



# AMERICA'S ESSENTIAL HOSPITALS

June 17, 2016

Mr. Andrew M. Slavitt  
Acting Administrator  
Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
Hubert H. Humphrey Building, Room 445-G  
200 Independence Ave. SW  
Washington, DC 20201

**Ref: CMS-1655-P: Medicare Program:**

- **Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System Policy Changes and Fiscal Year 2017 Rates; Quality Reporting Requirements for Specific Providers**

Dear Mr. Slavitt:

Thank you for the opportunity to submit comments on the above-captioned proposed rule. America's Essential Hospitals appreciates and supports the Centers for Medicare & Medicaid Services' (CMS') work to improve the delivery of high quality health care across the continuum. However, the current structure of certain programs aimed at improving quality has a disproportionately negative financial impact on essential hospitals—those that commit to serving low-income and other vulnerable patients. With that in mind, America's Essential Hospitals asks CMS to consider the unique challenges inherent in caring for our complex patient populations when finalizing this rule.

America's Essential Hospitals is the leading association and champion for hospitals and health systems dedicated to high-quality care for all, including the most vulnerable. Filling a vital role in their communities, our nearly 275 member hospitals provide a disproportionate share of the nation's uncompensated care and devote approximately half of their inpatient and outpatient care to Medicaid or uninsured patients. More than a third of patients at essential hospitals are racial or ethnic minorities who rely on the culturally and linguistically competent care that only essential hospitals can provide. Our members provide this care while operating on margins substantially lower than the rest of the hospital field—with a zero percent aggregate operating margin, compared

with 8.3 percent for all hospitals nationwide.<sup>1</sup> Through their integrated health systems, members of America’s Essential Hospitals offer a full range of primary through quaternary care, including trauma care, outpatient care in their ambulatory clinics, public health services, mental health services, substance abuse services, and wraparound services critical to vulnerable patients.

Our members also offer specialized inpatient and emergency services not available elsewhere in their communities. The high cost of providing complex care to low-income and uninsured patients leaves our hospitals with limited resources, driving them to find increasingly efficient strategies for providing high-quality care to their patients. But improving care coordination and quality while maintaining a mission to serve the most vulnerable is a delicate balance. This balance is threatened by payment cuts to hospitals—particularly the inequities built into the reductions from the quality improvement programs that were included in the Affordable Care Act (ACA).

Members of America’s Essential Hospitals constantly engage in robust quality improvement initiatives, ranging from preventing falls to reducing readmissions, patient harm events, and blood stream infections. They have created programs to break down language barriers and engage patients and families to improve the quality of care. To ensure our members have sufficient resources to continue these activities and are not unfairly disadvantaged for serving the most vulnerable among us, CMS should adopt the following recommendations when finalizing the above-mentioned proposed rule.

**1. CMS should ensure that data used to implement the ACA’s Medicare disproportionate share hospital (DSH) payment methodology accurately capture the full range of uncompensated care costs hospitals sustain when caring for the vulnerable.**

The Medicare DSH program provides crucial funding for the care provided by essential hospitals, including uncompensated care. In 2014, our members provided nearly \$8 billion in uncompensated care, representing 18.2 percent of all uncompensated care provided nationwide.<sup>2</sup>

As mandated by Section 3133 of the ACA, a large portion of Medicare DSH payments is now distributed based on a hospital’s uncompensated care level relative to all other Medicare DSH hospitals. While DSH hospitals continue to receive 25 percent of their otherwise payable Medicare DSH payments as a per-discharge adjustment payment, the remaining 75 percent is decreased to reflect the change in the national uninsurance rate and distributed based on uncompensated care burden (referred to as uncompensated care-based Medicare DSH payment). This change was in line with the Medicare Payment Advisory Commission’s (MedPAC’s) long-standing recommendation to incorporate uncompensated care into the Medicare DSH formula to better target dollars to hospitals with the greatest need. America’s Essential Hospitals has long

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<sup>1</sup>Landry C, Ramiah K, Rangarao S, Roberson B. 2014 *Essential Data, Our Hospitals, Our Patients; Results of America’s Essential Hospitals 2014 Annual Member Characteristics Survey. America’s Essential Hospitals*. June 2016. <http://essentialdata.info/>. Accessed June 13, 2016.

<sup>2</sup>Ibid.

supported this recommendation. We believe that effective implementation of the ACA provision should ensure such targeting occurs.

However, while effective targeting is important, we are concerned about the sustainability of continued reductions to the aggregate uncompensated care-based DSH payments that are occurring as coverage continues to expand and the national uninsurance rate falls. The aggregate amount of DSH payments CMS estimates for fiscal year (FY) 2017—approximately \$9.61 billion—represents a 33 percent reduction from the amount that would have been paid in the absence of the ACA-mandated cut to the uncompensated care pool. This amount will continue to decline with the national uninsurance rate, which in turn will reduce the amount of Medicare DSH payments distributed to hospitals to help cover the cost of uncompensated care. Even though the ACA has increased access to coverage nationally, essential hospitals still provide high levels of uncompensated care as part of their commitment to serving the vulnerable. Furthermore, hospitals in states that have not expanded Medicaid are not experiencing the drop in uncompensated care that hospitals in expansion states have seen. While targeting DSH payments based on a hospital's level of uncompensated care levels might mitigate this issue somewhat, the overall cuts are growing rapidly, such that the magnitude of cuts in the uncompensated care pool often outweigh any redistributive benefit. As a result, steep cuts to Medicare DSH payments are even more detrimental and unjustifiable for these hospitals.

Acknowledging that statute largely dictates the size of the uncompensated care pool, CMS should consider how its policy choices will impact hospitals that are essential to the communities they serve—particularly with respect to how the agency defines uncompensated care for purposes of allocating the uncompensated care-based Medicare DSH payments among eligible hospitals. CMS should continue to work on accurately capturing all uncompensated care costs, particularly as data sources evolve and low-income individuals who were previously uninsured gain access to coverage. CMS should aid the process by clarifying the Medicare cost report and other guidance to ensure Medicare DSH payments are targeted at the hospitals that need them most.

Below are specific comments of particular importance to ensuring essential hospitals receive adequate Medicare DSH payments to assist them in providing vital care to vulnerable populations.

- a. CMS should continue to use the most recently available estimates for determining the change in the number of uninsured.

**America's Essential Hospitals supports using the most recently available estimates for determining the change in the number of uninsured.** The ACA directs CMS to reduce the total amount of funds available for the uncompensated care-based Medicare DSH payment by the estimated decline in the national uninsurance rate. To set this amount, CMS should continue using the latest estimates from the Congressional Budget Office (CBO), including any revised estimates issued before the final rule. By using the latest estimates from the CBO, CMS will account for changing assumptions about the level of coverage expansion. **Therefore, for FY 2017 DSH payments, CMS should**

**continue using the latest estimates from the CBO for determining the national uninsured rate.**

We also urge CMS to provide ample opportunity for public comment before implementing its methodology for calculating the national uninsured rate in FY 2018. Under the provision of the ACA on Medicare DSH payments, CMS may use data sources other than CBO estimates to calculate the change in the rate of uninsured. CMS has not addressed this issue in the FY 2017 rule, and using a different data source for calculating the level of uninsured could significantly affect the level of DSH cuts. Accordingly, CMS should work closely with affected stakeholders and provide adequate notice to the public of anticipated changes to data sources used for its calculation of Factor 2, which is the change in rate of uninsured. We look forward to working with the agency as it determines which data source to use in FY 2018 and we urge CMS to choose a method that ensures the least disruption to Medicare DSH payments, while accurately measuring the uninsured rate.

- b. CMS should continue its work to accurately capture hospital uncompensated care costs in its calculation of Medicare DSH allocations.

**Given the importance of uncompensated care to the ACA-revised Medicare DSH program, we urge CMS to continue to refine its methodology to accurately capture uncompensated care costs.** Under the ACA's Medicare DSH methodology, CMS determines a hospital's qualifying uncompensated care burden by estimating the hospital's percentage of the total uncompensated care costs incurred by all DSH hospitals. Until now, CMS has been using a low-income insured days proxy, which is a hospital's Medicaid days plus Medicare supplemental security income (SSI) days as a percentage of all hospitals' low-income insured days. In FY 2017, CMS will continue to use the low-income insured days proxy for calculating a hospital's uncompensated care burden under the Medicare DSH methodology. However, CMS proposes that beginning in FY 2017, it will use three years of data to determine a hospital's Factor 3—its share of the uncompensated care burden—instead of the one year of data the agency has used to date.

