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Ms. Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Ref: CMS-1588-P: Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems (IPPS) for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Fiscal Year 2013 Rates

Dear Ms. Tavenner,

The National Association of Public Hospitals and Health Systems (NAPH) appreciates the opportunity to submit comments on the above-captioned proposed rule. While we thank the Centers for Medicare & Medicaid Services (CMS) for working to develop incentives that promote high-quality care, certain proposals will have a disproportionate negative financial impact on safety net hospitals due to the patient populations they serve. To this end, NAPH asks CMS to consider the unique challenges inherent in caring for our nation's most vulnerable patient populations when finalizing this rule.

NAPH represents the nation's major metropolitan-area safety net hospitals and health systems, which provide access to high-quality health care for all patients regardless of ability to pay. Our members predominantly serve patients covered by public programs and the uninsured—25 percent of the inpatient services provided by NAPH members are to Medicare beneficiaries, another 36 percent are to Medicaid recipients, and 18 percent are to uninsured patients.[1]

NAPH members play a vital role in their respective communities, averaging 2.9 times as many inpatient admissions as the hospital industry average. Many also provide specialized inpatient and emergency services not available elsewhere, such as trauma care, burn care, and neonatal intensive care. In the 10 largest U.S. cities, NAPH members operate 37 percent of all level I trauma centers and 57 percent of all burn-care beds.[2] Our members' ability to continue to provide

[1] Obaid Zaman, L. Cummings, and S. Laycox, "America's Safety Net Hospitals and Health Systems, 2010: Results of the Annual NAPH Hospital Characteristics Survey," National Association of Public Hospitals and Health Systems, May 2012, http://www.naph.org/Main-Menu-Category/Publications/Safety-Net-Financing/2010-NAPH-Characteristics-Report.aspx?FT=.pdf
[2] Ibid.

these important services for their communities and invest in improved care delivery depends on adequate Medicare reimbursement for the low-income Medicare patient populations they serve.

NAPH members' limited resources have propelled them to find increasingly efficient strategies for serving these low-income, vulnerable Medicare patients who have complex medical needs. Their commitment to providing high-quality care and eliminating health care disparities has proven crucial to their success. In fact, of the NAPH members who responded to a recent quality of care survey, 100 percent confirmed that they have a hospitalwide standing committee that oversees quality improvement activities and have developed plans to improve specific quality measures, including targeted plans to reduce and eliminate racial and ethnic health care disparities related to performance on Medicare Inpatient Quality Reporting (IQR) program measures.

NAPH members also recognize that physician alignment and leadership engagement are integral components of achieving real improvements in quality of care. The same quality of care survey found that almost 90 percent of respondents share quality performance data, including IQR data, with their physicians, and 80 percent engage their board of directors in quality improvement activities. Through these efforts, NAPH members have been able to effectively utilize their limited resources to provide high-quality care for the most vulnerable patients in their communities.

This commitment to quality improvement is not new. NAPH members have been leaders in quality improvement for decades. In fact, many innovations that have been proven to reduce preventable readmissions throughout the nation were first pioneered at NAPH hospitals. Two examples are Boston Medical Center's Project Re-Engineered Discharge (Project RED) and Wishard Health Services' Geriatric Resources for Assessment and Care of Elders (GRACE). In randomized controlled trials, Project RED led to a 30 percent reduction in 30-day readmission rates, and GRACE saved $1,500 per enrollee by reducing readmissions and unnecessary emergency department (ED) visits among high-risk, low-income populations.[3] [4]

In addition, as part of their quality improvement goals, some NAPH members were very early adopters of health information technology (HIT) and have been using it for decades. Overall, NAPH members are working diligently to become meaningful users of EHRs by investing in HIT. A recent NAPH HIT survey found that all members are participating or plan to participate in the Medicaid EHR Incentive Program, and all but one plan to participate in the Medicare EHR Incentive Program.[5] This level of participation is higher than the 74 percent of all hospitals nationally that plan to participate in an EHR incentive program.[6]

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[3] Brian Jack and Timothy Bickmore, "The Re-Engineered Hospital Discharge Program to Decrease Rehospitalization," *Care Management*, December 2010/January 2011: 12-15, http://www.bu.edu/fammed/projectred/publications/CMdec2010jan2011.pdf

[4] Christina Bielaszka-DuVernay, "The 'GRACE' Model: In-Home Assessments Lead To Better Care For Dual Eligibles," *Health Affairs*, Vol. 30, No. 3: 3431-3434 (March 2011), http://content.healthaffairs.org/content/30/3/431.short

[5] "Health Information Technology and the Safety Net," National Association of Public Hospitals and Health Systems Issue Brief, May 2012, http://www.naph.org/Links/POL/HIT-and-SN-Issue-Brief.aspx

[6] Ashish K. Jha, M. F. Burke, C. DesRoches, M. S. Joshi, P. D. Kralovec, E. G. Campbell, and M. B. Buntin, "Progress Toward Meaningful Use: Hospitals' Adoption of Electronic Health Records," *The American Journal of Managed Care*, Volume 17 (12 Spec No.): SP117-SP124 (Dec. 2011), http://www.ajmc.com/publications/issue/2011/2011-12-vol17-SP/Progress-Toward-Meaningful-Use-Hospitalsu2019-Adoption-of-Electronic-Health-Records

To build on these successful efforts, NAPH is partnering with CMS as one of the hospital engagement networks (HENs) funded through CMS' Partnership for Patients, a national initiative that aims to reduce preventable hospital-acquired conditions by 40 percent and preventable readmissions by 20 percent by 2013. As part of the NAPH Safety Network (NSN), NAPH hospitals are contributing to a potential savings of up to $35 billion across the health care system, including up to $10 billion in Medicare savings.[7] And, in addition to achieving the HEN-related patient safety and quality improvement goals, the NSN will focus on collecting and understanding differences in race, ethnicity, and language (R/E/L) collection in an effort to improve the uniformity and breadth of national R/E/L data collection standards. NAPH members see an average of 58 percent racial or ethnic minorities in their hospitals, and more than 100 languages are spoken by their patients.[8] Collecting and analyzing these demographic figures will go far in helping to eliminate disparities in care.

