Catholic Health Association of the United States

A Passionate Voice for Compassionate Care

June 16, 2015

Mr. Andrew M. Slavitt
Acting 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: File code CMS-1632-P

Re: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System Policy Changes and Fiscal Year 2016 Rates; Revisions of Quality Reporting Requirements for Specific Providers, Including Changes Related to the Electronic Health Record Incentive Program

Dear Mr. Slavitt:

The Catholic Health Association of the United States (CHA) is pleased to submit these comments on the Centers for Medicare & Medicaid Services' (CMS) proposed rule entitled Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System Policy Changes and Fiscal Year 2016 Rates; Revisions of Quality Reporting Requirements for Specific Providers, Including Changes Related to the Electronic Health Record Incentive Program (80 Federal Register 24324-24689, April 30, 2015).

We appreciate your staff's ongoing efforts 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 several aspects of the proposed rule.

- **FY 2016 Medicare-Severity Diagnosis-Related Group (MS-DRG) Documentation and Coding Adjustment**

Continuing Implementation of the American Taxpayer Relief Act Recoupments: The proposed rule would reduce payments in FY 2016 by 0.8 percent as a further step toward fulfilling the American Taxpayer Relief Act of 2012 (ATRA) requirement that CMS recoup $11 billion for

payments made in FYs 2010, 2011 and 2012. ATRA requires that the $11 billion be recouped over fiscal years 2014, 2015, 2016, and 2017. In the FY 2014 final rule, CMS adopted a policy to mitigate the impact of the ATRA payment cut on hospitals by reducing payment rates by 0.8 percent each year, FY 2014 through 2017. The cuts are cumulative, thus the 0.8 reduction proposed for FY 2016 would be on top of the 0.8 reductions made in FY 2014 and FY 2015 resulting in a cumulative reduction of 2.4 percent in FY 2016.

CMS estimates that the proposed FY 2016 adjustment, combined with leaving in place the -0.8 percent adjustments made for FY 2014 and FY 2015, will recover up to $3 billion in FY 2016 and, with the approximately $3 billion recovered in FYs 2014 and 2015, will leave about $5 billion remaining to be recovered by FY 2017. The proposed rule states that CMS has not yet addressed the specific amount of the final adjustment for FY 2017, but that it continues to believe that the proposed -0.8 percent adjustment for FY 2016 is a reasonable and fair approach that will help satisfy the requirements of the statute while mitigating extreme annual fluctuations in payment rates.

CHA appreciates CMS' proposal to continue to mitigate the impact of the ATRA payment cut on hospitals by reducing payment rates by 0.8 percent each year. The agency's policy is a prudent course and provides hospitals with additional time to manage these sizeable cuts. We are concerned, however, that CMS may impose a reduction in FY 2017 that is larger than an additional 0.8 percentage points. In responding to a comment in the DSH portion of the FY 2015 IPPS final rule regarding the actuaries' estimates of DSH payments, CMS agreed with commenters that "the documentation and coding numbers for future years could be more than a 0.8 percent reduction to comply with the $11 billion requirement, but those figures have not yet been determined. The reason for the higher possibility is that the number of discharges has decreased significantly." **CHA urges CMS not to increase the size of the reductions in FY 2017.**

- **Request for Comments on Possible Expansion of BPCI**

In the proposed rule, CMS indicates that it is evaluating the Bundled Payments for Care Improvement (BPCI) initiative for possible expansion and invites public input on an extensive list of issues affecting possible expansion. CMS, through its Center for Medicare and Medicaid Innovation (CMMI), is currently testing four models of bundled payments as part of the BPCI initiative. Organizations voluntarily enter into payment arrangements that include financial and performance accountability for episodes of care. The BPCI initiative is currently in the testing phase and must be evaluated and found to satisfy certain tests, as required by statute, before implementation can be expanded.

