



June 5, 2017

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1677-P
P.O. Box 8011
Baltimore, MD 21244-1850

File Code: CMS-1677-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 2018 Rates; Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Electronic Health Record (EHR) Incentive Program Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Provider-Based Status of Indian Health Service and Tribal Facilities and Organizations; Cost Reporting and Provider Requirements; Agreement Termination Notices

Dear Ms. Verma:

The Healthcare Financial Management Association (HFMA) would like to thank the Centers for Medicare & Medicaid Services (CMS) for the opportunity to comment on the 2018 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 2018 Rates; Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Electronic Health Record (EHR) Incentive Program Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Provider-Based Status of Indian Health Service and Tribal Facilities and Organizations; Cost Reporting and Provider Requirements; Agreement Termination Notices (hereafter referred to as the Proposed Rule) published in the April 28, 2017, *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 2018 IPPS Proposed Rule. Our members have significant concerns regarding the proposals related to the following:

- Changes to the Medicare Wage Index Timeframe
- Payment Adjustment for Medicare Disproportionate Share Hospitals (DSH)
- Hospital Readmissions Reduction Program (HRRP)
- Hospital-Acquired Condition (HAC) Program
- Hospital Value-Based Purchasing (VBP) Program
- Inpatient Quality Reporting (IQR) Program

Additional, in response to CMS's request for information for ideas for "regulatory, policy, practice and procedural changes to better achieve transparency, flexibility, program simplification and innovation," HFMA's members would like to offer suggestions related to the collection of quality data and the reporting of quality metrics, reducing the administrative burden across the care continuum, improving the effectiveness of fraud and abuse programs, and reducing regulatory barriers to improving patient outcomes.

Below please find specific comments on the items listed above.

Changes to Medicare Wage Index Timeframe

For the FY 2019 Wage Index, CMS is proposing to limit the time a provider has to dispute an adjustment once the January public use file (PUF) file is posted. For example, for CMS adjustments:

- Made between the date the January PUF is posted and 14 calendar days before the April appeals deadline, hospitals must dispute the correction by the April appeals deadline.
- Made between the date that is 13 calendar days before the April appeals deadline and 14 days before the May appeals deadline, hospitals must dispute the correction by the May appeals deadline.
- With respect to which hospitals were notified 13 calendar days before the May appeals deadline or later, hospitals may appeal to the Provider Reimbursement Review Board.

Hospitals would have to request the correction by the first applicable deadline. A hospital that fails to meet the procedural deadlines would not have a later opportunity to submit wage index data corrections or to dispute CMS's decision on requested changes.

HFMA's members report CMS has taken a more active role in the review of the Medicare Administrative Contractor's (MAC's) adjustments and final worksheet S-3 data. CMS is using the time between the November MAC deadline to submit the Healthcare Cost Report Information System data and have performed additional data analysis that results in follow-up questions or requests to hospitals for supporting data. These requests are channeled through the MACs and require time for hospitals to develop a response.

In the last couple of years, CMS has removed the wage index data of multiple hospitals until they feel they have sufficient support and explanations to allow the data to be included in the PUF and Tables 2 & 3. Currently, hospitals have one month to request corrections for errors in the April 28th PUF. The reduced timelines will require hospitals to review the posted PUF immediately to ensure that the data is correct and take any necessary action to correct. **HFMA's members are deeply concerned that the short timeline CMS is proposing for them to respond to detailed requests will not allow for comprehensive analysis and a thorough response. Therefore, we do not support the proposed change.**

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 support the changes CMS implemented to worksheet S-10 and its instructions in transmittal R10P240 that are effective for cost reporting periods beginning on or after Oct. 1, 2016. Further, our members appreciate the opportunity CMS provided during 2016 for hospitals to amend the data filed on worksheet S-10 for provider FY 2014. These are meaningful steps toward improving the accuracy of the data reported on worksheet 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 worksheet S-10 to calculate Factor 3. However, despite these needed steps, HFMA's members continue to believe it is premature to use worksheet S-10 to allocate the Uncompensated Care DSH payments.

