



A Passionate Voice for Compassionate Care

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Ms. Marilyn B. Tavenner
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-1607-P

Re: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Fiscal Year 2015 Rates; Quality Reporting Requirements for Specific Providers; Reasonable Compensation Equivalents for Physician Services in Excluded Teaching Hospitals; Provider Administrative Appeals and Judicial Review; Enforcement Provisions for Organ Transplant Centers; and Electronic Health Record (EHR) Incentive Program: Proposed Rule

Dear Ms. Tavenner:

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 Fiscal Year 2015 Rates; Quality Reporting Requirements for Specific Providers; Reasonable Compensation Equivalents for Physician Services in Excluded Teaching Hospitals; Provider Administrative Appeals and Judicial Review; Enforcement Provisions for Organ Transplant Centers; and Electronic Health Record (EHR) Incentive Program* (79 Federal Register 27978-28384, May 15, 2014).

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 2014 Medicare-Severity Diagnosis-Related Group (MS-DRG) Documentation and Coding Adjustment**

Implementing the American Taxpayer Relief Act Recoupments: The proposed rule would reduce payments in FY 2015 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. The \$11 billion to be recovered represents the amount of additional payments that CMS estimates were made in those fiscal years due to the effect of 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. 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 2015 would be on top of the 0.8 reduction made in FY 2014 resulting in a cumulative reduction of 1.6 percent in FY 2016.

CMS estimates that the proposed FY 2015 adjustment, combined with leaving in place the -0.8 percent adjustment made for FY 2014, will recover up to \$2 billion in FY 2015 and, with the approximately \$1 billion recovered in FY 2014, will leave about \$8 billion remaining to be recovered by FY 2017. CMS does not propose specific reduction levels for FYs 2016 and 2017 but projects that applying an additional -0.8 adjustment in each of those years, while retaining the prior years' adjustments, will fully recover the \$11 billion as required by ATRA. CMS states that all of the ATRA adjustments eventually will be offset by an equivalent positive adjustment once the full \$11 billion recoupment requirement has been realized. If 0.8 percentage point reductions are made also in FY 2016 and FY 2017, the cumulative level of the reduction will have reached 3.2 percent and would require a positive adjustment of about 3.2 percent in FY 2018.

Although CHA continues to disagree that \$11 billion in overpayments occurred, we recognize that ATRA does not give CMS discretion on the amount to be recovered. **We appreciate 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.**

Prospective Adjustment for FY 2010: In the FY 2013 rulemaking cycle, CMS proposed but did not finalize a prospective cut of 0.8 percent related to hospitals' documentation and coding in FY 2010. After reviewing comments from the hospital industry and the Medicare Payment Advisory Commission (MedPAC), CMS in its FY 2014 rulemaking concluded that the 0.8 percent figure was overstated and it indicated that a prospective reduction of 0.55 percent would be more appropriate, but it did not make any prospective adjustment in FY 2014. In the current proposed rule, CMS again postpones any prospective adjustment in light of the ongoing ATRA recoupment, but it reaffirms that it could consider applying an additional adjustment of .55 percent in future years' rulemaking. **CHA appreciates CMS' decision not**

to implement the additional adjustment in FY 2015 and urges the agency not to propose any additional documentation and coding cuts, beyond those required by ATRA, in future rulemaking.

- **Criteria for Medical Review of Inpatient Admissions.**

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 the FY 2015 proposed rule, CMS seeks public comment on whether to consider establishing an alternative payment methodology for short inpatient hospital stays and how it should be designed.

The Two Midnight Rule

In previous comments to CMS (FY 2013 OPSS 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.

Unfortunately, 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 are hearing 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 would like to point out 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 can be 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 should 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. That is, CMS might 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 would support such a policy containing 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, as was done in FY 2015 proposed rule, and these cases also would receive the full MS-DRG payment.

If CMS does decide to develop a short-stay policy, it would have to be done 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 of 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, capricious and not justified. In the FY 2014 rulemaking, CMS did not provide data justifying the \$220 million reduction.