Under the statute which provided CMMI the authority to undertake the BPCI (Section 1115A of the Social Security Act, as added by section 3021 of the Affordable Care Act) the Secretary may expand the duration and scope, including implementation on a nationwide basis, of a tested model. The expansion must be done through rulemaking and only for models for which:

1) the Secretary determines that the expansion is expected to either reduce Medicare spending without reducing the quality of care or improve the quality of patient care without increasing spending;
2) the CMS Chief Actuary certifies that the expansion would reduce (or would not result in any increase in) net Medicare program spending; and
3) the Secretary determines that the expansion would not deny or limit the coverage or provision of Medicare benefits.

The proposed rule states that the decision of whether or not to expand will be made by the Secretary in coordination with CMS and the Office of the Chief Actuary based on whether the evaluation findings meet the criteria for expansion.

CHA applauds and supports the work CMMI is doing to develop and test innovative payment and service delivery models, such as the BPCI initiative, in order to achieve the triple aim of better care for patients, better health in communities, and lower cost. We would like to offer the following comments for CMS to consider as it evaluates whether and how to expend BCPI:

Breadth and Scope of Expansion

Many of CHA's members are actively participating in BPCI and others are eager to join the initiative. We would like to see the continued opportunity for voluntary participation in the program. At the same time, it is imperative for CMS to undertake a comprehensive evaluation of program results to date to determine whether the goals of improving the quality of care and patient experience for beneficiaries while reducing costs are being met. In addition, CMS should establish a multi-stakeholder advisory board to work with CMS and its contractors on all aspects of expanding bundling, including program design, pricing, quality and minimizing burdens on participants.

Voluntary v. mandatory expansion: CMS specifically asked whether participation in an expanded bundling program should be voluntary or required. **CHA strongly believes expansion should be undertaken only on a voluntary basis**. Indeed, CMS lacks the statutory authority to require participation. Nothing in the language of the statute or the legislative history of the ACA supports concluding that Congress intended to delegate this type of policymaking authority to CMS. CMS may not rely on waiver authority under a demonstration program to mandate fundamental changes on beneficiaries and on all the relevant Medicare participating providers.

The CMMI statute provides for a testing phase (subsection (b)) and an expansion phase (subsection (c)). The statute clearly states that the Secretary's authority to waive requirements of titles XI and XVIII of the Act applies only to the subsection (b) testing phase. Specifically, the statute states:

> *"(d) Implementation.—*
> *(1) Waiver authority.—The Secretary may waive such requirements of titles XI and XVIII and of sections 1902(a)(1), 1902(a)(13), and1903(m)(2)(A)(iii) as may be necessary*

> *solely for purposes of carrying out this section with respect to testing models described in subsection (b).”*

The provision establishing the innovation center originated in the House Energy and Commerce committee, was included in the House-passed bill, and was retained by the Senate with no change to the waiver language. The House Report on the Affordable Health Choices Act of 2009, H.R. 3200, states: “The Secretary would have the authority to waive Medicare statutory requirements and certain Medicaid rules governing provider payments and state plans, but only for purposes of testing of models under this section.” (House Report 111-299 - America's Affordable Health Choices Act of 2009, Part 1, Committee on Energy and Commerce, October 14, 2009, p. 661 in reference to Sec. 1910, Establishment of Center for Medicare and Medicaid Payment Innovation (CMPI) within CMS).

The provisions of title XVIII of the Act stipulate what services are covered by Medicare, the entities that can provide them, and the scope and amount of payment, among many other detailed requirements. Medicare fee-for-service beneficiaries enjoy freedom of choice of providers and the statutory provisions govern payment for the providers delivering the services. Bundled payment programs, on the other hand, can require beneficiaries to receive services from providers participating in the bundled payment program. Bundled payment arrangements require waivers from various statutory provisions in order to limit coverage and payment of services to what is provided by entities participating in the bundled payment program and to the amount established for payment by the bundled payment arrangements. In a bundled payment program established through proper rulemaking, providers and suppliers could choose voluntarily to participate in the program and beneficiaries could make an informed choice to receive services from a bundled payment system entity or another entity. We note that a mandate on all hospitals to participate in a BPCI model also would require waiver of certain provisions of title XI of the Act, especially with respect to prohibitions on inducements.

