Catholic Health Association of the United States

A Passionate Voice for Compassionate Care

June 25, 2013

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–1599–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 2014 Rates; Quality Reporting Requirements for Specific Providers; Hospital Conditions of Participation: 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 2014 Rates; Quality Reporting Requirements for Specific Providers; Hospital Conditions of Participation (78 Federal Register 27486-27823, May 10, 2013).

We appreciate your staff's ongoing efforts to administer and improve the payment systems for acute inpatient hospital services and long-term care 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**

The proposed rule would reduce payments in FY 2014 by 0.8 percent to fulfill part of the American Taxpayer Relief Act of 2012 (ATRA) requirement that CMS recoup $11 billion in

alleged overpayments made in FYs 2010, 2011 and 2012. The $11billion to be recovered represents the amount of additional payments that CMS claims were made in those fiscal years due to the effect of documentation and coding changes which, according to CMS, do not reflect real changes in case-mix. ATRA requires that the $11 billion be recouped over fiscal years 2014, 2015, 2016, and 2017.

Although CHA disagrees with the determination that $11 billion in overpayments occurred in the referenced fiscal years, we recognize that ATRA does not give CMS discretion on the amount to be recovered. **We agree with CMS' proposal to mitigate the impact of the ATRA payment cut on hospitals by reducing payment rates by 0.8 percent each year. The agency's proposal has provided hospitals with additional time to manage these sizeable cuts.**

In the FY 2013 inpatient prospective payment system (PPS) rulemaking cycle, CMS proposed a prospective cut of 0.8 percent related to hospitals' documentation and coding in FY 2010. CMS did not finalize this cut, indicating that it would further analyze hospitals' assertion that the 0.8 percent figure was overstated – an assertion which the Medicare Payment Advisory Commission (MedPAC) believed had merit. In this FY 2014 proposed rule, CMS agrees with previous comments from CHA and other hospital associations that the 0.8 percent figure is overstated and it states that a prospective reduction of 0.55 percent would be more appropriate. The proposed rule solicits comments concerning whether any portion of the 0.8 percent proposed recoupment should be applied on a prospective basis to satisfy the prospective adjustment of 0.55. CMS notes that doing so would require relatively larger recoupment adjustments for FYs 2015, 2016 and 2017, but would eliminate the need for a future prospective adjustment.

While CHA appreciates the agency's acknowledgement that its proposal to make a documentation and coding cut of 0.8 percent in FY 2013 was overstated, as we previously noted, we are troubled that CMS continues to compare hospitals' documentation and coding practices in FY 2010 to their documentation and coding practices under an entirely different system in FY 2007. We also are concerned that necessitating larger adjustments in the future would be contrary to the agency's stated goal of mitigating extreme annual fluctuations in payment rates. **For these reasons, we urge CMS not to apply any portion of the 0.8 percent proposed recoupment on a prospective basis.**

In addition, our previous assertion that CMS's coding cuts are overstated is not limited to the 0.8 percent cut related to FY 2010 – it also applies to cuts the agency made related to FYs 2008 and 2009. CMS made one-time payment cuts of 5.8 percent to recoup what it stated were overpayments made in FYs 2008 and 2009. We note that MedPAC found that CMS could have overstated the size of required retrospective adjustment for FYs 2008 and 2009 by 0.36 percent and also overstated the size of required prospective adjustment stemming from FYs 2008 and 2009 by the same 0.36 percent, for a combined overstatement of 0.72 percent. In our comments on the FY 2013 proposed rule, CHA strongly urged CMS to apply a correction adjustment for these overstated payment reductions**. We continue to believe that CMS should correct its previous over-adjustments by implementing a one-time increase to inpatient payment**

rates. This correction of 0.72 percent should be applied to any prospective adjustment that CMS decides to make for documentation and coding occurring in FY 2010.

