

June 29, 2015

Andrew Slavitt  
Acting Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1632-P  
P.O. Box 8013  
Baltimore, MD 21244-1850

File Code: CMS- 1632-P

Re: 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 2016 Rates; Revisions of Quality Reporting Requirements for Specific Providers, Including Changes Related to the Electronic Health Record Incentive Program

Dear Mr. Slavitt:

The Healthcare Financial Management Association (HFMA) would like to thank the Centers for Medicare & Medicaid Services (CMS) for the opportunity to comment on the 2016 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 2016 Rates; Revisions of Quality Reporting Requirements for Specific Providers, Including Changes Related to the Electronic Health Record Incentive Program (hereafter referred to as the Proposed Rule) published in the April 30, 2015, *Federal Register*.

HFMA is a professional organization of more than 40,000 individuals involved in various aspects of healthcare financial management. HFMA is committed to helping its members improve the management of and compliance with the numerous rules and regulations that govern the industry.

### **Introduction**

HFMA would like to commend CMS for its thorough analysis and discussion of the myriad Medicare hospital reimbursement decisions addressed in the 2016 IPPS Proposed Rule. Our members have significant concerns regarding the proposals related to:

- Payment Adjustment for Medicare Disproportionate Share Hospitals (DSHs)
- Hospital Readmissions Reduction Program
- Hospital- Acquired Condition (HAC) Reduction Program
- Hospital Value-Based Purchasing Program (VBP)
- Hospital Inpatient Quality Reporting Program (IQR)
- Cost Offset Adjustments Associated with the Delayed Implementation of the “Two-Midnight” Rule
- Expansion of Bundled Payments for Care Improvement (BPCI) Program

Below please find specific comments on the items listed above.

**Payment Adjustment for Medicare DSH Hospitals**

HFMA appreciates CMS's comments in the Proposed Rule regarding the need to make appropriate clarifications and revisions to worksheet S-10. As we have discussed in our FY2014 and FY2015 comment letters on the proposed IPPS rule, HFMA believes the following needs to occur before CMS can use data from worksheet S-10 to allocate the uncompensated care pool to DSH-eligible hospitals:

- Worksheet S-10 needs significant modification and clarification of its related instructions.
- Audit guidelines for non-Medicare charity care and bad debt must be clearly articulated.
- A multi-year phase-in of the S-10 is necessary to minimize the negative impact on hospitals that see reduced uncompensated care payments as a result of shifting to an alternative data source.

**Clarifications and Modifications to the S-10:**

**Conflicting Instructions:** The initial instructions on the S-10 worksheet refer to the statutory requirement for hospitals to report costs "incurred by the hospital for providing inpatient and outpatient hospital services." However, the instructions for line 20 direct the hospital to report gross charges for charity care for the "entire facility," which is generally understood to include portions of the facility on the cost report that are not paid under the Inpatient Prospective Payment System (IPPS) or Outpatient Prospective Payment System (OPPS), such as inpatient rehab/psychiatric facilities and skilled nursing facilities (SNFs). This is problematic, as charity care is reduced to cost on line 21 using the hospital cost-to-charge ratio (CCR) on line 1. Given that the CCR for the hospital and subparts are in many instances very different, this will lead to an inappropriate reporting of charity care costs. A similar problem occurs on line 26 for bad debt reporting. CMS needs to clarify its instructions as to whether hospitals should report only charity care charges and bad debt expense related to inpatient and outpatient services on line 20 and 26. If CMS intends for hospitals to report subpart charity care charges, this should be done with separate lines and should have corresponding separate lines for CCRs to accurately adjust charges for each hospital type to cost.

**Timing of Cost Charity Care for Uninsured and Insured Patients (Lines 20-23, Columns 1 and 2):**

Instructions for line 20 state that charity care charges should be limited to services "delivered during this cost reporting period." This is problematic in that it does not reflect the reality of hospital operations and will ultimately understate charity care costs. Hospitals can grant charity care at any point in the patient account resolution process. Depending on the level of documentation required to obtain charity care and the patient's responsiveness in submitting the proper documentation, charity care can be granted long after the cost report for the fiscal year in which the services were delivered.

**CMS should correct the instructions for line 20 to better reflect the timing of when accounts are granted charity care. The language should read "charges written off during the period covered by the cost report."**

There are two issues with the instructions for line 22. First, a conforming change needs to be made as well to payments related to patients who have been granted charity care so that the instructions for handling payments will match the charges as amended above. **The instructions for line 22 should read "payments received during the period covered by the cost report."**

Second, the instructions also require that hospitals report payments “expected” as well as received. The difficulty is that the gross amounts expected from patients for whom there have been partial write-offs pursuant to a hospital's charity care policy are often not paid in full. Under proper accounting, the amount of such payments would have to be discounted to reflect the amount that is expected, in reality, to be paid. There is no discussion in the instructions on how such estimates should be made, how they will be reviewed by Medicare contractors, and how experience showing that a prior year's estimate was too high or too low should be reflected, if at all, on the current year's S-10. **We encourage CMS to limit partial payments reported on the S-10 to those actually received to reduce the administrative burden for hospitals. However, if CMS does not change the instructions, it needs to work with the industry to provide guidance to hospitals and contractors as to how these estimates will be handled in the S-10 instructions.**

**Calculation of Cost of Charity Care for Insured Patients (Lines 20-23, Column 2):** The methodology outlined to calculate the cost of charity care for insured patients (Column 2) is incorrect as it mixes “apples and oranges.” Instead of listing gross charges on Line 20, Column 2, the instructions state:

*Enter the total initial payment obligation of patients who are given a full or partial discount based on the hospital's charity care criteria...For patients covered by a public program or private insurer with which the provider has a contractual relationship (Column 2), **these are the deductible and coinsurance payments required by the payer** (emphasis added).*

Given that coinsurance and deductibles are typically a function of the payment rate (not gross charges) either negotiated with a private payer or set administratively by public payers, applying the hospital's cost-to-charge ratio (which is derived by dividing the cost to provide services by gross charges) will significantly understate the cost of charity care listed on Line 21, Column 2.

**To accurately arrive at the cost of charity care, HFMA recommends that CMS follow the methodology outlined in Section VI. Valuation of Charity Care of its *Principles and Practices Board Statement 15: Valuation and Financial Statement Presentation of Charity Care and Bad Debts by Institutional Healthcare Providers*<sup>1</sup> (hereafter referred to as P&P Board Statement 15). Section 6, subpart VI states the following:**

**6.1** *Although charges are the basis for charity care recordkeeping purposes, costs, not charges, should be the primary reporting unit for valuing charity care. Accounting Standards Update (ASU) – Health Care Entities (Topic 654): Measuring Charity Care for Disclosure, was issued to reduce the diversity of practice regarding the measurement basis used. The ASU requires that cost be used as the measurement basis for charity care. By contrast, there is great variance among providers' charges, and consequently very little comparability. Also, measures on charges provide little and potentially misleading information about the resources consumed in providing charity care.*

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<sup>1</sup> <http://www.hfma.org/Content.aspx?id=1069>

**6.2** In accordance with ASC paragraph 954-605-50-3, costs of charity care should be measured based on the provider's direct and indirect costs. If costs cannot be specifically attributed to services provided to charity care patients (for example, based on a cost accounting system), management may estimate the costs of those services using reasonable techniques. The method used to identify or estimate such costs should be clearly disclosed in the footnote.

