



June 15, 2016

Andrew Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1655-P
P.O. Box 8011
Baltimore, MD 21244-1850

File Code: CMS-1655-P

Re: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2017 Rates; Quality Reporting Requirements for Specific Providers; Graduate Medical Education; Hospital Notification Procedures Applicable to Beneficiaries Receiving Observation Services; and Technical Changes Relating to Costs to Organizations and Medicare Cost Reports

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 2017 Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2017 Rates; Quality Reporting Requirements for Specific Providers; Graduate Medical Education; Hospital Notification Procedures Applicable to Beneficiaries Receiving Observation Services; and Technical Changes Relating to Costs to Organizations and Medicare Cost Reports (hereafter referred to as the Proposed Rule) published in the April 27, 2016, *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 2017 IPPS Proposed Rule. Our members have significant concerns regarding the proposals related to the:

- Payment Adjustment for Medicare Disproportionate Share Hospitals (DSH)
- Hospital Readmissions Reduction Program (HRRP)
- Hospital and Critical Access Hospital (CAH) Notification Procedures for Outpatients Receiving Services
- Adjustment to Inpatient Prospective Payment Systems (IPPS) Rates Resulting from 2-Midnight Policy
- Hospital Acquired Condition (HAC) Program

- Hospital Value-Based Purchasing (VBP) Program
- Inpatient Quality Reporting (IQR) Program

Below please find specific comments on the items listed above.

Payment Adjustment for Medicare DSH Hospitals

HFMA appreciates CMS's thoughtful plan to transition the calculation of Factor 3, which is used to allocate the uncompensated care (UC) payment, to uncompensated care data from worksheet S-10. We fully appreciate and support the changes proposed to the timeframe for which charity care should be reported. This is a meaningful step forward toward improving the accuracy of the data reported on S-10. HFMA's members also appreciate and support the use of a three-year transition period to phase in the use of data from the S-10 to calculate Factor 3.

However, as we have discussed in our FY2014, FY2015, and FY2016 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.

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" in the first sentence of the instructions for line 20. This is generally understood to include portions of the facility on the cost report that are not paid under the IPPS or Outpatient Prospective Payment System (OPPS), such as inpatient rehab/psychiatric facilities and skilled nursing facilities (SNFs). The fourth sentence in the instructions further reinforces the interpretation that subparts should be included by stating: "Include charity care for all services except physician and other professional services" (emphasis added).

If CMS intends for hospitals to report charity care charges for subparts, it needs to list which ones should be included (similar to what can be interpreted from the bad debt instructions on line 26). If CMS does not intend for hospitals to report subpart charity care charges on line 20, the phrase "entire facility" in the first sentence needs to be changed to "hospital" and in the fourth sentence, the phrase "for all services except physician and other professional services" needs to specifically state what (if any subparts) services should be included on line 20.

Timing of Payments for Patients Approved for Partial Charity Care for Uninsured and Insured Patients (Line 22 Columns 1 and 2):

There are two issues with the instructions for line 22. As stated above, HFMA appreciates and supports CMS's proposed changes to line 20. Requiring reporting of charity care granted during the cost-reporting period (not just charity care provided and granted) more accurately reflects the uncompensated care

provided by hospitals. It also aligns with generally accepted accounting principles (GAAP), as CMS notes in the proposed rule.

However, a conforming change needs to be made to line 22 which currently reads, “Enter payments received or expected for services delivered during this cost report period,” (emphasis added). This is problematic in two ways.

First, the current S-10 instructions amended by the proposed rule require providers to recognize charity care during the cost-reporting period in which it is granted. However, it limits the recognition of offsetting revenue for patients granted partial charity care to the cost-reporting period in which services are provided. It is not uncommon to receive payments for services long after the cost report period ends. **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 and for which collectability is reasonably assured, in reality, to be paid. There is no discussion in the instructions of 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. If CMS makes the conforming change to line 22 discussed above, it will obviate the need for including “expected payments” in line 22. 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:

*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 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 Providers¹ (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.

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**

¹ “Valuation and Financial Statement Presentation of Charity Care and Bad Debts by Institutional Healthcare Providers,” HFMA, December 2012.

granted charity care during the cost-reporting period in question.

