



Charles N. Kahn III
President & CEO

June 26, 2018

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, D.C. 20201

RE: CMS-1690-P, Medicare Program; FY 2019 Inpatient Psychiatric Facilities Prospective Payment System and Quality Reporting Updates for Fiscal Year Beginning October 1, 2018 (FY 2019); Proposed Rule (Vol 83. No. 89), May 8, 2018

Dear Administrator Verma:

The Federation of American Hospitals (FAH) is the national representative of more than 1,000 investor-owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching, short-stay acute, inpatient rehabilitation, long-term acute care, inpatient psychiatric, and cancer hospitals in urban and rural America, and provide a wide range of acute, post-acute and ambulatory services. The FAH appreciates the opportunity to provide comments to the Centers for Medicare & Medicaid Services (CMS) on the above proposed rule (Proposed Rule) published in the Federal Register (83 Fed. Reg. 89 on May 8, 2018).

III.D.1. Wage Index Adjustment

CMS uses a wage index to adjust the labor-related portions of Inpatient Psychiatric Facility (IPF) payments under the IPF Prospective Payment System (PPS) and provides the

following context in the preamble to the Proposed Rule for the data source. “Since the inception of the IPF PPS, we have used the pre-floor, pre-reclassified acute care hospital wage index in developing a wage index to be applied to IPFs, because there is not an IPF specific wage index available. *We believe that IPFs compete in the same labor markets as acute care hospitals, so the pre-floor, pre-reclassified hospital wage index should reflect IPF labor costs.*” 83 Fed. Reg. 21104, 21110 (emphasis added).

The FAH agrees with the premise regarding labor market competition and has called for equity across hospitals in determining wage index values. Yet, as the preamble further acknowledges, “under the IPF PPS, the wage index is calculated using the IPPS wage index for the labor market area in which the IPF is located, *without* taking into account geographic reclassifications, floors, and other adjustments made to the wage index under the IPPS.” *Id.* at 21110 (italics added). In so doing, CMS has created a competitive disadvantage for IPFs in the labor market. The FAH believes that a modern, competitive labor marketplace requires that IPFs have the ability to obtain geographic reclassifications. This is particularly important in light of the accelerating movement towards alternative payment models that remove the barriers separating payment systems.

The labor market equity issue is also apparent in the so-called “frontier states.” An Affordable Care Act (ACA) provision established a floor on the area wage indexes in these extremely rural states. 42 U.S.C. 1395ww(d)(3)(E). Under that provision, states with a high share of low population-density counties have a “floor” on their area wage index of 1.00. Furthermore, in accordance with section 10324(a) of ACA, the frontier state adjustment is not subject to budget neutrality. Because CMS does not take this floor into account when applying the IPPS wage index to IPFs, the wage index for an acute hospital can be up to 30% higher than an IPF in that same labor market even though they typically compete for similar clinical and administrative staff. The FAH, therefore, recommends that CMS adopt wage index policies consistent with its stated philosophy – *that IPFs compete in the same labor markets as acute care hospitals*. Along those lines, we urge CMS not to disregard the frontier state “floor” when it applies the acute care hospital wage index to IPFs, including the non-application of budget neutrality, which is consistent with the IPPS payment methodology.

It is clear that the Secretary has broad authority to implement a prospective payment system for IPFs. The regulations governing the IPF PPS indicate that CMS should “adjust the labor portion of the Federal per diem base rate to account for geographic differences in the area wage levels using an *appropriate* wage index,” 42 C.F.R. § 412.424(d)(1), and that CMS will publish on an annual basis the “*best available* hospital wage index and information regarding whether an adjustment to the Federal per diem base rate is needed to maintain budget neutrality,” 42 C.F.R. § 412.428(c) (emphasis added). The regulatory guidance of using an *appropriate* wage index based on the *best available* hospital wage index and information is met with the use of the frontier state wage index floor of 1.0 to adjust IPF payments in a frontier state.