**6.3** In addition to care provided at no charge, providers' charity care policies usually include sliding-scale discounts for low-income, uninsured patients who have the ability to pay a small portion of their bills. Discounts offered under these policies are accounted for as a reduction of revenue.

**6.3(a)** Once a patient is determined to be eligible for a discount under the facility's charity care policy, the whole account is classified as charity care. As payments are received, revenue is recognized as receipts relating to charity care.

**6.3(b)** If a patient is not eligible for discounts under the facility's charity care policy, then any subsequent discounts, such as reduction to the standard managed care rate or a prompt pay discount, should not be accounted for as charity care. This is an important distinction, because only the charity care provided is included in disclosure footnotes.

**To conform to P&P Statement 15 and accurately calculate the cost of charity care, the instructions for worksheet S-10 should be updated to reflect the following:**

- **Line 20, Column 2:** Similar to Column 1, the dollar value in Column 2 should include the initial patient obligation at full charges for the entire facility for all accounts written off to charity care during the cost reporting period in question.
- **Line 22 Column 2:** The dollar value reported here should represent payments for specific patient accounts (e.g., not grants or other mechanisms of funding charity care which are captured on lines 17 & 18) from both patients and insurers (including governmental payers) for accounts that were granted charity care during the cost reporting period in question.

**Cost of Bad Debt Calculation (Lines 26-29):** The instructions for calculating the cost of bad debt are unclear and lead to an understatement of the actual cost to provide care for accounts written off to bad debt. The instructions for line 26 state:

*Enter the total facility (entire hospital complex) **amount of bad debts written off on balances owed by patients during this cost reporting period.** Include such bad debts for all services except physician and other professional services. The amount reported must also include the amounts reported on Worksheets: E, Part A, line 64; E, Part B, line 34; E-2, line 17, Columns 1 and 2; E-3, Part I, line 11; E-3, Part II, line 23; E-3, Part III, line 24; E-3, Part IV, line 14; E-3, Part V, line 25; E-3, Part VI, line 8; E-3, Part VII, line 34; I-5, line 5 (line 5.05, Column 2 for cost reporting periods that overlap or begin on or after January 1, 2011); J-3, line 21; and M-3, line 23. For privately insured patients, do not include bad debts that were the obligation of the insurer rather than the patient (emphasis added).*

First, if a hospital follows these instructions as they are currently written, bad debt and charity care expense calculated will be from different timeframes. The instructions for line 20 related to charity care state to *“Enter the total initial obligation of patients who were given full or partial discount...for care delivered during this cost reporting period”* (emphasis added).

As emphasized above, the instructions for bad debt (Line 26) ask for balances owed by patients written off during this cost reporting period. The amounts reported as written off for charity care on worksheet S-10 will represent care provided during the current period, while the bad debt amounts will represent a mix of care provided in the current and prior periods. **HFMA believes that the timing related to bad debt is correct in the instructions for Line 26. This mismatch is further reason for CMS to adjust its instructions related to Line 20 to more accurately reflect hospital operational realities related to the provision and recognition of charity care.**

Second, applying the hospital’s cost-to-charge ratio to the amount on Line 26 will understate the patient care expense related to insured accounts written off to bad debt. Given the increased cost sharing many insured individuals currently face, a growing portion of a hospital’s bad debt is related to deductibles, coinsurance, and copayments. As discussed above in the section on charity care for the insured, these amounts are not related to charges. Therefore applying a cost-to-charge ratio to these amounts is inappropriate and will result in the understating of expense related to providing care for patients whose cost-sharing is ultimately uncollectible and written off as bad debt.

While there is clear industry guidance to calculate bad debt expense for income statements, this expense is not the same conceptually as the actual cost to provide care, which is what CMS attempts to calculate on line 29. Such guidance exists for charity care (as described above). However applying it in this situation is not appropriate. **HFMA requests that CMS clearly articulate the various ways, beyond allocating DSH uncompensated care payments, that the data on worksheet S-10 will be used. Understanding the intended uses will allow us to assist you in developing a methodology that is more accurate for the intended purposes.**

#### *Audit Process for Charity Care and non-Medicare Bad Debt:*

Currently, there are no published charity care audit instructions for Medicare contractors to follow when reviewing non-Medicare charity care and non-Medicare bad debt. **HFMA strongly believes that CMS needs to clearly communicate criteria by promulgating specific regulations governing the non-Medicare bad debt and charity care be listed on worksheet S-10. The new instructions should require auditors to sample a hospital’s non-Medicare bad debt and charity care. In reviewing claims in the sample, if the hospital followed its own bad debt or charity care policy, an individual claim should be deemed “allowable” for reporting on the S-10. CMS should then apply an error rate derived from the “non-allowable” claims in the bad debt and charity care sample pools to the universe of claims from which each sample was taken.**

We believe this step is necessary immediately as we are deeply concerned by reports from members that MAC auditors, using varying criteria, have disallowed charity care claimed on Worksheet S-10 during audits related to “meaningful use” payments. In many instances, the MACs have not cited any specific regulation other than “instructions from CMS,” which they refuse to share with the hospital. The necessity of well documented and understood charity care audit guidelines will grow in importance if and when CMS uses data from worksheet S-10 to allocate the DSH uncompensated care pool.

**Use of Presumptive Eligibility Tools to Proactively Grant Charity Care:** Many MACs are disallowing charity care granted to patients based on the finding of a presumptive eligibility tool. When hospitals ask for a regulatory reference to support the MAC's disallowance, the MACs either reference "instructions from CMS" which they refuse to share (as discussed above) or they cite Section 312 of the Provider Reimbursement Manual (PRM)— Indigent or Medically Indigent Patients.

HFMA believes that citing Section 312 of the PRM is inappropriate for two reasons.

- 1) Section 312 of the PRM specifically addresses determining Medicare patients' indigence for the purposes of determining allowable Medicare bad debt. It was not intended to address how hospitals administer their charity care policies. HFMA would like to point out that there is a difference between "indigence" and charity care or financial assistance which CMS recognizes in Section 328 of the PRM. In many instances patients who are not considered indigent will qualify for charity care based on a hospital's charity care policy.
- 2) Even if Section 312 of the PRM did apply, consider that the requirements were drafted prior to the advent of presumptive eligibility tools. These tools allow hospitals to more quickly and accurately determine a patient's total resources using the process defined at Section 312 PRM point B with fewer burdens on both the patient and hospital than traditional documentation methods. However, many MACs will not accept this form of charity care identification and documentation because it is not specifically defined as an "allowable" documentation method in the PRM.