To ensure safety net hospitals have sufficient resources to continue to engage in robust quality improvement activities and are not unfairly disadvantaged for serving the most vulnerable among us, CMS should consider the following comments when finalizing the above-mentioned proposed rule.

1. <u>CMS should retain the existing definition of disproportionate share hospital (DSH) and indirect medical education (IME) bed days.</u>

In the final rule, CMS should not include labor and delivery bed days in the DSH and IME calculations. Starting in federal fiscal year (FFY) 2013, CMS proposes to include labor and delivery bed days in the DSH and IME calculations. This proposal is inconsistent with a long-standing CMS policy to exclude these bed days from DSH and IME calculations. In fact, in the FFY 2004 IPPS final rule, CMS explicitly excluded the bed days associated with healthy newborns from inpatient calculations related to Medicare DSH and IME payments.[9] Because Medicare does not usually cover health care services for infants, CMS explained that bed days associated with healthy newborn services should not be directly included in calculations of Medicare inpatient care costs. Therefore, it is also inappropriate to include healthy newborn bed days when calculating Medicare DSH and IME payments.[10] NAPH agrees with this rationale and believes the same logic applies to labor and delivery bed days, which are directly associated with healthy newborn days and also not usually covered by Medicare.

Further, labor and delivery bed days should continue to be treated differently than labor and delivery patient days. Since FFY 2010, labor and delivery patient days – which are attributable to the patient, not to the service associated with a particular acute care unit bed – have been included in the DSH calculation. As CMS stated in its FFY 2010 IPPS final rule, labor and delivery bed days often include various services for mothers and their newborns. While some of

[7] "Partnership for Patients: Better Care, Lower Costs," HealthCare.gov (a federal government website managed by the U.S. Department of Health & Human Services), posted: April 12, 2011, last updated: December 14, 2011, http://www.healthcare.gov/compare/partnership-for-patients/index.html

[8] Obaid Zaman, L. Cummings, and S. Laycox, "America's Safety Net Hospitals and Health Systems, 2010: Results of the Annual NAPH Hospital Characteristics Survey," National Association of Public Hospitals and Health Systems, May 2012, http://www.naph.org/Main-Menu-Category/Publications/Safety-Net-Financing/2010-NAPH-Characteristics-Report.aspx?FT=.pdf

[9] 68 *Federal Register*. 45415-45419 (Aug. 1, 2003).

[10] Ibid.

these services can be considered routine adult inpatient care and therefore associated with Medicare inpatient costs (e.g., postpartum services), other services, such as labor and delivery, are not.[11] Therefore, it is appropriate to exclude these bed days from DSH and IME calculations. This rationale remains valid and should apply to the current proposed rule.

For these reasons, CMS should remain consistent with its long-standing policy rationale and continue to exclude labor and delivery bed days in its DSH and IME calculations.

2. CMS should not implement a readmission adjustment policy that could threaten access to care for vulnerable patient populations.

In order to preserve access to care for our nation's most vulnerable patient populations, CMS should not implement a readmission adjustment policy that penalizes hospitals (i.e., reduces payments) for higher excess readmission ratios without sufficient risk adjustment. NAPH believes that the currently proposed readmission adjustment risk-adjustment methodology does not fully take into account all demographic and socioeconomic factors associated with excess readmissions. CMS' readmission adjustment policy applies a readmission adjustment penalty to a hospital's diagnosis-related group (DRG) base operating payments to account for excess readmissions. CMS proposes, as specified in the Affordable Care Act (ACA), that the *readmission adjustment factor*, which is used to determine the amount of the penalty, should be equal to the greater of:

(1) 1 minus the ratio of aggregate payments for excess readmissions and aggregate payments for all discharges, or
(2) The floor adjustment factor specified in the ACA—i.e., 0.99 for FFY 2013, 0.98 for FFY 2014, and 0.97 for FFY 2015.

However, this formula and the quality measures to be used for the program fail to adjust for demographic and socioeconomic factors such as race, ethnicity, language, income, education, health literacy, insurance status, functional status, postdischarge care support structure, and access to primary care. By overlooking these crucial factors, the readmissions reduction program will disproportionately penalize safety net providers who treat populations who are more likely to be readmitted regardless of the quality of care they receive. In particular, race and insurance status have been demonstrated to increase the risk of readmission. For example, a study in the *Journal of the American Medical Association* analyzed 30-day readmission rates for acute myocardial infarction (AMI), heart failure (HF), and pneumonia (PN), and concluded that African American patients are more likely to be readmitted than white patients.[12] Appropriate risk adjustment is critical to ensuring readmission measures account for real differences in quality and care coordination, rather than penalizing hospitals for factors unrelated to readmissions and beyond providers' control.

[11] 74 *Federal Register*.43899-43901 (Aug. 27, 2009).
[12] Karen E. Joynt, E. J. Oray, and A. K. Jha, "Thirty-Day Readmission Rates for Medicare Beneficiaries by Race and Site of Care," *Journal of the American Medical Association*, Vol. 305, No. 7: 675–681 (February 16, 2011).

