



A Passionate Voice for Compassionate Care

June 17, 2016

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: CMS-1655-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 2017 Rates; Quality Reporting Requirements for Specific Providers; Graduate Medical Education; Hospital Notification Procedures Applicable to Beneficiaries Receiving Observation Services; and Technical Changes Relating to Costs to Organizations and Medicare Cost Reports; Proposed Rule

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 and Proposed Policy Changes and Fiscal Year 2017 Rates; Quality Reporting Requirements for Specific Providers; Graduate Medical Education; Hospital Notification Procedures Applicable to Beneficiaries Receiving Observation Services; and Technical Changes Relating to Costs to Organizations and Medicare Cost Reports* (81 Federal Register 24946-25322, April 27, 2016).

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 2017 Medicare-Severity Diagnosis-Related Group (MS-DRG) Documentation and Coding Adjustment**

The proposed rule would reduce payments in FY 2017 by 1.5 percent as the final step in fulfilling the American Taxpayer Relief Act of 2012 (ATRA) requirement that CMS recoup \$11 billion in payments to IPPS hospitals. The \$11 billion total represents the amount of additional payments that CMS estimates were made in fiscal years 2010, 2011 and 2012 due to documentation and coding changes which CMS believes do not reflect real changes in case-mix. ATRA requires that the \$11 billion be recouped over fiscal years 2014, 2015, 2016 and 2017. Beginning with 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. As a result, a 0.8 percentage point adjustment was made three times from FY 2014 through FY 2016, for a cumulative three-year reduction to the payment rates of 2.4 percent. CMS now estimates that through FY 2016, only \$5.95 billion will have been recouped, and that an adjustment of negative 1.5 percent is required to reach the \$11 billion total by the end of FY 2017 as required.

Based on the projections of a total cumulative 3.2 percent reduction to the rates, the Congress enacted a policy change regarding future IPPS payment updates in section 414 of the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. Under CMS' original four-year plan to implement the recoupment through a cumulative adjustment of 3.2 percent, the payment rates would have been increased by 3.2 percent in fiscal year 2018 as the recoupment would be completed, and no further payment reductions required. MACRA replaced that one-time FY 2018 increase with increases of 0.5 percentage points over a six year period (FYs 2018 through 2023). Over that time this would have resulted in a cumulative 3.0 percent increase in the rates, short of the total 3.2 percent that would have been restored under prior law. Now that CMS has proposed a much larger percentage reduction for FY 2017, the cumulative reduction would be 3.9 percent, with only 3.0 percent eventually restored to the rates under the MACRA provision.

CHA is disappointed that CMS chose to wait until this year's rulemaking to make clear that the actuaries' projections were no longer valid and that a larger cumulative percentage reduction would be needed to meet the ATRA requirement. If that had been made clear in last year's rulemaking, the Congress would have had the opportunity to enact the MACRA provision in a way that was fair to hospitals. **CHA urges CMS to make every effort to interpret and apply ATRA to restore the 2017 documentation and coding adjustment amount to the anticipated 0.8 percent decrease. If CMS proceeds with the proposed 1.5 percent decrease, then it should takes steps to ensure that the additional 0.7 percent recoupment is restored to the standardized amount.**

- **Restoration of Payment Reductions Related to "Two Midnight" Rule**

CHA is pleased that CMS has recognized the inappropriateness of the 0.2 percent reduction to IPPS rates that has been in place since FY 2014 as an offset to adoption of the "two midnight"

policy. As we have commented before, this reduction was arbitrary, capricious and implemented without justification. **Therefore, we fully support the proposal in this rule to restore 0.2 percentage points to the rates prospectively and to provide for a positive 0.6 percentage point adjustment to compensate for the erroneous application of the negative adjustment for the past three fiscal years.**

- **Disproportionate Share Hospitals**

CHA supports the 2017 proposed change to use an average of data derived from three cost reporting periods instead of one cost reporting period to compute Factor 3. We believe that by doing so this would provide assurance that a hospital's uncompensated care payments remain stable and predictable and not subject to unpredictable swings and anomalies in a hospital's low-income insured days.