**HFMA requests that CMS explicitly define the use of presumptive tools as an acceptable method to identify and document "allowable" charity care for purposes of completing worksheet S-10. This should be included in the regulation promulgated as discussed above. In addition to the regulation articulated, CMS should update PRM 312 to specifically allow for the use of presumptive eligibility tools.**

**Finally, CMS must allow hospitals a mechanism to appeal adjustments to the S-10.** Currently, hospitals are only allowed to appeal adjustments that have a material settlement impact on the cost report. While the data used to calculate the uncompensated care payment will have a significant reimbursement impact on hospitals, it does not "settle" on the cost report.

#### Transition Period:

HFMA believes that transitioning from CMS's current method of distributing the uncompensated care pool using SSI and Medicaid days to a method based on S-10 data could cause a significant reallocation of the uncompensated care pool, creating "winners and losers." Preliminary analysis by Premier shows that 74% of hospitals have a difference in payments greater than -25% or +25% compared to what they are currently estimated to receive for uncompensated care payments.<sup>2</sup> HFMA strongly encourages CMS to use a transition period to minimize cash flow disruptions to hospitals that see a significant decrease in their uncompensated care payments as a result of the change in allocation methodology. We believe

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<sup>2</sup> Kugel, M; Lloyd, D; An Evaluation of the Disproportionate Share Hospital Payment Redistribution Methodology; Poster Displayed at 2014 Academy Health Research Meeting, June 8 – 10 San Diego

CMS should use a minimum of a three-year transition period that blends the allocation methodologies similar to what is currently done with decreases in wage index due to Metropolitan Statistical Area (MSA) changes. However, we would encourage CMS to conduct analysis to better understand the impact and use a phase-in period of appropriate duration to allow hospitals an opportunity to mitigate the negative financial consequences.

#### **Hospital Readmissions Reduction Program (HRRP)**

In prior comment letters (links included below), HFMA has expressed significant concern about the following:

- Insufficient risk adjustment for socioeconomic factors in the HRRP
- Potential negative impact on readmission rates for providers located in a health professional shortage areas
- Lack of accountability other providers in the delivery system face under the various Medicare payment systems for physicians and post-acute care

As of today, CMS has not addressed these issues in either the FY 2016 IPPS Proposed Rule or other appropriate venues. Therefore, we are compelled to reiterate our concerns below. Additionally, in the FY2016 IPPS proposed rule, HFMA has concerns regarding proposed changes to the pneumonia readmissions measure.

**Insufficient Risk Adjustment:** HFMA continues to be concerned by the dearth of patient socioeconomic variables included in the risk-adjustment mechanism, given the role that these factors play in a patient's likelihood of readmission. We appreciate CMS's attempt to analyze the impact of economic status (presented on pages 366-367 of the 2013 proposed IPPS rule) on the penalties meted out by the HRRP. However, we continue to believe that CMS's analysis under-appreciates the effect economic status has on readmissions. MedPAC analysis has shown that there is a positive relationship between the percentage of SSI beneficiaries in a hospital's patient population and the likelihood of incurring an HRRP penalty.<sup>3</sup>

***HFMA continues to strongly recommend that CMS conduct a thorough analysis of the role economic factors play in Medicare readmissions. We believe that this analysis should be conducted at the claims level for readmitted Medicare patients and match their zip codes to existing poverty data to provide an accurate understanding of the role socioeconomic conditions, which are beyond a hospital's control, play in readmissions.***

***Further, HFMA continues to recommend that CMS include SSI and other similar economic indicators (e.g., presence of Medicaid as a secondary payer) to improve risk adjustment until the National Quality Foundation (NQF) develops a readmissions measure that fully accounts for economic drivers. In the interim, HFMA supports MedPAC's proposal to evaluate a hospital's readmission rates against rates for a peer group of hospitals with a similar share of economically challenged Medicare beneficiaries as identified by the percentage of Medicare patients receiving Supplemental Social Security Income. Additionally, much like the excluded conditions, CMS should work with NQF to develop readmissions measures that fully account for economic drivers.***

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<sup>3</sup>[http://www.medpac.gov/chapters/Jun13\\_Ch04.pdf](http://www.medpac.gov/chapters/Jun13_Ch04.pdf)

We continue to believe that refining the risk-adjustment mechanism is necessary to ensure a level playing field for all hospitals while protecting safety net hospitals and their communities from the unintended and counterproductive consequences of an incomplete risk-adjustment mechanism. For these facilities, inpatient Medicare payments are a larger than average component of their revenue. Any reduction in Medicare payment related to an incomplete risk adjustment will have both direct and indirect consequences. As a direct consequence, it will limit hospitals' ability to invest in programs to reduce unnecessary readmissions, and the socioeconomic factors that cause them, further harming Medicare beneficiaries. Indirectly, it will reduce employment and increase the ranks of uninsured in these communities, as safety net hospitals will likely respond to additional financial pressure by reducing staffing levels.

**Relationship of HPSA on Readmission Rates:** Research shows patients who receive timely physician follow-up care post discharge are significantly less likely to be readmitted.<sup>4,5</sup> Given the role that timely follow-up care plays in reducing potentially preventable readmission rates, it is reasonable to ask how potentially preventable readmission rates for hospitals located in HPSAs compare to those that are not located in HPSAs. While research in this area is limited, previous work finds that Medicare beneficiaries living in HPSAs are more likely to experience a potentially preventable hospitalization.<sup>6</sup> **HFMA strongly recommends that CMS study the relationship between a hospital's readmission rates and the surrounding area's HPSA status. If CMS finds a positive correlation between readmission rates and hospital's location in an HPSA, HFMA believes that this factor needs to be accounted for when calculating a hospital's expected readmission rate.**

**Impact of Nursing Home Quality on Readmission Rates:** In previous comment letters, HFMA has expressed concern regarding both the general misalignment of incentives created by a lack of SNF readmission penalties and the specific impact that SNF quality has on readmissions rates. Congress has passed legislation implementing a SNF readmissions penalty beginning in FFY 2019 that will better align incentives. However, in the interim, there is no mechanism to adjust potentially preventable readmission rates for the quality of SNFs that Medicare beneficiaries use. The OIG has found that, on average, higher quality SNFs (those with a four- or five-star rating) have admission rates to acute care facilities that are four percentage points lower than lower quality SNFs (those with three stars or less).<sup>7</sup> While hospitals, in many instances, are partnering with SNFs to coordinate care transitions and improve the quality of care provided at SNFs, they cannot steer Medicare beneficiaries to SNFs that they believe to be high quality. Even if hospitals could steer patients, in many instances high quality SNFs may not have available beds (e.g., areas where high quality SNFs are less prevalent<sup>8</sup> or areas where high quality SNFs exist but they lack capacity to meet demand).