In a recent NAPH survey, the majority of NAPH members indicated that homelessness was a significant driver of readmissions at their hospital. In fact, one member recently discovered that the only significant predictor for readmissions at its hospital was homelessness. Two other NAPH members also recently did studies of unplanned readmissions to their hospitals and discovered that the primary driver of readmissions was patients who could not provide a phone number to hospital staff. In addition, around half of our members who stratified their readmission data by socioeconomic factors have found disparities by health literacy and for patients who lacked access to primary care follow-up in their neighborhoods.[13]

In addition, CMS' Hospital Compare data show that safety net hospitals are achieving lower mortality rates than the national average while patients are in the hospital, which means their higher readmission rates may be in part due to socioeconomic and social support factors in their patients' communities rather than to the quality of care provided by the hospital. These socioeconomic and community factors are largely outside of the hospital's control. For example, while only 8 percent of NAPH members perform better than the national average on the HF excess readmission ratio, 68 percent of NAPH members perform better than the national average on HF 30-day mortality rates. High readmission rates can often be the result of lower mortality rates and good access to inpatient hospital care.[14] When this is the case, hospitals should not be punished.

One way to represent differences in hospital patient populations is the disproportionate patient percentage (DPP), which includes the number of low-income Medicare and Medicaid patients a hospital sees. NAPH's analysis of hospital readmission statistics by DPP shows that for all three readmission conditions, high DPP hospitals (i.e., hospitals with a DPP in the top 50th percentile) had higher excess readmission ratios on average than low DPP hospitals. For example, for HF patients, hospitals with a DPP higher than the median hospital nationally had a .958 HF excess readmission ratio, compared to a .823 HF excess readmission ratio for hospitals with a DPP lower than the national median. Therefore, hospitals that care for a large number of low-income Medicare and Medicaid patients are more likely to have a higher excess readmission ratio, leading to a higher readmission adjustment factor and larger penalties.

As safety net hospitals typically have a high DPP, a disproportionate number of them are also likely to receive the maximum 1 percent readmission adjustment penalty in FFY 2013. Using CMS' FFY 2013 IPPS data set, NAPH found that 18 percent of hospitals with the highest DPP (i.e., hospitals with a DPP in the top 10th percentile) will be subject to the maximum 1 percent payment penalty in FFY 2013 compared to only 11 percent of hospitals with the lowest DPP (i.e., hospitals with a DPP in the bottom 10th percentile). This full 1 percent negative payment adjustment will be very challenging to overcome for providers with extremely thin margins.

Because safety net hospitals receive insufficient reimbursement for Medicaid and uninsured patients, many of them rely on their Medicare financial margins to stay afloat. Further cuts to reimbursement will threaten existing low-margin safety net services and threaten access to care for our nation's most vulnerable patient populations. For example, faced with readmission

[13] "NAPH Members Focus on Reducing Readmissions," National Association of Public Hospitals and Health Systems Data Brief, June 2011, http://www.naph.org/Main-Menu-Category/Publications/Quality/NAPH-Members-Focus-on-Reducing-Readmissions.aspx?FT=.pdf
[14] Ibid.

penalties, some safety net hospitals may be forced to eliminate ancillary services such as interpretive services, medical transportation, social work, patient navigation, and financial counseling for which they are poorly reimbursed. This would severely reduce access to care for many vulnerable patient populations. Again using CMS' FFY 2013 IPPS data set, NAPH found that 24 percent of our members will be subject to the full 1 percent floor adjustment in FFY 2013, compared with only 14 percent of non-NAPH members. As the maximum penalty increases to 2 percent in FFY 2014 and 3 percent in FFY 2015, the negative financial impact for these safety net hospitals will become even more severe.

Finally, because CMS must use the language included in the ACA, the agency will be applying the *excess* readmission ratio to all admissions, rather than to just the *re*admissions. According to the proposed rule, for each condition (e.g., AMI, HF, and PN), payments for excess readmissions would be determined by multiplying the number of admissions, the DRG payment per admission, and the excess readmission ratio. Applying the excess readmission ratio to all admissions will create unwarranted excess penalties for hospitals. Since CMS cannot change what is stipulated in the ACA, the agency should incorporate more sufficient risk adjustment to temper its readmissions policy, which will otherwise result in unwarranted excess penalties for hospitals.

For these reasons, in order to preserve access to care for our nation's most vulnerable patient populations, CMS should not implement a readmission adjustment policy that penalizes hospitals for higher excess readmissions without sufficient risk adjustment.

3. <u>CMS should not implement any new hospital value-based purchasing (VBP) program measures that do not properly risk adjust or have adequate performance periods.</u>

CMS should develop and validate risk-adjustment methodologies before adding new measures and new domains to the VBP program. The VPB program rewards acute care hospitals with incentive payments for the quality of care they provide to Medicare patients. The program currently evaluates hospitals' performance on quality-based measures in three domains – clinical process of care, patient experience of care, and outcomes. The VBP program is funded through a reduction in DRG base operating payments for each hospital discharge. This reduction will be 1 percent in FFY 2013 and will increase in later years. Hospitals will have a chance to earn back the reduction, plus additional incentives, based on their performance relative to other hospitals.