As we have discussed in our FY 2014, FY 2015, FY 2016, and FY 2017 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.
- Instructions and 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 first sentence of the instructions for line 20 directs the hospital to report gross charges for charity care for the "entire facility." 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). This interpretation for including charity care related to services provided in subparts is further reinforced by:

- The second sentence in the instructions for line 20, which states, "Include charity care for *all services except physician and other professional services...*" (emphasis added).
- The first sentence in the instructions for line 22, effective for cost reporting periods beginning prior to Oct. 1, 2016, which states, "Enter the actual charges for *the entire facility, except physician and other professional services...*" (emphasis added).
- The second sentence in the second paragraph for line 22, effective for cost reporting periods beginning on or after Oct. 1, 2016, which states, "...enter such payments received for the *entire facility, except physician or 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).
- Replace the language in the initial instructions that specifies providing data on “inpatient and outpatient hospital services” with data for the “entire hospital facility.”

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 the sentences cited above need to specifically state what (if any) services provided in subparts should be included on line 20.

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” by instructing hospitals to list amounts related to deductibles and coinsurance and then attempting to apply a cost-to-charge ratio to them to arrive at the cost. 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 Providers*”¹ (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.

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

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)

HFMA members continue to be concerned that the definition of bad debt is unclear and 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 or January 1, 2011); J-3, line 21; M-3, line 23; and N-4, line 9.

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 also 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), rural health clinics (RHCs) and federally qualified health centers (FQHCs), and hospital based federally qualified health centers (FQHCs).

Given that the instructions include Medicare bad debts on line 26 for services provided beyond the inpatient and outpatient settings, HFMA believes 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 LTCHs, distinct part psychiatric units, dialysis centers, CMHCs, RHCs, and FQHCs.

HFMA continues to ask CMS in the final rule to confirm that this interpretation is correct.

Additionally, HFMA continues to request 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 included 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,” cost sharing for non-Medicare payments related distinct part home health agencies should be included. CMS referenced this comment along with many others in the FY 2017 final rule. In the rule, CMS stated, “We intend to address many of these comments as part of our planned clarifications and revisions to Worksheet S–10.” HFMA’s members are frustrated that this issue, along with many of the concerns raised in the thoughtful comments provided in response to the FY 2017 proposed rule, was not definitively addressed in the revisions or the FY 2018 proposed rule.

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 continues to request 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.** Again, CMS referenced this comment in the FY 2017 final rule. In the rule, CMS stated, “We intend to address many of these comments as part of our planned clarifications and revisions to Worksheet S–10.” HFMA’s members are frustrated that this issue was not definitively addressed in the revisions or the FY 2018 proposed rule.

Second, line 26 commingles bad debt for uninsured patients who did not make any payment, uninsured patients who make partial payments, and patients who have some form of insurance but are not able to meet their cost-sharing responsibility. Unless bad debts are reported at gross charges and then reduced by subsequent lines for payments, discounts, charity care, recoveries, and allowable Medicare bad

debts, applying the hospital's cost-to-charge ratio to bad debt expense on line 26 (as current instructions indicate) will understate the patient care expense that is written off to bad debt. HFMA strongly recommends that CMS revise worksheet S-10 to address this issue. We believe amounts written off to bad debt for patients who make a partial payment (or those with some form of insurance) will continue to grow as health insurance benefit designs shift more costs at the point of care to the patient. HFMA appreciates that accounting for the cost of bad debts is a complex issue. Our members would greatly appreciate the opportunity to help CMS develop a methodology to accurately arrive at these costs.