HFMA recommends that CMS take the following steps to account for SNF quality in the HRRP:

<sup>4</sup> Hernandez, A., M. Greiner, G. Fonarow, B. Hammill, P. Heidenreich, C. Yancy, et. al. "Relationship Between Early Physician Follow-up and 30-day Readmission among Medicare Beneficiaries Hospitalized for Heart Failure." *JAMA* 303(17) (2010):1716-1722

<sup>5</sup> Misky, G., H. Wald, E. Coleman. "Post-hospitalization Transitions: Examining the Effects of Timing on Primary Care Provider Follow-up." *Journal of Hospital Medicine* 2010; DOI 10.1002/jhm.666.

<sup>6</sup> Parchman ML, Culler SD. "Preventable hospitalizations in primary care shortage areas. An analysis of vulnerable Medicare beneficiaries." *Arch Fam Med*. Nov-Dec 1999;8(6):487-491

<sup>7</sup> <http://oig.hhs.gov/oei/reports/oei-06-11-00040.pdf>

<sup>8</sup> <http://khn.org/news/a-top-rated-nursing-home-is-hard-to-find-in-texas-10-other-states/>

- **Conduct further research into the impact of SNF quality on hospital readmissions. If, as suggested by the OIG study, there is a measurable impact on potentially preventable readmissions, CMS should work with the NCQA to develop and include a mechanism to account for SNF quality in readmissions measures.**
- **Work with the hospital community and the Office of Inspector General to identify legal barriers that prevent hospitals and SNFs from collaborating and create sufficient exemptions that will further efforts to reduce preventable readmissions.**

**Changes to the Pneumonia Readmission Measure (NQF #0506):** CMS proposes to expand the patient population included in the pneumonia readmission measure for FY 2017 payment determination by including two groups of hospitalized patients:

- Patients with a principal discharge diagnosis of aspiration pneumonia
- Patients with a principal discharge diagnosis of either sepsis or respiratory failure who have a secondary diagnosis of pneumonia that is coded present on admission

The revised measure is conditionally supported by Measures Application Partnership (MAP) for use in the HRRP, pending approval of the NQF. **HFMA urges CMS not to finalize the revised Pneumonia Readmission Measure (NQF #0506) for inclusion into the HRRP until the measure has received NQF endorsement, as mandated by the Affordable Care Act.**

#### **HAC Reduction Program for FY 2016 and Beyond**

HFMA strongly supports efforts to reduce preventable HACs. Additionally, as we have discussed in our whitepaper, *Defining and Delivering Value*, we believe the shift to more outcomes focused quality measures is, in general, a positive one.<sup>9</sup> However, as we have previously commented, the current structure of the HAC program is flawed and inappropriately penalizes hospitals.

**Measure Overlap Between VBP and HAC Program:** There is significant overlap among the measures proposed for the 2016, 2017, and 2018 HAC Reduction Program and the 2016, 2017, and 2018 proposed value-based purchasing (VBP) programs. ***Given the significant overlap of the proposed HAC measures and the VBP program, HFMA strongly recommends eliminating the overlapping measures from the VBP program.*** While we believe it was appropriate to include patient safety measures in the outcomes domain of VBP prior to the implementation of the HAC reduction program, incorporating overlapping measures in both the VBP and HAC reduction program constitutes “double jeopardy,” penalizing a hospital twice for the same issue.

***If CMS insists on using the same measures for both the HAC program and the VBP outcome domain in 2016 and then transferring them into the safety domain in 2017 and thereafter, HFMA recommends that CMS remove the overlapping measures from the VBP calculation for hospitals that incur the HAC penalty.*** This allows CMS to achieve its policy goal of holding all hospitals accountable for HACs (beyond CMS’s current “never-event policy”) while not penalizing a hospital that incurs the HAC penalty three times for the same error. We believe this step is merited, given the outsized role that the outcomes domain plays in 2016 (40% weight) and the increasing emphasis placed on the safety domain. Safety increases from 15% to 20% in FFY 2017 and 25% in FFY 2018.

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<sup>9</sup> <http://www.hfma.org/ValueProject/Phase2/>

**PSI 90 Measure:** For FY 2017, CMS proposes to adjust the weighting across the two HAC domains so that Domain 1 (PSI-90) would be 15 percent and Domain 2 (CLABSI, CAUTI, Colon and Abdominal Hysterectomy SSI, MRSA Bacteremia, and CDI) would be 85 percent. While HFMA supports reducing the weighting on Domain 1, we believe this is insufficient due to continued concerns about the reliability of the PSI-90 measure. **HFMA believes this measure needs to be phased out and replaced with measures that have higher reliability.** This is an urgent need, given that smaller hospitals that do not have sufficient data to be scored on Domain 2 have their entire HAC score based on a flawed measure.

### **Hospital VBP Program**

In addition to the concerns discussed above regarding the significant and unacceptable overlap between the Hospital VBP and HAC reduction programs, as articulated in prior comment letters and reiterated below, HFMA continues to take issue with the overweighting of HCAHPS within the VBP program and the Medicare Spending Per Beneficiary (MSPB-1) measure. Additionally, in the FY2016 Proposed Rule, HFMA is supportive of the proposal to eliminate the clinical process of care sub-domain in FFY 18 due to the removal of two measures. However, we do not support moving PC-01 Elective Delivery Prior to 39 Weeks Completed Gestation into the safety domain.

**HCAHPS Weighting:** We continue to believe the HCAHPS domain is over-weighted. Currently, it comprises 25% of the overall VBP score for FFYs 2016-2018. While hospitals should focus on improving communication with patients and overall patient satisfaction, evidence has shown significant variation in scores due to differences in acuity level and region of the country.<sup>10</sup> Further, a study found that “patient satisfaction was independent of hospital compliance with surgical processes of quality care and with overall hospital employee safety culture.”<sup>11</sup>

*As in prior comment letters, HFMA strongly recommends that CMS conduct a patient-level study to better understand the relationship between HCAHPS scores and outcomes. This study should include the effect of factors beyond a hospital's control such as patient severity, socioeconomic factors, and region. Otherwise, CMS runs the risk of inappropriately penalizing facilities for a measure that may have little relationship to patient outcomes. We are also concerned that without understanding the relationship of patient acuity, socioeconomic factors, and geography on HCAHPS scores, CMS could inadvertently penalize hospitals that provide higher acuity services to a sicker patient population or disadvantage hospitals in one region over another.*

*Finally, we believe that CMS should significantly reduce the weighting of the HCAHPS domain until the relationship between HCAHPS scores and differences in location, socioeconomic risk adjustment, and acuity are better understood.*

**Efficiency Metric:** As of FY 2015, the VBP program includes an efficiency metric. The metric is defined as “inclusive of all Part A and Part B payments from 3 days prior to a subsection (d) hospital admission through 30 days post discharge with certain exclusions. It is risk adjusted for age and severity of illness, and the included payments are standardized to remove differences attributable to geographic payment adjustments and other payment factors.”