Reflecting all of these considerations, **CHA believes that the Medicare statute does not give CMS authority to compel providers, suppliers and beneficiaries to participate in an expanded bundled payment program. Expanding the program on a voluntary basis will maintain Medicare’s assurance of access to care and freedom to choice for all beneficiaries, regardless of their condition or severity of illness.**

Roles of Organizations and Relationships Necessary or Beneficial to Care Transformation

Precedence rules: The rules that determine which entity “owns” an episode are problematic. CMS should carefully review the current precedence rules and develop a new approach in an expanded bundling program.

For example, by far the most popular models in the demonstration are Models 2 and 3. Both models include post-acute care in the bundle, in combination with hospital care in Model 2 and alone following a hospital stay in Model 3. **There is considerable complexity and confusion concerning the rules which determine when a given beneficiary episode is assigned to a**

Model 2 or Model 3 provider. CMS should reexamine how to manage such conflicts in light of achieving the highest quality of care, patient experience and outcome, and cost-effectiveness, while bearing in mind the potential financial impact on providers who participate in the models.

Another example concerns the precedence rules for Model 2. At present, bundles automatically attribute to a physician group bundler even if the physician of a hospital bundler is also involved in the care. This puts hospitals at a distinct disadvantage and encourages physician groups to enter the program without the hospitals causing further fragmentation. **We believe a more equitable process to attribute the patients to a bundler would be to consider the role of the physicians who are part of the hospital group compared to those of the physician group, or developing a plurality of services model more closely aligned with MSSP.** Regardless of the method, hospital groups should be allowed as conveners and put on an equal playing field with physicians. Hospital systems have much to offer in terms of capital, post-acute care coordination (e.g., nurse navigators, care managers), electronic medical records, outpatient rehabilitation therapies, diagnostic testing facilities, long-standing quality reporting and improvement initiatives, data analysis capabilities and comprehensive financial metrics. A central tenant of the program is to bring providers together by removing the payment silos associated with standard fee-for-service payments. Hospitals have accepted the challenge and are forging relationships across the continuum to provide better care under the Triple Aim ™, CMS should ensure there is an avenue for them to participate.

Third party conveners: Third party, non-provider conveners have played a significant role in the bundling initiative. As part of its program evaluation, we urge CMS to review the relationship between providers and third parties, including financial arrangements, to identify and promote the structures that best align with BPCI program success, high-quality patient care, and sustainability.

Administering Bundled Payments

Currently only Model 4 makes payment prospectively. **CHA does not support expanding required prospective payment in the other three models.** Payment should continue to be made as usual under the IPPS and reconciled retrospectively for the bundled episodes.

However, CMS should consider setting price targets prospectively. Under the current retrospectively set targets, BPCI participants bear risk for prices that are unknown until months after an episode is completed. Setting targets prospectively will provide participants with greater predictability.

Data Needs

Ensuring that data on patients and spending is provided in a complete, transparent and timely manner should be a top priority for CMS in any expansion of the bundling program. **CMS should continue to provide monthly claims data to bundling participants, as it has been**

doing in the demonstration. CMS also should provide the 12 months of historical claims prior to anchor admission for all patients accreting into a bundled payment arrangement. These should be delivered as quickly as is feasible. This will assist program participants in risk stratification, readmission prediction and also speed the design of interventions designed to avert avoidable events.

Quality Measurement and Payment for Value

CMS should make sure that any expansion of the bundling initiative includes a robust, effective and appropriate quality program. CHA encourages CMS to focus on outcome-based measures more directly tied to the specific conditions and procedures included in the bundles. The measures selected should protect beneficiaries, improve the quality of care and evaluate the success of the program. CHA does not believe there is a need for efficiency measures, as they would duplicate the function of payment reconciliation which already determines success in terms of efficiency of care. The one area of exception could be efficiency measures designed to protect beneficiaries by ensuring that services are not reduced to such an extent that quality of care or outcomes is reduced. Finally, CHA believes that it would be premature to apply measure-based payment incentives to an expanded bundling program.