V. Update on IPF PPS Refinements and Comment Solicitation

- *Cost Reporting by IPFs*

CMS indicates that it has observed in recent years that “over 20 percent of IPF stays reported no ancillary costs, such as laboratory and drug costs, in their cost reports, or laboratory or drug charges on their claims.” *Id.* at 21115. The preamble raises concerns about this trend, because “we pay only the IPF for services furnished to a Medicare beneficiary who is an inpatient of that IPF (except for certain professional services), and payments are considered to be payments in full for all inpatient hospital services provided directly or under arrangement (see 42 CFR 412.404(d)), as specified in 42 CFR 409.10.” *Id.* (emphasis added). The preamble goes on to note that CMS may share its findings with the CMS Office of the Center for Program Integrity and CMS Office of Financial Management for further investigation.

This discussion echoes concerns that CMS raised in 2015 concerning IPFs’ failure to “report ancillary costs, such as laboratory and drug costs, in cost reports or charges on claims.” 80 Fed. Reg. 46694. The preamble goes on, “Until further analysis is completed, we can only surmise that the stays did not require ancillaries and therefore, were not provided, or that the ancillary services were separately billed . . . [¶] Ancillary costs such as laboratory costs and drugs are already included in the Medicare IPF PPS per diem payment and should not be unbundled and billed separately to Medicare. We expect that the IPF would be recording the cost of all drugs provided to its Medicare patients on its Medicare cost reports and reporting charges for those drugs on its Medicare claims.”

As a general matter, IPFs are fully aware that the IPF PPS payment is “payment in full for all inpatient hospital services” and covers ancillary costs. CMS’s assumption that any costs that are not reflected in a cost report are likely billed separately is simply incorrect. Rather, as a general practice, our members do not bill separately for ancillary costs, including laboratory or drug costs. Because these costs often represent a relatively low portion of our member hospitals’ costs, they typically do not make a separate charge for ancillary services. The costs associated with ancillary services are typically reported in the routine cost center in the Medicare cost report.

CMS has long understood that a Medicare provider need not report the cost of ancillary services separately where those costs are insignificant, as reflected in the following discussion of all-inclusive rates in the Provider Reimbursement Manual: “Certain ancillary services may not be considered sufficiently significant to justify a separate calculation of costs for Medicare and non-Medicare patients.” Provider Reimbursement Manual - I, § 2208.1A. In the case of laboratory and drug costs, such costs on average represent approximately 1% and 4% respectively, of the costs of IPF services. Thus, they are not considered sufficiently significant to justify a separate calculation of costs in our view.

INPATIENT PSYCHIATRIC FACILITIES QUALITY REPORTING (IPFQR) PROGRAM

VI. E. Improving Patient Outcomes and Reducing Burden Through Meaningful Measures

The FAH commends CMS for its proposed application of the Meaningful Measures initiative to the hospital IPFQR Program. Prioritizing and reducing the number of quality measures in this program addresses our previously expressed concerns about the burden of managing many measures.

VI. F. Proposed Removal or Retention of IPFQR Program Measures

1. Considerations for Removing or Retaining Measures

a. Proposed New Removal Factor

In the Proposed Rule, CMS proposed to adopt an eighth quality measure removal factor. This new quality removal factor aligns across both programs and would serve to remove measures where “the costs associated with a measure outweigh the benefit of its continued use in the program.” The FAH supports the proposal to add an eighth factor, identified as the cost associated with a measure outweighing the benefit of its continued use in the program, to the lists of factors used for considering removal of measures from the Hospital IQRP Program. This proposed new factor is appropriate for moving toward measure sets that meet the goal of streamlining measures with a focus on those that will work toward the best outcomes for patients. The FAH appreciates that CMS has identified costs beyond those associated with data collection and submission. However, the costs associated with tracking performance and investing resources for quality improvement should be considered as well. It would be useful for CMS to clarify in the Final Rule the nature of the burden removal of a measure relieves, methods or criteria used to assess when the measure cost or burden outweighs the benefits of retaining it and the measure should be proposed for removal.

2. Proposed Measures for Removal

The FAH supports the proposed removal of some measures from the IPFQR Program. The FAH supports the removal of the Influenza Vaccination Coverage Among Healthcare Personnel (NQF #0431) measure from the IPFQR Program beginning with FY 2020 payment determination under our proposed measure removal Factor 8 as this measure poses information collection and submission burden and the benefits are offset by other healthcare employer requirements that ensure that healthcare personnel be vaccinated against influenza.

The FAH supports the removal of the Alcohol Use Screening, SUB-1 (NQF #1661) measure from the IPFQR Program beginning with the FY 2020 payment determination under the proposed measure removal Factor 8 as data show that the benefit of this measure has greatly diminished given the high levels of performance across facilities.