Audit Process for Charity Care and Non-Medicare Bad Debt

HFMA generally supports using data reported on the S-10 to calculate "Factor 3." However, before this occurs, we believe CMS needs to audit the S-10 data that will be used. CMS stated in the 2018 IPPS proposed rule that they will not subject the Worksheet S-10 for desk review by the MACs until FFY2017 cost reports are filed. We believe that it is unreasonable of CMS to distribute \$2.3B or one-third of the uncompensated care pool in FFY 2018 based on un-audited data from FFY2014. HFMA's members believe it is unfair that payments are directly linked to data that has not been audited by the CMS or the MAC. Our members are concerned about the integrity of the data these payments are based on. Hospitals rely on CMS to perform its due diligence to ensure the proper payment is made to all providers.

Currently, there are no published audit instructions for MACs to follow when reviewing non-Medicare charity care and non-Medicare bad debt. While CMS states in the FY 2018 proposed rule that it is working on audit instructions for the MACs, it will not make these (or any other audit guidance) publicly available. In general, HFMA's members have long considered this stance inappropriate and counter-productive. This policy of opacity results in the various MACs (and sometimes different offices of the same MAC) taking different interpretations of the Provider Reimbursement Manual (PRM) and other CMS guidance. This manifests itself as inappropriate disallowances. When this occurs, providers, the MAC, and CMS waste time and resources during the appeal of these inappropriate adjustments.

Specific to the S-10, guidance for completing the worksheet is limited to vague instructions (as discussed above). Further, unlike other worksheets that have an impact on payment and are audited by the MACs, the PRM is silent on the treatment of non-Medicare bad debt and charity care. This silence is appropriate, as each hospital's financial assistance policy and broader community benefit strategy reflects the needs of its community. However, 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 PRM, which pertains to determining indigence for purposes of identifying Medicare bad debt. **Given HFMA members' experience with these audits, we strongly encourage CMS to recognize the uniqueness of the circumstances surrounding the S-10 and release the audit criteria for non-Medicare bad debt and charity care claimed on the worksheet.**

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. **HFMA strongly supports CMS's position on identifying charity care for reporting on the S-10. We strongly urge CMS to codify its stance in the Provider Reimbursement Manual.** Further, we suggest that CMS provide continuing education to its contractors. It appears that some Medicare Administrative Contractors (MACs) may not be aware of CMS's 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.

CMS proposes to use three years of data to calculate factor 3 during the transition between the current method of using Medicaid and Supplemental Security Income days to data from the S-10. **HFMA believes that even after this transition is complete, CMS should continue using a rolling three-year period of the most recently audited cost reports to determine factor 3.** Our members are concerned that if CMS elects to use one year of S-10 data this could cause significant swings in a hospital's uncompensated care payments due to inappropriate audit adjustments. We believe using a rolling three-year period could help to reduce the impact of these events.

Hospital Readmissions Reduction Program (HRRP)

HFMA appreciates CMS's proposal to address the well-documented impact of social determinants of health on hospital readmissions. We generally support CMS's proposal to create cohorts of hospitals based on the percentage of their patients who are eligible for both Medicare and Medicaid. However, we believe this may be a short-term solution and, as in previous years, continue to offer CMS suggestions for methodologies to explore as it seeks to refine risk adjustment methodologies for its various quality payment programs (e.g., HRRP, VBP, HAC, and alternative payment models). Finally, HFMA's members would like to comment on the possible incorporation of the Hospital-Wide All-Cause Unplanned Readmission (HWR) (NQF #1789) into the VBP program in the future.