Cost of Bad Debt Calculation (Lines 26-29)

HFMA members continue to be concerned that the definition of bad debt is unclear and that the methodology CMS uses to arrive at the cost of bad debt significantly understates the uncompensated care expense that hospitals incur as a result of uncollectible accounts.

The instructions for calculating the cost of bad debt are unclear. 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.

The instructions for line 26 include not only Medicare bad debts for inpatient and outpatient services but for swing beds, services reimbursed under TEFRA, inpatient psychiatric PPS, inpatient rehabilitation PPS, long-term care hospital (LTCH) PPS, cost-based (CAH), skilled nursing facility (SNF) PPS, other health services reimbursed under titles V or XIX, Part B Dialysis, Community Mental Health Centers (CMHCs), and rural health clinics (RHCs) and federally qualified health centers (FQHCs).

Given that the instructions include Medicare bad debts on line 26 for services provided beyond the inpatient and outpatient setting, HFMA believes that hospitals should include non-Medicare bad debts for services provided in the following settings whose expenses are included on the hospital cost report: skilled nursing beds (both swing beds and distinct part facilities), distinct part inpatient rehabilitation units, distinct part LCTHs, distinct part psychiatric units, dialysis centers, CMHCs, RHC and FQHCs. **HFMA asks CMS in the final rule to confirm that this interpretation is correct.**

Additionally, HFMA requests that CMS define any additional distinct part units or services that are not listed in the instructions for line 26 but should be included in that line as bad debt. As an example, there is no cost sharing for home health services in the Medicare benefit design and therefore it is not including on the listing of items/services to include in line 26. However, if CMS truly intends for the bad debt expense to represent the “entire hospital complex,” distinct part home health agencies should be included.

The Medicare bad debt 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 Jan. 1, 2011); J-3, line 21; and M-3, line 23 is netted of any recoveries received during the cost report year. HFMA believes that it is appropriate to also net any non-Medicare bad debt claimed on line 26 for recoveries. However, the S-10 instructions are silent on the

issue. **HFMA requests that CMS in the final rule clarify whether or not non-Medicare bad debt claimed on line 26 should be netted of recoveries received during the cost report period.**

Second, line 26 co-mingles bad debt for both uninsured patients and patients who have some form of insurance but are not able to meet their cost sharing responsibility. Applying the hospital's cost-to-charge ratio to the amount on line 26 will understate the patient care expense-related deductibles and coinsurance for 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. Therefore we anticipate that the degree to which bad debt expense is growing and will continue to do so as more cost is shifted to insured patients through less generous benefit designs. **HFMA strongly recommends that CMS revise worksheet S-10 and, similar to line 20 for charity care, require separate reporting for bad debt written off for the uninsured and for those who are insured but cannot afford their cost sharing.** CMS can apply the cost to charge ratio to bad debt for the uninsured and then net that amount of patients to arrive at an accurate estimation of bad debt expense for the uninsured. However, as described above, using a similar methodology related to balances after insurance for the uninsured will result in an inaccurate cost finding.

Therefore, 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 of arriving at the cost of bad debt related to insured patients who are unable to satisfy their cost sharing requirements.

Audit Process for Charity Care and Non-Medicare Bad Debt:

Currently, there are no published audit instructions for Medicare contractors to follow when reviewing non-Medicare charity care and non-Medicare bad debt. In this vacuum, our members who have undergone "meaningful use audits" report that MACs have disallowed charity care, citing justifications ranging from arbitrary federal poverty limits to inappropriately citing section 312 of the Provider Reimbursement Manual (PRM), which pertains to determining indigence for purposes of identifying Medicare bad debt. Further, one of the common issues experienced by hospitals during "meaningful use" audits is the disallowance of charity care granted using a presumptive eligibility tool.

In communications with HFMA, CMS has stated that its position on charity care is as follows:

Hospitals provide varying levels of charity care, which must be budgeted for and financed by the hospital depending on the hospital's mission, financial condition, geographic location and other factors. In advance of billing, hospitals typically use a process to identify who can and cannot afford to pay in order to anticipate whether the patient's care needs to be funded through an alternative source, such as a charity care fund.

Depending on a variety of factors, including whether a patient self-identifies as medically indigent or underinsured in a timely manner, care may be classified as either charity care or bad debt; however, a provider MAY NOT write off an account as charity care and also claim it as a Medicare bad debt. If the provider writes the account off as bad debt, Medicare has guidelines that they must follow including section 312 "Indigent or Medically Indigent Patients." If the provider writes the account off as charity care they must follow their charity care

policy. Medicare does not dictate or have requirements for the hospital's charity care policies because charity care is not reimbursable by Medicare.