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

In the FY 2013 Medicare Outpatient Prospective Payment System (OPPS) proposed rule, CMS invited public input on the difficult issues arising under current policies regarding Medicare coverage and inpatient versus outpatient status. In its comments, CHA stated that it is concerned about both uncertainty faced by hospitals and the negative effects on beneficiaries related to the increasing treatment of beneficiaries as outpatients receiving observation services for longer periods of time in lieu of admitting them. We noted that the decision whether or not to admit a patient rests with the patient's physician, who is most familiar with the patient's condition and medical needs and who possesses the training, knowledge and experience required to make complex medical judgments. This view is included in the Medicare benefit policy manual and we are pleased that CMS repeats it in the preamble of the proposed rule:

> *Our current manual instructions state that, typically, the decision to admit a beneficiary as an inpatient should be made within 24 to 48 hours of observation care, and that expectation of an overnight stay may be a factor in the admission decision (Section 20.6, Chapter 6 and Section 10, Chapter 1 of the Medicare Benefit Policy Manual (MBPM)). We state that physicians should use a 24-hour period as a benchmark, that is, they should order admission for patients who are expected to need hospital care for 24 hours or more, and treat other patients on an outpatient basis. We state that, generally, a beneficiary is considered an inpatient if formally admitted as an inpatient with the expectation that he or she will remain at least overnight, whether or not the beneficiary is later discharged or transferred and is not present overnight. Nevertheless, our longstanding policy consistently has been that we do not define or pay under Medicare Part A for inpatient admissions solely on the basis of the length of time the beneficiary actually spends in the hospital. Rather, we rely on the physician to use his or her clinical judgment and evaluation of the patient's needs to make the determination. We have stated in our manual guidance that the inpatient admission decision is a complex medical judgment that should take into consideration many factors, such as the patient's medical history and medical needs, the types of facilities available to inpatients and outpatients, the hospital's bylaws and admission policies, the relative appropriateness of treatment in each setting, patient risk of an adverse event, and other factors described in the MBPM provisions. The physician or other practitioner responsible for a patient's care at the hospital also is responsible for deciding whether the patient should be admitted as an inpatient.*

Increasingly, however, Medicare Administrative Contractors (MACs) and Recovery Audit Contractors (RACs) are questioning and auditing the clinical decisions made by physicians about the need for inpatient admission versus outpatient observation. Such after the fact second-

guessing fails to acknowledge the judgment made by the physician based on what was knowable at the time of the decision and has serious consequences for hospitals and patients. We believe that increased medical review combined with ambiguous criteria and guidelines are the major factors in the increase of observation services. Together they have created financial uncertainty for both hospitals and beneficiaries – and subjected both to additional financial burden.

In our comments on the 2013 OPPS proposed rule, CHA indicated that time-based admission policies may hold some promise, but that we are more skeptical of the appropriateness of using more specific clinical criteria and do not believe requiring prior authorization for admissions is a fruitful area of pursuit. We continue to hold these views. We also encouraged adoption of these principles:

- 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
- Hospitals should receive fair and adequate payment for the services they provide

CMS correctly identifies the need to improve clarity and consensus among the various stakeholders - hospitals, beneficiaries and program integrity and other contractors – on this issue with respect to inpatient admissions and appropriate Medicare payment while taking into account the impact of any changes on beneficiary liability, spending under the program and feasibility of implementation. We are pleased that CMS recently issued both a ruling and a proposed rule on Part B rebilling subsequent to a Part A inpatient denial, and that the IPPS proposed rule further addresses these issues**. CHA is very concerned, however, that the proposals taken together do not adequately address the current problems and will not reduce the use of observation services**.

We urge CMS to make these changes in the proposed policy:

- **Stipulate that the medical necessity of the admission will be sustained for cases satisfying the two midnight rule unless there is clear evidence of fraud and abuse. If providers remain vulnerable to RAC audits, even after the two midnight stay guideline is met, the policy will fall short of its goal.**

- **Clarify (or revise) the policy to clearly state that current policy essentially does not change for admissions failing to meet the two midnight guideline. That is, despite the fact these short-stay cases are likely candidates for medical review, the physician's decision to admit will not be overturned if the documentation in the medical record supports admission.**

- **Revise the time-based instructions to begin when a physician orders inpatient admission, not when the beneficiary is moved from any outpatient area to a bed in the hospital in which additional hospital services will be provided.**

- **Improve the situation for beneficiaries by revising program regulations so that observation services will count toward meeting the 3-day prior hospital stay requirement for Medicare coverage of skilled nursing facility care. This policy could apply to all observation services or just those which are provided within the 72-hour bundling window. We recognize that the 3-day requirement is statutory and cannot be waived, but CMS does have administrative discretion to specify how the rule will apply in these situations.**

CHA strongly opposes CMS' rare exercise of its general authority to provide for exceptions and adjustments to IPPS payments under section 1886(d)(5)(I)(i) of the Act to offset the additional costs of the proposed new admissions policies, which the agency estimates to be $220 million in FY 2014. CMS proposes to reduce the national standardized amount, the Puerto Rico-specific standardized amount and the hospital-specific rates by 0.2 percent.