However, the patient mix at all hospitals nationwide varies greatly. Those hospitals that see a large number of low-income, vulnerable populations will be negatively impacted by measures that aren't appropriately risk adjusted before implementation. Using existing performance periods and risk-adjustment methodologies, NAPH found that its members will on average earn back less in VBP incentives than the 1 percent initial reduction because of lower performance on Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) measures. The risk-adjustment methodology currently used for the HCAHPS survey does not adequately adjust for biases related to the use of emergency care and other specialized services that require patients to transfer to safety net providers outside of their communities. Many NAPH members provide burn, trauma, neonatal, behavioral health, and other specialized services that are otherwise

unavailable in their communities.[15] Since HCAHPS measures are not sufficiently risk adjusted for these factors, many NAPH members will be unfairly penalized for factors unrelated to the quality of care they provide.

Going forward, appropriate risk adjustment is critical to ensuring VBP incentive payments reward safety net hospitals for providing high-quality care, rather than penalizing them for patient mix, insurance status, hospital size, geography, and other factors unrelated to quality and beyond the control of providers. **For this reason, CMS should further risk adjust or delay inclusion for any VBP program measures that haven't been risk adjusted, including the proposed Medicare spending per beneficiary measure, the Agency for Health Research and Quality (AHRQ) patient safety composite (PSI) measure, and the central-line associated blood stream infection (CLABSI) measure.**

In addition, CMS should require performance periods of at least 1 year for all VBP program measures. CMS proposes the following performance periods for new VBP measures for the FFY 2015 program.

- Medicare spending per beneficiary measure (part of the newly proposed efficiency domain)—8-month performance period
- AHRQ PSI composite measure (part of the outcomes domain)—9-month performance period
- CLABSI measure (part of the outcomes domain)—11-month performance period
- AMI-10: statin prescribed at discharge measure (part of the clinical process of care domain)—9-month performance period

Shorter performance periods compromise the reliability and validity of the measures and may result in financial penalties that do not accurately reflect hospitals' comparative performance. For example, many health conditions are more prevalent during humid months and when the air is saturated with pollen. Without a full 12 months of data, both efficiency and outcome measures would be biased based on geographic location and climate as well as patient mix. During certain months of the year, patients with certain conditions such as chronic obstructive pulmonary disease will be more likely to need hospital care. Hospitals with a greater percentage of these patients would be penalized for serving their increased health needs. **For this reason, CMS should require performance periods of at least 1 year for all VBP program measures.**

More specific comments on the efficiency domain and its associated Medicare spending per beneficiary measure, the clinical process of care domain, the AHRQ PSI measure, and the CLABSI measure are included below.

a. <u>CMS should lower the initial weight for the new efficiency domain.</u>

CMS should lower the weight (e.g., to 5 percent) for the new efficiency domain to account for inadequate risk adjustment and an insufficient performance period. For FFY 2015, CMS is proposing a 20 percent weight for the new efficiency domain, which only has one

[15] Obaid Zaman, L. Cummings, and S. Laycox, "America's Safety Net Hospitals and Health Systems, 2010: Results of the Annual NAPH Hospital Characteristics Survey," National Association of Public Hospitals and Health Systems, May 2012, http://www.naph.org/Main-Menu-Category/Publications/Safety-Net-Financing/2010-NAPH-Characteristics-Report.aspx?FT=.pdf

measure – the new Medicare spending per beneficiary measure. However, CMS has not taken into account the effect of socioeconomic factors on providers' ability to perform on this measure, which represents the totality of this domain. Just as socioeconomic factors influence readmissions and other health outcomes, these factors also influence the range and intensity of services provided to Medicare patients – and thus the amount of Medicare spending per patient. For example, patients with less community support and access to primary care outside the safety net may delay medical treatment until they are very ill. In addition, many safety net hospitals are tertiary referral centers that receive high-acuity, high-cost patients referred by other hospitals. Therefore, CMS should lower the efficiency domain's initial weight to give hospitals, CMS, and quality experts more time to gain experience with the efficiency measure before there is a significant payment impact. During this time, CMS should also examine risk-adjustment methodologies and any unintended consequences associated with the measure, such as non–safety net hospitals referring more complex patients to safety net hospitals in greater numbers.

In addition, as mentioned above, performance periods that are shorter than a year compromise the reliability and validity of any measure. Because the Medicare spending per beneficiary has an initial 8-month performance period, the data is even more likely to provide an inaccurate comparison across hospitals.

Finally, as detailed below, giving a domain with only one measure, a 20 percent weight effectively gives that single measure much more weight – and therefore importance – than any other measure in the VPB program. **For these reasons, CMS should lower the weight of the efficiency domain for FFY 2015.**

b. <u>CMS should raise the proposed new weight for the clinical process of care domain.</u>

CMS should raise the weight (e.g., to 40 percent) of the clinical process of care domain for FFY 2015 to avoid any large fluctuations in hospitals' VBP scores. CMS proposes a 20 percent weight for the clinical process of care domain for FFY 2015. This domain has a 70 percent weight for FFY 2013 and a 45 percent weight for FFY 2014. While NAPH understands the shift to relatively lower process measure weights over a 3- to 5-year window, reducing the weight of this domain from 70 to 20 percent over a 2-year period is too drastic. Such drastic shifts could lead to great uncertainty about a hospital's VBP incentive payment. This type of payment uncertainty can be extremely challenging for a hospital's long-term strategic planning processes related to capital investment. For example, because of large fluctuations in Medicare payment, many hospitals may be reluctant to go forward with large capital projects, such as the expansion of outpatient indigent clinics in the community.