Waivers

We urge CMS to include in any expansion of the bundling program the waivers that CMS proposed to apply within the Medicare Shared Savings Program (MSSP) for those providers who take risk should apply to any expansion of the BPCI program:

- Hospital discharge planning requirements that prohibit hospitals from specifying or otherwise limiting the information provided on post-hospital services;
- The skilled-nursing facility (SNF) three-day stay rule, which requires Medicare beneficiaries to have a prior inpatient stay of no fewer than three consecutive days to be eligible for Medicare coverage of inpatient SNF care;
- Medicare requirements for payment of telehealth services, such as limitations on the geographic area and provider setting in which these services may be received; and
- The homebound requirement for home health, which requires that a Medicare beneficiary be confined to the home to receive coverage for home health services.

In addition, CMS should also include waivers of:

- The IRF "60% rule," which requires that at least 60 percent of an IRF's patients have one of 13 qualifying conditions; and
- The LTCH "25% Rule," which reduces payment for certain patients based on the volume of patients transferred to an LTCH from a particular general acute-care hospital.

CMS should also correct an unfortunate flaw in how the waivers in the current program are applied. In certain circumstances, a beneficiary may be treated as part of a bundle that is later

rescinded or due to date lags may be determined to be ineligible for the bundle. Beneficiaries can then be subjected to additional copays and costs they did not anticipate. CMS should adopt a "good faith" rule that allows patient episodes meeting eligibility criteria and requiring a waiver at the time the bundler includes them in the bundle to be considered part of the program even if later found ineligible for additional payments and allows the waivers that were applied to the episode to remain effective even if the bundle is later nullified.

- **Disproportionate Share Hospitals (DSH)**

CHA is concerned about the lack of transparency in the DSH factor calculations, especially Factor 1, and we urge considerably greater openness and detailed information about the calculations. For example, to create the DSH baseline, CMS uses four components: the annual update percentage, the percentage change in the number of discharges, case-mix change, and "other." For the FY 2015 final rule, CMS used an "other" factor of 1.035 for FY 2014. In the FY 2016 proposed rule, the "other" factor for FY 2014 falls to 0.9993, a very substantial change for which no explanation is given despite attempts to get additional information from CMS during the comment period. This one change alone would reduce the DSH baseline by about $480 million without explanation. **CHA strongly urges CMS to provide full information concerning its calculation of the DSH factors, including all assumptions and projection components.** Lacking this information, the public is unable to review CMS' calculations and provide meaningful comments.

As we did in our comments on the FY 2015 proposed rule, **CHA supports CMS' proposal to use Medicare SSI days and Medicaid days as a proxy for uncompensated care until the quality of the S-10 data can be improved. We urge, however, that the use of the proxy be temporary and that CMS work with hospitals to improve the completeness and accuracy of the S-10 data.** CHA does not oppose CMS' FY 2016 proposal to hold constant the cost report years used to calculate Medicaid days and to again use data from the 12-month 2012 or 2011 cost reports, and we support using cost report data for these years from the most recent HCRIS database available for FY 2016 rulemaking.

CMS must make sure that the S-10 is revised to accurately and comprehensively report all types of uncompensated care, inducing charity care, bad debt and the unreimbursed costs of public health care programs such as Medicaid, the Children's Health Insurance Program and state and local indigent care programs. CHA urges CMS to work with stakeholder groups to revise and improve the S-10.

CHA recommends that CMS articulate a plan for using the S-10 data source for uncompensated care. We also urge CMS to ensure that a future transition from the current proxy to the S-10 data goes smoothly and is done in a way that avoids wide swings in payments. CMS might consider a phase in period of blending S-10 data and the proposed proxy with a gradually increasing share based on S-10.