CHA notes that there is no statutory requirement that CMS make budget neutrality adjustments for changes in coverage decisions or service volume. Moreover, applying budget neutrality to volume changes or coverage decisions would violate the fundamental structure and policy that have governed the IPPS since its inception in 1983. IPPS payments 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 has never made budget neutrality adjustments for these changes.

CMS' proposal is essentially a coverage decision, or a clarification of policy, that the agency believes would lead to a net increase of about 40,000 inpatient hospital admissions. Admissions would increase because hospital services would be covered under Part A if the physician expects that the beneficiary's length of stay will exceed a 2-midnight threshold or if the beneficiary requires a procedure specified as inpatient-only. We emphasize that the proposal would *not* increase payment rates for inpatient cases, which are made budget neutral as part of the annual rate adjustment process, but would only cause an increase in the volume of inpatient cases, which is not subject to budget neutrality.

In addition, we question CMS' projection that changes in inpatient volume will lead to a net increase in payments. The proposed rule merely asserts this conclusion and does not provide the assumptions and data behind it, thus denying our ability to review this critical element of the proposed policy. In addition, inquiries made of CMS were not successful in obtaining additional information. We note that many hospitals which have simulated the impact of the proposed policy are projecting that their payments will decrease if the policy is finalized. They believe that

the net effect of the changes will be a net decrease in Medicare payments for inpatient and outpatient services.

CHA strongly urges CMS not to use the general exceptions authority to impose an inappropriate budget neutrality requirement.

- **Disproportionate Share Hospitals (DSH)**

Medicare Advantage Patient Days: **CHA opposes the changes in the proposed rule to count Medicare Advantage (MA) patient days in the Medicare fraction of the DPP calculation.** Although the government has filed an appeal in the *Allina Health Services v. Sebelius* case in which the verdict was adverse to the government, the proposed rule seeks comment on the agency's proposal to readopt the policy of counting the days of patients enrolled in MA plans in the Medicare fraction of the DPP. We continue to oppose this policy because it would inappropriately reduce DSH payments. The *Allina* court rejected CMS's previous attempt at rulemaking on this issue in part because CMS failed to provide a reasoned explanation for its reversal of its previous position. The current rulemaking suffers from the same flaw. If CMS intends to pursue this policy change, it should fully provide its reasoning and allow stakeholder comment. If the new policy is ultimately implemented, either through adequate rulemaking or if plaintiffs continue to prevail in the Allina case, it must be applied prospectively only.

ACA Medicare DSH Reductions: The proposed rule also would implement the changes to DSH payments enacted by the Affordable Care Act (ACA). CHA is concerned about the DSH reductions required by law and urges CMS to implement them with utmost caution and using accurate data. **We are concerned that CMS is under-estimating the amount of DSH payments that would be made without the changes made by Section 3133 of the ACA.** That is, the agency is under-estimating the amount of payments that would be made under section 1886 (d)(5)(F) before the change in payments due to the addition of section 1886(r). The 25% portion of that payment, the so-called "empirically justified DSH," will adjust automatically and is subject to final reconciliation, but CMS proposes to determine the 75% portion of the payment in the final rule and will make no future adjustments. The amount of the 75% portion is Factor 1 of the Uncompensated Care portion of the DSH payment. Thus, to the extent that CMS under-estimates this factor, the uncompensated care payments to hospitals will be too low. The CMS projection of DSH appears out of line with the recent growth trend of DSH payments. We question whether the CMS estimate is consistent with the trend line and fully accounts for the impact of the ACA Medicaid expansion. Since CMS proposes that the uncompensated care factors will be fixed in the final rule and not subject to subsequent adjustment or reconciliation, any CMS under-estimate of DSH will reduce payments to hospitals inappropriately and contrary to the law.

