July 10, 2020

Submitted electronically via: www.regulations.gov

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

Re: CMS-1735-P – Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2021 Rates; Quality Reporting and Medicare and Medicaid Promoting Interoperability Programs Requirements for Eligible Hospitals and Critical Access Hospitals

Dear Sir or Madam:

Business Group on Health (The Business Group) appreciates the opportunity to respond to the Centers for Medicare and Medicaid Services’ (CMS's) notice of proposed rulemaking revising the Medicare hospital inpatient prospective payment systems (IPPS).

The Business Group represents a network of today’s largest and most progressive employers, including 74 Fortune 100 companies, providing health coverage for 60 million workers, retirees and their families in 200 countries.

As the largest single payer for health care in the US, Medicare must lead the way and partner with the private sector to drive delivery transformation away from a dysfunctional fee-for-service (FFS) system to one that will reduce overall costs and
improve health outcomes by adopting alternative payment models, managing the total cost of care, managing population health, and keeping people well.

Specific to the proposed rule, the Business Group is commenting on proposed changes to quality improvement programs, including initial public disclosure of electronic clinical quality measures (eCQMs), and use of private payer data for potential revisions to relative payments under FFS Medicare.

**Refinements to Quality Improvement Programs**

While the Business Group urges CMS to accelerate and increase the impact of performance and quality on reimbursement in the traditional FFS program beyond what is proposed in this rule, we appreciate the efforts proposed by CMS in this rule to refine various quality improvement programs, (namely the **Hospital-Acquired Condition Reduction Program (HAC)**, **Hospital Inpatient Quality Reporting Program (IQR)**), to better adjust payments within Medicare FFS for quality and outcomes. Additionally, we welcome greater public disclosure of meaningful quality information, in this case disclosure of eCQMs data for the first time.

We also support CMS efforts to reduce the administrative burden for providers of collecting and reporting data without sacrificing the meaningfulness of quality information available to the public and also ensuring that CMS has a more robust dataset to make payment decisions. Some examples of striking this balance that the Business Group supports in the proposed rule include the proposed changes to:

**Inpatient Quality Reporting Program (IQR) Streamlining and Improving Data Reporting**

- Progressively increasing the number of quarters for which hospitals are required to eCQMs under the IQR program from the current one quarter to all four quarters by calendar year (CY)2023. We encourage CMS to consider a quicker ramp up towards four quarters of data prior to 2023. More data will lead to a better assessment of where hospitals stand overall on quality and makes it less likely that hospitals will choose and report on only the top performing quarter.
- Beginning public disclosure of eCQM data from 2021 that will be available to the public beginning in 2022, as mentioned above.
- Aligning reporting requirements for chart-abstracted measures (CAMs) with eCQM data over a 2-year time period.
• Aligning the data submission quarters and hospital selection criteria for data validation for reporting for the IQR program with those for the HAC (see below) program.

**Hospital Acquired Conditions (HAC) Payment Program**

• Modernize the submission of data for the HAC program by requiring electronic submission of PDFs using a CMS-approved secured file transfer system, beginning in 2023.
• As mentioned above in the IQR program, efforts to reduce administrative burden for data validation and aligning the time periods for data submission.

**Reporting of Payer-Specific Prices Negotiated with Medicare Advantage (MA) Plans and All Payers to CMS for Potential Revisions to Relative Payments for FFS Medicare**

The proposed rule requests comments on the requirement for hospitals to report median payer-specific negotiated charges for MA plans and commercial payers, for periods ending on or after January 1, 2021 and the potential use of this data to update the methodology for calculating the IPPS Medicare Severity-Diagnosis Related Group (MS-DRG) beginning with 2024 payments.

The Business Group has concerns about the use of private payer negotiated rates to reweight MS-DRGs for FFS reimbursement because they may not be representative, could lead to distortions and other problems due to:

• Private payment strategies to improve quality and reduce costs:
  o Payment bundles for certain medical procedures, which may not include the same inpatient services as Medicare FFS and may include outpatient services,
  o Centers of excellence that affect local costs for certain complex diagnoses or procedures and whose payments may reflect additional benefits or services provided,
  o ACOs and other capitated arrangements that are not easily translated into DRG-specific payments,
  o Performance guarantees and other payment withholds, bonuses, and adjustments tied to quality improvement, outcomes, patient experience, and/or consumer satisfaction, which may not be captured in the negotiated rates,
- Other value-based purchasing strategies, and
- Payment based on patient volume and steerage towards more efficient providers that result in variable negotiated rates.

- The impact of provider consolidation (health system and certain physician specialty groups) upon private sector prices in many localities, which would then be incorporated into FFS Medicare payment rates. According to the Commonwealth Fund 2017 study, 90% of all metropolitan areas had highly concentrated hospital markets (47% highly concentrated, 43% super concentrated).

Though we do not recommend it, if CMS proceeds to reweight MS-DRGs using data from either MA plans or other private payers, MA plan rates could be more representative because the patient populations are similar and the factors that influence costs for diagnoses and services are more comparable.

Additionally, if private sector negotiated rates are used for reweighting, though the proposed rule suggests that any changes would be budget-neutral and not affect overall Medicare spending, CMS should consider that there could be some cost-shifting to the private sector to the extent that reweighting leads to big shifts in relative MS-DRG reimbursements. Providers whose reimbursement decreases could attempt to charge higher prices to private payers while those gaining from a reweighting would have no incentive to reduce prices for private payers. The Business Group is concerned about the potential for cost-shifting and would strongly oppose Medicare payment changes that would increase employers and plan participants costs.

Thank you for considering our comments and recommendations. Please feel free to contact me (kelsay@businessgrouphealth.org), Steve Wojcik (wojcik@businessgrouphealth.org), the Business Group’s Vice President of Public Policy or Matthew Sunduck (sonduck@businessgrouphealth.org), Policy Associate to discuss.

Sincerely,

Ellen Kelsay
President and CEO