- **The Two Midnight Rule**

The proposed IPPS rule for FY 2016 does not address the two midnight rule or short stay policy, but indicates that these issues may be addressed in the forthcoming proposed OPPS rule for 2015. CHA reiterates its FY 2015 comments for CMS' consideration as it prepares the OPPS proposed rule.

CMS finalized in FY 2014 its proposed "two midnight" rule as an attempt to clarify which hospitalizations would be considered inpatient admissions payable under the IPPS. While CHA appreciates CMS' efforts at needed clarification, the final two midnight rule does not adequately address the concerns of providers, physicians or beneficiaries and has instead created more confusion. In addition it has focused increased scrutiny on hospital stays of less than two midnights, creating further issues and problems.

In previous comments to CMS (FY 2013 OPPS and FY 2014 IPPS proposed rules) CHA encouraged adoption of five principles as CMS developed new policies to address the increase in contractor denials of inpatient admissions and, largely as a result, hospitals' use of observation services to the detriment of beneficiaries:

- CMS should provide clear guidance to enable doctors and physicians to act with more certainty;
- Patients should receive timely and appropriate care in the most appropriate setting;
- The treating physician's judgment should be recognized as the primary factor in admission decisions;
- Confusion and financial impact for beneficiaries should be minimized; and
- Hospitals should receive fair and adequate payment for the services they provide.

The two-midnight rule fails to reflect these principles. Clinicians are struggling to make the decisions required by the two-midnight rule. The rule bears no logical relation to care protocols or patient care. Our member hospitals' case managers struggle in turn to determine from physicians whether a patient will be in the hospital for at least two midnights. Hospitals are expending a great deal of effort and money to try to implement the policy, but are finding successful implementation not just difficult but impossible. The rule is burdensome and cannot be implemented fairly and consistently.

CHA also is concerned about the adverse consequences of the rule on patients. Our member hospitals continue to hear many patient complaints about confusion as to whether they are an inpatient or outpatient, as well as complaints about the higher costs if the inpatient stay is denied and they are billed as an outpatient. Delivering care in the outpatient setting means higher beneficiary out-of-pocket costs as the beneficiary is responsible for any deductible and copayment amounts for the Medicare covered Part B services as well as for the full cost of items or services excluded from coverage under Part B, such as self-administered drugs.

CHA again observes that the two-midnight policy is not consistent with the Medicare Benefit Policy Manual, which states that generally "a patient is considered an inpatient if formally admitted as inpatient with the expectation that he or she will remain at least overnight and occupy a bed even though it later develops that the patient can be discharged…" It also states that the physician or other practitioner is responsible for deciding whether a patient should be admitted as an inpatient, based on a "complex medical judgment which can be made only after the physician has considered a number of factors." Furthermore, subsequent reviews of an inpatient admission should consider only the information available at the time the decision to admit was made. (See Section 10, Chapter 1 of the Medicare Benefit Policy Manual (MBPM)).

CHA strongly urges CMS to revise the two-midnight policy to conform to the principles articulated in the benefit policy manual.

A hospital stay ordered by an authorized clinician in compliance with Medicare rules should be considered to be an inpatient stay if the treating clinician determined that the patient required inpatient care and provided supporting documentation. CMS and its contractors should not overrule the judgment and decision of the treating clinician based on an after-the-fact review of the medical record performed by a medical adviser who did not examine the patient and who has the benefit of information not available when the admission decision was made. **Absent evidence of fraud, a physician's decision to admit should not be overturned if the documentation in the medical record supports admission.**

In light of the problems hospitals have been having with the two-midnight rule, CMS and Congress have delayed the enforcement, though not the implementation, of the policy. CHA appreciates the enforcement delay, and urges CMS to continue it until the policy is revised and improved.