In the FY 2018 proposed rule, CMS proposes to account for social determinants of health using the proportion of a hospital's dually eligible Medicare patients as a proxy for social determinants of health. The HRRP would be calculated by comparing a hospital's excess readmissions ratio to other hospitals whose ratio of dually eligible patients to patients enrolled in Medicare fee-for-service (FFS) and Medicare Advantage is in the same quintile. **HFMA supports this proposal as a transitional mechanism to adjust the HRRP to account for social determinants of health.**

However, our members continue to strongly encourage CMS to explore methods of adjusting the HRRP for social determinants of health that are more accurate. Educational attainment and income levels^{2,3,4} are widely viewed as key social determinants of health and also strong proxies for others that are less easily measured (e.g., access to transportation, availability of fresh foods that comport with a prescribed diet). **Therefore, HFMA strongly encourages CMS to explore developing an adjustment mechanism that uses a patient's zip code tied to Census Bureau data on both educational attainment and income.** In addition to zip code, we also encourage CMS to explore, and if evidence supports, adjust readmissions rates for the quality of the post-acute setting to which a patient is discharged and the availability of primary care (e.g., Health Professional Shortage Area (HPSA)).

Relationship of HPSA to Readmission Rates: Research shows patients who receive timely physician follow-up care post discharge are significantly less likely to be readmitted.^{5,6} 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.⁷ **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 a 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 the impact of SNF quality on readmissions rates. 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).⁸ Hospitals are providing quality and resource use data to patients

²Bailey SC, Fang G, Annis IE, et al. "Health literacy and 30-day hospital readmission after acute myocardial infarction." *BMJ Open* 2015;5:e006975. doi: 10.1136/bmjopen-2014-006975

³Arbaje AI, L Wolff J, Yu Q, Powe NR, Anderson GF, Boulton C. "Postdischarge environmental and socioeconomic factors and the likelihood of early hospital readmission among community-dwelling Medicare beneficiaries." *Gerontologist*. 2008;48(4):495-504.

⁴Calvillo-King L, Arnold D, Eubank KJ, Lo M, Yunyongying P, Stieglitz H, et al. "Impact of social factors on risk of readmission or mortality in pneumonia and heart failure: systematic review." *J Gen Intern Med*.2012;28(2):269-82.

⁵Hernandez, 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.

⁶Misky, 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.

⁷Parchman 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.

⁸"Medicare Nursing Home Resident Hospitalization Rates Merit Additional Monitoring," DHHS Office of Inspector General, November 2013.

and their families about potential sites of post-acute care. Despite this evidence, often the patient or the patient's family selects a lower quality option for reasons of convenience. Additionally, many hospitals are partnering with SNFs and other post-acute providers to coordinate care transitions and improve the quality of care provided at SNFs. However, hospitals cannot steer Medicare beneficiaries to SNFs that they know to be high quality. Even if hospitals could steer patients, high-quality SNFs may not have available beds or may not exist in the patient's preferred geographic area.⁹

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

- **Conduct further research into the impact of SNF and other post-acute provider 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 Quality Forum (NQF) and other stakeholders 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, SNFs, and other post-acute providers from collaborating and create sufficient exemptions that will further efforts to reduce preventable readmissions.**
- **Allow hospitals to recommend their patients use specific SNFs and other post-acute providers that data indicates are higher quality.**

Hospital-Wide All-Cause Unplanned Readmission (HWR): CMS added the hospital-wide readmissions measure (NQF #1789) to the Inpatient Quality Reporting (IQR) Program in the FFY 2015 Final Rule. The measure is currently reported on CMS Hospital Compare. **HFMA's members believe that if CMS incorporates the HWR into the HRRP, it needs to remove the six existing measures on which the HRRP is currently based.** We realize that the agency would need to work with Congress to remove the statutorily mandated measures – Acute Myocardial Infarction (AMI), Pneumonia (PN), and Heart Failure (HF). Failing to remove the six current readmissions measures used in the HRRP would penalize hospitals twice for the same readmission. **Further, we believe that if the HWR is implemented it should occur in a budget-neutral manner, as suggested in the HHS Office of the Assistant Secretary for Planning and Evaluation's (ASPE's) recent report to Congress¹⁰.** While moving to a hospital-wide measure reduces the number of hospitals that are penalized, it significantly increases the dollar amount of the penalty assessed to each hospital impacted.