Hospitals are required to report their uncompensated care costs and other indigent patient care costs on worksheet S-10 of the Medicare hospital cost report form. In previous years, CMS had concluded that due to shortcomings with worksheet S-10, it had to deviate from the common definition of uncompensated care and instead use the low-income insured days proxy to estimate hospital uncompensated care costs. However, CMS proposes to begin phasing in the use of uncompensated care data from the S-10 in FY 2018. In FY 2018, CMS will phase in one year of S-10 data from FY 2014 cost reports, while using two years of low-income insured days data. In FY 2019, CMS will use two years of S-10 data and one year of low-income insured days. By FY 2020, CMS proposes to use three years of S-10 data and to no longer use the low-income insured days proxy. As CMS begins to transition to using the S-10 worksheet, we urge the agency to incorporate the following recommendations that will ensure a more accurate representation of each hospital's total uncompensated care costs.

- z. CMS should capture all uncompensated costs that hospitals treating low-income patients incur by measuring uncompensated care costs as well as low-income insured days.*

**CMS should use a hybrid methodology that includes both a hospital’s low-income insured days and uncompensated care costs from the S-10 to calculate its Factor 3.** Specifically, we recommend that beginning in FY 2020, when CMS plans to transition entirely to the S-10, CMS instead use a weighted average of low-income insured days and uncompensated care costs from the S-10, with the low-income insured days weighted 25 percent and the S-10 data weighted 75 percent. The association has long supported MedPAC’s recommendation to account for care provided to *all* low-income patients, including those with no ability to pay, and to incorporate the costs of such care into the Medicare DSH formula.<sup>3</sup> Any measure of uncompensated care, however, should account for the different sources of uncompensated care burden hospitals incur as they treat low-income patients in a changing coverage landscape.

By continuing to partially incorporate low-income insured days in the calculation of a hospital’s DSH payments, CMS will ensure that hospitals that treat low-income patients—specifically, Medicaid patients and Medicare dual eligible beneficiaries—will be able to continue to fulfil their mission to treat the most vulnerable. Medicare dual eligible beneficiaries are more likely to suffer from chronic illness and are also costlier to treat.<sup>4</sup> By completely omitting the low-income insured days proxy once it transitions to the S-10, CMS would be overlooking the important role of certain hospitals who treat disproportionate numbers of Medicaid and Medicare dual eligible beneficiaries in serving their communities. Because of the high cost of treating these patients and the underpayment associated with Medicaid, including a low-income insured days proxy in the Factor 3 calculation will provide a more complete measure of each hospital’s commitment to providing uncompensated care.

The need to use low-income insured days is also underscored by the different nature of uncompensated care hospitals provide as some states expand Medicaid while others do not. As some states expand Medicaid, previously uninsured patients will transition to Medicaid, and the cost of treating these patients would be captured by the inclusion of the low-income insured days proxy. Weighting the S-10 at 75 percent and low-income insured days at 25 percent will ensure that hospitals with high levels of uncompensated care costs will receive targeted DSH payments while also not minimizing the importance of treating Medicaid and Medicare dual eligible patients and the associated costs.

Including low-income insured days is also a reasonable policy choice from a logistical perspective. Because the updated worksheet S-10 currently in use is relatively new, hospitals are still gaining experience in accurately reporting data on it. Moreover, certain lines of the S-10 and the corresponding instructions are unclear and will require

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<sup>3</sup>See, e.g., Medicare Payment Advisory Commission. Report to Congress, Medicare Payment Policy. March 2000. [http://www.medpac.gov/documents/reports/Mar00\\_Entire\\_report.pdf](http://www.medpac.gov/documents/reports/Mar00_Entire_report.pdf). Accessed May 30, 2016.

<sup>4</sup>Kasper J, O’Malley M, and Lyons B. *Chronic Disease and Co-Morbidity Among Dual Eligibles: Implications for Patterns of Medicaid and Medicare Service Use and Spending*. Kaiser Commission on Medicaid and the Uninsured. July 2010.

further clarification by CMS. Since FY 2014, CMS has used the low-income insured days metric and noted it is an acceptable proxy for the treatment costs of the uninsured patients.<sup>5</sup> Furthermore, CMS plans to include low-income insured days in FYs 2018 and 2019 during its phase-in of S-10 data. Including low-income insured days in FY 2020 and beyond would be an extension of this policy that would also ensure continuity and avoid disruptions in Medicare DSH payments to hospitals.

In addition to incorporating our recommended weighted average of S-10 data and low-income insured days, as CMS begins to use data from the S-10 worksheet, it should consider the following refinements to the worksheet S-10 so the data captured on it accurately represent uncompensated care costs.

- ii. CMS should not apply a trim to hospital cost-to-charge ratios (CCRs) until it identifies the reasons for variations in CCRs and gives hospitals using different methodologies adequate time to produce CCRs that are usable for converting costs to charges on the cost report.*

In the rule, CMS proposes that due to “extremely high” uncompensated care costs reported by some hospitals on worksheet S-10, the agency will identify hospitals with high CCRs and apply a trim methodology to assign an alternate CCR. The proposed methodology would assign the statewide average to hospitals with CCRs greater than three standard deviations above the national average CCR. CMS would then use this alternate CCR, instead of the CCR reported on the worksheet S-10, to convert the hospital’s uncompensated care charges to costs. We urge CMS to consider the negative impact this proposal would have on many hospitals and to consider the reasons that hospitals subject to the trim might report high CCRs. **Instead of applying an across-the-board trim, CMS should evaluate CCRs on cost reports to identify misreported, erroneous values and not penalize hospitals that are accurately reporting information under a CMS-sanctioned methodology.**

Due to their differing charge structures, some hospitals have been using alternative, CMS-approved methodologies to apportion their costs on their cost reports. Accordingly, the CCRs calculated on their cost reports might end up being higher than other hospitals. These hospitals are not falsely reporting information or inflating their costs. Instead of subjecting these hospitals to the CCR trim, which ends up penalizing these hospitals by drastically reducing their uncompensated care costs, CMS should focus on understanding the underlying reasons for varying CCRs. **If CMS intends to require that hospitals revise their charge structures and cost apportionment methodologies, the agency should provide hospitals sufficient lead time to bring their systems in line with these requirements.**

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<sup>5</sup>See, e.g., Centers for Medicare & Medicaid Services, Fiscal Year 2014 Inpatient Prospective Payment System Proposed Rule, 78 Fed. Reg. 27486, 27589 (May 10, 2013).

*iii. CMS should include all patient care costs when using worksheet S-10 to determine uncompensated care costs.*

The current worksheet S-10 does not account for all patient care costs when converting charges to costs. Most importantly, the current worksheet ignores the costs to hospitals of training medical residents. As CMS transitions to using the S-10 as the data source for measuring uncompensated care costs, the agency should refine the worksheet to incorporate all patient care costs, including teaching costs, into any determination of costs for use in the CCR. In particular, CMS should follow these guidelines:

- Use the total of worksheet A, column 3, lines 1 through 117, reduced by the amount on worksheet A-8, line 10, as the cost component.
- Use worksheet C, column 8, line 200, as the charge component.

Because the line items noted above are not limited to Medicare-allowable costs and include additional patient care costs, such as the cost of graduate medical education (GME), the result would more accurately reflect the true total cost of hospital services provided than does the CCR currently used in worksheet S-10.

