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Chiquita Brooks-LaSure, MPP
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services

June 28, 2021

RE: RIN 0938–AU44 Medicare Program

Dear Ms. Brooks-LaSure:

On behalf of the Purchaser Business Group on Health (PBGH), a nonprofit coalition representing nearly 40 private employers and public entities across the U.S. that collectively spend $100 billion annually purchasing health care services for more than 15 million Americans and their families, I offer the following comments regarding the 2022 Medicare Inpatient Perspective System (IPPS) Rule and associated policies. Our comments are focused on three distinct sections:

- Hospital Price Transparency
- Hospital Graduate Medical Education Policy
- Health System Quality Improvement

Hospital Price Transparency

Section V.L. of the Preamble: Market-Based MS-DRG Relative Weight Policy – Proposed Repeal

The proposed rule would repeal a policy that was finalized in the FY 2021 IPPS rulemaking cycle which created a new market-based methodology for estimating Medicare Severity Diagnosis Related Groups (MS-DRG) relative weights based on median payer-specific negotiated charge information collected on Medicare cost reports. The new methodology was scheduled to begin in FY 2024.

While PBGH does not wish to offer recommendations regarding the repeal of the relative weight policy for Medicare Advantage payments, we are concerned that CMS simultaneously proposes to repeal the mandatory disclosure of median

payer-specific negotiated charges on the Medicare cost report, included in the initial rule to enable the change in Medicare Advantage payment policy.

We believe that widespread health system price transparency is a necessary, though not sufficient, requirement to enable a high quality, affordable health care system. Hospitals and health systems, health plans, and many other actors have used the pervasive opacity in health care prices and quality to increase costs without any meaningful improvements in quality. Put plainly, we believe that price and quality transparency should be the broad expectation of health care providers and that prices and quality information should only be kept private when absolutely necessary.

While CMS may choose to withdraw the Medicare Advantage payment change, the new transparency on negotiated rates for Medicare Advantage plans has real value on its own as a tool for purchasers, consumers, researchers, and policymakers to better understand Medicare Advantage plan payment methodologies and levels. As noted in the 2021 IPPS, when the policy was finalized, the new transparency requirement will impose a relatively small administrative burden given the hospitals' simultaneous requirement to report on payer-specific negotiated rates as part of the hospital transparency rule.

To promote continued price transparency, we recommend:

- CMS continue to require health hospitals and health systems report median payer-specific negotiated charge by MS-DRG its the Medicare cost report for all Medicare Advantage payers.
- Further, to enable purchasers to understand the full distribution of negotiated prices, require hospitals to report payer-specific negotiated rate at the 10th, 25th, 75th, and 90th percentiles, in addition to the median negotiated rate.

Additional Recommendations for Related CMS Efforts toward Price Transparency

In November 2019, CMS finalized the Hospital Price Transparency Rule (RIN-0938–AU22) which requires hospitals to publicly disclose pricing information including negotiated rates, through machine-readable files so that researchers, consumers, and policymakers can make informed decisions about the costs of health care. The rule went into effect on Jan. 1, 2021.

Unveiling health care prices, specifically negotiated rates, is a critical step toward driving value into the health care system and empowering consumers, employers and policymakers with the information needed to make informed decisions about health care purchasing. PBGH strongly supported when it was proposed the hospital price transparency rule and our members have begun to use the information gleaned from the new transparency requirements.

Unfortunately, while the rule has been in effect for six months, recent a recent study found that just 25 percent of the largest hospitals are fully compliant with the requirements set out in the rule.[1] Further, it has been reported that some hospitals have intentionally worked to make their price transparency information difficult to find by web search engines.[2]

The current rule allows CMS to issue a mere $300 per day civil monetary penalty for non-compliant hospitals. To put this into perspective, the average net patient revenue at U.S. hospitals was $334.5 million in 2018.[3] If a hospital were subject to non-compliance penalties for a full year, they would be subject to an aggregate fine of $109,500 – just 0.03% of net patient revenue for the year, or, putting it differently, the amount of revenue that hospital earns every three hours.