We also believe CMS' proposed Factor 2 methodology to account for the change in the uninsured inappropriately inflates the DSH reduction. The problem arises because CMS is using

calendar year CBO estimates of the number of uninsured in a payment system tied to the federal fiscal year. Thus, under the CMS proposed methodology, DSH cuts based on increased insurance coverage would take place beginning October 1, 2013, three months before the coverage expansions even begin to occur on January 1, 2014. We urge CMS to use a weighted average to blend the CBO estimates for the parts of the two separate calendar years that are part of FY 2014. This would lead to a larger Factor 2 number, which when applied to the 75 percent pool would decrease the Medicare DSH reduction by about $500 million.

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, but we urge that this be temporary and that CMS work with hospitals to improve the completeness and accuracy of these data. We recommend setting a timetable for using S-10 data and phasing in such use by blending S-10 data and the proposed proxy with a gradually increasing share based on S-10. Establishing a timetable would set expectations and encourage hospitals to work with CMS to improve these data.

CHA does not support the proposed method for payment of the DSH uncompensated care payment as periodic interim payments rather than on a per discharge basis through the PRICER. CMS' proposal not to make these payments through the PRICER would affect the rates on which Medicare Advantage (MA) plans often base their payments. We are concerned that this will dramatically reduce payments to hospitals including many safety net hospitals. If this policy were scheduled to begin in a few years, the facilities would be able to consider this in their contract negotiations, but this cannot be accomplished to affect the FY 3014 MA contracts. This unintended and unexpected decline in revenue is very concerning.

We urge CMS to make the DSH uncompensated care payments (DSH UC) through the PRICER. A fixed per discharge amount could be determined for each hospital based on its total DSH uncompensated care payment and the projected number of discharges for the year. To the extent that a hospital's actual volume differs from projected volume, payments would be adjusted at the time cost report settlement. (Note that CHA is not proposing that the total DSH UC payment determined in the final rule be reconciled, but rather just the amount paid out so that the actual number of discharges are reflected.) We believe that this method of payment is more consistent with the statute because DSH UC payments are DSH payments under section 1886 (d)(5)(F). As such, we believe that they must be considered in determining each case's outlier payment and are concerned that CMS' proposal appears at odds with the law.

If CMS finalizes it proposal to make periodic interim payments for DSH UC, we urge the agency to alter the PRICER similarly to how it deals with IME where there is an additional line to net it out on the PRICER. For DSH, it could have an additional line with a factor to gross up the payments. Thus, CMS should pay uncompensated care on a per-discharge basis, or if not, alter the PRICER to include the estimated uncompensated care payments to ensure interim rates are more accurate.

- **Hospital Readmissions Reduction Program.**

The FY 2014 proposed rule extends the readmissions reduction program to three additional conditions: chronic obstructive pulmonary disease (COPD), total knee arthroplasty and total hip arthroplasty. **CHA supports the inclusion of the hip and knee procedures but opposes addition of COPD.** We understand CMS' rationale for recommending COPD, but we are concerned that this condition could be susceptible to unintended consequences. If hospitals focus on keeping patients with COPD out of the hospital, some patients may return in such serious condition that they are costlier and a greater mortality risk. In its June 2013 report to Congress, MedPAC has expressed concern about a potential relationship between the heart failure readmissions and mortality measures – specifically, these measures have a negative correlation meaning that decreasing heart failure readmissions rates are correlated with increasing heart failure mortality rates.

We also note that COPD is a condition that is sensitive to environmental factors (e.g. weather patterns, pollen counts, pollution etc.) that are very clearly outside the control of the providers and differ geographically. Exacerbations of the condition can be related to the patients' socio-economic status (e.g. availability of air conditioning, exposure to cigarette smoke, ability to purchase hypoallergenic bedding etc.). For all of these reasons, we urge CMS not to include COPD in the readmissions reduction program.