In the rule, CMS addresses the issue of including GME costs in the CCR but opts not to incorporate GME costs when converting uncompensated care charges to costs. The decision not to include these costs will disproportionately impact teaching hospitals by reducing their share of the uncompensated care pool in relation to other hospitals. Essential hospitals are committed to training the next generation of health professionals. In 2014, our average member hospital trained 270 physicians, more than six times as many as other U.S. teaching hospitals.<sup>6</sup> Further, our members trained an average of 50 physicians above their GME funding cap, versus 21 at other teaching hospitals.<sup>7</sup> So, the costs associated with direct graduate medical education constitute a significant portion of overall costs at essential hospitals. By leaving out these costs in the CCR, CMS is understating teaching hospitals' uncompensated care costs when it converts those hospitals' uncompensated care costs to charges. CMS states that the purpose of uncompensated care payments is to cover the costs of treating the uninsured. However, simply incorporating GME costs into the CCR does not pay for the costs of training residents. Rather, it more accurately measures the uncompensated care costs of a hospital when it converts charges to costs by including the full range of costs incurred by teaching hospitals but not by other hospitals. By leaving out these costs, CMS' proposed CCR for determining uncompensated care costs will penalize hospitals such as academic medical centers, which also tend to provide high levels of uncompensated care. **We therefore strongly urge CMS to include teaching costs in converting charges to costs, as this would ensure accurate distribution of the uncompensated care pool funds to those hospitals with the highest levels of uncompensated care.**

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<sup>6</sup>Landry C, Ramiah K, Rangarao S, Roberson B. *2014 Essential Data, Our Hospitals, Our Patients; Results of America's Essential Hospitals 2014 Annual Member Characteristics Survey*. America's Essential Hospitals. June 2016. <http://essentialdata.info/>. Accessed June 13, 2016.

<sup>7</sup>Ibid.

CMS also should include the cost of providing physician and other professional services when calculating uncompensated care. In addition to employing physicians and paying community specialists directly for providing care to patients, many essential hospitals subsidize the cost of physician services to ensure vulnerable patients continue to have access to necessary physician care. Because hospitals regularly incur these costs when providing charity care and other uncompensated care, CMS should recognize these costs when determining uncompensated care. **By refining worksheet S-10 to reflect these issues, CMS will accurately measure the uncompensated care costs hospitals incur to serve low-income and uninsured patients.**

*iv. CMS should issue clarifying guidance as soon as possible to improve the consistency and accuracy of worksheet S-10 data and, in particular, the accuracy of charity care reported on the S-10.*

A review of worksheet S-10 data indicates an inconsistency in how hospitals categorize and report charity care versus bad debt. While CMS can overcome this data limitation by using the sum of charity care and bad debt, the agency should still issue clarifying guidance so there is consistency across the hospital industry in how charity care and bad debt are reported.

**America's Essential Hospitals commends CMS for revising the charity care instructions on the S-10 to include all charity care written off in a cost reporting period.** As is, the use of charity care from the S-10 provides an incomplete picture of actual costs of charity care and thus is not ready for use in a hospital's uncompensated care calculation. The current instructions call for charity care that was *delivered* (not necessarily written off) during the period to be recorded on line 20.<sup>8</sup> However, due to the amount of time often involved in determining if a patient is eligible for a hospital's charity care policy, hospitals often determine and write off charity care outside of the fiscal year in which they provide the services. Therefore, if a hospital determines other services also should have been characterized as charity care after the cost report is filed, such costs would not be captured on worksheet S-10 for any year. This results in an understatement of actual charity costs. For this reason, we have urged CMS to revise its instructions to capture all charity care written off (as opposed to provided) during the period, and we are encouraged to see that CMS will revise the charity care instructions accordingly.

**CMS should also treat the unreimbursed portion of state or local indigent care programs as charity care.** Many state or local indigent care programs are not insurance programs, but rather sources of funding to help subsidize hospitals' overall uncompensated care costs. The unreimbursed portion (i.e., the shortfall) should be treated the same as charity care.

**Moreover, the agency must revise the current worksheet S-10 so data on Medicaid shortfalls better resemble actual shortfalls hospitals incur.** Even though CMS is not proposing, as of yet, to include Medicaid shortfalls from the S-10 in the calculation of

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<sup>8</sup>Medicare Provider Reimbursement Manual, Part 2, Provider Cost Reporting Forms and Instructions, Form CMS 2552-10S-10 Instructions, § 4012.

uncompensated care costs, data on Medicaid shortfalls will be increasingly useful as previously uninsured low-income individuals gain access to insurance through Medicaid and additional states expand Medicaid. Data on the unreimbursed costs of providing care to Medicaid patients (many of whom were formerly uninsured) will provide valuable information on Medicaid underpayment and, thus, should be measured accurately. The current data on Medicaid shortfalls underestimate the amount of shortfall. First, GME-related costs are excluded, while GME-related reimbursements are included. Without the necessary revision to the CCR mentioned above, counting payments but not costs is an inaccurate way to measure shortfall. Second, the worksheet should be consistent in allowing hospitals to reduce their Medicaid revenues by the amount of any Medicaid non-federal share funding they provide, whether through provider taxes, intergovernmental transfers (IGTs) or certified public expenditures (CPEs). Like provider taxes and assessments, provider-funded IGTs and CPEs are contributions to the nonfederal share of Medicaid payments and often are critical to a state's ability to make such payments. Allowing offsets for one such type of contribution and not others distorts shortfall amounts and might create inequities among hospitals. This is particularly detrimental in a context where the shortfall is counted as uncompensated care and the uncompensated care-based DSH payments are determined on a relative basis. If hospitals are to receive a portion of their DSH payments based on their relative uncompensated care, relative amounts must be calculated in an equitable and uniform manner. **Thus, to create more consistency and accuracy in worksheet S-10 data, CMS should make the above-mentioned adjustments.**

*v. CMS should clarify that only payments actually received offset charity care costs.*

To appropriately determine the uncompensated care costs associated with charity care patients, CMS should clarify that only payments actually received from patients, and not those expected to be received, offset charity care costs. Despite patients' cost-sharing responsibility, many charity care patients might not pay their share. It makes no sense—and would be factually incorrect—to count expected payments when determining the costs that remain uncompensated. **Therefore, CMS should ensure uncompensated care costs associated with charity care accurately reflect the true payments received.**

*vi. CMS should consider modifications to the low-income insured days proxy that will more accurately measure each hospital's uncompensated care burden.*

As CMS continues to use its low-income insured days proxy, the agency should consider the following shortcomings of the proxy:

- The current methodology, which uses a hospital's low-income insured days as a proportion of all hospitals' low-income insured days, does not capture the extent to which low-income patients make up a hospital's overall patient population.
- The use of only inpatient days does not capture the significant amount of low-income care hospitals provide in the outpatient setting. In addition to their commitment to treating the most vulnerable in the inpatient setting, essential hospitals provide comprehensive, coordinated care in the outpatient setting to

disproportionately high numbers of uninsured patients, many of whom have multiple comorbidities and chronic conditions. These hospitals should not be penalized in the distribution of uncompensated care payments by excluding the high levels of uncompensated care they provide in the outpatient setting.

- The use of only inpatient days does not account for the full variation in the amount of resources required to treat certain patients, such as those with complex conditions.

**These considerations further highlight the need to capture accurate uncompensated care data so CMS can refine its methodology for distributing uncompensated care-based Medicare DSH payments.** At the very least, until CMS is able to refine its methodology for distributing the uncompensated care-based Medicare DSH payments using uncompensated care data, the agency should weigh each hospital's SSI and Medicaid days by its total patient days, rather than using the SSI and Medicaid days without any weights, so the data used to compare hospitals capture the disproportionate nature of some hospitals' commitment to low-income populations.

**2. CMS should use the final FY 2017 Inpatient Prospective Payment System (IPPS) rule to correct for past payment cuts resulting from the two-midnight policy and to provide additional clarity on its policies to preserve physician judgment and ensure patients receive the appropriate level of care in the hospital.**

In the FY 2014 IPPS final rule, CMS announced that, due to an expected increase in inpatient stays under the two-midnight policy, it would reduce the standardized inpatient hospital payment for hospitals by 0.2 percent. However, empirical and anecdotal evidence from hospitals has suggested that since CMS announced the two-midnight policy, more stays are shifting from the inpatient to the outpatient setting.<sup>9</sup> America's Essential Hospitals believes CMS should not have cut hospital inpatient payments when the policy was not fully implemented and the anticipated shift to inpatient stays was not shown to have occurred.

- a. CMS should finalize its proposal to reverse the payment cut associated with the two-midnight policy.