The FAH supports removal of the two measures: (1) Assessment of Patient Experience of Care measure; and (2) Use of an EHR measure from the IPFQR Program beginning with the FY

2020 payment determination under our proposed measure removal Factor 8 as the costs associated with a measure outweigh the benefit of its continued use in the program.

In addition, CMS is proposing to remove Tobacco Use Screening, TOB-1 (NQF #1651), Tobacco Use Treatment Provided or Offered at Discharge and Tobacco Use Treatment at Discharge (TOB-3 and TOB-3a, NQF #1656) from the IPFQR Program beginning with the FY 2020 payment determination. The FAH supports removal of these measures as proposed.

The FAH does not support removal of the measures (1) Hours of Physical Restraint Use, HBIPS-2 (NQF #0640); and (2) Hours of Seclusion Use, HBIPS-3 (NQF #0641) from the IPFQR Program for the FY 2020 payment determination and subsequent years. The FAH believes that although these measures are high-performing, it is important for patient safety to continue ensuring that physical restraint use and hours of seclusion use be kept to the lowest levels possible.

VI. H Possible IPFQR Program Measures and Measure Topics for Future Consideration

The FAH fully supports the development of measures that track Patient and Experience and Functional Outcomes and applauds CMS' focus in the future development and adoption of a patient reported outcome measure that assesses change in patient reported function based on the change in results on the standardized depression assessment instrument between admission and discharge. The FAH further understands and agrees on the need for inpatient IPFs to administer a standardized depression assessment instrument that will serve as a gold standard for development of the patient reported outcome measure. The FAH suggests that CMS elicit feedback from IPFs as to which standardized depression assessment instrument should be adopted and whether different instruments should be used for different segments of the population.

Accounting for Social Risk Factors in the IPFQR Program

FAH members have a long-standing belief that additional risk adjustment should be used to address social risk factors. Our members urge CMS to continue to analyze the impact of social risk factors on psychiatric hospital quality measures.

PROMOTING INTEROPERABILITY AND ELECTRONIC INFORMATION EXCHANGE

X. Request for Information on Promoting Interoperability and Electronic Healthcare Information Exchange Through Possible Revisions to the CMS Patient Health and Safety Requirements for Hospitals and Other Medicare- and Medicaid-Participating Providers and Suppliers

CMS is seeking feedback in the Proposed Rule on how it could advance the electronic exchange of information in support of care transitions between providers using: CoPs, CfCs, and RfPs for Long-Term Care Facilities. Specifically, CMS is considering revising these to require providers to electronically perform a variety of activities, including: transfer of medically necessary information from a hospital to another facility upon a patient transfer or discharge;

transfer of discharge information from a hospital or post-acute provider to a community provider, if possible; and providing patients access to certain information via electronic means, if requested, including directing that information to a third-party application.

The FAH has long supported efforts to achieve comprehensive interoperability and data liquidity – the free flow of meaningful, actionable information that supports and enhances patient care within and across settings. Our members have a vested interest in data flow to improve patient care, workflow efficiencies and clinician satisfaction, population health and payment models, and research. However, the FAH does not support the proposed revision of the CoPs, CfCs, and RfPs related to interoperability and the exchange of health information. The current ecosystem is simply not mature enough to facilitate the movement of this information, as evidenced by the obstacles that currently prevent seamless information exchange and would make it exceedingly difficult for hospitals and other providers to comply with the requirements. The FAH appreciates CMS’s acknowledgement of this in the Proposed Rule, noting that, “While both adoption of EHRs and electronic exchange of information have grown substantially among hospitals, significant obstacles to exchanging electronic health information across the continuum of care persist. Routine electronic transfer of information post-discharge has not been achieved by providers and suppliers in many localities and regions throughout the Nation.” 83 Fed. Reg. 21135.