We continue to question CMS' projection that changes in inpatient volume flowing from the two-midnight policy will cause a net increase in combined IPPS and OPSS 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 which modeled the impact of the two-midnight policy on their payments found that they decreased rather than increased. They found that the net effect of the changes is a net decrease in Medicare payments for inpatient and outpatient services.

CHA also observes, as we did in our comments on the FY 2014 proposed rule, 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 care following a hospitalization.

- **Transparency of Hospital Charges**

The Affordable Care Act (ACA) requires hospitals to make public a list of their standard charges for the items and services they furnish. In the proposed rule, CMS reminds hospitals of this requirement; encourages that the information be made available in a consumer friendly manner; and expects that the information will be updated annually. Hospitals can either make public a list of their standard charges (whether that be the chargemaster itself or in another form of their choice), or their policies for allowing the public to view a list of those charges in response to an inquiry.

CHA supports CMS' proposal to give hospitals flexibility in how they make their charge information public. We believe that giving hospitals flexibility in meeting the statutory requirement will allow beneficiaries and the public to receive the necessary information without creating unnecessary burden beyond what is created by the requirement itself to release the data.

CHA notes that hospital charge data does not necessarily provide consumers with the kind of information they really need. We support improving consumer access to meaningful and appropriate price and quality information so they can make informed choices about their

healthcare, and will continue to work with the hospital industry and other stakeholders to improve transparency.

- **Release of Medicare Advantage Risk Adjustment Data**

CMS proposes to expand the uses and reasons for disclosure of risk adjustment data submitted by Medicare Advantage Organizations (MAOs). The existing purposes for which CMS may use or disclose this data are (1) to determine the risk adjustment factors used to adjust Medicare Advantage payments; (2) to update risk adjustment models; (3) to calculate Medicare DSH percentages; (4) to conduct quality review and improvement activities; and (5) for Medicare coverage purposes. CMS proposes to add these purposes:

1. To conduct evaluations and other analysis to support the Medicare program (including demonstrations) and to support public health initiatives and other health care-related research.
2. For activities to support the administration of the Medicare program.
3. For activities conducted to support program integrity.
4. For purposes permitted by other laws.

CHA is concerned about the expansiveness of the proposed new purposes, which would seem to justify release of these sensitive data for almost any activity given how broad they are. We believe that **CMS must further specify and narrow the purposes for which the data could be released.**

The description of the proposal in the preamble includes a couple of constraints. First, it states that “CMS may release the minimum data it determines is necessary for one or more of the purposes listed...” Second, it states that release is:

- (iv) Subject to the aggregation of payment data to protect commercially sensitive data.

The proposed rule, however, offers no elaboration of “commercially sensitive data.” The rule should state specifically that price and charge data are “commercially sensitive data.” **CHA recommends that the regulatory language to be codified should state specifically that price/charge data would not be collected, released or used since they are not relevant to the risk adjustment model used by CMS.**

Finally, the preamble indicates that the data would not include medical records and other data collected for purposes of risk adjustment data validation (RADV) audits. Rather, CMS proposes to authorize use or release of encounter data records, including contract, plan and provider identifiers, but not payment data at the level of an encounter record. CMS does propose to release aggregate payment information, and seeks comment on approaches to aggregating payment data for release as well as whether releasing payment data at the level of an encounter record would reveal proprietary negotiated payment rates.

CHA notes, however, that **the text of the proposed regulations language fails to exclude the additional data collected as part of audits and thus these data appear to be within the scope of the**

releasable data. The regulation language states: “Risk adjustment data are all data that are used in the development and application of a risk adjustment payment model.” Without a specific exclusion, this would seem to include audit data and these audit data include price and charge information. In effect, none of the limitations or specifications described in the preamble is included in the current or proposed regulations except for the restriction on “commercially sensitive data.” **CHA strongly believes that these proposed restrictions should not be included solely in the preamble but must be codified in the regulations. CHA urges CMS to revise the regulation text accordingly.**

- **Disproportionate Share Hospitals (DSH)**

As we stated in comments on the FY 2014 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.**

CMS must make sure that the S-10 is revised to accurately and comprehensively report all types of uncompensated care, including 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 setting a timetable for using S-10 data. 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.