As we have indicated in comments to prior proposed rules, **CHA is generally supportive of CMS' proposal to transition to the use of uncompensated care costs, as derived from the Worksheet S-10 cost report, to replace the current use of Medicare SSI days and Medicaid days as a proxy for uncompensated care.** We strongly urge, however, that CMS develop a longer phase-in for incorporating the data from the S-10 cost reports and that CMS include Medicaid shortfalls and other types of uncompensated care into the definition.

CHA recommends a longer phase-in of the use of S-10 cost report data than the 3-year transition period proposed by CMS and would instead suggest a 5-year transition period to mitigate wide swings in hospital payments from year-to-year. While we are pleased that CMS articulated a plan and timeline for incorporating the use of S-10 data, CHA strongly urges that CMS adopt a longer phase-in period. For example, with a 5-year phase-in period CMS could still begin incorporating the use of S-10 cost report data in FY 2018, but use S-10 data to allocate 20 percent of the payments in 2018, 40 percent in 2019, 60 percent in 2020, 80 percent in 2021, and rely solely on S-10 data in 2022. This transition would involve using 3-years of Medicare SSI days and Medicaid days in each year, and transitioning to using 3-years of S-10 data over the 5-year phase-in. Specifically under a 5-year phase-in approach, 2018 would use 2014 S-10 cost report data, 2019 would use 2014 and 2015 S-10 cost report data, 2020 would use 2014, 2015, and 2016, and so forth. A longer phase-in period would allow CMS to continue to fine-tune the accuracy, consistency and completeness of the S-10 data before relying solely on that data, and would give hospitals more time to ensure accurate reporting based on any revised instructions CMS may issue with respect to the timing of reporting charity care and other revisions.

CHA does not support the CMS proposal to exclude Medicaid shortfalls reported on Worksheet S-10 from the definition of uncompensated care for purposes of calculating Factor 3. In addition to the components proposed by CMS (cost of charity care and non-Medicare bad debt expense), **CHA believes that uncompensated care should also include the unreimbursed costs of public health care programs, including Medicaid, the Children's**

Health Insurance Program and state and local indigent care programs. This approach would be a fairer way to allocate uncompensated care dollars to hospitals, especially given that analyses we have reviewed suggest that hospitals located in states that opted out of Medicaid expansion do significantly better under the CMS proposed approach than hospitals located in states that have expanded Medicaid. Broadening the definition to include Medicaid shortfalls and other forms of unreimbursed costs of other public health care programs would help make the allocation more equitable.

- **Medicare Outpatient Observation Notice (MOON)**

The Notice of Observation Treatment and Implication for Care Eligibility (NOTICE) Act requires hospitals and critical access hospitals (CAHs) to give Medicare beneficiaries receiving observation services for more than 24 hours both a written notice (the Medicare Outpatient Observation Notice (MOON)) and an oral explanation concerning their outpatient status and its implications. CMS makes several proposals to implement the NOTICE Act.

CHA strongly supports providing patients with this critical information. Medicare beneficiaries are entitled to know and understand their status in the hospital. However, we have concerns with some aspects of the implementation proposals.

Effective date and enforcement: The NOTICE Act requires that these procedures be effective starting August 6, 2016. However, the final rule implementing the Act will likely be published only a few days before that date. Our members are very concerned that they will not be able to operationalize the Act's requirements in so short a time. At least six months following the issuance of the final rule and required forms would be needed to operationalize and implement these procedures. **CHA urges CMS to adopt an implementation delay or enforcement grace period of at least six months, and to undertake extensive education efforts during that time, to ensure that hospitals are able to fully understand and implement the new regulations.**