In general, domain weights should be proportional to the number of measures in the domain. Otherwise, CMS is implying that some measures are more important than others. For example, since the efficiency domain only has one measure, and CMS is proposing a 20 percent weight for that domain, that one measure would effectively have a 20 percent weight. On the other hand, since the clinical process of care domain has 13 measures, each measure would only have a 1.54 percent weight if the entire domain's weight is 20 percent (i.e., 20 percent divided by 13). In addition, the science of quality measurement has yet to determine how to effectively weigh different types of measures relative to others. Therefore, until there is evidence indicating

otherwise, since there are 12 more clinical process of care measures than the one efficiency measure, the clinical process of care measures should have a significantly higher collective weight than the efficiency measure.

For these reasons, CMS should raise the weight of the clinical process of care domain for FFY 2015.

c. CMS should eliminate the AHRQ PSI composite measure from the FFY 2015 VBP program.

CMS should exclude the AHRQ PSI composite measure from the final rule because the measure is unreliable, lacks sufficient exclusion criteria, is redundant, and has an insufficient performance period. CMS is proposing to include a composite measure of PSIs developed and maintained by AHRQ. However, according to a CMS-funded reliability analysis, this PSI composite measure is unreliable.[16] In addition, the administrative claims data used for this composite measure do not adequately capture the appropriate clinical information necessary to fully represent the quality of care provided at a hospital. Specifically, an inadequate number of exclusion criteria currently exist for these PSI indicators. Because claims data do not contain a sufficient amount of clinical information, many patients could be included in the numerator who would be appropriately excluded based on a review of their more-detailed clinical record.

Some redundancy also exists among some of the indicators included within the PSI composite measure and other measures included or proposed for the FFY 2015 VBP program. For example, there is some overlap between the National Healthcare Safety Network (NHSN) CLABSI measure and PSI-7, which is a component of the PSI composite measure. Further, there is a low correlation between the AHRQ PSI composite measure definitions for CLABSI, which are based on claims data, and the NHSN measure definitions for CLABSI, which are based on reportable lab data. Including both creates inconsistent patient safety definitions and duplicate reporting requirements for hospitals.

Finally, this new composite measure would have 9-month performance period, which, for reasons stated previously, would compromise its reliability and validity. **For these reasons, CMS should eliminate the AHRQ PSI composite measure from the final rule.**

d. CMS should delay finalizing the CLABSI measure from the FFY 2015 VBP program.

CMS should delay finalizing the CLABSI measure from the FFY 2015 VBP program until hospitals gain more experience reporting this measure. This measure assesses the rate of laboratory-confirmed cases of bloodstream infection or clinical sepsis among patients in the intensive care unit. The measure is reported through the Centers for Disease Control and Prevention's (CDC's) NHSN. However, some hospitals are currently having difficulty reporting this measure due to obstacles such as the significant amount of training and staff time required to

[16] Eric Schone, Mai Hubbard and David Jones, "Reporting Period and Reliability of AHRQ, CMS 30-day and HAC Quality Measures – Revised," Results of Reliability Analysis from Mathematica Policy Research, Quality Improvement Group Office of Clinical Standards & Quality, Centers for Medicare & Medicaid Services, November 18, 2011, http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/hospital-value-based-purchasing/Downloads/HVBP_Measure_Reliability-.pdf

collect and report this measure. Because of these challenges, all hospitals are not reporting the CLABSI measure to the CDC with the same level of accuracy. In addition, CMS has yet to complete any CLABSI validation testing. While validation testing has occurred at the state level, each state uses a slightly different validation methodology. Since not all hospitals in all states are reporting this data as completely as others, this measure will not accurately reflect real quality differences between hospitals and will not enable valid comparisons across different types of hospitals. In addition, since CLABSIs are so rare, any small deviations in reporting can mean profound differences in comparative performance between hospitals. Therefore, while it is appropriate for the CLABSI measure to be included in pay-for-reporting programs, it is not yet ready to be included in a pay-for-performance program.

In addition, this measure's proposed 11-month performance period would, for reasons stated previously, compromise the reliability and validity of the measure. **For these reasons, CMS should delay finalizing the CLABSI measure until different types of hospitals get more experience reporting this measure.**

4. CMS should not finalize any new IQR program measures without significantly changing its risk-adjustment methodologies and making additional, measure-specific changes.

NAPH supports CMS' proposal to significantly reduce the number of measures in the IQR program. CMS is proposing to reduce the number of measures in the IQR program from 72 to 59. These changes include eliminating existing, redundant measures. NAPH appreciates any efforts by CMS to reduce the reporting burden on hospitals. Better alignment of quality measures across various reporting programs will enable hospitals to use their limited resources for quality improvement as opposed to duplicate reporting activities. **Therefore, CMS should finalize this proposal to reduce the number of measures in the IQR program.**

However, CMS should make significant changes to its risk-adjustment methodologies regarding newly proposed readmission and outcome measures. In the proposed rule, CMS recommends additional questions to the HCAHPS survey as well as the following new measures for the FFY 2015 IQR program:

- a hospitalwide 30-day all-cause readmission rate measure
- a hip-knee surgery hospital-level 30-day all-cause readmission rate measure
- a hip-knee surgery hospital-level complication rate measure

Failure to fully risk adjust measures by both demographic and socioeconomic factors can potentially penalize safety net hospitals for social and community factors that are unrelated to the quality of care that they provide. The following sections provide specific concerns regarding the proposed hospitalwide all-cause readmission rate measure, the hip-knee surgery hospital-level all-cause readmission rate measure, the hip-knee surgery hospital-level complication rate measure, and the changes to the HCAHPS survey.

a. CMS should not finalize the hospitalwide all-cause readmission rate measure, the hip-knee surgery hospital-level all-cause readmission rate measure, and the hip-knee surgery hospital-level complication rate measure.