Given our concerns about the two-midnight policy, America's Essential Hospitals is pleased to see that the agency is responding to feedback from stakeholders by reversing the payment cut. In its annual payment update to Medicare inpatient payment rates, CMS includes a 0.8 percentage point increase, which would reverse the payment cut first instituted in FY 2014. **We urge CMS to finalize this proposal, which would reverse the previous three years of payment cuts and also permanently adjust payment rates going forward.**

- b. Moving forward, CMS should clarify policies that preserve physician judgment and ensure patients receive the appropriate level of care in the hospital.

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<sup>9</sup>Sheehy AM, et al. Observation and Inpatient Status: Clinical Impact of the 2-midnight Rule. *Journal of Hospital Medicine*. February 2014;9:203-209.

In the calendar year (CY) 2016 Outpatient Prospective Payment System final rule, CMS made changes to medical review criteria and the review process for the two-midnight policy. These changes included a new exception for short inpatient stays (those lasting fewer than two midnights) that the admitting physician believes are necessary and are documented by the physician in the medical record. CMS also changed the medical review process by giving quality improvement organizations (QIOs)—instead of Medicare Administrative Contractors or Recovery Auditors—the authority to review post-payment claims for patient status. Since then, CMS has put in place a temporary pause in QIO reviews while it works with QIOs to enforce standardization of two-midnight reviews and consistent enforcement of the policy. We urge CMS to provide clear guidance to providers and other involved parties, such as reviewing entities, on how the new policy should be implemented. CMS also should regularly oversee and monitor this program during this transition to QIO review, as there are only two QIOs nationwide (Levanta and KEPRO), and it is imperative that they have sufficient resources to implement this rule appropriately.

**Through separate rulemaking, CMS can modify its requirement for skilled nursing facility (SNF) coverage to ensure that the period of observation care in the hospital counts toward meeting the three-day Medicare payment requirement for patients who are admitted to the hospital and then receive treatment in a SNF.** Medicare will only cover SNF stays for beneficiaries who were inpatients for at least three days during the preceding hospital stay. This requirement can confuse beneficiaries, who often don't know their status as inpatients or outpatients. CMS has acknowledged this issue and addressed it in the context of pioneer accountable care organizations (ACOs) by introducing a waiver of the three-day SNF coverage requirement for beneficiaries in pioneer ACOs. This flexibility is a step in the right direction, but it should be extended beyond the demonstration to cover patients in all hospitals.

**3. CMS should ensure the newly proposed scoring methodology and the quality measures in the Hospital-Acquired Condition (HAC) Reduction Program are tailored to accurately measure hospitals' improvements on HACs and do not disproportionately penalize certain types of hospitals.**

**CMS should continue to examine its methodology for determining whether a hospital is penalized under the HAC Reduction Program because the methodology is skewed against large hospitals and teaching hospitals, which provide essential care to vulnerable populations.** The ACA requires the secretary of health and human services (HHS) to adjust payments to hospitals with high rates of HACs. Specifically, for hospitals that rank in the top quartile of hospitals nationally for HACs during the applicable period, CMS will adjust payments to 99 percent of what they would otherwise have been. The ACA also requires the secretary to provide confidential HAC reports to applicable hospitals so the hospitals can review and correct the information. Information pertaining to hospitals' performance on HAC measures will then be posted publicly on the Hospital Compare website. CMS finalized guidance on implementing the HAC Reduction Program in the FY 2014 IPPS rule, with the program beginning in FY 2015.

America's Essential Hospitals supports Congress' aim to reduce HACs that create serious adverse outcomes for patients and can lead to death or disability. HACs also burden hospitals and the overall health care system. Our hospitals are committed to improving quality by eliminating HACs and are at the forefront of using evidence-based guidelines to prevent HACs and improve the overall patient experience. However, many of the measures included in the HAC Reduction Program are unreliable indicators of quality of care. For example, the Agency for Healthcare Research and Quality (AHRQ) patient safety indicator 90 (PSI 90) composite measure is claims-based, and the events in this measure occur infrequently. As detailed below, these factors make this measure a poor indicator of the true quality of care provided and, as such, the measure should be removed from the HAC program. Alternatively, we urge CMS to delay implementation of the proposed modified PSI 90 measure, as the proposed changes are substantive, and hospitals and CMS need adequate time to become familiar with the measure in its new form.

The nature and volume of care essential hospitals provide to vulnerable populations make them likely to be disproportionately included in the top quartile of hospitals, based on the total HAC score. As highlighted in a December 2014 America's Essential Hospitals research brief,<sup>10</sup> patient acuity and status as an essential hospital were associated with a higher proportion of penalties under the HAC Reduction Program. Our analysis found that even though mortality rates among essential hospitals were either lower or not statistically different than those of other hospitals, essential hospitals were nearly 8 percentage points more likely to be penalized under the HAC Reduction Program.

Further analysis of the effects of the current HAC Reduction Program shows that the program in its current form has severely impacted DSH hospitals, teaching hospitals, and urban hospitals. Many of the measures in the HAC Reduction Program occur disproportionately in teaching hospitals and hospitals providing highly specialized services and should not be measured as a true difference in performance when compared with other types of hospitals. For example, many of our hospitals provide high-risk procedures, not often performed at the hospitals against which our members are measured, such as cancer surgery, which involve a higher risk of acquiring a condition such as an accidental puncture or laceration.<sup>11</sup> In these cases, the higher risk of infection does not reflect poor quality of care at the hospital, but rather reflects the types of procedures performed. Thus, essential hospitals might report higher infection rates than other hospitals. Even a minimal increase in the number of infections could place a hospital in the top quartile for these measures. **To provide the most accurate assessment of care quality, CMS should only include measures in the HAC Reduction Program that accurately gauge quality, include appropriate risk-adjustment, and are not inherently skewed against teaching hospitals, large hospitals, and hospitals that provide care to vulnerable populations.**

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<sup>10</sup>*HAC Reduction Program Penalties: An Undue Burden on Essential Hospitals?* Essential Hospitals Institute. December 2014. <http://essentialhospitals.org/wp-content/uploads/2014/12/HAC-research-brief-12-18.pdf>. Accessed June 2015.

<sup>11</sup>Kin C, et al. Accidental Puncture or Laceration in Colorectal Surgery: A Quality Indicator or a Complexity Measure? *Diseases of the Colon & Rectum*. 2013;56(2):219-225.

The following comments provide specific recommendations for ensuring the HAC Reduction Program accurately measures hospitals' performance and does not unfairly penalize certain hospitals.

- a. CMS should remove the PSI 90 measure from the HAC Reduction Program and ensure measures in the program more accurately reflect hospitals' quality of care.

America's Essential Hospitals believes the PSI 90 measure is not an appropriate quality indicator. PSI 90 measures are administratively measured using claims data and are not clinically reported. Since the claims data used in calculating the PSI 90 metrics are not clinically validated, the data do not accurately represent the quality of care provided at a hospital. Hospitals are able to track clinically based data and monitor patients' progress based on the entirety of their clinical record. Placing excessive emphasis on claims-based data unreliably represents a hospital's actual progress in improving quality. In addition, many of the PSI 90 measures are rare events and do not meet the high-volume requirement for the HAC Reduction Program. These factors make the PSI 90 measure a poor indicator of the true quality of care provided. **We urge CMS to remove the PSI 90 measure from the HAC Reduction Program.**

- b. Alternatively, CMS should delay adoption of the proposed modified PSI 90 measure for the HAC Reduction Program to ensure the agency has sufficient time to identify any unintended consequences of the modified measure.

CMS proposes the adoption of a modified PSI 90 measure beginning with FY 2018 payment determination. Specifically, CMS proposes an expansion of the measure from eight to 10 component indicators, and a new weighting system of the component indicators. The weighting of the component indicators would no longer be based solely on volume of events, but rather, the volume and "harm weights" associated with the events would be incorporated through the methodology. The agency believes that these refinements to the PSI measure will provide a more reliable and valid signal of patient safety events.