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

CHA strongly supports the draft recommendation of the NQF Risk Adjustment Expert Panel regarding risk adjustment for sociodemographic factors, and urges CMS to account for these factors in the risk adjustment used in calculating the claims-based quality measures used in all three pay-for-performance programs. 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.

- **Hospital Readmissions Reduction Program**

For FY 2017, CMS proposes to expand the scope of applicable conditions and procedures in the Hospital Readmissions Reduction Program (HRRP) to include patients who are readmitted following coronary artery bypass graft (CABG) surgery. For this condition, CMS developed a Hospital-Level 30-Day All-Cause Unplanned Readmission Following Coronary Artery Bypass Graft (CABG) Surgery measure. The NQF Measure Applications Partnership (MAP) Hospital workgroup supported the measure for use in the HRRP conditional on attainment of NQF endorsement. On February 5, 2014, CMS submitted the measure to NQF for endorsement. **CHA believes CABG measure should not be included in the HRRP until the NQF endorses the measure.** We believe that the statute requires CMS to use only NQF-endorsed measures.

For FY 2015, CMS proposes to use a revised version, labeled Version 3.0, of the CMS Planned Readmission Algorithm for the AMI, HF, PN, COPD, and THA/TKA readmission measures as well as for the CABG readmission measure proposed for inclusion in the HRRP starting in FY 2017. Version 3.0 incorporates improvements that were made based on a validation study of the algorithm. **CHA believes the revised version 3.0 of the planned readmission algorithm should be submitted for NQF review. We also urge CMS to work with the physician and hospital communities to identify other planned readmissions that should be excluded. In addition, we continue to urge CMS to exclude from the HRRP admissions unrelated to the prior hospital stay, including for example admissions for chemotherapy, trauma, burns, end stage renal disease, maternity, and substance abuse. These and admissions for other conditions unrelated to the initial admission should always be excluded because, by their nature, they are not preventable readmissions.**

CHA continues to be concerned that CMS' methodology for risk-adjusting the readmissions measures is inadequate and disadvantages hospitals serving a high percentage of low-income patients by imposing unnecessary and inappropriate payment reductions. CMS should include additional patient characteristics beyond the medical diagnosis, age and gender included in the currently endorsed NQF risk adjustment methodology. CHA believes that patient race, language, life circumstances, environmental factors and socioeconomic status (SES) should be included in the risk-adjustment methodology because these factors have an impact on health outcomes. Absent these adjustment factors, the readmissions reduction program may disadvantage hospitals serving a large number of minorities, and by penalizing these hospitals, the program could in turn disproportionately harm minority patients. **CMS should work with hospitals and the NQF to make changes consistent with the report of NQF's task force on SES factors**, as discussed above. We believe that these changes can be made in a manner that does not weaken the standards hospitals must meet or lead to lower quality patient care in hospitals treating a disproportionate share of low-income patients.

In the interim until the NQF-endorsed measure is revised to include SES factors, CMS should vary the HRRP adjustment by decile of, for example, disproportionate share (DSH) patient percentage or Medicare/Medicaid dual-eligible status. MedPAC also has expressed concern about this issue and has discussed employing a stratification approach similar to what hospital groups have recommended.

For example, one way to address the issue of readmissions reduction for hospitals with high shares of low-income patients is to compute penalties by comparing hospitals with a peer group serving a similar share of low-income patients. All hospitals would continue to report their all-condition risk-adjusted readmission rate. However, when computing penalties, each hospital's target readmission rate would be based on the performance of hospitals with a similar patient profile. (see June 2013 MedPAC Report to the Congress)

CHA believes an approach such as this would not require a material change to the measures, and thus would be within CMS' current legal authority. **We strongly urge CMS to include such an adjustment in the final rule, which could be included as an interim final rule subject to comment if necessary.** An adjustment of this nature should be adopted for FY 2015 while CMS works to improve the risk-adjustment methodology.