CMS should include both demographic and socioeconomic factors in its risk-adjustment methodologies for the hospitalwide readmission measure, the hip-knee readmission measure, and the hip-knee complication rate measure. The hospitalwide readmission measure assesses the risk-standardized rate of unplanned, all-cause readmissions within 30 days of hospital discharge. The hip-knee readmission measure assesses the rate of hospital-level all-cause readmissions within 30 days for patients discharged from the hospital following an elective primary total hip arthroplasty (THA) or total knee arthroplasty (TKA). The hip-knee surgery hospital-level complication rate measure evaluates complications occurring after THA and TKA.

The measures currently adjust for a limited subset of patient characteristics, including age, gender, medical diagnosis, and comorbidities. However, studies have shown that socioeconomic factors such as mental illness, poor social support, and poverty are also associated with higher readmission rates and worse outcomes. [17,18] In addition, many patients seen by safety net hospitals have limited English proficiency and community support, and therefore encounter more challenges with complying with hospital discharge plans or following up with a provider in their community outside of the safety net setting. For these reasons, safety net hospitals often have higher readmission rates that do not necessarily reflect real differences in the quality of care they provide. Sufficient risk adjustment is essential to ensuring readmission and outcome measures represent real differences in quality and care coordination, rather than penalize hospitals for factors beyond their control. **Therefore, CMS should revise its risk-adjustment methodologies for these measures or exclude them from the final rule.**

CMS should also incorporate a shorter postdischarge evaluation period (e.g., 7 days postdischarge) for the hospitalwide all-cause readmission measure and the hip-knee surgery all-cause readmission measure. CMS proposes a 30-day postdischarge evaluation period for these measures. However, the further the readmission window expands from a hospital discharge, the more patient and community-related factors come into play, which are not appropriate for measuring hospital accountability. For example, as patients spend more time in their home environment, factors unrelated to their hospital visit, such as limited health literacy, gain more and more influence over their health status. These circumstances then become determining factors in whether patients are readmitted. Readmission rates during a shorter time period are more likely to reflect real differences in the quality of care provided during the inpatient stay. **Therefore, CMS should shorten the postdischarge evaluation period for these two newly proposed readmission measures.**

In addition, for both readmission measures, CMS should develop broader exclusions for planned readmissions, including readmissions for trauma, burns, dialysis, and substance abuse. The hospitalwide all-cause 30-day readmission measure currently excludes patients who

[17] Farhan J. Khawaja, N. D. Shah, R. J. Lennon, J. P. Slusser, A. A. Alkatib, C. S. Rihal, B. J. Gersh, V. M. Montori, D. R. Holmes, M. R. Bell, J. P. Curtis, H. M. Krumholz, and H. H. Ting, "Factors Associated With 30-Day Readmission Rates After Percutaneous Coronary Intervention," *Archives of Internal Medicine,*, Vol. 172, No. 2: 112–117 (2012).
[18] Karen E. Joynt and A. K. Jha, "Thirty-Day Readmissions — Truth and Consequences," *New England Journal of Medicine*, Vol. 366: 1366–1369 (April 12, 2012).

- died during the index admission or within the 30-day postdischarge period;
- were transferred to another acute care hospital;
- were discharged against medical advice; or
- were admitted for cancer treatment, primary psychiatric disease, or physical rehabilitation and prosthetic services.

The 30-day hip-knee surgery readmission measure currently excludes patients who

- have hip fractures;
- are undergoing revision procedures, resurfacing procedures, or partial hip arthroplasty;
- were transferred in to the index hospital; or
- had more than two THA/TKA procedure codes during the index hospitalization.

However, unplanned readmissions are often significantly overestimated because of insufficient exclusions for planned readmissions.[19] Several additional types of readmissions should be excluded from these readmission measures due to the nature of the illness, injury, or treatment. Specifically, planned readmissions that are part of a patient's natural disease or treatment progression and readmissions that are mostly influenced by nonhospital community factors, such as patient characteristics and home environments, should be excluded. These planned readmissions, including those for trauma, burns, dialysis, and substance abuse, are not suitable for public reporting of unplanned hospital readmissions because they do not represent real differences in quality of care or effective care coordination processes. **For these reasons, CMS should develop broader exclusions for the newly proposed hospitalwide all-cause readmission measure and hip-knee surgery all-cause readmission measure**.

b. <u>CMS should work to link existing data sources with its HCAHPS survey results, delay finalizing HCAHPS care transition questions, and translate the HCAHPS survey into additional languages.</u>

CMS should use existing data sources whenever possible to obtain the information necessary to risk adjust the HCAHPS survey results to limit the burden on hospitals. For the FFY 2015 IQR program, CMS proposes to add the following questions to the "About You" section of the HCAHPS survey for purposes of risk adjustment:

- During this hospital stay, were you admitted to this hospital through the emergency room?
- In general, how would you rate your overall mental or emotional health?