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, the current structure of the HAC program is flawed and inappropriately penalizes hospitals due to poorly constructed measures, has the potential to penalize hospitals twice for the same error due to duplication of measures in the HAC program and the

⁹ Appleby, J., "A Top-Rated Nursing Home Is Hard to Find In Texas, 10 Other States," *Kaiser Health News*, May 2015.

¹⁰ Office of the Assistant Secretary for Planning and Evaluation. "Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs," Dec. 21, 2016. <https://aspe.hhs.gov/pdf-report/report-congress-social-risk-factors-and-performance-under-medicare-value-based-purchasing-programs>

¹¹ "HFMA'S Value Project: Phase 2: Defining and Delivering Value," HFMA, June 2012. hfma.org/valueproject

Safety Domain in the VBP, and inadequate adjustment to measures to account for clinically complex patients. We believe that CMS needs to address the following issues.

Remove PSI 90: The measures that make up the PSI 90 composite use hospital claims data to identify patients who have potentially experienced a safety event. However, claims data does not fully reflect the details of a patient’s history, course of care, and clinical risk factors. As a result, the rates derived from the measures are inexact. PSI data may assist hospitals in identifying patients whose cases merit deeper investigation with the benefit of the full medical record. But, the measures are ill-suited to drawing meaningful conclusions about hospital performance on safety issues.

Therefore, HFMA believes CMS should phase out the PSI 90 composite measure altogether in FY 2018 (instead of 2019) and not replace it with the modified measure in FY 2023 as proposed. Instead, PSI 90 should be replaced with alternative measures that address a variety of quality and safety issues. Until PSI 90 is phased out and replaced, hospitals without enough data to report at least one of the infection measures in Domain 2 should be excluded from the HAC Reduction Program. We urge CMS to amend the program to include only hospitals with enough data to report at least one of the infection measures in Domain 2. In addition, hospitals eliminated for lack of Domain 2 data also should be excluded from the pool of hospitals from which CMS determines the penalty quartile.

Measure Overlap Between VBP and HAC Program: There is significant overlap among the measures proposed for the 2018 HAC reduction program (and implied for future years in the discussion of applicable time periods) and the 2018 - 2023 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.*** We have long believed it was appropriate to include patient safety measures in the outcomes domain of VBP prior to the implementation of the HAC reduction program. However, 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 2018 (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.

Inadequate Risk Adjustment for Clinically Complex Patients: We are particularly concerned about the disproportionately negative impact the program has on facilities that tend to be safety net hospitals. As proof of this, the FY 2017 proposed rule points out that, 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. The ASPE’s report to Congress suggests that much of the performance gap between safety net and non-safety net hospitals can be explained by adjusting for clinical complexity. Safety net hospitals typically serve a larger population of clinically complex patients than non-safety net hospitals. Clinical risk assessments using data submitted on the claim don’t pick up all of a patient’s co-morbidities. Thus, what appears to be attributable to socio-economic circumstances might be a proxy for underlying

clinical issues.¹² HFMA's members strongly encourage CMS to work with stakeholders to identify and test mechanisms to adjust PSI 90 (if it continues to be included in the HAC program) and the various measures that make up Domain 2 to better reflect an individual patient's degree of clinical complexity. Beyond the measures tested in the ASPE's report, HFMA recommends that CMS explore the relationship between residence in a nursing facility and probability of contracting Methicillin-resistant Staphylococcus aureus or C. diff or suffering from a catheter-associated urinary tract infection or a central-line associated bloodstream infection. Research demonstrates that residents of nursing facilities are more likely to be colonized with the bacteria that cause these infections¹³. Data to perform this analysis should be available from the source of admission code in field locator 15 on the UB-04.

Hospital VBP Program

HFMA continues to have concerns regarding many 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 VBP and HAC reduction programs (discussed below in the HAC section), the overweighting of the Patient and Caregiver Centered Experience of Care/Care Coordination domain, the construction of the Efficiency and Cost Reduction domain, and adjusting the VBP program for social determinants of health.