Finally, the Total Hip Arthroplasty and Total Knee Arthroplasty (THA/TKA) 30-Day Readmission Measure is intended to include only patients who have an elective THA or TKA and to exclude patients who have a principal discharge diagnosis of femur, hip, or pelvic fracture on their index admission since hip replacement for hip fracture is not an elective procedure. CMS has learned that hospitals frequently code hip fractures occurring during the same admission as a THA as either a principal or secondary diagnosis. Therefore, for FY 2015 **CMS proposes to refine the measure to exclude patients with hip fracture coded as either principal or secondary diagnosis during the index admission. CHA supports this refinement to the measure.**

- **Hospital Wage Index for Acute Care Hospitals**

CMS proposes to use different labor market areas in FY 2015 than it used for FY 2014 based on new geographical boundaries of Core-Based Statistical Areas (CBSAs) established by OMB. OMB issued Bulletin No.13-01 on February 28, 2013, which established revised definitions or delineations for Metropolitan Statistical Areas, Micropolitan Statistical Areas and Combined Statistical Areas based on OMB 2010 standards and 2010 Census population data. CMS also proposes a wage index transition period applicable to all hospitals that experience negative impacts due to the proposed implementation of the new OMB delineations. The proposed transition methodology is similar to the one used in the FY 2005 IPPS final rulemaking to mitigate any negative financial impacts. CMS believes, due to the significant negative payment impacts, that a longer transition period should be granted to urban to rural transitions than to hospitals switching between urban labor market areas.

For hospitals that are currently located in an urban county that would become rural under the new OMB delineations (and have no form of wage index reclassification or designation in place for FY 2015), CMS proposes to assign them the urban wage index of the CBSA in which they are physically located for FY 2014 for a period of three years (with the rural and imputed floors applied and with the rural floor budget neutrality adjustment applied to the area wage index).

In addition, CMS proposes a one-year blended wage index for all hospitals that would experience any decrease in their actual payment wage index (a hospital's actual wage index used for payment, which accounts for all applicable effects for reclassification and redesignation) due to the proposed implementation of the new OMB delineations. In situations where the proposed FY 2015 wage index with the FY 2015 CBSAs (new OMB delineations) is lower than then proposed FY 2015 wage index with FY 2014 CBSAs, CMS proposed computing a blended wage index, consisting of 50 percent of each of the two wage indexes added together. CMS believes that a one-year, 50/50 blend would mitigate any short-term instability and negative payment impacts, but extending the transition period beyond one-year would reduce the accuracy of the overall labor market area wage index given the number of hospitals affected.

CHA supports using the new OMB CBSAs and the transition policies included in the proposed rule.

Rural Reclassification as CAHs. The proposed adoption of the new OMB labor market area delineations could affect CAHs, which must either be physically located in a rural area or have been reclassified as rural under §412.103.

Facilities currently participating as CAHs that were previously located in rural areas may be subsequently located in urban areas as a result of the new delineations. As it had done in both the FY 2005 IPPS final rule and the FY 2010 IPPS/LTCH PPS final rule, CMS proposes that effective October 1, 2014, currently participating CAHs that are located in an area that has been redesignated from rural to

urban under the new OMB delineations will again be treated as rural for two years from the date the new delineations are implemented. An affected CAH would have two years from the date the redesignation takes effect to reclassify as rural and thereby retain its CAH status. If a CAH fails to reclassify within those two years, it would lose its CAH status. CMS proposes to make this policy apply to this and all future new OMB labor market area delineations.

CHA agrees with this proposed policy and also recommends that a similar two year grace period be provided for sole community and Medicare-dependent hospitals to give them time to reclassify from urban-to-rural under 42 CFR 412.103.

- **IME Medicare Part C Add-On Payments to Sole Community Hospitals (SCHs) Paid According to Their Hospital-Specific Rates**

Currently, sole community hospitals are eligible to receive Medicare Advantage (MA) indirect medical education (IME) payments only if they are paid on the federal rate rather than the hospital-specific rate. **The proposed rule would extend eligibility for these payments to include hospitals paid on the hospital-specific rate. CHA supports this change.**