As mentioned earlier, the risk-adjustment methodology currently used for the HCAHPS survey does not adequately adjust for biases related to the use of emergency care and other specialized services that require patients to transfer to safety net providers outside of their communities. Many NAPH members provide burn, trauma, neonatal, behavioral health, and other specialized services that are otherwise unavailable in their communities. For example, in 31 communities

[19] Beejal Y. Amin, U. Modhia, K. Mauro, L. Na, S. Takemoto, C. P. Ames, V. Deviren, D. Chou, S. Berven, and P. V. Mummaneni, "Pitfalls of Calculating Hospital Readmission Rates Based Solely on Nonvalidated Administrative Datasets," Presentation at 28th Annual Meeting of the AANS/CNS Section on Disorders of the Spine and Peripheral Nerves, Walt Disney World Swan and Dolphin, Orlando, Florida, March 7–10, 2012, http://w3.cns.org/dp/2012DSPN/113.pdf

across the country, NAPH members are either the only level I trauma center or the only trauma center of any level in their community.[20] Many NAPH hospitals also operate the only psychiatric EDs in their community.[21]As a result, NAPH members see a disproportionate share of transferred patients who may be unfamiliar with the hospital and the community. Since these patients lack a personal connection with the hospital or the community it serves, they may be less likely to rate their care highly. In fact, patients who receive emergency care, psychiatric care, or trauma care that requires a hospital transfer have been found to rate their overall hospital experience lower than patients receiving scheduled care in their own community.[22]

While obtaining patient information is important for risk adjustment, requiring hospitals to collect additional HCAHPS information can be excessively burdensome for hospitals with limited resources. Existing data sources may be able to provide the information needed to risk adjust by source of hospital admission and behavioral health status. For example, CMS should explore information from its own cost reports. These costs reports include detailed information at the hospital level on source of admission and behavioral health services. In addition, CMS should also explore using existing datasets with patient-level information, such as the Medicare Provider Analysis and Review dataset. **Before finalizing the additional "About You" questions on the HCAHPS survey, CMS should first try to collect this information from existing data sources.**

CMS should also provide more information on how it plans to use the mental/emotional health question data before finalizing this new HCAHPS measure. Patients can be particularly sensitive to questions regarding mental or emotional health. Therefore, their responses to self-reported mental or emotional health status questions are often inaccurate and unreliable. **To ensure the HCAHPS information collected is accurate across all hospitals, CMS should provide more details about this new mental/emotional health question and ensure that this question is appropriately validated to solicit the desired response.**

CMS should also delay finalizing its newly proposed care transition questions until they are field tested for validity. CMS proposes a 3-item care transition measure to be added to the existing HCAHPS survey beginning with January 2013 discharges. This measure would include the following items:

- During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left.
- When I left the hospital, I had a good understanding of the things that I was responsible for in managing my health.
- When I left the hospital, I clearly understood the purpose for taking each of my medications.

NAPH supports care coordination HCAHPS questions because of the importance of effective care coordination to improving the patient experience of care and the quality of care. However,

[20] Obaid Zaman, L. Cummings, and S. Laycox, "America's Safety Net Hospitals and Health Systems, 2010: Results of the Annual NAPH Hospital Characteristics Survey," National Association of Public Hospitals and Health Systems, May 2012, http://www.naph.org/Main-Menu-Category/Publications/Safety-Net-Financing/2010-NAPH-Characteristics-Report.aspx?FT=.pdf

[21] Ibid.

[22] See, e.g., *2010 Hospital Pulse Report: Patient Perspectives on American Health Care*, Press Ganey, 7 (2010), http://www.pressganey.com/researchResources/hospitals/pulseReports.aspx

before finalizing these questions, CMS should release additional evidence supporting their inclusion. In the proposed rule, CMS does not fully demonstrate how these additional questions will effectively assess meaningful differences in the quality of care transitions. Specifically, CMS should further field test these measures to determine the relationship between responses to these questions and patient outcomes. **Until further evidence is discovered through field testing, CMS should delay finalizing these care transition questions.**

Finally, CMS should have the HCAHPS survey translated into additional languages that reflect the patients served by safety net hospitals. While NAPH is encouraged that the HCAHPS survey was recently translated into additional languages such as Russian and Chinese, the survey is still inaccessible to many patients. More than 100 languages are spoken by patients at NAPH member hospitals.[23] Translating the HCAHPS survey into additional languages will allow safety net hospitals to increase their HCAHPS response rate and more accurately reflect the care they give to all patients. **Therefore, CMS should ensure that the HCAHPS survey is translated into additional languages.**

c. CMS should consider any increases in hospital burden as the agency expands reporting requirements for the CLABSI and catheter-associated urinary tract infection (CAUTI) measures.

CMS should fully consider both the quality improvement benefits and the additional reporting burden for hospitals if it proposes in the future to expand reporting requirements for the CLABSI and CAUTI measures beyond the intensive care unit (ICU). Though no formal proposals were made, CMS is seeking comment on whether it should expand the reporting of both the CLABSI and CAUTI IQR measures beyond the ICU. Currently, these measures have been required for reporting only in the ICU. NAPH strongly supports quality improvement efforts to reduce the number of CLABSIs and CAUTIs through greater transparency. **However, before expanding reporting requirements, CMS should also consider the burden associated with additional reporting and examine ways it might reduce such burden.**

5. CMS should delay finalizing any new hospital-acquired conditions (HAC) measures until the multiple federal HAC reporting requirements are better aligned and not finalize any new HAC measures that fail to meet its high volume requirement.

CMS should eliminate its proposed two new HACs from the final rule and should harmonize HAC reporting before adding any new conditions to the HAC program. Under the HAC program, which was included in the Deficit Reduction Act of 2006, hospitals do not receive additional Medicare payment for secondary diagnoses that were not present on admission. For FFY 2013, CMS is proposing the following new conditions for the HACs program:

- surgical site infection following cardiac implantable electronic device procedures

[23] Ibid.