Short-Stay Payment Policy

CHA does not believe that a short-stay payment policy in isolation would address the issues adversely affecting providers, physicians and beneficiaries. The problems created by the two-midnight rule only can be addressed by eliminating the presumption that stays of less than two-midnights should be denied on grounds that the care could have been provided on an outpatient basis. Rather than creating a different payment for short hospital stays, CHA's preference would be that properly admitted inpatient stays continue to be paid at the full DRG amount.

Nevertheless, we recognize that CMS might consider a reduced payment for short-stay cases together with the changes in the two-midnight policy which we have recommended above. For example, CMS could revise the two-midnight policy to conform to the benefit policy manual so that all inpatient admissions ordered by an authorized clinician in compliance with Medicare rules are considered to be an inpatient stay if the treating clinician had determined that the patient required inpatient care and had provided supporting documentation. If the resulting hospital stay were less than two midnights, CMS might make a reduced payment. **CHA could support such a**

policy if it contained both of these elements: elimination of the presumption that short-stay cases do not require inpatient care and adoption of a short-stay payment policy.

Payment of the short-stay case could be based on something like the post-acute transfer policy. We note that the typical pattern is for the most intensive services and higher costs to occur on the first and last days of the inpatient stay, and this should be taken into account in designing the short-stay payment. CMS should develop a payment amount that is empirically based on actual charges in short-stay cases to ensure that the payment is adequate to cover the cost of the services provided. Inpatient admissions involving procedures on the inpatient-only list should not be part of any short stay payment policy but should receive the full, unreduced MS-DRG payment. CMS should continue to solicit annually for additional exceptions to the short-stay payment policy, and these cases also should receive the full MS-DRG payment.

If CMS does decide to pursue a short-stay policy, it must be developed with careful analysis and signification opportunities for input from providers and other stakeholders.

Restoration of Reduction to Standardized Amounts

CHA continues to believe that the 0.2 percent reduction applied to the FY 2014 national standardized amount, the Puerto Rico-specific standardized amount and the hospital-specific rates made by CMS to offset the additional costs of the proposed new admissions policies in the FY 2014 final rule was arbitrary and capricious and not justified. In the FY 2014 rulemaking, CMS did not provide data justifying the $220 million reduction.

We continue to question CMS' assertion that changes in inpatient volume flowing from the two-midnight policy will cause a net increase in combined IPPS and OPPS payments. The FY 2014 rule asserted this conclusion but did not provide the assumptions and data behind it, thus denying the public the opportunity to review and comment on this critical element of the policy. Hospitals have found that the two-midnight policy led to decreased payment rather than higher payments. They found that the net effect of the changes is a decrease in combined Medicare payments for inpatient and outpatient services for short stay cases.

CHA also observes, as we did in our comments on the FY 2014 and FY 2015 proposed rules, that applying budget neutrality to volume changes or coverage decisions violates the fundamental structure and policy that have governed the IPPS since its inception in 1983. The IPPS payment system is designed to adjust automatically to both the level and reasons (i.e., as reflected in service mix) of hospital admissions, which vary from year to year based on many factors, and these changes are incorporated into the base for determining budget neutrality in future years. The Secretary had never previously made budget neutrality adjustments for these types of changes.

CHA notes that the 0.2 percent reduction in the standardized amounts was built into the base rates and thus carries forward to FY 2015. **We strongly urge CMS to restore the 0.2 percent**

reduction that was made to the standardized amounts. We also urge the agency to release data on actual inpatient and outpatient experience under the two-midnight policy.

Skilled Nursing Facility (SNF) Prior Hospitalization Requirement

CHA would also like to reiterate its strong recommendation that any time spent in observation should count towards the three-day stay prior hospitalization requirement for Medicare payment of SNF stays. In the FY 2014 final rule, CMS established a policy to count observation time toward determining whether the patient stay included at least two midnights. CMS did not, however, revise its definition of the duration of the inpatient stay for the purpose of satisfying the three-day requirement. We recognize that the three-day requirement is statutory and cannot be waived, but CMS does have administrative discretion to specify how the rule will apply in these situations. We urge CMS to take steps to remove the huge financial burdens placed on beneficiaries who discover Medicare will not pay for their skilled nursing car following a hospitalization.