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<sup>10</sup> [http://www.washingtonpost.com/national/patient-ratings-to-affect-medicare-payments-to-hospitals/2011/04/28/AFpecP9E\\_story.html](http://www.washingtonpost.com/national/patient-ratings-to-affect-medicare-payments-to-hospitals/2011/04/28/AFpecP9E_story.html)

<sup>11</sup> <http://archsurg.jamanetwork.com/article.aspx?articleid=1679648>

As discussed in previous comment letters, physicians control the majority of decisions that impact spending across an episode of care. Therefore, it will be difficult to isolate and ascribe responsibility for a beneficiary's overall spending to a given hospital. CMS needs to work with the hospital community to develop and implement efficiency metrics sensitive enough to measure spending that hospitals directly influence. Any metric that does not achieve this goal will ultimately reflect variations within physician practices, not underlying hospital cost efficiency. This will only penalize hospitals for the clinical preferences of community physicians, a factor that is beyond the control of hospitals.

***HFMA continues to strongly recommend that CMS take the following steps to ensure that hospitals aren't inappropriately penalized for factors beyond their control related to the overall efficiency of patient care.***

- ***Reduce the weighting of the efficiency metric until after the "physician value-modifier" (or its successor) is implemented into the physician fee schedule for all physicians. Hospitals should not be expected to bear the brunt of penalties related to physician preferences. Implementing a penalty on only one side of the equation will only further misalign the financial incentives between physicians and hospitals and fail to improve the quality of care for Medicare beneficiaries.***
- ***Work with hospitals to refine the efficiency metric. Limiting measurement to only conditions related to the index admission would be a significant improvement over all spending over a 30-day period and would be a more accurate proxy for factors within a hospital's control.***
- ***As discussed under the readmissions section, CMS needs to understand the impact of operating in a HPSA on hospital-specific readmissions rates. If there is a positive correlation between being located in a HPSA and higher potentially preventable readmission rates, this will also likely negatively impact the efficiency metric for hospitals in HPSAs. CMS should adjust the efficiency metric to mitigate the impact of operating in a HPSA on the hospital efficiency measure.***
- ***As discussed under the readmissions section, CMS needs to understand the impact of quality in SNFs and other post acute settings on hospital specific readmissions rates. If there is a positive correlation between receiving patients from low quality post-acute care and higher potentially preventable readmission rates, this will also likely negatively impact the efficiency metric for hospitals in HPSAs. CMS should adjust the efficiency metric to mitigate the impact of SNF quality on the hospital efficiency measure.***

**Moving PC-01 (Elective Delivery Prior to 39 Weeks Completed Gestation) Into the Safety Domain:** In its FY 2013 proposed rule comment letter, HFMA opposed the inclusion of PC-01 in the hospital IQR program. At the time, we questioned how many hospitals would have a sufficient volume of Medicare deliveries to report this measure. Given this concern, we also believed (and continue to believe) that the measure is inappropriate to include in either hospital IQR or VBP. Based on analysis of the most recently available Hospital Compare data for this measure, only 52 percent<sup>12</sup> of eligible hospitals have a score calculated for this measure. **The remaining 48 percent lacked a sufficient number of cases to report the data.** HFMA strongly recommends that instead of moving PC-01 to the Safety Domain, it should remove the measure immediately from both the hospital VBP and IQR programs.

<sup>12</sup> <https://data.medicare.gov/data/hospital-compare>, HFMA Analysis

We agree with CMS that sufficient evidence exists to link pre-term elective deliveries to neonatal mortality and morbidity as well as increased risk of complications for the mother as a result of elective induction. However, we do not believe it is appropriate to use limited hospital resources to report a measure with limited applicability to the Medicare population.

### **Hospital IQR Program**

HFMA's Value Project Report, *Defining and Delivering Value*, found that only 45 percent of hospitals agreed that quality metrics were either "very consistently" or "somewhat consistently" defined across payers. ***Moving forward, HFMA believes that CMS needs to convene a working group across the various Medicaid programs and major national/regional payers in an effort to align quality metrics across payers.*** This would greatly reduce the administrative burden on hospitals and also facilitate the transition to accountable care models.

Specific to the proposed rule, HFMA is concerned by the:

- Required submission of electronic clinical quality measures (eCQM) in the hospital IQR
- Lack of NQF endorsement of newly proposed measures
- Appropriateness of the proposed efficiency metrics
- Lack of socioeconomic risk adjustment and potential for overlap posed by the Excess Acute Care Days after AMI and HF Hospitalization
- Expansion of populations covered by the PN Readmissions (NQF #0506) and mortality measures (NQF #0468)

**Required Submission of Electronic Clinical Quality Measures (eCQM):** CMS proposes to require electronic reporting of 16 of 28 available eCQMs that span at least three national quality strategy domains in the hospital IQR beginning with the FY 2018 payment determination (CY 2016 data submission). HFMA strongly supports efforts to reduce the administrative burden of quality reporting by using eCQMs. However, given the continued concerns about the accuracy and comparability of eCQMs to chart abstracted measures we believe mandatory submission of eCQMs is premature. **HFMA strongly believes that CMS needs to delay mandatory reporting of eCQMs until these issues are resolved.**

**Lack of NQF Endorsement:** CMS proposed the addition of eight new measures for the FY 2018 IQR program: Hospital Survey on Patient Culture, Clinical Episode-based Payment Measures for Kidney/Urinary Tract Infection, Cellulitis, Gastrointestinal Hemorrhage, and Lumbar Spine Fusion/Refusion, and Elective THA/TKA, and Excess Acute Care Days after AMI and HF Hospitalization. While all eight measures are MAP supported they have not been NQF endorsed. **HFMA believes these measures need to receive NQF endorsement prior to inclusion in the IQR.**

**Efficiency Metrics Include Spending Over Which Hospitals Have Little Control:** Similar to the general Medicare Spending Per Beneficiary measure the Clinical Episode-based Payment Measures for Kidney/Urinary Tract Infection, Cellulitis, Gastrointestinal Hemorrhage, and Lumbar Spine Fusion/Refusion, and Elective THA/TKA reflect the decisions of a broad array of healthcare providers across the care continuum. ***We believe that CMS should delay the inclusion of these measures into the IQR until physicians and all settings of post-acute care have a similar measure. Further, before implementation into the IQR, the issues outlined above in the discussion of the MSPB included in VBP must be addressed appropriately for these specific measures.***

*Excess Days in Acute Care Hospitalization For AMI and HF*: CMS proposes to add a measure for both AMI and HF excess days in acute care to develop a holistic picture of a hospital's propensity to have a patient return to any acute care setting (inpatient readmission, outpatient observation, or emergency department (ED)) within 30 days of discharge. HFMA agrees with CMS that such a holistic view is necessary to ensure that hospitals are not substituting observation care and ED visits for a readmission. However, beyond the lack of NQF endorsement, HFMA has two significant concerns regarding these measures.