Additionally, in the FY2018 Proposed Rule, HFMA members are concerned about proposed addition of a pneumonia payment measure in the 2022 program year.

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 2018-2020. 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.¹⁴ 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."¹⁵

Currently, the only measure in the efficiency domain is the HCAHPS. 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.

¹² Office of the Assistant Secretary for Planning and Evaluation. "Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs," Dec. 21, 2016. <https://aspe.hhs.gov/pdf-report/report-congress-social-risk-factors-and-performance-under-medicare-value-based-purchasing-programs>

¹³ Lagnado, L., "The Bug Problem in Nursing Homes," *The Wall Street Journal*, May 15, 2017

¹⁴ Rau, J., "Patient Ratings to Affect Medicare Payments to Hospitals," *The Washington Post*, April 28, 2011.

¹⁵ 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.

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 and Cost Reduction Domain: As of FY 2015, the VBP program includes an efficiency metric—the Medicare Spending per Beneficiary (MSPB). The MSPB 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.” Subsequently, in the FFY 2017 Final Rule, CMS added the AMI and HF payment per 30-day episode measures (beginning with FY 2021 payments), and has proposed to include the PN 30-day episode measure for program year FY 2022 in the current proposed rule. All three measures are similar in construction and scoring to the MSPB.

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.

- Work with hospitals to refine the efficiency metrics. Limiting measurement to only conditions directly related to the index admission in all four measures 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 below in detail, CMS needs to understand the impact of social determinants of health on measures of Medicare spending and adjust these measures to avoid penalizing hospitals for factors beyond their 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 in a HPSA and higher potentially preventable readmission rates, this will also negatively impact efficiency metrics for hospitals in HPSAs. CMS should adjust its efficiency metrics to mitigate the impact of operating in a HPSA on hospitals.
- 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 low-quality post-acute care providers and higher potentially preventable readmission rates, this will also 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 explicitly recommend that beneficiaries use high-quality SNFs.
- CMS needs to remove AMI, HF, and PN (if finalized for FY 2022 payments) cases from the MSPB-1 measure for payment year FY 2021. Otherwise, the efficiency domain will penalize hospitals twice for high-expenditure cases related to those conditions.

- In scoring the efficiency measures under achievement, CMS compares the measure for each hospital to the median 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 zero achievement points. What this means, in effect, is that half of all hospitals will receive zero points under the achievement threshold for the MSPB, AMI, HF, and PN (if finalized) measures. 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.

Adjusting the VBP for Social Determinants of Health: HFMA strongly urges CMS to adjust the VBP program for social determinants of health. Existing evidence suggests that patients suffering poor social determinants of health are likely to have lower scores across measures in all four domains due to factors beyond a hospital’s control. Research suggests that both educational attainment and income impact mortality¹⁶ and readmissions.¹⁷ HFMA’s members note that five of the six outcomes metrics are mortality measures. Readmissions are a key driver of increased episode spending for Medicare patients, which impacts the efficiency measures. Another key driver of efficiency is the use of institutional post-acute care. Evidence suggests that dually eligible patients are more likely to use institutional post-acute care settings.¹⁸

In the near term, HFMA’s members believe that CMS should use a similar approach to the HRRP to score the VBP. CMS should calculate the attainment scores for each individual cohort of hospitals. The cohort would be determined by grouping hospitals with similar proportions of dually eligible Medicare patients together. This method should be used until CMS can work with the NQF and other stakeholders to develop a more accurate way to risk-adjust individual measures to reflect the impact a patient’s social determinants of health has on that measure.

Incorporating a Pneumonia Payment Measure for the FY 2022 Payment Year

CMS proposes to add the Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for PN to the efficiency and cost reduction domain beginning in FY 2022. While the measure was recently endorsed by the NQF, it is 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 pneumonia payment measure until the issues related to overlap with MSBP, risk adjustment, and scoring are resolved. Please see the discussion above regarding the Efficiency and Cost Reduction Domain for specific suggestions for resolving these issues.**

¹⁶ Calvillo-King L, Arnold D, Eubank KJ, Lo M, Yunyongying P, Stieglitz H, et al. “Impact of social factors on risk of readmission or mortality in pneumonia and heart failure: systematic review.” *J Gen Intern Med.* 2012;**28**(2):269–82.