CMS has further clarified that it interprets the above to mean that if a presumptive methodology is part of a hospital's charity care policy, it may be used in identifying amounts reported on S-10. CMS indicates that it has provided this guidance to its contractors and is in the process of updating the PRM to reflect this position.

HFMA strongly supports CMS's position on identifying charity care for reporting on the S-10 and encourages CMS to expedite its updating of the PRM. Further, we suggest that, until the PRM is updated, CMS should provide continuous education to its contractors, as it appears that some Medicare Administrative Contractors (MACs) may not be aware of its position. Finally, given some MACs' continued mistreatment of charity care on the S-10, HFMA believes that 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 in the future, it does not "settle" on the cost report that it is reported on.

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 area (HPSA)
- Lack of accountability other providers in the delivery system face under the various Medicare payment systems

As of today, CMS has not addressed these issues in either the FY 2017 IPPS Proposed Rule or other appropriate venues. Therefore, we are compelled to reiterate our concerns below.

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 acknowledgement in the proposed rule about the "important role that sociodemographic status plays in the care of patients." However, our members continue to be frustrated by CMS's unwillingness to address this issue while it awaits the results of the National Quality Foundation's (NQF's) two-year trial to determine if risk adjusting for sociodemographic factors is appropriate. What further fuels hospitals' frustration on this issue is that, despite a limited evidence base (similar to hospitals), CMS is taking steps to resolve this issue in other payment systems. In its 2017 Medicare Advantage Call Letter CMS stated that it:

"will implement as proposed an interim analytical adjustment to account for low income subsidy/dual eligible and/or disability status. The adjustment factor will vary by a contract's proportion of low income subsidy/dually eligible and disability status beneficiaries. Through this interim adjustment, CMS seeks to more accurately capture true plan performance, while work continues by the HHS Assistant Secretary for Planning and Evaluation (ASPE) and measure stewards in this important area."

HFMA fully supports CMS's efforts to work with the NQF and other measure developers to develop an accurate mechanism to account for the impact of socioeconomic variables in hospital readmissions rates and other outcomes measures. **However, similar to the interim measure that CMS put into place for Medicare Advantage plans to ensure that the Star Ratings System did not penalize health plans that enroll individuals who face socioeconomic challenges or are low-income disabled, HFMA demands that CMS implement MedPAC's proposal to stratify readmission rates based on Supplemental Security Income (SSI) days. We believe evaluating a hospital's readmission rates for purposes of the HRRP against rates for a peer group of hospitals with a similar share of economically challenged Medicare beneficiaries balances CMS's concerns about masking disparities while avoiding penalizing a hospital just because it serves a disadvantaged population.**

Failure to take this step will perpetuate the unintended and counterproductive consequences of an incomplete risk-adjustment mechanism in the HRRP. Recent research has confirmed that safety net hospitals are disproportionately adversely impacted by the readmissions penalty due to their patient populations, not their care processes. Patient-specific factors explained approximately 60 percent of the observed differential in readmission rates between high- and low-DSH hospitals.²

Typically for hospitals serving disadvantaged populations, 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 the 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.^{3,4} 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.⁵ **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 a hospital's location in an HPSA, HFMA believes that this factor needs to be accounted for when calculating a hospital's expected readmission rate.**

² [Sheingold, S.H., Zuckerman, R., Shartzer, A., et al.](#), "Understanding Medicare Hospital Readmission Rates And Differing Penalties Between Safety-Net And Other Hospitals," *Health Affairs*, January 2016, pp. 124-131.

³ 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.

⁴ 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.

⁵ 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.

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 Office of Inspector General (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).⁶ 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 prevalent⁷ 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:

- **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 National Committee for Quality Assurance (NCQA) to develop and include a mechanism to account for SNF quality in readmissions measures.**
- **Work with the hospital community and the OIG to identify legal barriers that prevent hospitals and SNFs from collaborating and create sufficient exemptions that will further efforts to reduce preventable readmissions.**

Hospital and CAH Notification Procedures for Outpatients Receiving Services

The proposed rule includes regulations to implement the NOTICE Act which would require hospitals and CAHs, as a Medicare condition of participation, to provide to individuals receiving outpatient observation services for more than 24 hours both a written notice and an oral explanation that the individual is an outpatient⁸ receiving observation services and the implications of that status. The proposed notice process would be effective Aug. 6, 2016.