- 1) The risk adjustment mechanism does not take into account socioeconomic factors. For a full discussion of these concerns, please see the HRRP section of the comment letter.
- 2) Given that the measure includes readmissions as a component, if each measure is implemented, the IQR program will measure readmissions twice for HF and AMI—once through the standard readmission measure and once through the “Excess Days” measure. If and when the “Excess Days” measures are incorporated into the VBP program, this could lead to double jeopardy in the sense that a hospital is penalized for the same readmission twice in the VBP program. **HFMA strongly recommends that CMS delay implementation of the AMI and HF “Excess Days” measures until the risk adjustment mechanism incorporates socioeconomic factors and CMS has resolved the issue of measuring the same readmission twice.**

*Expansion of Populations for Pneumonia Readmissions (NQF #0506) and Mortality (NQF #0468)*

*Measures*: CMS proposes to expand the patient population included in the pneumonia readmission and mortality measures by including two groups of hospitalized patients:

- Patients with a principal discharge diagnosis of aspiration pneumonia
- Patients with a principal discharge diagnosis of either sepsis or respiratory failure who have a secondary diagnosis of pneumonia that is coded present on admission

The revised measures are conditionally supported by MAP pending approval of the NQF. **HFMA urges CMS not to finalize the revised Pneumonia Readmission Measure (NQF #0506) and Mortality Measure (NQF #0468) for inclusion into the IQR until the measure has received NQF endorsement.**

**Cost Offset Adjustments Associated with the Delayed Implementation of the “Two-Midnight” Rule**

As part of CMS's two-midnight rule, the 2014 IPPS rule finalized a proposed .2 percent budget neutrality adjustment. The proposed rule estimated that this would reduce overall payments to hospitals by \$220 million. In its comment letters on the 2014 and 2015 proposed IPPS rules HFMA encouraged CMS to forgo the budget neutrality adjustment.

**HFMA continues to believe that the budget neutrality adjustment is unnecessary as analysis has shown that CMS's projection overstated the positive impact on hospitals of the two midnight rule.** Repealing the reduction would give CMS an opportunity to reevaluate the need for and scale of any necessary budget neutrality adjustment required by implementation of the two midnight rule.

**Expansion of the Bundled Payment for Care Improvement (BPCI) Program**

HFMA fully supports CMS's goal of transitioning 50 percent of Medicare fee-for-service (FFS) payments to value-based arrangements (defined by CMS as models such as Medicare Shared Savings Program

(MSSP), Pioneer ACOs, Next Generation ACOs, Bundled Payments for Care Improvement, and other similar models) by the end of 2018. We appreciate CMS's outreach to the hospital community as it contemplates expanding episodic payments into the IPPS. We continue to hear feedback from members participating in BPCI that there are significant design issues with the episodes and participants in the program face many operational and administrative barriers. Below please find our responses to the questions posed in the Proposed Rule. While many of the responses were included in our proactive comment letter (link included below), we have supplemented these comments where necessary.

1. What should be the breadth and scope of an expansion (which models, geographies, voluntary/mandatory)?
  - Any expansion should be voluntary. At this point it's too early to comment on which models should be expanded. HFMA believes CMS needs to better understand and publicize the results of various bundling efforts that are currently in the field before contemplating an expansion of any particular bundled payment model.
2. How should episodes be defined (including MS-DRGs, readmissions, length, initiating event)?
  - If an episode's duration extends beyond discharge, families of related MS-DRGs should not be used as the construct for an episode. While clinically related MS-DRGs may share a similar cost profile for the acute hospitalization, as discussed further in the section on risk adjustment there can be significant cost variation related to the patient's underlying condition in the post-acute period.
  - As a conceptual example, two patients—one with no complicating conditions, one with severe schizophrenia—both undergo an episode of care for Major Joint Replacement of the Lower Extremity. Even if care is optimally managed for both patients across the care continuum, under the BPCI Models 2 and 3, costs for the episode of care involving the patient with severe schizophrenia will be considerably higher than the benchmark because the bundle is organized around a construct (an MS-DRG) that does not fully take into consideration underlying conditions that drive spending as the duration of the episode increases. However, in the situation outlined above, it would be appropriate to use an MS-DRG if an episode of care were limited to Part A and B services provided from three days prior to admission to discharge from the acute facility.
  - HFMA believes CMS should also work with state Medicaid plans and private sector health plans (both in their Medicare Advantage and "commercial" business lines) to develop a common definition for each episode. Taking this approach should lead to administrative simplification and potentially help increase the overall volume within bundles to improve statistical validity of benchmark prices (discussed further below).
3. Which models should be expanded?
  - Again, HFMA believes that at this point it's too early to comment on which models should be expanded. CMS needs to better understand and publicize the results of the various bundling efforts in the field before contemplating an expansion of a bundle.

- As a general rule, only models where all participating hospitals have sufficient volume in an episode to create statistical stability in the underlying benchmark price should be considered for mandatory expansion.

4. What roles of organizations and relationships are necessary or beneficial to care transformation?

Managing across a continuum of care—even for an episode that spans only from the three days prior to admission to discharge—requires willing partners. It's unrealistic to think that a health system will own all of the necessary assets to manage an episode of care. Therefore, if CMS makes bundling or episodic payments mandatory for one set of providers, it needs to make them mandatory for all of the providers involved in an episode of care.

5. How should bundled payment rates be set?

The price for a bundled payment should be set to reflect the cost incurred by an efficient group of providers plus a reasonable return to support capital replacement and societal mission. Once the bundled price is set, it should not be recalculated as is currently done in the BPCI program. The only exception should be for risk adjustment to allow for changes in the population of patients qualifying for the bundle from the benchmark/price-setting period to the performance period. Please see below for a complete discussion of issues in the current BPCI program with price setting and risk adjustment.

**Risk Adjustment:** HFMA believes the current mechanisms the Center for Medicare & Medicaid Innovation (CMMI) is using to risk adjust the BPCI program are insufficient.

First, the current bundles are based on “clinical episode families” comprising groups of related MS-DRGs. Analysis has shown that there is significant cost variation across MS-DRGs within the same clinical episode family. This will have the most significant impact on Model 2 and 3 participants. Based on analysis by the Health Care Incentives Improvement Institute (HCI3), the average episode cost for major joint replacement is \$20,522. However there is significant variation in the episode prices in the underlying MS-DRGs (469 - \$32,345; 470 - \$19,638).<sup>13</sup> Even a slight change in the mix of cases compared to the baseline data will have a significant impact on the participant’s actual performance relative to the target price. This impact will be the result of chance, not efforts (successful or otherwise) to re-engineer care delivery for major joint replacement procedures.