The proposed changes to the PSI 90 measures are "substantive changes," as acknowledged by the agency itself, in the proposed rule. It is imperative that the modified measure be fully vetted and approved through a consensus-building approach that involves the public and interested stakeholders to ensure measure validity and reliability. CMS should ensure it has sufficient time to identify any unintended consequences of collecting the measure. Should the agency move forward with the use of this measure, America's Essential Hospitals encourages CMS to **reconsider FY 2018 implementation of the modified PSI 90 measure in the HAC Reduction Program, and allow adequate time for hospitals to understand and become familiar with the refinements by first including the measure in the Hospital Inpatient Quality Reporting (IQR) Program for at least two years.**

- c. CMS should examine the new scoring methodology for the HAC Reduction Program to ensure it does not unfairly penalize essential hospitals.

CMS proposes a new scoring methodology for FY 2018 for the HAC Reduction Program that would use continuous measure scores to compare a hospital's performance scores for each measure with the national mean. The agency believes this new scoring methodology will address concerns identified with current decile-based scoring, including penalty threshold ties, Total HAC scores determined solely on Domain 1 scores, and difficulty distinguishing top performers from low performers. CMS states in the proposed rule that the new methodology will create "a more level playing field for hospitals with data in only Domain 1." We share CMS' concern that, under the current methodology, hospitals are potentially disadvantaged because their Total HAC scores were determined solely on their Domain 1 score, as they had no Domain 2 scores. Additionally, America's Essential Hospitals shares CMS' belief that performance scores should reflect true differences in performance.

While CMS indicates that the new scoring methodology will leave largely unchanged the proportion of penalized teaching, urban, and high-DSH hospitals, we have concerns about the exception CMS notes—i.e., an increase in penalization rates among "moderately high (50 to 60 percent) DSH hospitals." **We encourage CMS to closely monitor the effects the new scoring methodology might have among essential hospitals that serve a larger volume of vulnerable patients.** We also urge CMS to provide robust guidance and support to hospitals to avoid confusion as the agency implements its new methodology.

- d. CMS should maintain the current applicable period of performance data (i.e., 24 months) used to calculate the Total HAC scores to ensure optimal reliability within the HAC Reduction Program.

CMS proposes permitting flexibility to use a period other than the 24 months from which data are collected to calculate Total HAC scores under the HAC Reduction Program, beginning in FY 2017. CMS proposes an abbreviated, 15-month performance period for the Domain 1 measure (i.e., PSI 90 composite measure) for the FY 2018 HAC Reduction Program, and a 21-month period for FY 2019. The agency proposes to continue its use of the 24-month performance period for the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) measures found in the HAC Reduction Program.

Mathematica Policy, a CMS contractor, found that the PSI 90 measure—which is the sole measure in Domain 1—was most reliable with a 24-month reporting period and unreliable with a reporting period less than 12 months.<sup>12</sup> We have concerns that the proposed shortening of the applicable period for Domain 1 data will impact the reliability of measure scores. Additionally, CMS is proposing substantial changes to the PSI 90 measure, to be implemented in FY 2018, and has not yet performed an updated reliability analysis of the modified PSI 90. We appreciate the agency's consideration of potential provider burden associated with using a combination of ICD-9 and ICD-10 data. However, it is important to maintain a high level of reliability—i.e., the extent to

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<sup>12</sup>Mathematica Policy Research (November 2011). Reporting period and reliability of AHRQ, CMS 30-day and HAC Quality Measures—Revised. [https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/hospital-value-based-purchasing/Downloads/HVBP\\_Measure\\_Reliability-.pdf](https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/hospital-value-based-purchasing/Downloads/HVBP_Measure_Reliability-.pdf). Accessed May 2016.

which variation is due to variation in quality of care, not the sample of cases observed—to ensure program integrity and avoid unfairly penalizing certain categories of hospitals. **We urge CMS to maintain the 24-month applicable reporting period to ensure reliability in the HAC Reporting Program.**

- e. CMS should include additional risk-adjustment factors in the HAC Reduction Program quality measures.

**To more precisely gauge a hospital’s performance on HAC measures, CMS should consider sociodemographic factors, such as the patient’s location before admission or after discharge, the patient’s primary language, and the patient’s income.** The risk-adjustment used for the HAC measures in both domains 1 and 2 is insufficient to account for the many variables outside hospitals’ control that can affect rates of infection and complications. For example, residence is an important determinant of a patient’s condition before coming to the hospital. Patients’ primary language can impact their ability to communicate with hospital staff. And both can contribute to a higher risk of infection or other complications. Having a lower income also can greatly impact a patient’s chance of developing a complication after high-risk procedures. Studies have shown that lack of resources, both financial and educational, are associated with worse pressure ulcer outcomes following care for a spinal cord injury.<sup>13</sup> The populations essential hospitals serve are among the most vulnerable. For them, even common conditions, such as high blood pressure, diabetes, and asthma, often become worse because of social determinants of health (e.g., having no place to store medications or syringes properly).

**Sociodemographic factors should be included in the HAC Reduction Program’s risk-adjustment methodology so the measures more accurately reflect quality outcomes within hospitals’ control.**

- f. CMS should use its exceptions and adjustment authority to ensure payment reductions under the HAC Reduction Program are applied to base operating DRG payments only and not to indirect medical education (IME) and DSH payments.

As noted above, the ACA states that the payment penalty for hospitals that rank in the top quartile of hospitals nationally for HACs should be “equal to 99 percent of the amount of payment that would otherwise apply to such discharges under this section or section 1814(b)(3).”<sup>14</sup> The unspecified section referred to is section 1886 of the Social Security Act, which includes not only the base operating DRG payment, but also add-on payments that are critical to essential hospitals, including IME and DSH payments. Due to the high volume of low-income patients our member hospitals treat, as well as the fact that a large number of our members are teaching hospitals, cuts to IME and DSH payments in addition to base operating DRG payments would be unsustainable.

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<sup>13</sup>Saunders LL, et al. The Relationship of Pressure Ulcers, Race, and Socioeconomic Conditions After Spinal Cord Injury. *Journal of Spinal Cord Medicine*. 2010;33(4):387-395.

<sup>14</sup>Social Security Act § 1886(p)(1).

Essential hospitals already operate with much lower margins than other hospitals nationally. Without IME and DSH payments, essential hospitals face difficult financial decisions that could impact their ability to maintain vulnerable patients' access to care. The secretary of HHS has authority under section 1886(d)(5)(I)(i) of the Social Security Act to make exceptions and adjustments to payments made for inpatient hospital services. **To maintain the purpose of these add-on payments—which is to help account for the increased resources needed to care for complex patients and train future physicians—and to minimize the disproportionate effect of the HAC Reduction Program on essential hospitals, the secretary should use her authority to apply the HAC reduction to base operating DRG payments only.**

- 4. Before expanding the Hospital Readmissions Reduction Program (HRRP) to include additional conditions, CMS should develop a sufficient risk-adjustment methodology, with guidance from current legislation and related secretarial recommendations, to ensure essential hospitals are not disproportionately penalized.**

Reducing preventable readmissions is of paramount concern to America's Essential Hospitals and its members. We believe that any program directed at reducing readmissions must target readmissions that are preventable and include appropriate risk-adjustment methodology. America's Essential Hospitals has previously expressed concern that the HRRP unduly penalizes hospitals that serve the nation's most vulnerable populations because it fails to account for external factors that explain higher readmission rates.

Hospitals are not the only stakeholders concerned about this program. Recently, the House of Representatives approved H.R. 5273, the Helping Hospitals Improve Patient Care Act. In part, this bill would amend the HRRP to level the playing field for hospitals that are disproportionately penalized by the program: those that care for large numbers of low-income and other disadvantaged patients. This provision—modeled on H.R. 1343, the Establishing Beneficiary Equity in the Hospital Readmission Program Act—recognizes the socioeconomic complexities of vulnerable populations when calculating quality measures to ensure that hospitals are assessed on the work they do, rather than on the patients they serve.

Based on the HRRP adjustment factors established by the ACA, hospitals will face a 3 percent reduction for FY 2017 and beyond. Given essential hospitals' already low operating margins, their ability to provide care to all patients, including our nation's most vulnerable, will be profoundly impacted if the necessary risk adjustments are not made to accurately measure readmissions.