HFMA fully supports providing education to patients about the financial implications of the health care they receive. This is one of the core tenets of guidance we, along with other industry stakeholders, have developed for healthcare providers in the areas of patient financial communications⁹ and price

⁶ "Medicare Nursing Home Resident Hospitalization Rates Merit Additional Monitoring," DHHS Office of Inspector General, November 2013.

⁷ [Appleby, J.](#), "A Top-Rated Nursing Home Is Hard To Find In Texas, 10 Other States," *Kaiser Health News*, May 2015.

⁸ CMS defines outpatient to mean a person who has not been admitted as an inpatient but is registered on hospital/CAH records as an outpatient who receives services (versus only supplies) directly from the hospital/CAH.

⁹ "Patient Financial Communications Best Practices," HFMA, Patient Financial Communications.

transparency.¹⁰ While transparent communications are necessary to educate beneficiaries on the financial implications of an “observation stay” vs. an “inpatient admission,” education alone will not shield beneficiaries from the adverse financial impacts of outdated policies that do not reflect the way care is currently delivered. Included below the signature line are links to previously submitted comment letters that offer suggestions to mitigate the financial harm that occurs to patients when their care is paid for under “observation” as opposed to inpatient status.

Regarding the proposed rule, we appreciate CMS’s efforts to improve communications with Medicare beneficiaries receiving services in observation. Our members offer the comments below to ensure that the requirements of the NOTICE Act and Medicare Outpatient Observation Notice (MOON) process achieve the goal of improving Medicare beneficiaries’ understanding of observation status.

Improving Beneficiary Understanding

HFMA members suggest that CMS take the following steps to make the MOON document an effective tool for communicating the financial implications of observation status to Medicare beneficiaries.

- 1) CMS states in the proposed rule that a draft of the MOON is (as of the release of the proposed rule) being reviewed by the Office of Management and Budget (OMB). **We strongly recommend that the final MOON be written at a level that requires a seventh grade or lower reading comprehension level.** The concepts covered in the MOON are exceedingly complex. If the MOON does not simplify them for the Medicare beneficiary, notification may be provided but understanding will not be improved.
- 2) In the proposed rule, CMS discusses the myriad of benefit designs and circumstances that will affect a specific beneficiary’s out-of-pocket costs related to observation services. As part of this discussion, CMS references the beneficiary educational resources it has developed to help beneficiaries understand their financial responsibility. **HFMA strongly recommends that CMS include these links on the MOON that is provided to beneficiaries with a description of each resource that will help quickly guide beneficiaries to the appropriate resource.**
- 3) CMS mentions in the proposed rule that, once the MOON is approved by the OMB, it will translate a version for providers into Spanish. However, the rule is silent on CMS’s intention to make a copy of the MOON available in other languages spoken by Medicare beneficiaries. If CMS fails to make copies of the MOON available in common languages spoken by Medicare beneficiaries other than English and Spanish, it would be culturally insensitive and do those beneficiaries a great disservice. **HFMA recommends CMS follow the standard that HHS has set for hospitals in its interpretation of Title VI of the Civil Rights Act of 1964 by making copies of the MOON available in languages**

¹⁰ “Price Transparency in Health Care: Report from the HFMA Price Transparency Task Force,” HFMA,

spoken by the lower of 5 percent or 1,000 Medicare beneficiaries, whichever is less. These copies of the MOON should be publicly available on CMS's website for download.

- 4) **HFMA's members believe that hospitals should have the option to deliver the MOON to individuals (as defined in the proposed rule) who have spent less than 24 hours in observation status.** Based on our members' experience helping Medicare beneficiaries navigate the complex payment rules related to inpatient and observation services, we find 24 hours to be an arbitrary demarcation. Given that observation services are most often provided on the same units as inpatient care, it is not uncommon for a beneficiary who spends the night to assume that his or her care would be covered as an inpatient stay. This situation can arise from a billable observation stay as short as six hours or less.