The proposed policy also includes a provision, however, to disregard the amount of MA IME payments in determining which of the two payment rates, federal or hospital-specific, is higher. Thus, in theory, this change could result in a hospital being paid on the hospital-specific rate when the federal rate, if these payments were included, would have been higher. In such a situation, under CMS' proposal, the hospital would be paid the hospital-specific rate even though that rate might have been lower had MA IME payments been included in the federal rate portion of the comparison. Such a hospital would not be disadvantaged with respect to MA IME since it would still get those payments, but it would be disadvantaged under DSH. To receive DSH payments and DSH uncompensated care payments, a hospital must be paid based on the federal rate and qualify for empirically justified DSH payments, as determined at cost report settlement. **CHA opposes this portion of the proposed policy and recommends that the MA IME payments be included in the federal rate for purposes of making the comparison.**

- **Claims Required in Provider Cost Reports and for Provider Administrative Appeals**

CMS proposes to revise the cost reporting regulations to require providers to include appropriate claims for specific items in their Medicare cost report as a condition for receiving Medicare payment for those items. The requirement to include a claim for a specific item already exists in the appeals regulations as a condition of establishing jurisdiction for appeals to the Provider Reimbursement Review Board (PRRB). To avoid duplicative requirements, CMS is proposing to remove this requirement from the appeals regulations and instead only include it in the cost reporting regulations.

Moving the requirement from the appeals stage to the cost reporting stage imposes an automatic additional requirement on all hospitals and may result in excessive discretion being vested in MACs. Under the proposed regulations, a MAC will make the determination as to whether to accept a hospital's cost report or amendments to specific items on the cost report. The version of the cost report accepted by the MAC is the cost report that is used to determine whether there is an appropriate claim for an item, and thus whether the hospital will be reimbursed for that item. If the MAC does not accept a hospital's amended cost report with an adjustment to a particular item, then that cost report would not be used to consider whether there was an appropriate claim for reimbursement. Furthermore, if a hospital were to appeal a claim to the PRRB, the determination of whether the PRRB has jurisdiction over a specific item would depend on whether the MAC accepted the version of the provider's cost report in question. If the MAC did not accept an amended cost report in which a hospital makes a change to a specific item, the PRRB would not have jurisdiction over a claim in the amended cost report. In this way, the proposed regulation would be an impediment to hospitals by delegating an inordinate amount of decision-making authority to the contractor.

CHA opposes this change in the appeals requirement because it would diminish hospitals' appeals rights. CMS should not require hospitals to include claims for specific items on their Medicare cost reports as a condition of reimbursement. If the final rule includes this requirement, it should also include a provision to require MACs to accept amended cost reports as long as they are filed within the applicable time limits.

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

CMS proposes to make two adjustments to the domain weights in the VBP program for FY 2017. The weight for the Clinical Care – Process domain would decrease from 10 percent to 5 percent. The rationale offered is that with the proposed removal of topped out measures, this domain would have many fewer measures (three compared with eight for 2016). The weight for the safety domain would increase from 15 percent to 20 percent.

CHA believes CMS should not make this change to the domain weights for FY 2017.

While we recognize that the proposed removal of topped out measures reduces the number of process of care measures to three, evidence-based process of care measures play an important role in quality improvement. We note that there are other domains with three (outcomes) or fewer (efficiency) measures for which proposed weights are much higher.

CHA has concerns with Clinical Care-Outcomes domain. The three mortality measures which comprise that domain have substantial reliability issues. While CHA agrees that the future trend should be towards outcome measures, it also believes for that reason that the measures used must meet high standards of reliability and accuracy. Until CMS can include in the VBP additional and more reliable outcome measures, it should consider decreasing the weight given the outcome domain and increasing the weight of the process domain.

We continue to have concerns with the use of the Medicare spending per beneficiary efficiency measure for the VBP program. Hospitals have very little control over differences in the value of this measure over the time period it covers (three days prior to admission and 30 days post discharge), with the possible exception of preventable readmissions, which are measured separately in the readmission reduction program. Factors that are outside the control of the hospital, such as the availability of post-acute care services in the community and physician practice patterns, contribute to differences in this measure. As we noted above this measure, and the risk-adjusted 30-day readmissions and mortality measures, should be adjusted for appropriate sociodemographic factors.