There is also significant cost variation within an MS-DRG, depending on the patient’s underlying diagnosis code. For example, based on analysis by HCI3, the average episode cost for percutaneous coronary intervention is \$15,693. However, for patients with acute myocardial infarction/cardiac dysrhythmias, it’s \$17,293, for those with stable coronary artery disease, it’s \$14,147, and for those with other principal diagnoses, it’s \$18,292.<sup>14</sup> Again, any variance in the distribution of primary diagnoses during the performance period relative to the distribution during the historical period used to set the target will impact a participant’s performance. As a result, a participant’s financial results reflect both changes in care delivery and random variation.

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<sup>13</sup> <http://www.hci3.org/sites/default/files/files/HCI-IssueBrief-5-2012.pdf>

<sup>14</sup> <http://www.hci3.org/sites/default/files/files/HCI-IssueBrief-5-2012.pdf>

**Recommendation:** CMMI needs to incorporate a mechanism to eliminate the impact of random variation on the financial outcome of episodes. Without this modification to the program, participants are managing not only performance risk but insurance risk as well. Given that the price variation occurs in the post-acute portion of the episode, we believe that CMMI needs to develop target costs based on the patient's principal diagnosis or develop clinical families of related principal diagnoses that have similar cost profiles. While CMMI could retrospectively adjust the target price based on the mix of MS-DRGs, HFMA does not believe this is a viable long-term solution. First, given that MS-DRGs were developed as a measure of resource utilization in acute settings, they may not be the best predictor of necessary post-acute resource utilization. Second, as discussed below, HFMA strongly believes participants need a benchmark that is prospectively set and not subject to subsequent adjustments.

Second, HFMA is also concerned that participants whose patient population includes a larger share of dual-eligible patients could be disadvantaged in an episodic payment model. As research has shown, dual-eligible patients typically incur a higher cost, particularly across longer episodes. While this may not be as much of an issue with procedure-focused MS-DRGs, it causes concern for medical MS-DRGs (e.g., pneumonia, congestive heart failure).

**Recommendation:** CMMI should incorporate some level of adjustment for socioeconomic (SES) factors into each bundle's target price. As a long-term solution, HFMA encourages CMMI to explore incorporating the NQF SES risk adjustment measure once it is adopted. However, in the interim we ask that CMMI explore basing SES risk adjustment on a hospital's SSI ratio as a proxy. For post-acute providers, as an interim step toward SES adjustment, CMMI should calculate an SSI ratio for the facility and incorporate that into target price setting.

**Re-Pricing the Target Price:** CMMI recalculates the target price in the initial and subsequent reconciliation periods. This was not communicated to participants prior to the start of the program as they were under the impression that the target price CMMI communicated to them at the outset of the program would be the final target price used for all reconciliations. Further, CMMI initially stated that the target price would be trended forward based on state experience.

Currently, the target price changes based on precedence rules and adjustment of national trend factors. Given that this can occur through several reconciliation periods, the actual target price is unknown for up to a year after the conclusion of an episode. While the quarter-over-quarter change is capped at plus or minus 3.5 percent, CMMI's approach to the target price is detrimental to participants for the following reasons:

- A shifting benchmark makes it difficult to focus on changes that will reduce episode spending when the baseline fluctuates without sufficient explanation as to why it changed. These random fluctuations can have a de-motivating impact on individuals involved in care process redesign.
- The reasons for the changes in the benchmark appear to be random within episodes, making it exceedingly difficult to communicate the reasons for the change to participating physicians. This could strain the relationship between collaborating organizations. The risk of this occurring is exacerbated for participants who have gain-sharing agreements with physicians and other providers.

- A national trend factor, as opposed to a state one, will disadvantage organizations in high cost-growth areas while rewarding organizations in low-cost growth areas. Instead of being rewarded for making care delivery more efficient, hospitals are rewarded or penalized based on geography.

Recommendation: CMMI should move to a stable prospectively set target price. Not only is this accepted practice in commercial bundling arrangements, but CMMI is implementing a similar conceptual model in the “Next Generation” ACO program in response to criticisms about the benchmark in the Pioneer program. Additionally, any changes in the composition of BPCI participants in a market that would impact assignment of cases based on precedence rules should be factored in at the beginning of a new contracting period. Implementing these changes to the program will give participating organizations a clear target to work toward.

For future programs, CMMI needs to communicate issues related to setting and updating target prices much more clearly so that hospitals have sufficient information to determine whether or not they want to participate.

## 6. How should CMS mitigate the risk of high cost outliers?

While CMMI attempts to control for insurance risk using winsorization, this still leaves organizations participating in episodes with relatively small volumes exposed to insurance risk. For example, during Phase 1, an organization with approximately 300 joint replacement procedures incurred a significant loss relative to the target price on just two cases. One of the cases was a non-elective joint replacement for an individual with late-stage chronic disease. The individual required an extended stay in a post-acute facility, not as a result of the joint replacement procedure, but due to the underlying chronic condition. In this example, the winsorization and related risk track did not reduce the organization’s exposure to extreme outliers sufficiently to shield it from insurance risk. Had the participant been in Phase 2, the organization would have owed CMMI a significant payable and as a result has elected not to proceed to the risk-bearing phase.

Recommendation: CMMI needs to take additional steps to reduce participants’ exposure to extreme outliers beyond winsorization for participants with relatively low volumes of episodes. If additional statistical trimming is not possible, CMMI should consider other program design changes. As an example of a possible solution for participants with volumes below a specific threshold, CMMI should consider offering an upside-only model similar to what is currently available to participants in the first contract period in the Medicare Shared Savings Program. While CMMI and CMS would like to see physicians, hospitals, and post-acute care providers engage in two-sided risk models, it may not be practical for organizations with relatively low episode volumes to do so as they will expose themselves to insurance risk, which they are not positioned to successfully manage.

Long-term, CMMI needs to work with state Medicaid programs and private health plans to implement a refined episodic payment methodology across payers. In doing so, CMMI needs to explore methods that would allow participants to aggregate volume across payers (providing a larger base to improve statistical stability of target and actual pricing) while maintaining separate target prices for each payer that is reflective of historically negotiated or administratively set rates for units of service. Beyond improving the statistical stability of calculations related to a given episode (which would likely encourage more organizations to participate), doing this would align

incentives across payers for episodes, which would have a multiplier effect on the inherent incentives to redesign care delivery for an episode. Further, to the extent that administrative processes related to episode management are aligned (similar to the episodes developed under Arkansas's Health Care Payment Improvement Initiative), it would reduce administrative costs and reporting burden.

Given that standardizing bundles across the public and private sector at a national level will take a considerable period of time, CMS will need to pursue one or more of the following options to protect delivery systems from high-cost outliers:

- Develop a mechanism similar to the current IPPS outlier payment for episodes of care that provides additional payment for high-cost outliers (if CMS/CMMI ultimately moves to a prospective bundle).
- Implement additional stop-loss thresholds beyond those currently available via winsorization for catastrophic cases where the actual cost (payments from CMS to the various providers involved) exceeds the target price.