In our comments on the FY 2013 proposed rule, we stated that we did not believe CMS had met the statutory requirements concerning excluded readmissions. The AMI measure included a limited set of exclusions, but the HF and PN measures had none. **CHA is pleased that the FY 2014 proposed rule excludes certain planned readmissions and we support this change**. **We also urge CMS to work with the physician and hospital communities to identify other planned readmissions that should be excluded. In addition, admissions unrelated to the prior hospital stay, including for example admissions for chemotherapy, trauma, burns, end stage renal disease, maternity, and substance abuse should always be excluded because, by their nature, they are not preventable readmissions.**

CHA also is concerned that CMS' methodology for risk-adjusting the readmissions measures is inadequate and would disadvantage 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 currently included in the NQF-endorsed 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 also have an impact on health outcomes.** Absent these adjustment factors, the readmissions reduction program may disproportionately affect hospitals serving a large number of minorities, and by penalizing these hospitals, the program could in turn disproportionately harm minority patients.

The FY 2013 proposed rule included an erroneous table showing the projected impact of the readmissions reduction program by decile of disproportionate share (DSH) patient percentage. Errors in the CMS table masked the relationship wherein hospitals with the highest levels of low income patients have higher readmissions rates and thus experience greater reductions under the program. A corrected table would have shown that a relationship did exist, as CHA and other commenters noted, but CMS did not correct the table in the FY 2013 final rule or in the proposed FY 2014 rule. MedPAC has recently expressed concerned about this issue and in its June 2013 report to Congress discusses a stratification approach similar to what hospital groups recommended last year:

> *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—it would not be adjusted for SES and thus disparities would not be masked. However, when computing penalties, each hospital's target readmission rate would be based on the performance of hospitals with a similar patient profile. (page 108, 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 subject to comment if necessary – that is, as an interim final rule. An adjustment of this nature should be adopted for FY 2014 while CMS works to improve the risk-adjustment methodology.

- **Labor and Delivery Beds in Direct Graduate Medical Education Payments**

CHA does not support the proposal to include labor and delivery beds in the count of available beds used in the direct graduate medical education (GME) calculation. While we acknowledge CMS' general practice of treating the counting of beds and patient days similarly, we believe labor and delivery services should be an exception, as is the case with healthy newborn nursery services. This differentiation is justified because Medicare does not generally pay for women undergoing labor and delivery services.

We do not object to the inclusion of labor and delivery patient days in the calculation of the Medicare DSH formula because the DSH Patient Percentage (DPP) is greatly dependent upon Medicaid inpatient days and Medicaid covers a large portion of labor and delivery services. Given the large percentage of Medicaid births, and the fact that the DSH percentage is based on Medicaid patient days, it is sensible to include labor and delivery patient days in the DSH calculation.

However the inclusion of labor and delivery beds in the calculation of the Medicare GME and IME formulas is a different matter. Theses formulas are based on a hospital's ratio of residents-

to-beds. Including labor and delivery beds in them is unreasonable, because Medicare pays for less than 1 percent of all births. We urge CMS not to make the proposed change to the GME allocation formula. In our FY 2013 comments, we opposed including labor and delivery beds in IME, but we supported the DSH change. For IME, we urge CMS to return to the policy established in the FY 2010 final rule, including labor and delivery patient days in the DSH calculation and but excluding labor and delivery beds from the GME and IME calculations.

In last year's proposed IPPS rule, CMS estimated the IME reduction in payments at $170 million and the current proposed rule would cut additional $15 million from teaching hospitals. The lost revenue and impact of these reductions builds the longer they remain in place. The put teaching hospitals and patient care at risk at a time when many teaching hospitals are already struggling.

- **Refinement of Relative Weight Calculation**

The proposed rule increases the number of cost to charge ratios (CCRs) used to convert charges to cost from the current 15 to 19 by adding new CCRs for Implantable Devices Charged to Patients, Computerized Tomography (CT), Magnetic Resonance Imaging (MRI), and Cardiac Catheterization. **CHA supports use of the new CCRs for implantable devices and cardiac catheterization but opposes using the CCRs for MRI and CT**. Due to the way that many hospitals report and allocate (for example, by square footage) the cost of expensive equipment, the data used to calculate these CCRs do not capture all of the equipment cost of these imaging services. That is, not all of the costs of the equipment are reported in the relevant cost center but are spread across other cost centers. This causes the CCRs to be unrepresentative and lead to seriously underestimated costs for these services. We urge CMS to examine the resulting costs and consider whether they appear credible. Because the costs of these expensive imaging services are calculated to be about the same as a simple x-ray of the comparable body area, we think CMS should determine that the results are not credible and reject using these CCRs. We urge CMS not to change the CCR used for these services and to work with hospitals to improve how the costs of the relevant equipment is reported on the cost report so that the more detailed CCRs might be used in the future.