State Requirements

Our members have made us aware that several states (e.g., New York, Maryland, Pennsylvania, Connecticut, Vermont, and Illinois) have requirements similar to the NOTICE Act. We ask that CMS in the final rule state that if a hospital is satisfying the state requirements related to observation notification, that it will have satisfied the NOTICE Act requirements. This will prevent beneficiary confusion from receiving essentially the same notice twice and decrease the administrative burden on hospitals.

Adjustment to IPPS Rates Resulting from 2-Midnight Policy

In the FY2017 IPPS rule, CMS proposes to reverse the inappropriate reduction to IPPS payment rates related to the 2-midnight policy. In FY 2017, the reversal will occur by increasing rates .2% to permanently and prospectively remove the .2% reduction. An additional .6% increase for only FY2017 will address the effects of the rule for FY2014 through FY2016.

HFMA strongly supports this proposal as our members have long believed the adjustment was both inappropriate and illegal. However, instead of adjusting claims by .6% for FY2014 through FY2016, our members request that you calculate hospital-specific adjustments for each impacted year to ensure that each hospital receives the reimbursement it was owed by the program for providing services to beneficiaries. Otherwise, we are concerned that slight changes in volume, case mix, and add-on payment factors from the year the reduction was incurred to the repayment year will have the unintended consequence of under-reimbursing some organizations and over-reimbursing others. To minimize administrative burden and expedite repayment, HFMA believes that hospitals should receive a lump-sum payment based on the most recent Provider Statistical & Reimbursement Report (PS&R) available for the impacted years when the rule is finalized. The lump-sum payment can be adjusted as necessary when the related Medicare cost reports are finalized. **Further, HFMA believes that CMS should repay these funds with interest.**

HFMA is deeply concerned that the proposed rule was silent on how CMS plans to adjust cost targets across the variety of programs that compare hospitals and other providers to historical expenditure data. Examples of these programs include, but are by no means limited to, the "per spend" and episode measures in the Hospital Value Based Purchasing program, population level cost targets in the variety of CMS/Center for Medicare & Medicaid Innovation (CMMI) ACO models, and episode-based models like Comprehensive Care for Joint Replacement (CJR) and Bundled Payments for Care Improvement (BPCI). **HFMA fully supports CMS's policy that providers should not be held accountable for changes in expenditure that are policy related (which are beyond their control). This has been articulated in**

numerous proposed and final rules for various alternative payment models. Our members believe that this instance is no exception and we request that for each program, CMS articulate a plan to adjust the relative cost targets for this change in policy.

Hospital-Acquired Condition (HAC) Program

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.¹¹ However, as we have previously commented, the current structure of the HAC program is flawed and inappropriately penalizes hospitals. We are particularly concerned about the disproportionate negative impact the program has on facilities that tend to be safety net hospitals. As proof of this, the proposed rule points out that using FY 2016 data, 33 percent of hospitals with less than 25 beds, 50 percent of hospitals with more than 500 beds, and 28 percent of moderately high DSH hospitals are penalized. We believe that CMS needs to make the following changes to the program.

Measure Overlap Between VBP and HAC Program: There is significant overlap among the measures proposed for the 2017 HAC reduction program (and implied for future years in the discussion of applicable time periods) and the 2017 - 2022 proposed 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 safety domain in 2017 (and thereafter as implied by the discussion of applicable time periods in the HAC section), 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.

Patient Safety Indicator-90 (PSI 90) Measure: HFMA continues to be concerned about the reliability of the PSI-90 measure for FY2017. Further, while we appreciate the changes CMS proposes to both the PSI-90 measure for FY2018 and the overall HAC scoring methodology, we are unconvinced that these will substantially remediate the issues that limit PSI-90’s reliability for use in a pay-for-performance or penalty program. **HFMA believes this measure needs to be phased out and replaced with measures that have higher reliability in both the HAC and VBP programs.**

Hospital VBP Program

HFMA continues to have concerns regarding a number of issues related to the Hospital VBP program that CMS has yet to sufficiently address. HFMA has commented on these issues in prior comment letters (links available below the signature line). As done in prior years, our members would like to take the opportunity to reiterate our concerns on the significant and unacceptable overlap between the Hospital

¹¹ “HFMA’S Value Project: Phase 2: Defining and Delivering Value,” HFMA, June 2012.