These obstacles are amplified in the patient discharge and transfer arenas because post-acute providers and behavioral health providers were ineligible for the EHR Incentive Programs under the Health Information Technology for Economic and Clinical Health (HITECH) Act, which have been instrumental in enabling acute care hospitals to achieve so much of the potential that EHRs specifically and HIT generally offer. As such, post-acute providers and behavioral health providers have not been able to adopt HIT to the extent of hospitals and CAHs. Thus, were CMS to move forward with revisions to the CoPs, CfCs, and RfPs, hospitals and CAHs would be unable to meet these requirements because of the lack of providers available to accept that information electronically. And, for post-acute care and behavioral health providers, it would be unfair, and tantamount to an unfunded mandate, to require that these providers adopt and maintain expensive EHRs and other HIT through CoPs, CfCs, and RfPs when they receive no corresponding financial assistance to do so.

The lack of providers in a position to accept this information electronically raises questions regarding how providers would be deemed in compliance with such requirements. How would providers prove during a survey process that they are “interoperable?” Would they need to send information to other providers electronically? Ensure those providers ultimately received the information? Receive information from other providers? And/or receive information and incorporate it into an actionable format in the EHR? These are just a sampling of the multitude of questions that would arise in determining compliance – and many of them would hinge not on the individual provider’s action, but the actions of HIT vendors and other providers over whom the hospital has virtually no control. For example, one provider may be able to send the information electronically, but the receiving provider is unable to accept it. Or, a provider may be unable to incorporate the information it receives into its EHR in a format acceptable to the surveyors due to the limitations of the EHR itself, for example, the misaligned standards, semantics, and specifications that currently hinder data flow and useable data across vendor

platforms. Additionally, the CoPs, CfCs, and RfPs are infrequently updated relative to the annual Medicare payment rules. As such, it is possible that the proposed revisions to these requirements could quickly become outdated and hinder future HIT-related innovation, and in many cases even before they are finalized.

Failure to comply with CoPs, CfCs, or RfPs, carries serious penalties for health care providers, including the potential inability to treat Medicare and Medicaid beneficiaries. Such penalties also have profound consequences for patients as well, as they may lose the ability to receive treatment in their communities. Imposing these penalties on providers and patients in the face of an immature health information ecosystem – and the significant implementation issues raised above – would only restrict rather than facilitate patients’ access to care and information exchange.

The FAH appreciates CMS’s focus on interoperability and shares CMS’s frustrations regarding the lack of actionable, accessible electronic information, as well as the desire to accelerate an interoperable health system that improves the safety and quality of care, enables innovations, and achieves the best possible outcomes for patients. To continue to address these concerns, the FAH recommends that CMS permit the numerous public and private initiatives in this area, some of which are nascent, time to mature and advance our shared goals. CMS and ONC should also continue to work to improve the capabilities of EHRs and other HIT, including: simplifying information exchange across HIT vendor platforms; identifying patients across vendor platforms; and simplifying clinician workflow related to sending, receiving, incorporating, and utilizing information.

As CMS states in the Proposed Rule, there are “several important initiatives that will be implemented over the next several years to provide hospitals and other participating providers and suppliers with access to robust infrastructure that will enable routine electronic exchange of health information.” *Id.* These initiatives include the TEFCA, which is still in draft form; the revamped and refocused Promoting Interoperability Program, which was recently proposed; the Prevention of Information Blocking Attestation;¹ and the MyHealthEData initiative, which was announced earlier this year, among others. There are also private-sector led efforts underway to advance other components of the interoperability puzzle, such as plug-and-play interoperability among devices and systems.² The FAH provided feedback on these and other initiatives and looks forward to continuing to work with CMS, ONC, and other private-sector partners to realize the promise of HIT to improve our nation’s health care system.

¹ Eligible hospitals, eligible professionals, and CAHs participating in the Promoting Interoperability Programs must attest to the Prevention of Information Blocking Attestation. *The Medicare and Medicaid EHR Incentive Programs Prevention of Information Blocking Attestation Fact Sheet*, October 2017, available at: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/EHR_InformationBlockingFact-Sheet20171106.pdf.

² Center for Medical Interoperability, *Fact Sheet*, available at: <http://medicalinteroperability.org/wp-content/uploads/2017/01/CMI-Overview-Jan2017.pdf>.

The FAH appreciates the opportunity to submit these comments. If you have any questions, please contact me at 202-624-1534, or Steve Speil, Executive Vice President Policy, at sspeil@fah.org or 202-624-1529.

Sincerely

A handwritten signature in black ink, appearing to read "Steve Speil". The signature is fluid and cursive, with a large initial "S" and a stylized "E".