For these same reasons, CHA is concerned about the potential future addition to the VBP program of episode of care spending measures as discussed in the proposed rule. These measures would be constructed in the exact same way as the current Medicare spending per beneficiary measures, but limited to specific diagnoses. In addition to suffering the problems of lack of hospital control over measure performance and insufficient risk adjustment, the addition of these condition-specific measures would be duplicative with the existing total Medicare spending per beneficiary measure.

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

CHA has ongoing concerns about the HAC Reduction Program which will take effect beginning in FY 2015. We believe that the statutory requirement to penalize one-fourth of hospitals with a one percent reduction in DRG payments is too blunt an instrument to succeed as a quality improvement tool, as by its design some hospitals will be inequitably penalized. Further, the HAC measures are fully duplicated in the VBP program, which is designed to reward improvement as well as achievement on quality measures and uses continuous scoring scale rather than the bright penalty line drawn in the HAC Reduction Program. As a result of the overlap, a single event could contribute to lower reimbursement for the case under the original HAC MS-DRG penalty, a penalty under VBP and a HAC reduction penalty. Despite these strong objections to the HAC Reduction Program, we recognize that CMS must implement the program within the statutory constraints. We strongly suggest, however, that CMS coordinate the HAC and VBP programs so that measures are not included in both programs at the same time.

CHA supports the proposal to modify the weighting scheme in the HAC Reduction Program beginning in FY 2016. Specifically, we agree that the healthcare associated infection measures reported by hospitals through the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) should be given greater weight than the AHRQ PSI composite measure. CHA remains concerned that the AHRQ PSIs are calculated from claims data which are a less complete and reliable data source than medical-record based reporting systems, and which offer only limited capacity for appropriate clinical exclusions. In addition,

because CMS only releases information on hospital performance on the AHRQ measure once a year, it has limited benefit for hospitals' ongoing quality improvement efforts.

CHA supports the proposed addition to the HAC Reduction Program of an exceptions process for hospitals that have experienced a natural disaster or other extraordinary circumstances beyond their control. A similar exceptions process is in place for the inpatient quality reporting (IQR) program and the VBP program, and it is appropriate for hospitals to have an opportunity to seek exception from the HAC reduction program when extraordinary circumstances impede their ability to improve performance on the HAC program measures. An exceptions policy should exempt qualifying hospitals from the HAC penalties for fiscal years when extraordinary circumstances were in effect during the HAC program measure performance periods.

- **Reporting of Electronic Clinical Quality Measures**

CHA is pleased that CMS is taking steps to align the IQR program with the meaningful use electronic reporting requirements under the Medicare EHR Incentive Program by making the reporting deadlines consistent and by counting the reporting of some electronically specified measures toward satisfying both programs. However, more steps need to be taken to fully align these programs in the future. As we understand the proposed rule, there are 12 measures that would be required under the IQR program for FY 2017 which could be reported as electronic clinical quality measures and be used for both programs.

CHA does not agree with the proposal to continue to treat electronic clinical quality measures on *Hospital Compare* in direct comparison with chart-abstracted measures on the same topics. There is no process in place yet for validation of the electronic clinical quality measures, and the specifications are sufficiently different to make such a comparison unfair. We are pleased that CMS is working toward developing a data validation approach for the electronic measures, and urge that work be completed and the process adopted as soon as practical given the need for appropriate testing.

In addition, the proposal to treat some meaningful use measures as “voluntary” measures for the purpose of the IQR program is confusing to hospitals. Some measures included in the proposed voluntary reporting were previously removed from the IQR program because uniformly high hospital performance levels had led them to become “topped out.” CMS should work toward full alignment of these programs under which a hospital could submit just once a set of electronic clinical quality measures that are requirements under both programs in order to achieve a full IPPS update factor. To accomplish this, the electronic measures would need to be NQF endorsed; recommended for use by the Measures Application Partnership; fully specified and tested; and subject to data validation.

In closing, thank you for the opportunity to share these comments in regard to the proposed FY 2015 IPPS rule. We look forward to working with you on these and other issues that continue

Ms. Marilyn B. Tavenner
June 30, 2014
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to challenge and strengthen 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,

A handwritten signature in black ink that reads "Michael Rodgers". The signature is written in a cursive style with a long horizontal flourish at the end.

Michael Rodgers
Senior Vice President
Public Policy and Advocacy