- a. CMS should include risk-adjustment methodology that accounts for social and community-level factors in the existing and proposed applicable conditions.

**CMS should ensure the methodology for calculating a hospital's number of excess readmissions includes adequate risk adjustment for the existing five applicable conditions and for the condition finalized for inclusion in the FY 2017 program.**

The current HRRP tracks a hospital's readmissions based on five applicable conditions:

acute myocardial infarction (AMI), heart failure (HF), pneumonia (PN), acute exacerbations of chronic obstructive pulmonary disease (COPD), and elective total hip arthroplasty (THA) or total knee arthroplasty (TKA) (hip or knee replacement, respectively). In prior rulemaking, CMS finalized the inclusion of an additional condition—the hospital-level, 30-day, all-cause, unplanned readmission following coronary artery bypass graft (CABG)—for FY 2017 payment adjustment. The methodology used to calculate these readmission measures does not incorporate appropriate risk adjustment for sociodemographic status, language, insurance status, postdischarge support structure, or other factors that reflect the unique difficulties involved in providing care to vulnerable populations.<sup>15</sup>

The HRRP already has disproportionately penalized many providers. For example, an analysis of the penalties for FY 2013 shows that 44 percent of hospitals serving a large proportion of the poor receive high penalties compared with 30 percent of other hospitals.<sup>16</sup> Also, teaching hospitals and large hospitals, both of which tend to provide care to vulnerable populations, more often face higher penalties.<sup>17</sup> These data support the proposition that higher readmissions are partly caused by socioeconomic and social support factors in patients' communities, rather than solely by the quality of care the hospital provides.

Empirical research shows that for certain conditions, such as HF, low mortality corresponds with high readmission rates, and therefore readmissions might be necessary to stabilize certain patients and prevent death.<sup>18</sup> However, as the program stands, hospitals with high readmissions rates but low mortality rates would receive higher penalties. In its June 2013 report to Congress, MedPAC identified this inverse relationship between readmission rates and mortality rates for HF as one of four issues of concern with the HRRP.<sup>19</sup> America's Essential Hospitals previously noted that CMS' Hospital Compare data illustrate that hospitals providing care to vulnerable populations are achieving lower mortality rates than the national average while patients are in the hospital. Thus, when outside sociodemographic factors are minimized, patients at essential hospitals have better health outcomes when they receive inpatient hospital care.

America's Essential Hospitals urges CMS to include factors related to a patient's background—sociodemographic status, language, and postdischarge support structure—in its risk-adjustment methodology. These underlying factors frequently drive readmissions to essential hospitals. In addition, the timing of a readmission might have different causal factors, including social determinants of health. A retrospective study of an academic medical center found that late readmissions (eight to 30 days after discharge) were associated with markers of chronic illness burden, including social

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<sup>15</sup>Nagasko EM, et al. Adding Socioeconomic Data to Hospital Readmissions Calculations May Produce More Useful Results. *Health Affairs*. 2014; 33(5): 786-791.

<sup>16</sup>Joynt KE, Jha AK. Characteristics of Hospitals Receiving Penalties Under the Hospital Readmissions Reduction Program. *Journal of the American Medical Association*. 2013;309(4):342-43.

<sup>17</sup>Ibid.

<sup>18</sup>Ibid.

<sup>19</sup>See, e.g., Medicare Payment Advisory Commission. *Report to Congress, Medicare and the Health Care Delivery System*. June 2013. [http://www.medpac.gov/documents/reports/jun13\\_EntireReport.pdf](http://www.medpac.gov/documents/reports/jun13_EntireReport.pdf). Accessed June 2015

determinants of health.<sup>20</sup> Such research further emphasizes the need to risk adjust for sociodemographic factors, which greatly affect the populations served by essential hospitals, in the HRRP.

By not considering the full range of differences in patients' backgrounds that might affect readmission rates, readmission measure calculations will inevitably be skewed against hospitals providing essential care to low-income individuals, including the uninsured. A recent Harvard Medical School study found that current risk-adjustment strategies fail to control for many patient characteristics that put essential hospitals at risk for unfair penalties.<sup>21</sup> This failure to risk adjust could cause hospitals treating a large proportion of low-income or racial and ethnic minorities to face penalties at an increased rate, further diminishing resources at hospitals that often operate at a loss.<sup>22</sup>

In 2014, the National Quality Forum (NQF) convened an expert panel to examine whether the lack of sociodemographic adjustment might lead to incorrect conclusions about quality (i.e., the conclusion that hospitals with a disproportionate share of disadvantaged patients provide lower quality simply as a function of their case mix). The panel, which ultimately recommended risk adjusting certain quality measures for sociodemographic factors, found that excluding such factors could lead to greater disparities in care. For example, disadvantaged populations could lose access to care if providers who work primarily with them are asked to achieve the same results as those who work with wealthier populations.<sup>23</sup> Without proper risk adjustment, those providers (many of them essential hospitals) could be forced to absorb a greater proportion of readmissions penalties, leaving them with even fewer resources to treat disadvantaged populations.

Furthermore, the NQF board of directors approved the Sociodemographic Status (SDS) Trial Period (SDS Trial Period) in July 2014. The SDS Trial Period is a two-year period in which NQF will allow inclusion of SDS factors in risk adjustment of performance measure scores when there are conceptual reasons and empirical evidence that inclusion is appropriate. At the end of the Trial Period, a determination will be made to either make the policy change (or some modification) permanent, extend the trial period, or rescind the temporary policy change. Additionally, as required by the Improving Medicare Post-Acute Care Transformation (IMPACT) Act, HHS' Office of the Assistant Secretary for Planning and Evaluation (ASPE) is currently conducting studies and making recommendations on the issue of risk adjustment for socioeconomic status on quality measures and resource use. The work of both ASPE and NQF reflect a movement in quality measurement that acknowledges the important role sociodemographic status plays in the care provided by essential hospitals. This

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<sup>20</sup>Graham KL, Wilker EH, Howell MD, Davis RB, Marcantonio ER. Differences Between Early and Late Readmissions Among Patients: A Cohort Study. *Annals of Internal Medicine*. 2015;162:741-749.

<sup>21</sup>Barnett ML, Hsu J, McWilliams JM. 2015. Patient Characteristics and Differences in Hospital Readmission Rates. *JAMA Intern. Med*. doi:10.1001/jamainternmed.2015.4660

<sup>22</sup>Reiter KL, Jiang HJ, Wang J. 2014. Facing the recession: how did safety-net hospitals fare financially compared with their peers? *Health Services Research*. 49(6):1747-66. doi: 10.1111/1475-6773.12230.

<sup>23</sup>See, e.g., NQF Technical Report. *Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors*. August 2014.

[http://www.qualityforum.org/Publications/2014/08/Risk\\_Adjustment\\_for\\_Socioeconomic\\_Status\\_or\\_Other\\_Sociodemographic\\_Factors.aspx](http://www.qualityforum.org/Publications/2014/08/Risk_Adjustment_for_Socioeconomic_Status_or_Other_Sociodemographic_Factors.aspx). Accessed June 2015.

movement also is seen in other agency programs, such as the star ratings system. After receiving stakeholder concerns that the current Medicare Advantage Star Rating system creates a disincentive for plans to serve dually eligible or low-income beneficiaries, CMS recently proposed to implement risk adjustment for a subset of star ratings measures that is meant to adjust for plans serving this vulnerable population. **We urge CMS to examine closely the findings of both the NQF Trial Period and ASPE, and to align its quality programs across settings, to capture accurate hospital quality performance and not unfairly penalize hospitals that serve the vulnerable.**

In addition, adding new measures to the HRRP without first addressing the inadequacies in the existing methodology would further exacerbate the already negative impact this program could have on essential hospitals and the vulnerable populations they serve. **For these reasons, CMS should include a sufficient risk-adjustment methodology that accounts for patient sociodemographic factors in the HRRP.**

- b. CMS should re-evaluate the HRRP to mitigate the effects that a decrease in the national readmissions rate could have on a hospital's readmissions penalty.