We are pleased that CMS has sent a first round of warnings to noncompliant hospitals, but believe that continued non-compliance undermines the efforts of purchasers and consumers to pursue higher value care. In our analysis of hospital transparency files, we find wide variability in how hospitals report their data, making it difficult to compare negotiated prices between hospitals.

To hold hospitals accountable for their requirements and to maximize the value of the price transparency made available under the rule, we recommend that CMS:

- Continue to vigorously pursue full compliance by all hospitals by issuing civil monetary penalties against non-compliant hospitals and publicly release information regarding hospitals that are either non-compliant or have taken steps to make their information difficult to access.
- Substantially increase the civil monetary penalty for non-compliance. Recognizing that a flat penalty would have a differential financial affect on hospitals, recommend adjusting the penalty to vary by hospital size.

[1] https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2781019
[2] https://www.wsj.com/articles/hospitals-hide-pricing-data-from-search-results-11616405402
[3] https://blog.definitivehc.com/revenue-trends-at-u.s.-hospitals

Specifically, we recommend CMS impose a civil monetary penalty for non-compliance of $300 per day per hospital licensed bed.[4]

- Work with stakeholders, including purchasers, hospitals, and consumers, to provide more detailed guidance enabling fully standardized reporting across hospital systems.

Hospital Graduate Medical Education Policy

Section V.J of the Preamble: Proposed Payments for Indirect and Direct Graduate Medical Education Costs

The proposed rule would implement a critical component of the Consolidated Appropriations Act, 2021 which created 1,000 new Medicare-funded graduate medical education (GME) residency positions, expanded opportunities for rural residency training, and allows hospitals with low resident full-time equivalent (FTE) caps and/or per resident amounts (PRAs) due to short-term resident rotations to reset. These changes result in increased opportunities for hospitals to receive Medicare payment for resident training which is the first significant increase in Medicare funding for residency training in nearly 25 years.

PBGH supports CMS's proposal to implement the new GME slots but has specific recommendations for ensuring the increased funding for Medicare GME results in long-lasting, equitable changes in the composition and distribution of physicians in the U.S. health workforce. In particular, we support CMS's efforts to prioritize hospitals and residency programs that are located in Health Professional Shortage Areas (HPSAs) when distributing new Graduate Medical Education (GME) positions to hospitals. The current supply, makeup, and distribution of the U.S. health workforce is not adequate to meet the needs of our nation's families, children, and seniors. Primary care and behavioral health represent the areas with the most significant shortages nationwide.

The maldistribution physicians and ongoing physician shortages has plagued the U.S. health care system for too long. While we support CMS's proposal to prioritize hospital and residency programs that are in HPSAs when distributing GME positions, we are disappointed that the proposal does not account for where trainees ultimately practice medicine, and therefore may not have a

[4] The average number of licensed beds among acute care hospitals in the US is 197. Our proposed penalty would cost the average hospital $59,100 per day. We believe penalties of this magnitude would provide sufficient motivation for hospitals to redouble their effort to come into compliant with the rules.

lasting impact on mitigating physician shortages or the geographic distributions of physicians. We recommend that CMS include an additional factor in the methodology for prioritizing hospitals for new residency slots by prioritizing GME slots for hospitals based on the percentage of trainees who ultimately choose to practice medicine in HPSAs, not just be trained in HPSAs.

CMS proposes that only those hospitals that meet at least one of the following four criteria will be eligible to apply for new GME slots:

1) Rural hospitals or those with a rural designation
2) Hospitals for which the reference resident level of the hospital is greater than the otherwise applicable resident limit (over cap hospitals)
3) Hospitals in states with a new medical school or branch campus
4) Hospitals that serve areas designated as Health Professional Shortage Areas (HPSAs) In other words, hospitals that do not meet one of the above criteria will not be considered a qualified hospital and cannot apply for new GME slots

PBGH does not take a position on the eligibility criteria proposed by CMS, but we recommend that CMS use its discretionary authority to add two additional qualifying criteria:

1) Small hospitals with less than 250 beds
2) Hospitals with only one residency program

According to the American Academy of Family Physicians, "Small and single-residency program hospitals function with small, relatively tight GME budgets and therefore are typically not able to function above their [GME] cap. Adding these qualifying criteria would allow small hospitals and single residency program hospitals to expand even though they are financially constrained from being over cap and wouldn't otherwise qualify for additional slots, even though these hospitals could be effectively addressing physician shortages. For example, single-residency hospitals tend to be community hospitals instead of large academic institutions and are therefore effectively meeting the needs of a community that otherwise may be underserved."