VBP and HAC reduction programs (discussed above), the overweighting of the HCAHPs, and the overweighting of the Medicare Spending per Beneficiary (MSPB-1) measures in the VBP program.

Additionally, in the FY2017 Proposed Rule, HFMA members are concerned about proposed addition of acute myocardial infarction (AMI) and heart failure (HF) payment measures in the 2021 program year and the changes to the measure cohort for pneumonia (PN) mortality for 2021. Finally, HFMA would like to offer CMS feedback on the use of outcome and expenditure measures to create a value composite metric.

HCAHPS Weighting: We continue to believe the Person and Community Engagement Domain is overweighted. Currently, it comprises 25 percent of the overall VBP score for FFYs 2017-2019. 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.¹² 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.”¹³

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.

Until the impact on HCAHPS scores of external factors that are beyond a hospital’s control are better understood and accounted for, CMS should significantly reduce the weighting of the HCAHPS domain.

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.”

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.

¹² Rau, J., “Patient Ratings to Affect Medicare Payments to Hospitals,” *The Washington Post*, April 28, 2011.

¹³ Lyu, H., Wick, E.C., Housman, M., et al., “Patient Satisfaction as a Possible Indicator of Quality Surgical Care,” *JAMA Surgery*, April 2013, pp. 362-367.

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.

- 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 socioeconomic factors on measures of Medicare spending and adjust the MSPB and other episode-specific (e.g., proposed additions of AMI and HF in 2021) spending measures so as not to penalize a hospital for factors beyond its control.
- As discussed under the readmissions section, CMS needs to understand the impact of operating in an HPSA on hospital-specific readmissions rates. If there is a positive correlation between being located in an 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 an 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 areas where there is a dearth of high-quality SNF providers. CMS should adjust the efficiency metric to mitigate the impact of SNF quality on the hospital efficiency measure given that hospitals can't steer beneficiaries to high-quality SNFs.
- If CMS, against the recommendation of the Measure Applications Partnership (MAP), finalizes the inclusion of an AMI and HF payment in 2021 and beyond, these episodes will need to be removed from the MSPB-1 measure. Otherwise, the efficiency domain could penalize a hospital twice for the same cases.
- In scoring the MSPB under the achievement, CMS compares the MSPB for each hospital to the median MSPB for all hospitals during the performance period to create a ratio that is used to allocate between 0 – 10 achievement points. CMS sets the achievement threshold at the all-hospital median and the benchmark (for which full points are awarded) at the lowest spending ratio decile. A hospital whose spending ratio was at or above the threshold would receive 0 achievement points. What this means, in effect, is that half of all hospitals will receive 0 points under the achievement threshold. While they may receive a score based on improvement, this is not sustainable over the long term. Even an episode of care delivered in the most efficient manner possible will require resources and program spending. HFMA believes that CMS needs to set a flat threshold that does not create an unsustainable "tournament" among hospitals.

AMI Payment and HF Payment Measures in the FY 2021 Program Year

CMS proposes to add the Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for HF (NQF #2436) (HF Payment) and Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Acute Myocardial Infarction (AMI) (NQF #2431) to the efficiency and cost reduction domain beginning in FY 2021. While the measures are NQF endorsed, they

are not supported by the MAP for inclusion in the Hospital VBP due to concerns about overlap with the MSPB and a lack of risk adjustment for socioeconomic factors that are beyond a hospital's control. Additionally, CMS proposes to use the same flawed achievement scoring system based on the median of all hospitals for the performance period. **HFMA strongly encourages CMS not to adopt the AMI and HF payment measures until the issues related to overlap with MSBP, risk adjustment, and scoring are resolved. Please see the discussion above regarding the MSPB for specific suggestions for resolving these issues.**

MORT-30-PN (Updated Cohort) Measure in the FY 2021 Program Year

CMS proposes to use a 23-month performance period for FY 2021 in order to adopt the pneumonia mortality measure with the updated patient cohort into the Hospital VBP program as soon as possible. However, CMS's analysis of the measure shows that using a compressed performance period (23 months as opposed to the 36 that is standard with other mortality measures) results in only moderate accuracy for the measure. **HFMA believes that CMS should remove the measure for the FY 2021 VBP program. Our members believe it is inappropriate to base payment to hospitals on a measure that is only moderately accurate. Further, before reinstating the measure in 2022 with a 35-month performance period, HFMA believes that CMS needs to demonstrate the pneumonia measure is highly accurate.**