Under the existing method for calculating a hospital's readmission penalty, hospitals might continue to face penalties, even as they reduce their excess readmissions, if the national readmission rate continues to improve. MedPAC has noted that the manner in which the readmission penalty is calculated is counterintuitive because improvements in readmission rates nationally can result in higher penalties for individual hospitals.<sup>24</sup> We recognize that CMS does not have authority to change the formula for calculating the readmissions penalty, because the ACA codified the formula. However, the fact that hospitals continue to receive increasing penalties even while they make significant improvements indicates even further the need for CMS to adopt the recommendations in this letter. **CMS should re-evaluate the HRRP to ensure hospitals are not unduly penalized while they reduce unnecessary readmissions, given that hospitals' efforts to improve quality of care will not immediately be reflected in their readmissions adjustment factors.**

5. **CMS should only include measures in the Hospital Value-Based Purchasing (VBP) Program that have been proved to improve patient outcomes, do not overlap with existing measures, and incorporate risk adjustment for sociodemographic factors.**

The VBP Program, authorized by the ACA, continues CMS' efforts to link Medicare payments to improved quality of care in inpatient hospital settings. The program evaluates hospital performance on quality measures and provides incentives to encourage hospitals to improve the quality and safety of care for all patients. The incentive payments are funded through a reduction in DRG base operating payments for each hospital discharge. Hospitals will have a chance to earn back the reduction, plus additional incentives, based on their performance relative to other hospitals. **As the program evolves, CMS should ensure the measures by which hospitals are**

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<sup>24</sup>See, e.g., Medicare Payment Advisory Commission. Comment Letter to CMS on FY 2014 IPPS Proposed Rule. June 2013. <http://www.medpac.gov/documents/comment-letters/medpac's-comment-on-cms's-acute-and-long-term-care-hospitals-proposed-rule.pdf?sfvrsn=0>. Accessed June 2015.

**evaluated are proved to actually improve patient outcomes and increase quality for all patients.**

- a. CMS should ensure the validity of the hospital 30-day, episode-of-care, risk-standardized payment measures for AMI and HF before implementation in FY 2021.

To better understand the service utilization and costs associated with AMI and HF, CMS proposes to expand the VBP Program in FY 2021 by adding condition-specific payment measures to the efficiency and cost-reduction domain. This domain now consists of one measure: payment-standardized Medicare spending per beneficiary (MSPB).

America's Essential Hospitals supports the evolution of value-based purchasing as it shifts the health care market from volume to value. Essential hospitals continuously work to increase coordination between hospitals and physicians to optimize care. One essential hospital in Colorado uses care managers and adds social workers to their personnel to address the social determinants of health that often drive cost. However, improving care coordination and quality while maintaining a mission to serve the most vulnerable is a delicate balance.

A key component of defining value is appropriate measurement. It is important for policymakers to seek guidance from organizations with measurement expertise, such as the NQF and its Measures Application Partnership (MAP), a multistakeholder partnership that guides HHS' selection of performance measures for federal health programs. NQF endorsement and MAP approval are imperative to ensure measure validity and reliability. Through these processes, HHS, the public, and other stakeholders can fully vet and approve measures through a consensus-building approach. In the case of the proposed AMI and HF episode-based payment measures, neither received MAP support. **CMS should not add measures about which participants raised significant concerns during measure development processes.**

MAP members expressed concern that condition-specific payment measures might overlap and double count services already captured in the MSPB measure. Additionally, these stakeholders expressed concerns about risk adjustment for SDS factors and a desire to have more experience with the measure in the IQR Program to understand whether there might be unintended consequences or a need to adjust for such factors. These two measures are also included, along with the pneumonia 30-day episode-of-care payment measure, in the NQF SDS Trial Period, the results of which are forthcoming. It would be premature for CMS to adopt these measures before first examining closely the recommendations of NQF related to SDS adjustment for these measures.

We urge CMS to use the years between now and FY 2021 to ensure the validity of these measures and to address MAP stakeholder concerns about how SDS factors can be incorporated into the measures to improve quality of care while not unduly penalizing essential hospitals.

**6. CMS should continue to adapt the domains and weights in the VBP Program to emphasize the importance of measures that improve patient outcomes.**

In prior rulemaking, CMS finalized this domain and weight structure for the FY 2018 VBP Program:

- safety: 25 percent
- clinical care: 25 percent
- efficiency and cost reduction: 25 percent
- patient- and caregiver-centered experience of care/care coordination: 25 percent

Beginning in FY 2019, CMS proposes to rename “patient- and caregiver-centered experience of care/care coordination” as “Person and Community Engagement” to better align with CMS’ quality strategy. America’s Essential Hospitals supports CMS’ continued efforts to appropriately define the domain and weight structure.

As outlined above, the agency adopted equal weight of 25 percent for each of the four domains, for the FY 2018 program. CMS is not proposing changes to the domain weighting for FY 2019. However, we continue to urge CMS to look closely at the domains, the measures included in them, and their weighting. **CMS should lower the weight for the efficiency domain.** The efficiency and cost reduction domain currently has only one measure: the MSPB measure. Giving a domain with only one measure a 25 percent weight effectively gives that single measure much more weight—and, therefore, more importance—than any other measure in the VBP Program. The VBP Program was created to improve quality and patient outcomes. The measure currently in the efficiency domain does not lead to quality improvements because it solely reflects Medicare payments for services provided. Efficiency is an important component of overall hospital performance improvement; however, this measure does not truly address hospital efficiency because Medicare payments are currently more reflective of the services a hospital provides and the patients it cares for, rather than its efficiency.

CMS proposes to add two condition-specific payment measures to the efficiency and cost-reduction domain in FY 2021; however, as noted above with regard to these new measures, we are concerned about issues raised by MAP participants during the measure development process. While we support the addition of measures within this domain, we urge CMS to closely examine such measures to ensure that the domain is weighted in a manner by which hospitals are focused on improving patient outcomes.

**7. CMS should continue to refine the IQR Program measure set so it contains only reliable and valid measures that provide an accurate representation of hospital quality of care.**

**CMS should continue to tailor the IQR Program measure set so the measures it includes help hospitals improve care quality and benefit the public by accurately reflecting the care those hospitals offer.** America’s Essential Hospitals supports the creation and implementation of measures that lead to quality improvement. But before including measures in the IQR Program, CMS must verify that the measures are properly constructed and do not lead to unintended consequences. CMS also should

ensure the IQR Program includes new measures for at least two years before adding those measures to the VBP or HAC Reduction programs. As highlighted by the Committee on Core Metrics for Better Health at Lower Cost, appointed by the Institute of Medicine, there is a need to reduce the burden of unnecessary and unproductive reporting by reducing the number, sharpening the focus, and improving the comparability of measures.<sup>25</sup> The committee set forth a measure set of “vital signs” for tracking progress toward improved health and health care in the United States. While this starting set might be imperfect, it emphasizes the importance of streamlining measures to promote greater alignment and harmonization and to reduce redundancies and inefficiencies in health system measurement.

CMS proposes to remove 15 measures from the IQR Program for the FY 2019 payment determination. Of these measures, 13 are electronic clinical quality measures (eCQMs) and two are structural measures. America’s Essential Hospitals supports removing measures that are “topped out” and, thus, no longer accurately capture distinctions in quality of care. Removing these measures reduces the administrative burden on hospitals and ensures the IQR measure set is kept up to date and includes only measures that result in better patient outcomes. Any new measures added should be reliable, valid, and useful in improving the quality of hospital care.

CMS proposes refining two measures—30-day episode-of-care payment measure for pneumonia and the modified PSI 90 measure—and adding four new measures to the IQR Program for FY 2019 payment determination, including: three clinical, episode-based payment measures; and one outcome measure for excess days in acute care after hospitalization for pneumonia.

The following comments provide specific recommendations for ensuring the IQR Program provides accurate information to beneficiaries on hospital quality of care and does not unfairly penalize certain hospitals.

- a. CMS should only include measures in the IQR Program that are NQF-endorsed and supported by the MAP.