- **Value-based Purchasing Program**

CMS proposes to remove two of the three remaining clinical process of care measures, move the third measure to the safety domain, and eliminate the clinical process of care domain entirely. CHA understands that topped out measures do not assist in distinguishing among hospitals' performance. **However, CHA does not agree with the removal of the entire process of care domain from the VBP program beginning in FY 2018.** Clinical process of care measures can play an important role in quality improvement, and CMS should retain this domain in the VBP program and seek to add measures to it in future years. Until then, it should be retained with a zero weight.

CMS intends to consider adding condition-specific Medicare spending per beneficiary measures to the VBP program in future years. CHA has concerns about the addition of more measures of program spending. First, none of the listed measures (nor the three condition-specific episode of care spending measures currently in the IQR program) have been endorsed by the National Quality Forum. CHA opposes the addition of any measure to the VBP or any other quality program that has not received NQF endorsement. Moreover, while our hospitals are building relationships with other providers in working to prevent unnecessary readmissions and addressing care transitions more broadly, we remain concerned that factors outside hospital control, such as the availability of post-acute services in the community and physician practice patterns, contribute to differences in hospital performance on this type of measure. Finally, condition-specific measures would directly overlap with the existing overall Medicare spending per beneficiary measure.

CMS notes that the Agency for Healthcare Research and Quality Patient Safety Indicator (PSI) composite measure, PSI-90, is undergoing NQF review, which may result in the addition of three more component PSIs. CHA has ongoing concerns about PSI-90, which is calculated from claims data which are less reliable and complete for this purpose than medical-record-based

reporting. Numerous specific flaws in the PSI-90 measure were set forth in a recent article published in the Journal of the American Medical Association.[1]. **CMS should seek to replace PSI-90 with more reliable measures of patient safety.**

- **Hospital-Acquired Condition (HAC) Reduction Program**

CHA supports the proposal to reduce the weight given to PSI-90 in calculating a hospital's total score under the HAC reduction program to 15 percent beginning in 2017. Indeed, **CHA further urges that CMS eliminate this measure entirely from the HAC reduction program beginning in 2018**. At that point, the NHSN measures for central line bloodstream infection and catheter-associated urinary tract infection will be expanded to include patients outside the intensive care unit, permitting more hospitals to receive a Domain 2 score.

CHA supports the proposal to create an extraordinary circumstances exception policy under the HAC reduction program. Hospitals experiencing a natural disaster or other extraordinary circumstance should be able to request temporary relief from requirements under this program as they already can from the VBP and IQR programs. The proposal to build on the existing exceptions process is reasonable and avoids creating additional administrative hurdles. **CHA also supports the proposed extraordinary circumstances exception policy in the Hospital Readmissions Reduction Program.**

- **Inpatient Quality Reporting Program**

CHA supports alignment of electronic reporting of clinical quality measures under the IQR program and the Medicare Electronic Health Record (EHR) Incentive Program. Hospitals should be able to submit these measures once and receive credit under both programs. Full alignment therefore requires that electronically specified measures be NQF endorsed, recommended for use by the Measure Applications Partnership, fully specified and tested, and subject to data validation procedures.

CHA opposes the proposed requirement that hospitals begin mandatory reporting of electronic clinical quality measures (eCQMs) beginning in the third quarter of 2016 for 2018 payment under the IQR program. This schedule would mean that hospitals participating in the IQR program would have to report eCQMs before such reporting is required to demonstrate "meaningful use" under the Medicare Electronic Health Record (EHR) Incentive Program. **While CHA supports working toward alignment of reporting under these two programs, the IQR program should not move ahead of the meaningful use requirements,** which for 2017 permit hospitals to demonstrate meaningful use either through electronic reporting or through attestation. A significant number of hospitals do not expect to be able to participate electronic reporting by the third quarter of 2016 due to ongoing technical issues that pose barriers to electronic reporting.