¹⁷ Arbaje AI, L Wolff J, Yu Q, Powe NR, Anderson GF, Boulton C. “Postdischarge environmental and socioeconomic factors and the likelihood of early hospital readmission among community-dwelling Medicare beneficiaries.” *Gerontologist.* 2008;**48**(4):495–504.

¹⁸ Office of the Assistant Secretary for Planning and Evaluation. “Report to Congress: Social Risk Factors and Performance Under Medicare’s Value-Based Purchasing Programs,” Dec. 21, 2016. <https://aspe.hhs.gov/pdf-report/report-congress-social-risk-factors-and-performance-under-medicare-value-based-purchasing-programs>

Inpatient Quality Reporting (IQR) Program

HFMA's whitepaper, *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 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 for hospitals. ***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 facilitate the transition to accountable care models. We also believe that harmonizing hospital measures with other stakeholders would give CMS's efforts to collect Electronic Clinical Quality Measures (ECQMs) much-needed focus on areas that will drive improved patient outcomes.

Specific to the proposed rule, HFMA is concerned by the lack of a definitive quality measurement strategy for the IQR and ECQMs, and potential future IQR measures.

Lack of a Definitive Quality Strategy for Hospitals for the IQR and ECQMs:

HFMA's members are concerned that many of the measures CMS is considering (or has included) in the IQR are not focused on the greatest areas of opportunity for hospitals to improve the quality or the efficiency of care they deliver. When these metrics are focused on valuable activities that could improve patient outcomes, it's questionable whether the hospital has significant influence over the activities encouraged by the measures. Complicating matters, it is questionable whether some of the proposed or incorporated measures are sufficiently reliable and accurate. Some measures lack endorsement by the NQF and/or MAP, providing the public with limited insight on whether the measures are reliable and accurate enough for public reporting. The three measure sets discussed in the next section provide examples of these issues.

HFMA generally supports the goal of using EHRs to collect clinically relevant quality measures in a timely manner with reduced administrative costs. And at the tactical level, HFMA's members support the proposed rule's reduced reporting requirements for ECQMs. However, we believe CMS's current ECQM efforts may be more focused on using the EHR to collect data than tied to an overarching framework that will improve the quality of care. Evidence of this includes:

- The number of "topped-out" or otherwise removed measures that can be reported to satisfy ECQM requirements in 2018, 2019, and 2020.
- CMS's acknowledgement in the proposed rule that hospitals are struggling to find applicable measures to report from the list of 15 measures provided.

To alleviate concerns about the usefulness of the data collected by the hospital IQR program and through the EHR, HFMA strongly encourages CMS to work with stakeholders (hospitals, physicians, patient and consumer advocates, and other care purchasers) to identify a set of actionable national goals for quality improvement. With these goals defined, we believe that CMS can then work with the hospital community to define the areas where hospitals have oversight for the clinical processes that must change for the overarching national quality goals to be achieved. Using those areas as a guide, CMS and other purchasers should select a limited set of relevant core measures that will provide useful information to patients about hospital quality and serve as a north star for hospital performance improvement efforts.

Potential Future IQR Measures:

The FY 2018 proposed rule includes a robust discussion of a range of measures CMS is considering including in the IQR program in future years. Based on the material provided in the proposed rule, HFMA's members have significant concerns about the following sets of measures:

- Quality of Informed Consent Documents for Hospital-Performed Elective Procedures
- Four End-of-Life Measures for Cancer Patients
- Two Nurse Staffing Measures

HFMA's members do not support the potential inclusion of these measures into the IQR program. We believe these measures are prime examples of the issues we describe in the preceding section. Below are our specific concerns.