CMS proposes to refine IQR Program measures, including by expanding the cohort for the pneumonia payment (PN Payment) measure—i.e., total payments made on behalf of the Medicare beneficiary for a 30-day episode-of-care. The MAP conditionally supported the PN Payment measure, pending an examination of SDS factors and NQF review as part of the SDS Trial Period. America’s Essential Hospitals filed a joint appeal of this measure, among other cost and resource use measures undergoing review in the Trial Period.<sup>26</sup> That appeal is in process, with resolution pending. NQF endorsement and MAP approval are imperative to ensure measure validity and reliability. Through these processes, measures are fully vetted and approved through a consensus-building

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<sup>25</sup>Institute of Medicine Committee on Core Metrics for Better Health at Lower Cost. Blumenthal, D, Malphrus, E, McGinnis, J.M. *Vital Signs: Core Metrics for Health and Health Care Progress*. Washington, DC: The National Academies Press; 2015.

<sup>26</sup>Appeal of NQF #2431, 2436 and 2579 from the Cost and Resource Use Measure Endorsement Project. April 5, 2016. [https://essentialhospitals.org/wp-content/uploads/2016/05/NQF-Cost-and-RU-Appeal\\_2016-04-05\\_FINAL.pdf](https://essentialhospitals.org/wp-content/uploads/2016/05/NQF-Cost-and-RU-Appeal_2016-04-05_FINAL.pdf)

approach that involves the public and interested stakeholders. America's Essential Hospitals continues to believe that well-designed measures of cost and resource use are important tools for facilitating improvements in the value of care—delivering the same or better outcomes at lower cost. **However, CMS should not add measures that have not yet been fully vetted through the NQF processes.**

CMS proposes adding three clinical, episode-based payment measures to supplement the existing MSPB measure, and one outcome measure related to excess days in acute care after hospitalization for pneumonia (PN Excess Days). All four proposed measure additions lack NQF endorsement. Additionally, the MAP did not support including the three episode-based payment measures in the IQR Program, with MAP members expressing concern that condition-specific measures might overlap with services the MSPB measure already captures. As for the PN Excess Days measure, CMS states in the proposed rule that there are concerns the current readmission measure for pneumonia does not capture the full range of unplanned acute care in the post-discharge period. As such, the proposed PN Excess Days measure counts all use of acute care occurring in the 30-days post-discharge period, including observation days and emergency department visits. This newly proposed measure has not yet received NQF endorsement. **We urge CMS to delay adoption of the PN Excess Days measure in the IQR Program until the measure can also undergo proper vetting by NQF, including the review of the measure as part of the SDS Trial Period.**

CMS should work collaboratively with interested stakeholders through a transparent process to ensure that its policies, including those for quality measures, allow hospitals to provide the best care for patients in the most appropriate setting, as determined by the physician. **CMS should wait for NQF endorsement and MAP approval, and then allow hospitals the opportunity to gain experience with these measures, before publicly reporting the measures through the IQR Program.**

America's Essential Hospitals supports hospital quality improvement efforts gained through public reporting. However, **thorough public testing and vetting must be undertaken before CMS makes any data available to the public. CMS should also provide hospital-specific, confidential reports** to hospitals to allow them to undertake quality improvement efforts, without the measures' inclusion in the IQR Program and public reporting.

- b. CMS should risk adjust measures in the IQR Program for sociodemographic factors and other appropriate factors.

**CMS should incorporate evidence-based risk adjustment for sociodemographic factors in its methodology for calculating outcome measures in the IQR Program so the results are accurate and reflect differences in the patients being treated by hospitals.** CMS should not add any proposed measure until it is appropriately risk adjusted and should suspend or remove other readmissions measures until they incorporate appropriate risk-adjustment methodology.

A growing body of literature shows that race, homelessness, cultural and linguistic barriers, low literacy, and other socioeconomic factors can skew performance on certain

quality measures, such as those for readmissions.<sup>27</sup> Outcomes measures, especially readmissions measures, do not accurately reflect hospitals' performance if they do not account for sociodemographic factors that can complicate care. Factors outside of hospitals' direct control, such as homelessness, income, education, and primary language, can influence patients' health care outcomes. Patients who do not have a reliable support structure upon discharge are more likely to be readmitted to a hospital or other institutional setting.

The need to account for sociodemographic factors has been increasingly suggested for quality measurement programs. For example, MedPAC made this recommendation for the HRRP.<sup>28</sup> As mentioned above, an NQF panel issued recommendations proposing that certain quality measures be risk adjusted for sociodemographic factors. This growing consensus lends support to the importance of risk adjustment to ensuring accurate and useful information in quality reporting programs. **Therefore, CMS should not include in the IQR Program outcome measures sensitive to sociodemographic factors until the measures have been risk adjusted for those factors.**

**8. CMS should ensure electronic reporting is a viable option for all hospitals and address the discrepancies between electronic and chart-abstracted measures before requiring hospitals to electronically report measures.**

**CMS should not require providers to electronically report electronic clinical quality measures (eCQMs) until these measures are reliable, valid, and have accurate specifications. CMS should work with electronic health record (EHR) vendors to make electronic reporting of measures a viable option for all hospitals. Until CMS has taken these steps to ensure that eCQMs are ready for public reporting, the agency should allow providers to report these measures through attestation.**

For the FY 2019 payment determination (using measure data collected in CY 2017), CMS proposes to remove 13 eCQMs from the IQR Program and require hospitals to electronically report four quarters of data for all 15 remaining eCQMs. In contrast, in CY 2016, hospitals can voluntarily choose only four eCQMs and report one quarter of data. CMS also proposes to remove the same 13 eCQMs from the Medicaid and Medicare EHR Incentive Programs.

While America's Essential Hospitals supports this effort to align the IQR Program with the EHR Incentive Programs, we remain concerned about outstanding issues with the reliability of data produced by certified EHR technology. The data extracted from EHRs differ from the data obtained from chart-abstracted measures and, therefore, are not reliable for display in a publicly reported program. These issues also have been

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<sup>27</sup>America's Essential Hospitals. Sociodemographic Factors Affect Health Outcomes. October 21, 2015. <http://essentialhospitals.org/institute/sociodemographic-factors-and-socioeconomic-status-ses-affect-health-outcomes/>. Accessed November 2015.

<sup>28</sup>See, e.g., Medicare Payment Advisory Commission. *Report to Congress, Medicare and the Health Care Delivery System*. June 2013. [http://www.medpac.gov/documents/reports/jun13\\_EntireReport.pdf](http://www.medpac.gov/documents/reports/jun13_EntireReport.pdf). Accessed June 2015.

highlighted by the Government Accountability Office, which notes that “HHS has not yet developed a comprehensive strategy to address concerns with the reliability of CQMs collected using certified EHRs.”<sup>29</sup> Due to the differences between data extracted from eCQMs and chart-abstracted quality measures, CMS should adopt a validation process and conduct robust testing that would ensure data being extracted from eCQMs are accurate and comparable to chart-abstracted data.

Further, for CMS to finalize this requirement before all measures are fully electronically specified and field tested would be premature. In general, electronic measures have specific requirements about what type of information should be documented; they require more standardization than non-electronic measures. Without detailed electronic specifications available far enough in advance, many providers will not have enough time to bring their reporting systems up to date to report these measures when required. Providers are adapting their workflows to ensure meticulous entry of standardized data into their EHRs. However, it is a process that requires extensive training and resources. Often, the data produced by chart-abstracted measures and eCQMs vary widely. Therefore, it is unwise to finalize any electronic measure until there is enough evidence of its validity in the field to justify its inclusion as a truly meaningful electronic measure.

In addition, to secure sufficient vendor participation, CMS must be more flexible with patient-level data transfer standards. This could include adopting data transmission standards EHR vendors already use. Without vendor support, most hospitals find it impossible to report measures electronically. If these challenges remain unaddressed, they will continue to plague hospitals as they electronically report measures. **Therefore, CMS should continue to work with EHR vendors to make electronic reporting a viable option for all hospitals.**

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America’s Essential Hospitals appreciates the opportunity to submit these comments. If you have questions, please contact Erin O’Malley, director of policy, at 202-585-0127.

Sincerely,

Bruce Siegel, MD, MPH  
President and CEO

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<sup>29</sup>Government Accountability Office. *Electronic Health Record Programs: Participation has Increased, but Action Needed to Achieve Goals, Including Improved Quality of Care*. March 2014. 37. <http://www.gao.gov/assets/670/661399.pdf>. Accessed May 30, 2016.