PRM, determining that a patient is indigent is a crucial component of bad debt activity because providers do not have to engage in “reasonable collection efforts” for debts associated with indigent beneficiaries. For non-Medicaid eligible Medicare beneficiaries, one guideline under the PRM is that the provider “should take into account a patient's total resources which would include, but are not limited to, an analysis of assets (only those convertible to cash, and unnecessary for the patient's daily living), liabilities, and income and expenses.” CMS proposes to change the word “should” to “must” in its codification of the policy, transforming it from a recommendation or guideline to a regulatory requirement and applying it retroactively.

In addition, this proposed change is contrary to a preceding requirement under PRM Section 312 that says for non-Medicaid beneficiaries, “the provider should apply its customary methods for determining the indigence of patients to the case of the Medicare beneficiary under the following guidelines.” However, the customary methods for determining indigence of patients under a hospital’s established financial assistance policy may not be the same as the guidelines in the PRM, now proposed as a new regulatory requirement. Moreover, a Medicare requirement to

evaluate assets, liabilities and other elements of total resources would directly conflict with some state prohibitions on performing asset tests as part of indigence determination

Of greatest concern, this proposed change will be an unnecessary burden on an already marginalized population. Indigent individuals often face difficulty in acquiring the kind of paperwork CMS is proposing to require hospitals to collect under the proposed bad debt rules. Proving the existence or lack of various assets is complex, particularly for an individual already facing a medical crisis. We must seek the least-intrusive way to ensure that those who are truly indigent receive appropriate financial assistance without creating barriers that prevent those same people from seeking assistance. **We strongly urge CMS to withdraw this change and maintain the existing policies for determining indigence.**

Bad Debt Related to Dually-eligible Beneficiaries

The most complex of the policies put forth by CMS relates to dually eligible Medicare/Medicaid beneficiaries, particularly where a dually eligible beneficiary may not have full Medicaid eligibility. In these cases, hospitals are obligated to bill the beneficiary's state Medicaid plan to determine whether the state is responsible for paying Medicare deductibles and coinsurance. The state Medicaid plan would then be obligated to provide remittance advice indicating whether it is responsible for beneficiary cost sharing. CMS reports that state plans do not always fulfill their obligation to provide remittance advice. Despite the provider taking the necessary action to seek payment of coinsurance and deductibles from the state, CMS indicates that the lack of remittance advice from the relevant state agency means the hospital cannot claim the unreimbursed amounts as bad debt.

This policy seems highly unfair and punitive to hospitals who have taken the necessary action to collect deductibles and coinsurance yet have been unsuccessful due lack of state cooperation. Hospitals serving dually eligible beneficiaries would be unduly burdened by this proposal. **If the hospital can document that it has undertaken a reasonable collection effort to collect deductibles and coinsurance owed from the state and the state has not fulfilled its obligation to provide remittance advice or payment, CHA believes the hospitals should be able to claim the amounts as a bad debt eligible for Medicare reimbursement.**

Hospital Quality Programs

- **Electronic Clinical Quality Measures (eCQMs)**

CMS proposes to transition the number of calendar quarters for which hospitals must report eCQMs under both the Inpatient Quality Reporting (IQR) Program and the Medicare Promoting Interoperability Program from one calendar quarter to a full calendar year. In addition, data on eCQM performance would be publicly reported beginning with the 2021 data submissions. CHA is concerned that beginning public reporting of eCQMs with data submitted for 2021, which under the proposal would be for two calendar quarters, may not be sufficient to

appropriately measure hospital performance. All measures currently displayed on *Hospital Compare* reflect hospital performance for 12 months or more. **Before finalizing public reporting of eCQM data from 2021 or any year, CMS should provide analysis that demonstrates the underlying data would allow for valid and meaningful comparisons of eCQM performance across hospitals.**

- **Medicare Promoting Interoperability Program Measures**

CHA supports the proposal to continue the Query of Prescription Drug Monitoring Program (PDMP) measure as a voluntary measure for reporting in 2021. We agree with CMS that state PDMPs are still maturing, and as a result, there is too much variation in how electronic health records are able to integrate PDMP queries.

- **Data Validation**

CHA supports the proposal to combine validation of chart-abstracted measures and eQMs and to reduce the number of hospitals randomly selected for validation. Data validation is important to the integrity of scoring for Medicare's hospital pay for performance programs and for meaningful public display of quality performance. Reducing the burden of validation will allow hospitals to focus quality-related resources on quality improvement and other activities of benefit to patients.

In closing, thank you for the opportunity to share these comments on the proposed FY 2021 IPPS rule. We look forward to working with you on these and other issues that continue to challenge and strengthen the nation's hospitals. If you have any questions about these comments or need more information, please do not hesitate to contact me or Kathy Curran, Senior Director Public Policy, at 202-721-6300.

Sincerely,



Lisa A. Smith
Vice President.
Public Policy and Advocacy