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[1] Rajaram R, Barnard C, Bilimoria KY. Concerns About Using the Patient Safety Indicator-90 Composite in Pay-for-Performance Programs. JAMA. 2015;313(9):897-898.

Furthermore, CMS has only recently (80 FR 16804-16921) proposed changes to the standards for certification of EHR technology under the EHR Incentive program. **CHA believes that any consideration of mandatory electronic reporting under the IQR program should be delayed until the standards for such reporting are settled and electronic reporting is required under the EHR Incentive program.** We agree with CMS that performance on electronically reported measures, which we believe should continue to be voluntary, should not be displayed on *Hospital Compare* until such time as these measures can be validated.

CHA is supportive in concept of the proposal to develop a set of EHR-based core clinical data elements that would be reported by hospitals and used for risk adjusting claims-based measures and other purposes. However, like reporting of eCQMs, the reporting of clinical data elements cannot be considered under the IQR program alone. **We urge CMS to consider core data element reporting in developing and finalizing standards under EHR Incentive program.**

CMS proposes eight new measures for addition to the IQR program beginning in 2018. Seven are claims-based measures, five of which assess Medicare expenditures for condition-specific episodes of care and two which measure use of observation days and emergency department visits as well as readmissions during an episode of care. The other measure is an annual survey regarding hospitals' internal use of surveys on patient safety culture. **None of the proposed new measures is NQF endorsed, and CHA believes that all measures considered for addition to the IQR program should first be endorsed by the NQF.**

For this reason, CHA also opposes the proposed changes to the readmission and mortality for pneumonia patients until the revised measures are reviewed and endorsed by the NQF. The changes would greatly expand the scope of these measures to include patients with aspirational pneumonia and those with pneumonia that is present on admission and secondary to sepsis or respiratory failure. Changes of this magnitude make these new measures that should undergo careful review prior to use for quality reporting. **CHA also opposes the expansion of the pneumonia readmission measure in the Hospital Readmissions Reduction Program.**

- **Quality Programs: Risk Adjustment and Sociodemographic Factors**

CHA again urges CMS to move forward in risk adjusting quality measures for sociodemographic factors, as recommended by the NQF Risk Adjustment Expert Panel in its 2014 report. In particular, the NQF panel recommended that performance accountability programs should include risk adjustment for those sociodemographic factors for which there is a conceptual relationship with outcomes or processes of care and empirical evidence of such an effect, for reasons unrelated to quality of care. This would apply to all the measures used in the readmissions reduction program; the mortality and efficiency measures used in the VBP program; and the AHRQ PSI 90 measure currently used in both the VBP and HAC reduction programs, and potentially to other risk-adjusted measures.

Sociodemographic factors such as income, education, race, homelessness and language proficiency have been shown to have a significant relationship to health outcomes. Failing to

adjust for them in performance-based payment incentive programs can result in unnecessary and inappropriate payment reductions for providers that serve a high percentage of disadvantaged patients, harming both the patients and the providers by depriving them of the resources they need to make sure every patient receives quality care. In addition, more could be done to use performance measurement systems to identify and eliminate health disparities.

We also endorse the use of performance measure stratification as a tool to identify and reduce health disparities, and the call for a national strategy to identify and collect data on the key sociodemographic factors relevant to health in order to identify health disparities and develop appropriate performance measures. Differences in performance measure outcomes due to actual variation in the quality of care provided to subgroups of patients should not be tolerated. Even with measures risk adjusted for sociodemographic factors, we must monitor the effect of such programs on vulnerable and disadvantaged populations and the providers that serve them to ensure they are not being harmed.

In closing, thank you for the opportunity to share these comments in regard to the proposed FY 2016 IPPS rule. We look forward to working with you on these and other issues that continue to challenge and make stronger the country'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,

Michael Rodgers
Senior Vice President
Public Policy and Advocacy