CHA notes that the new CCRs would significantly reduce the payment for many DRGs in which imaging is used, and many of these DRGs are used for trauma patients. We are concerned about the impact of the change on the nation's trauma centers. We also are very concerned that the negative impact of this policy in the IPPS would be magnified greatly if this policy were adopted for the outpatient prospective payment system (OPPS) where each service is priced separately rather that highly bundled as in the IPPS. In addition, reductions in the OPPS rates would carry over to physician office and free-standing imaging services due to the cap established by the Deficit Reduction Act (DRA).

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

CHA supports the proposed removal of three measures from the VBP program beginning with the FY 2016 payment. The measures PN-3b "Blood culture performed before first antibiotic received in hospital" and HF-1 "Discharge planning" are no longer NQF endorsed and have been recommended for removal by the Measure Application Partnership. CMS reports that the measure AMI-8 "Primary PCI received within 90 minutes of hospital arrival" is "topped out." CHA agrees that topped out measures should be removed from the VBP program so that the program focuses on measures where there is room for improvement and where meaningful distinctions in hospital performance can be made.

CHA does not support the domain weights proposed for FY 2016. First, while we support the concept of an efficiency domain we continue to believe that the Medicare spending per beneficiary measure, which is not yet NQF endorsed, is not an appropriate 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 (3 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. In addition, this measure, and the risk-adjusted 30-day readmissions and mortality measures, should be adjusted for appropriate demographic and socioeconomic factors including age, sex, race and severity of illness.

CHA agrees that the VBP should move in the direction of focusing more on outcomes. However, the proposed 40% weight for the outcome domain is much too high given the limitations of the current outcome measures. As discussed above we believe that the risk adjustment for the mortality measures is insufficient, and the claims-based AHRQ PSI measures are not reliable for payment purposes. Moreover, while the proposed reduction in the patient experience of care domain weight from 30% to 25% is moving in the correct direction, we believe this level is still too high given the evidence that patients who are sicker, have longer stays and those with depression symptoms correlate with lower HCAHPS scores. Finally, we believe that the proposed weight of 10% for the clinical process of care measures understates their importance in light of the limitations of the outcomes measures.

CMS proposes to restructure of the domains for FY 2017 and later to better align with the National Quality Strategy (NQS). Measures in the current four domains would be remapped into five domains. CHA supports the NQS and appreciates the value of constructing VBP Program domains that parallel system-wide quality improvement goals. In particular, we believe that hospitals have an important role to play in promoting improvements to community and population health. It appears that CMS intends to continue separate scoring of the outcomes (mortality) and process of care domains within a broader clinical care domain label, and if so, the proposed restructuring would seem to have a relatively small effect on a hospital VBP scores.

Given our concerns about the weighting of the current domains, CHA believes that at this stage of the VBP program it is most important that CMS address the appropriate weighting of the domains, and the selection and proper risk adjustment of the measures contained within them. Moving forward with restructuring of the domains should be given low priority at this time.

CHA supports the proposed addition of a VBP waiver application process for hospitals that have experienced a natural disaster or other extraordinary circumstances beyond their control. A hospital in such circumstances can already apply for a waiver of data submission deadlines under the inpatient quality reporting program (IQR), but CMS correctly points out that some hospitals may be able to meeting reporting deadlines but would have their quality performance negatively affected as a result of the disaster or other extraordinary circumstances. The proposed policy would ensure that these hospitals would not be penalized under the VBP program for poor performance for reasons outside their control.

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

CHA recognizes that CMS must implement section 3008 of the Affordable Care Act, which requires that, beginning in FY 2015, one-fourth of IPPS hospitals will receive a 1% reduction in DRG payments each year based on performance related to HACs. We believe this policy is too blunt an instrument to succeed as a quality improvement tool, as by its design some hospitals will be inequitably penalized. Further, it is duplicative of the VBP program, which is designed to reward improvement as well as achievement on quality measures, including HACs, using a continuous scoring scale rather than the bright penalty line drawn in the HAC Reduction Program. Despite these strong objections to the HAC Reduction Program, we recognize that CMS must propose a program within the statutory constraints.