Composite Value Scores

In the proposed rule, CMS asks for feedback on how it could possibly pair payment measures (e.g. AMI and HF payment) with outcome measures (e.g., AMI and HF mortality) to create a true value measure. HFMA generally supports the goal of developing measures of value. **However, our members believe CMS will need to resolve issues around socioeconomic risk adjustment before it can proceed. Also, given that hospitals with higher mortality rates will likely have lower spending, CMS will need to develop a methodology to adjust for this. HFMA believes that CMS should explore comparing hospital-specific episode expenditure to peers with rates of mortality in the same decile. Finally if, after resolving the issues discussed above, CMS moves forward with a composite measure, HFMA believes that the performance and baseline periods used for both the outcome and expenditure measures need to be from the same time period.**

Inpatient Quality Reporting (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. Our members applaud CMS's recent work with a wide range of industry stakeholders to develop core measures sets around seven key areas. While some of the measures in the sets are applicable to hospitals, there is no standardized set of measures that has been harmonized across purchasers. **Given its leadership role in the Core Measures Collaborative, HFMA asks CMS to invite stakeholders from the hospital industry to participate in a process to harmonize quality measures for hospitals.** 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 Inpatient Quality Reporting (IQR) Program
- Clinical Episode Based Payment Measures which are not supported by the NQF or MAP

- Lack of socioeconomic risk adjustment and potential for overlap posed by the Excess Acute Care Days after Pneumonia Hospitalization

Required Submission of eCQM: CMS proposes to require reporting of 15 eCQMs in the hospital IQR for FY 2017 reporting period /FY 2019 payment. 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.**

Additionally, HFMA is concerned by the potential for double jeopardy. If a hospital isn't able to submit eCQMs, it is penalized under the meaningful use program. Under the proposed rule, if a hospital doesn't submit all 15 eCQMs, it will also be penalized under the IQR. **HFMA believes that a provider that is unable to submit eCQMs should only be penalized under the meaningful use program and not both the meaningful use program and the IQR.**

Clinical Episode-Based Payment Measures which are not supported by the NQF or MAP

CMS proposes three new expenditure measures—aortic aneurysm, cholecystectomy and common duct exploration, and spinal fusion. They are similar to the MSPB measure and are intended to reflect Medicare “resource use” during episodes of care. These measures reflect the decisions of a broad array of healthcare providers across the care continuum. These measures are neither NQF-endorsed nor supported by the MAP for inclusion in the IQR. **We believe that CMS should delay the inclusion of these measures into the IQR until all settings of post-acute care have a similar measure. We also believe that issues related to risk adjustment and scoring must be fully addressed before incorporation in the IQR. For a more detailed discussion of these issues and proposed solutions, please see the discussion of the MSBP in the section on value-based purchasing and HRRP (above).**

Lack of socioeconomic risk adjustment and potential for overlap posed by the Excess Acute Care Days after Pneumonia Hospitalization

CMS proposes to add a measure for excess days in acute care after pneumonia hospitalization 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 sections of the comment letter discussing the HRRP.
- 2) Given that the measure includes readmissions as a component, if each measure is implemented, CMS will measure readmissions (and eventually penalized hospitals) twice for pneumonia—once through the standard readmission measure in the HRRP and once through the “excess days” measure in VBP. 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. **HFMA strongly recommends that CMS delay implementation of the**



pneumonia “excess days” measures until the risk adjustment mechanism incorporates socioeconomic factors and CMS has resolved the issue of measuring the same readmission twice in different measures.

HFMA looks forward to any opportunity to provide assistance or comments to support CMS’s efforts to refine and improve the 2017 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:

- <http://www.hfma.org/Content.aspx?id=32061>
- <https://www.hfma.org/content.aspx?id=21502>
- <http://www.hfma.org/Content.aspx?id=21963>

Readmissions:

- <http://www.hfma.org/Content.aspx?id=32061>
- <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=32061>
<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=32061>
<http://www.hfma.org/Content.aspx?id=23440>
<https://www.hfma.org/content.aspx?id=21502>

Observation Payment Policy:

<http://www.hfma.org/Content.aspx?id=30027>
<http://www.hfma.org/content.aspx?id=20026>