Health System Quality Improvement

Section IX B: Closing the Health Equity Gap in CMS Hospital Quality Programs – Request for Information

In line with Executive Order 13985, "Advancing Racial Equity and Support for Underserved Communities Through the Federal Government," CMS is seeking public input on how to address health disparities through hospital quality programs.

PBGH supports CMS's commitment to addressing health disparities and closing the health equity gap in CMS hospital quality programs and offer a number of recommendations to achieve those goals. **In particular, we recommend that CMS stratify all hospital quality measures by race and ethnicity initially, but to ultimately expand to a broader set of characteristics that include primary language, geographic location, socioeconomic status, gender identify, sexual orientation, age and ability status.**

PBGH strongly supports CMS's efforts to collect a standardized set of demographic data elements by hospitals at the time of admission. As noted above, a critical first step in being able to identify underlying disparities in health care delivery - and to then to reduce these disparities - is collecting and reporting on disaggregated data including race, ethnicity, primary language, geographic location, socioeconomic status, gender identify, sexual orientation, age and ability status. For too long, collecting disaggregated data has been identified as an insurmountable barrier in being able to hold the health care system accountable for reducing disparities and improving the health of all people. We applaud CMS for identifying the need to establish standardized data collection practices across hospitals as an essential part of this RFI.

Section IX C: Hospital IQR Program

PBGH strongly opposes the removal of "Death Among Surgical Inpatients with Serious Treatable Complications" (PSI-4) from the Inpatient Quality Reporting (IQR) Program. This measure is of critical importance to the public and to purchasers for the following key reasons:

PSI-4 is a powerful and important patient safety measure, and patient safety is one of the most significant death risks Medicare beneficiaries and the public will ever encounter. According to a landmark article in The BMJ that summarized earlier research, safety problems in U.S. hospitals are estimated to kill over 250,000 people every year. Despite this, there are relatively few patient safety measures reported in the IQR or used in payment programs, especially considering the evidence of the risk faced by Medicare beneficiaries and the public at large. CMS should be adding more patient safety measures, not removing them.

PSI-4 is one of the highest priority measures for purchasers and consumers. The Leapfrog Group uses PSI-4 in its Leapfrog Hospital Safety Grade, which assigns letter grades to hospitals based on their record of patient safety, and thus provides important safety information to thousands of consumers and purchasers. Without a doubt, PSI-4 is the measure in the Safety Grade that resonates most with purchasers and consumers.

Deaths counted in PSI-4 can be prevented by hospitals; deaths from all causes are not always the fault of the hospital. The Hybrid Hospital-Wide All-Cause Risk Standardized Mortality measure is not a replacement for PSI-4 as the proposed rule suggests, because many hospital deaths are not related to preventable safety problems. While the all-cause mortality measures are useful, they are not a substitute for reporting hospital mortality from preventable safety problems that occur after surgery. Medicare beneficiaries deserve to know which hospitals perform best at protecting patients from surgical harm.

PSI-4 is a Surgical Measure. When consumers are researching hospitals, they are often searching for a place to have a surgical procedure. There are very few measures that are focused on surgical safety or surgical outcomes in general. CMS should be adding more surgical outcome measures, not removing the one most important to consumers and purchasers.

Improvements to PSI-4 can occur while the current measure continues to be included in the IQR and is publicly reported. Medicare beneficiaries and the public deserve the best available information to protect their lives and health, and PSI-4 provides that. We are aware that the measure developer has suggested refining the types of surgical patients and complications included in the measure. However, these improvements will only strengthen an already robust measure and can be made while the current measures continue to be used in the IQR and in public reporting.

We urge CMS to continue to require hospital to report PSI-04 in the IQR program.

Thank you for your time and consideration. If you have any questions or would like to discuss further, please contact Shawn Gremminger, Director of Health Policy, at sgremminger@pbgh.org.

Sincerely,

/s/

William Kramer, MBA
Executive Director, Health Policy