MISSOURI HOSPITAL ASSOCIATION

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TO: Centers for Medicare & Medicaid Services
Department of Health and Human Services
CMS-6082-NC

FROM: Sarah M. Willson, MBA, BSN, FACHE
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SUBJECT: Patients Over Paperwork Administration Burden Reduction

The Missouri Hospital Association, representing 143 member hospitals, appreciates the intent and efforts of the Centers for Medicare & Medicaid Services to reduce regulatory requirements that impede the efficient delivery of quality patient care. In its solicitation for more regulatory reform comments, CMS notes that it previously received comments on more than 1,110 regulatory topics and has resolved or is actively addressing more than 80 percent of them. The agency included a sample of its accomplishments.

However, new final CMS regulations and pending proposed regulations provide ongoing opportunities to scale back counterproductive regulatory burdens for hospitals. For example, proposed rules CMS-3295-P (Medicare and Medicaid Programs; Hospital and Critical Access Hospital (CAH) Changes to Promote Innovation, Flexibility, and Improvement in Patient Care) and CMS-3317-RCN Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies have significant regulatory and financial implications. MHA urges CMS to scour these regulations for opportunities to reduce regulatory burden before promulgating the final rules.

The following comments are specific regulatory reform suggestions made by or on behalf of Missouri hospitals.

Transparency. MHA previously has commented on various aspects of CMS' proposed rules regarding transparency of hospital pricing and will do so again. Specific to the matter of regulatory burden in the latest proposed rules, MHA recommends that CMS allow hospitals the flexibility to publish charge data in well-established service groupings such as MS-DRGs, APCs

or other similar groupings. Also, we note that some states, including Missouri, have enacted laws dictating what hospital pricing data must be disclosed to the public. CMS' regulatory standards should take into consideration these state laws on hospital price transparency to limit the disruption and inefficiency of contradictory federal and state standards.

One of the stated goals of expanded hospital price transparency is to provide the patient or prospective patient with understandable information about his or her out-of-pocket expenses. Charges listed in hospital chargemasters are irrelevant to cost-sharing determinations, both for private and public coverage. In the Medicare fee-for-service program, patient out-of-pocket expenses are based on cost-sharing amounts tied to established fee schedules. Private insurers commonly provide cost estimator calculators for their beneficiaries. Since Medicare and Medicare Advantage plans are controlled by CMS regulation, MHA recommends that CMS create a standardized tool for beneficiaries to use to determine out-of-pocket expenses. It would be duplicative, inefficient and confusing for each Medicare hospital to create its own calculator.

Access to Rural Care. Lack of access to broadband connectivity or similar high-speed internet service is an ongoing concern in parts of rural Missouri. Approximately 22 percent of Missourians still lack access to such services. Recently, one rural hospital partnered with a health care system to provide an updated electronic medical record system only to find that broadband coverage was insufficient to support it. CMS has proposed new interoperability standards by regulation, however, hospitals' inability to support an EMR system advanced enough to meet the requirements is real. Additional layers of regulatory requirements for those providers who cannot comply, through no fault of their own, will have serious consequences.

Also, rural Missouri hospitals operating Rural Health Clinics urge CMS to consider changing its regulations and payment updates to provide for parity of payment between Rural Health Clinics and Federally Qualified Health Clinics. They argue that RHCs do the same work, but are paid far less than FQHCs.

Behavioral Health. Missouri's Emergency Room Enhancement Project is an exemplary model for building infrastructure to care for patients with behavioral health conditions. The ERE program helps connect behavioral health patients presenting at our hospitals' emergency department with community support and follow-up, minimizing institutional care. The ERE Program also ties into the Certified Community Behavioral Health Clinic demonstration model deployed throughout Missouri under the leadership of U.S. Senator Roy Blunt. Phelps Health and Your Community Center in Rolla, Missouri, provide federal officials with an example of how the hospital, ERE Program and Certified Community Behavioral Health Clinic collaboration works in concert to provide comprehensive care for behavioral health patients.

MHA also encourages CMS to consider ways in which its regulations and programs can be revamped to better support the needs and outcomes of patients in memory care programs. The large and aging baby boomer population is projected to boost the incidence of Alzheimer's and other dementia-related conditions. To consider its options, the Department of Health and Human Services should consider the creation of a secretarial task force to review care options, with a focus on family caregiver support. The task force or CMS staff should consider engaging with Perry County Memorial Hospital in Perryville, Missouri, which has established an advanced memory care program in a small rural community.

Opioid Abuse Treatment. Missouri has taken advantage of the federal resources afforded states to implement programs to combat opioid abuse. Yet, recent figures indicate the state's opioid-related deaths have increased more than 17 percent. The following are regulatory relief recommendations that would be useful to health care providers in Missouri in addressing opioid treatment barriers and challenges.

- Eliminate any regulatory policies requiring preauthorization for patients to receive services related to opioid use disorder.

- Reduce or eliminate the requirements to obtain a DATA 2000 Buprenorphine Waiver. The additional training requirements are a deterrent to increased access to pharmacotherapy alternatives.

Data Collection. MHA recommends expanded use of third-party data aggregators to measure quality. The burden associated with quality data compilation is significant, especially for smaller rural hospitals.

Also, MHA recommends that CMS consider expanded use of payer data to capture CMS metrics, as appropriate. This has been done for influenza immunizations. It may be useful as a means of tracking mammography, cervical cancer screening, colon cancer screening, and pneumonia vaccinations, among others. Nursing staff indicate that getting these data elements into the electronic medical record to be sent to CMS requires a significant expenditure of staff time.

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