- iatrogenic pneumothorax with venous catheterization

In addition to the existing HAC program, under a new ACA HAC program, beginning in FFY 2015, hospitals scoring in the top quartile for HACs will have their Medicare payments reduced by 1 percent for all DRGs. The conditions would include those already included in the existing HAC program and other conditions selected by the Secretary of the U.S. Department of Health and Human Services. Without a single reporting mechanism for HACs, all new measures will unnecessarily increase the reporting burden on hospitals without necessarily further advancing patients' quality of care. **Therefore, CMS should delay finalizing any new conditions until HAC reporting requirements are better aligned.**

In addition, CMS should not finalize any new HAC program measures that fail to meet its high volume requirement, including the surgical site infection following cardiac implantable electronic device procedures measure. As CMS states in the proposed rule, under the HAC program, CMS is supposed to only finalize new HACs that are high cost and/or high volume. NAPH believes that the surgical site infection following cardiac implantable electronic device procedures HAC does not meet this high volume requirement. According to the proposed rule, there were only 859 of these HACs in in FFY 2011. **For this reason, CMS should eliminate the surgical site infection following cardiac implantable electronic device procedure measure from the final rule.**

6. <u>CMS should not implement a negative documentation and coding adjustment for FFY 2010.</u>

CMS should eliminate the negative 0.8 percent documentation and coding adjustment for FFY 2010 from the final rule. CMS is proposing a net 2.3 percent market basket update for FFY 2013, which is an update to the standardized amount paid to acute care hospitals under the IPPS. This update accounts for an initial 3.0 percent market basket update, a 0.8 percentage point productivity reduction, a 0.1 percentage point reduction required by the ACA, and a 0.2 percentage point total documentation and coding increase.

The net positive 0.2 percentage point documentation and coding adjustment includes a positive 2.9 percentage point adjustment to remove the effect of a onetime negative 2.9 percent recoupment adjustment in FFY 2012, a negative 1.9 percentage point adjustment to account for the remaining documentation and coding adjustments for FFYs 2008 and 2009 that have not been previously accounted for, and a negative 0.8 percentage point documentation and coding adjustment for FFY 2010.

CMS asserts that the negative adjustments result from changes in documentation and coding that did not reflect real changes in patient case mix. However, an American Hospital Association analysis has concluded that CMS vastly overstates the impact of upcoding, while disregarding the effect of hospitals' increasingly acute patient case mix. This analysis indicates a large portion

of the change CMS attributes to upcoding is actually the continuation of historical increases in patient severity, not the effect of documentation and coding.[24]

CMS' failure to account for historical increases in patient severity creates a flawed methodology for calculating the impact of documentation and coding changes. Now more than ever, hospitals are relying on IPPS payments to support quality improvement for low-income Medicare patients. Short-term payment reductions challenge hospitals' capacity to invest in improvements, and reductions such as these that are calculated using a flawed approach present unnecessary obstacles to hospitals' progress. **For these reasons, CMS should eliminate the 0.8 percent documentation and coding adjustment for FFY 2010.**

7. CMS should allow residency programs sufficient time to fill their residency slots.

NAPH supports CMS' proposal to allow new residency programs 5 years rather than 3 years to build a program before determining the program's residency slot cap. This proposal would impact new teaching hospitals operating a resident training program for the first time on or after October 1, 2013. Since new residency programs need at least 3 to 5 years to completely build a multiyear residency program, filling a large percentage of these new slots within a 3-year period would be extremely difficult for most programs. **Therefore, NAPH applauds CMS' proposal to allow new programs 5 years to fill their slots and recommends that it be finalized.**

CMS should also give residency programs more time and flexibility to fill residency slots that they gain as a result of Section 5503 of the ACA. Section 5503 of the ACA includes increases in hospital residency caps, provided the hospitals meet certain requirements. CMS is proposing that residency programs must fill at least half of any new residency slots they gain as a result of Section 5503 for at least 1 of the first 3 years after they are awarded the slots.

Safety net hospitals serve as the training ground for a large percentage of the country's physicians, nurses, and other health care professionals. In 2010, NAPH members alone trained 21 percent of future doctors, and more than 9 percent of future allied health professionals trained at acute care facilities.[25] But logistical concerns and limited resources make it difficult for NAPH members to expand their residency programs quickly. The current proposal does not allow enough time for many safety net hospitals to develop and sustain a program with a steady number of residents. For example, given the lengthy accreditation and site visit processes new programs must go through, the timeframes CMS proposes will be impossible for many awardees to meet. The pressure to fill these slots in the first few years could force safety net hospitals to divert crucial resources, such as funding needed to recruit and retain faculty, away from building long-term, sustainable residency programs. **For these reasons, CMS should allow residency programs more time and flexibility to fill Section 5503 residency slots.**

[24] "Fact Sheet: Medicare Documentation and Coding Adjustments," American Hospital Association, January 13, 2012, http://www.aha.org/content/12/12factsheet-coding.pdf

[25] Obaid Zaman, L. Cummings, and S. Laycox, "America's Safety Net Hospitals and Health Systems, 2010: Results of the Annual NAPH Hospital Characteristics Survey," National Association of Public Hospitals and Health Systems, May 2012, http://www.naph.org/Main-Menu-Category/Publications/Safety-Net-Financing/2010-NAPH-Characteristics-Report.aspx?FT=.pdf

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NAPH appreciates the opportunity to submit these comments. If you have any questions, please contact Xiaoyi Huang or Kevin Van Dyke at (202) 585-0127.

Sincerely,

Bruce Siegel, MD, MPH
President and Chief Executive Officer