The measures proposed for use in HAC Reduction Program include Agency for Healthcare Research and Quality (AHRQ) patient safety indicators (PSIs) and healthcare associated infection measures reported by hospitals through the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN). Most of these measures are used or proposed for use in the VBP program or are part of the existing preventable HACs payment adjustment policy. CHA is very concerned about this overlap. As CMS' proposal stands, a single event could contribute to lower reimbursement for the case, a penalty under VBP and a HAC reduction penalty. CMS should do everything possible to minimize measure overlap among the three programs.

CHA recommends that the final rule give less weight to AHRQ PSI measures rather than the proposed 50% weighting. In general, CHA has concerns about relying too heavily on the AHRQ PSIs for the HAC Reduction Program, or for any other payment program, including the VBP program. These measures were not developed for use in hospital payment and 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 these measures are calculated using older data and reported only annually and therefore have very limited use for hospital quality improvement activities. For example, the performance data on the AHRQ PSI measures that is currently available on *Hospital Compare* is for the period July 1, 2009 through June 30, 2011.

- **Inpatient Quality Reporting (IQR) Program**

CHA supports the proposed removal of eight measures from the IQR program beginning with the FY 2016 payment determination. It is important that measures included in the IQR program be valid in assessing hospital performance on important quality indicators, and useful to patients and the public. Two of the measures proposed for removal are no longer NQF endorsed, four are topped out or recommended for removal by the MAP, and one (immunization for pneumonia) does not reflect the most recent clinical guidelines. We agree that the participation in the stroke registry is not necessary, and suggest that CMS reconsider the usefulness of continuing to include all the other registry participation measures.

CHA also supports the proposed modifications of existing measures. **In particular, we believe the readmission measures are strengthened by the addition of the planned readmission algorithm**. However, as discussed earlier we continue to believe that the risk adjustment used for these measures and others (mortality, Medicare spending per beneficiary) should be further improved to reflect demographic and socioeconomic factors. Expanding the CLABSI and CAUTI measures to include medical and surgical wards as well as ICUs will increase the reporting burden on hospitals and on NSHN systems, and we urge CMS to take the time to gain experience with these expanded measures in the IQR program before hospital performance on the expanded measures is applied for payment purposes in the VBP and HAC Reduction programs.

CHA does not support the addition of the measures proposed for 2016. The mortality and readmission measures for acute ischemic stroke have not been NQF endorsed or MAP supported**.** It is important that all measures proposed for addition to the IQR program have subjected to the rigors of the NQF evaluation process and found to be qualified for endorsement before they are used in public reporting. We are concerned that stroke severity and socioeconomic status are not included in the risk adjustment for these measures, and that unrelated readmissions are not excluded from the readmission measure.

Similarly, the proposed measure of Medicare payment associated with a 30-day episode of care for heart attack patients is not NQF endorsed, suffers from the same risk adjustment limitations as the existing risk-adjusted measures, and should not be added to the IQR program measure set. CHA has further concerns about this proposed measure because, like the overall Medicare spending per beneficiary measure, it assumes that hospitals have control over Medicare spending for services outside the inpatient stay than is realistic. It would not make sense to add a measure

of Medicare spending that essentially duplicates the heart attack readmission measure and additionally reflects cost variation that the hospital cannot control.

CHA agrees that it is appropriate to focus on quality improvements with respect to COPD and acknowledges that the readmission and mortality measures related to COPD are NQF endorsed. However, we have similar concerns here as with the stroke measures. In particular, the continued addition of readmissions measures to reporting and payment penalty programs with insufficient attention to unintended consequences for safety net hospitals and the people they serve is very troubling. We believe these measures are not yet ready for addition to the IQR and urge CMS instead to continue to refine them.

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 allowing hospitals to voluntarily report electronically on a specific subset of 16 IQR measures and use this report to satisfy the reporting requirement for the Incentive Program. It is very important, however, that, CMS proceed as proposed to exclude the electronically-reported data from public reporting on *Hospital Compare*. It would not be fair to compare results for hospitals reporting on chart-abstracted and electronic versions of the same measure.

In closing, thank you for the opportunity to share these comments in regard to the proposed FY 2014 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