7. Should CMS make a single bundled payment for care to a convener or other entity for the episode?

Given that hospitals have limited experience acting as a Third Party Administrator (TPA), CMS should move forward with making a single bundled payment on a pilot basis. The pilot should be used to better understand the challenges organizations encounter and the most effective solutions developed in response. CMS will also need to provide additional infrastructure funding to the convener or other entities involved in distributing payments to help them develop/support the administrative systems necessary to manage payments to providers and other entities who participate in an episode of care. Currently, these systems are not commonly found in hospital organizations.

8. What type of data is needed in the marketplace to expand this type of model?

*Recommendation:* CMMI needs to provide participants with all data, methods, and underlying calculations necessary to replicate the reconciliation results. This check is necessary to ensure that inadvertent errors did not occur (as will happen from time to time) when the contractor reconciled actual episode prices to targets. The ability to replicate the reconciliation results also helps maintain a transparent and open relationship among the BPCI participant, CMMI, and CMMI's contractor.

Second, HFMA continues to hear from both current and potential BPCI participants that the process of identifying new episodes to participate in is challenging due to a lack of flexibility on the part of the program. If a participant or potential participant has requested data for an episode of a specific duration (e.g., PCI- 90 days) for initial analysis, the program will not accommodate subsequent data requests for the same episode of a shorter duration (e.g., PCI-30 days). Instead, the participant (or potential participant) will need to manipulate the data themselves to understand the potential opportunity created by participating in the episode. While this is possible for the example above, if a participant (or potential participant) had initially asked for an episode of shorter duration (e.g., PCI-30 days) and wanted to evaluate the potential of a longer episode, they would have insufficient data to complete the analysis.

In some instances, additional data requests were accommodated. However, there were still issues with the satisfaction of the request as data was not provided in a timely manner to complete the analysis prior to CMMI's deadline. Given the issues CMMI is having satisfying data requests from both participants (and potential participants), this calls into question the organization's ability to manage the program beyond a relatively limited pilot.

*Recommendation:* CMMI and CMS need to develop data capabilities that are more responsive to provider needs. CMMI also needs to impose more strenuous service-level agreements on the contractor it uses for data extraction.

Third, CMMI initially specified a file layout for the data it would send participants to support their efforts to appropriately manage patient care. Based on this file format, participants developed analytic tools to turn the data into actionable information for care improvement. However, CMMI, without warning, changed the file format, making it impossible to upload files for analysis. This significantly delayed participants' ability to address variances with CMMI and provide feedback reports to participating physicians.

*Recommendation:* CMMI needs to develop a consistent file layout/format. Once the format is established, CMMI should not make additional changes. If a change is unavoidable, the change should be communicated with sufficient lead time to allow participants and their consultants to change their analytic systems.

9. How can health information technology be used and encouraged in coordinating care across settings, including post-acute care?

Post-acute care providers were not included in the HITECH funding. This omission has left a significant gap in the care continuum in terms of readily accessible patient information once patients move to a post-acute setting. Given that most of the variability in the cost of an episode beyond 30 days is driven by post-acute care spending, this is a significant blind spot.

One of the other challenges facing hospitals (and this extends beyond health IT) is that the BPCI program is based on an "open network" design. Beneficiaries can receive any component of their care from any provider, regardless of whether or not they are participating in the bundle. Under the current open network model, bundle participants will need access to a regional health information exchange to have a clear, real-time picture of the services provided to a patient whose episode of care is attributed to the hospital.

10. What quality measures could be applied to episodes and how can value-based purchasing be applied to the BPCI initiative?

CMS should work with the NQF to develop risk adjusted (including but not limited to accounting for prior patient functional status, primary disease state severity, confounding co-morbidities, patient socioeconomic status) functional outcome measures to apply to bundles. While process measures are valuable to health systems to monitor adherence to clinical care pathways, the care team should be allowed the flexibility to monitor the metrics they believe will achieve the desired outcome as defined by CMS. Given the inability of researchers to link process measures to meaningful

outcomes, making this transition will minimize the element of “teaching to the test” and free care teams to focus on activities they believe are of high-value for individual patients.

11. What should be the parameters of a transition period from Medicare FFS payment to bundled payment under an expanded model?

If there's a mandatory transition, it should be phased in over a number of years. Also, there should be a minimum volume threshold. Before a hospital is transitioned into a bundle it must surpass the minimum number of qualifying cases for the bundle. This not only supports the statistical validity of the calculated episode price but helps to focus practice improvement and network development efforts.

HFMA looks forward to any opportunity to provide assistance or comments to support CMS's efforts to refine and improve the 2016 IPPS Proposed Rule. As an organization, we take pride in our long history of providing balanced, objective financial technical expertise to Congress, CMS, and advisory groups.

We are at your service to help CMS gain a balanced perspective on this complex issue. If you have additional questions, you may reach me or Richard Gundling, Vice President of HFMA's Washington, DC, office, at (202) 296-2920. The Association and I look forward to working with you.

Sincerely,



Joseph J. Fifer, FHFMA, CPA  
President and Chief Executive Officer  
Healthcare Financial Management Association

#### **About HFMA**

HFMA is the nation's leading membership organization for more than 40,000 healthcare financial management professionals. Our members are widely diverse, employed by hospitals, integrated delivery systems, managed care organizations, ambulatory and long-term care facilities, physician practices, accounting and consulting firms, and insurance companies. Members' positions include chief executive officer, chief financial officer, controller, patient accounts manager, accountant, and consultant.

HFMA is a nonpartisan professional practice organization. As part of its education, information, and professional development services, HFMA develops and promotes ethical, high-quality healthcare finance practices. HFMA works with a broad cross-section of stakeholders to improve the healthcare industry by identifying and bridging gaps in knowledge, best practices, and standards.

#### **Links to Comment Letters**

DSH Reduction:

<https://www.hfma.org/content.aspx?id=21502>

<http://www.hfma.org/Content.aspx?id=21963>

Readmissions:

<http://www.hfma.org/Content.aspx?id=23440>  
<https://www.hfma.org/content.aspx?id=21502>  
<http://www.hfma.org/Content.aspx?id=1318>  
<http://www.hfma.org/Content.aspx?id=1311>  
<http://www.hfma.org/Content.aspx?id=1306>  
<http://www.hfma.org/Content.aspx?id=13904>

Value-Based Purchasing:

<http://www.hfma.org/Content.aspx?id=23440>  
<https://www.hfma.org/content.aspx?id=21502>  
<http://www.hfma.org/Content.aspx?id=1007>  
<http://www.hfma.org/Content.aspx?id=1306>  
<http://www.hfma.org/Content.aspx?id=13904>

HAC Penalty:

<http://www.hfma.org/Content.aspx?id=23440>  
<https://www.hfma.org/content.aspx?id=21502>

BPCI:

<http://www.hfma.org/Content.aspx?id=31072>  
<http://www.hfma.org/Content.aspx?id=1279>