When the notice is given: CMS proposes that written notice is to be provided when a beneficiary receives outpatient services for more than 24 hours and before 36 hours or earlier if transferred, discharged or admitted. There is some ambiguity about when the 24-hour clock begins, and whether notice must be provided between the 24th and 36th hour or can be given earlier. CMS should be very clear about what action triggers the beginning of the 24-hour period. As to when the communication must occur, requiring that the notice be delivered within a narrow, 12-hour window of time would pose significant, and unnecessary, logistical and operational challenges. **While the Act only requires notice be given to individuals in observation/outpatient status for more than 24 hours, CHA urges CMS to permit hospitals to provide the notice to a patient earlier than that, but within the required 36 hours.**

Coordination with State requirements: A number of states, including New York, Connecticut, Maryland, Illinois, and Pennsylvania, have already implemented similar notice requirements,

and others may follow. **We urge CMS to take steps to prevent hospitals from having to comply with duplicative and/or inconsistent state and federal requirements.** For example, compliance with substantially equivalent state requirements could be deemed compliance with the NOTICE Act. Additional guidance is needed to avoid a situation in which hospitals have to give patients two somewhat different notifications, potentially provided at different times, informing them about generally the same issue. The intent of the NOTICE Act is to provide patients with clear and relevant information, not to confuse them with competing pieces of paper.

Language of the MOON: CHA supports CMS' proposal to develop a standardized form that hospitals can use with patients. It is critically important that this form be written using clear, simple, understandable language so that it can achieve its purpose – to effectively inform patients of their status and its implications. Medicare beneficiaries' reading skills vary greatly. In addition, patients who present at a hospital are often incapacitated or in distress, affecting their focus and reading comprehension. **We urge CMS to take great care in developing the language of the form, and to develop a beneficiary education campaign so Medicare beneficiaries are aware of the concepts involved before they receive the MOON incident to care.** CMS is developing English and Spanish versions of the MOON. **We urge CMS to commit to making the form available over time in more languages.**

- **Quality Programs: AHRQ PSI 90 Composite Quality Measure**

A number of proposals relate to the Agency for Healthcare Research and Quality Patient Safety Indicator (PSI) composite measure, PSI-90, which is used in the VBP and HAC Reduction programs as well as the IQR Program. This measure recently was re-specified and re-endorsed by the NQF, and as a result of the substantial changes in the measure CMS is proposing to adopt the modified version (renamed as the “Patient Safety and Adverse Events Composite”) for the IQR and HAC Reduction programs in FY 2018. (The VBP program requires that measures have been posted for at least one year on the Hospital Compare website before a performance period can begin, and for this reason CMS says it will propose addition of this measure to the VBP in future rulemaking.)

CHA has previously expressed its 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. For example, numerous specific flaws in the PSI-90 measure were set forth in an article published in the Journal of the American Medical Association.¹ **We again urge CMS to phase out the use of PSI-90 and replace it with more reliable measures of patient safety.**

Performance Period. Because the implementation of ICD-10 *occurred* in the middle of what would normally be the 24-month performance period for PSI-90, CMS proposes a shortened

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.

ICD-9 only performance period for the VBP, HAC Reduction and IQR Programs for FY 2018. Instead of beginning July 1, 2014 and ending June 30, 2016, the performance period would run from July 1, 2014 through September 30, 2015, a period of 15 months. While CHA agrees that it would be inappropriate to mix claims data using both ICD-9 and ICD-10 coding, we are concerned that the modified PSI-90 measure may not be reliable when a shorter performance period is used. The 2011 analysis that CMS cites in the proposed rule does not address the modified version with its new components and weights. **Therefore, CHA believes that CMS should suspend PSI-90 from inclusion in calculating scores for the VBP and HAC programs and suspend it from public reporting on *Hospital Compare* until a 24-month performance period can be re-established, or until AHRQ has satisfactorily demonstrated that the shorter performance period will produce equitable results.** This time period will also allow hospitals to gain experience with the modified measure before it is used in the pay-for-performance programs. We note that beginning with FY 2018, the Domain 2 infection measure component of the HAC Reduction Program will include measures that are no longer limited to intensive care unit patients only. This should make it possible to calculate performance scores for hospitals more broadly without reliance on the PSI 90 measure.

- **Value-Based Purchasing (VBP) Program**

CMS proposes the addition of two new measures to the efficiency domain beginning in FY 2021, specifically measures of risk-stratified payment associated with a 30-day episode of care for heart failure and for acute myocardial infarction respectively. These measures have been endorsed by the NQF, but the Measures Application Partnership (MAP) did not support the measures, due to concerns about overlap with the Medicare Spending for Beneficiary (MSPB) measure and lack of information on whether the measures should be risk-adjusted for sociodemographic factors. **CHA believes these measures should remain in the IQR program at this time, but not added to the VBP program. If CMS finalizes the addition of these measures to the VBP program, CHA believes that the existing measure of total MSPB should be adjusted accordingly to ensure that there is no overlap and double-counting of these costs in the efficiency domain.**

CHA supports the proposal by CMS to include non-ICU CAUTI and CLABSI measure data in hospitals' VBP performance beginning with the FY 2019 program year.

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

In addition to the changes regarding the PSI-90 measure discussed above, CMS proposes to modify the scoring system for the HAC Reduction program by replacing the current decile-based scoring approach with a "Winsorized Z-score" methodology. CHA understands that adding this complexity to program scoring will result in a smoother distribution of scores and avoid unintended anomalies resulting from the current decile-based scoring method. However, we continue to have ongoing concerns about a program that imposes a substantial penalty on a fixed number of hospitals each year, regardless of whether quality improvement has occurred

and regardless of whether hospitals with only slightly better performance may receive no penalty.

- **IQR Program Measures**

CHA supports the proposed removal beginning with the 2019 payment determination of two structural measures that reflect whether hospitals participate in systematic clinical data base registries for nursing sensitive care and general surgery, but encourages CMS to implement the removal for the 2018 payment determination. That is, hospitals should not have to report on these measures by March 2017 in order to be eligible for a full update factor for FY 2018. CHA also supports the removal of two “topped out” chart-abstracted measures, STK-4 (Thrombolytic therapy) and VTE-5 (VTE discharge instructions). **We also support the removal of 13 electronic Clinical Quality Measures as proposed by CMS.**

CMS proposes the addition of four measures to the IQR Program, none of which have been endorsed by the NQF: Excess Acute Care after Hospitalization for Pneumonia, and three measures reflecting Medicare “resource use” during episodes of care for aortic aneurysm, cholecystectomy and common duct exploration, and spinal fusion. **CHA does not support inclusions of these measures, as it continues to believe that only measures that have been endorsed by the NQF should be considered for inclusion in the IQR Program measure set.** The endorsement process identifies needed refinements or problems with measures, and these should be considered prior to adoption.

Electronic Clinical Quality Measures

CHA is pleased that CMS proposes to align the electronic reporting requirements in the IQR program with the meaningful use requirements under the Medicare EHR Incentive Program beginning with CY 2017 reporting/FY 2019 payment. The same set of 15 electronic clinical quality measures are proposed for both programs, and the reporting deadline would be the same. **However, we are concerned that the increase in the number of electronic measures that must be reported, from 4 in 2016 to 15 in 2017, is too big a step. CMS should consider phasing in the increase in the number of required measures to allow hospitals, vendors and CMS’ own systems more time to adapt to electronic reporting of quality measures.** For example, CMS might begin by increasing the length of the reporting period and continue to require hospitals to report four measures, the current number, with the option to voluntarily report on additional measures. If CMS does choose to mandate an increase in the number of measures that must be reported, we urge them to require no more than 6-8.

- **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

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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.

CMS states that it is considering use of stratification by race, ethnicity, sex and disability in reporting performance on *Hospital Compare*. While we are supportive of the use of performance measure stratification as a tool to identify and reduce health disparities, we urge CMS to continue to explore appropriate risk adjustment of measures, including risk adjustment for socioeconomic factors. A key principle should be that 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 2017 IPPS rule. We look forward to working with you on these and other issues that continue to challenge and strengthen the nation'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,

A handwritten signature in black ink that reads "Michael Rodgers". The signature is written in a cursive, flowing style.

Michael Rodgers
Senior Vice President
Public Policy and Advocacy