Quality of Informed Consent Documents for Hospital-Performed Elective Procedures: CMS proposes requiring hospitals to abstract up to 100 patient informed consent (PIC) documents. The abstracted PIC documents will be used to evaluate hospitals based on the quality of those documents. CMS estimates it will require approximately four to five hours of hospital staff time to abstract this data. CMS is interested in the measure due to concerns that informed consent documents are frequently generic, lack information that is relevant to the procedure, and include illegible, hand-written information. Moreover, patients are often given and asked to sign the informed consent document minutes before the start of a procedure, a time when patients are most vulnerable and least likely to ask questions. Further, CMS indicates it hopes the measure will pave the way for a metric related to shared decision-making in the future.

HFMA's members do not support including this measure in the IQR at any future point. First, HFMA's members question the value of this metric. Communicating the information necessary to achieve informed consent and documenting that consent is part of Medicare's conditions of participation (CoP). If there are hospitals that are not meeting the requirements set out in the CoP, we strongly believe the issue should be addressed through existing processes instead of layering on a new metric that does nothing to solve the alleged underlying issue. To this point, CMS acknowledges in the proposed rule that, "(T)he MAP did not support this measure, indicating concern about the lack of evidence that implementation will affect hospital practices and the complexity of existing guidelines, regulations and state laws related to informed consent."

Second, we appreciate that in isolation the measure's administrative burden appears low. However, when viewed in context with the volume of "low administrative burden" requirements that have been foisted onto hospitals over the past decade, the collective administrative burden is immense, costly, and doesn't commensurately improve value for the patient (e.g., responding to Recovery Audit Contractor (RAC) auditors, see prior comment letters on this topic, links included below).

Third, HFMA's members doubt this measure will lead to improved patient engagement. CMS suggests its long-term goal is encouraging shared decision-making conversations with patients. HFMA supports this goal and believes these conversations should occur between a patient and the physician who referred the patient to the hospital for services. In many instances the referring physician will be a "community physician" with privileges to perform services at the hospital, not a hospital employee. In this very

common scenario, if the physician does not initiate the shared decision-making discussion, there is little the hospital can do without running the risk of interfering with the patient-physician relationship. CMS recognizes this flaw in the proposed rule by stating, “the MAP noted that this measure captures the quality of informed consent documents rather than the quality of communication between patients and their providers.” If an NQF-approved shared decision-making measure does not exist, HFMA’s members strongly recommend that CMS work with stakeholders to develop one for physicians. We believe it should be deployed on a voluntary basis in the Merit-based Incentive Payment System (MIPS) and in appropriate alternative payment models (APMs). Similar to electronic reporting or other high priority measures, bonus points should be awarded for reporting the shared decision-making measure.

Further, like end-of-life planning conversations, a true shared decision-making discussion that helps a patient identify treatment options aligned with the patient’s values requires staff time¹⁹ (either the physician or a properly trained nurse) and decision-making aids. Therefore, we believe CMS should work with Congress to provide payment for these services that provide both value to the patient and have the potential to reduce unnecessary expenditures for the Medicare program.

Finally, HFMA’s members request that CMS work with hospitals, patient advocates, Congress, and states to streamline the amount of paperwork that patients (or their families) are required to sign prior to or upon admission. We believe eliminating outdated or duplicative documents could free up scarce hospital resources to improve patient engagement prior to admission. Instead of having to focus on collecting signatures on numerous documents that are of little value to the patient, hospital staff could focus on educating the patient about the patient’s procedure (or condition) and upcoming hospital stay.

Four End-of-Life Measures for Cancer Patients: CMS seeks to implement four palliative care measures for patients who die of cancer. The goal of these measures is to improve end-of-life care for terminally ill patients. The four measures are:

- (NQF #0210): Proportion of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life (EOLChemo)
- (NQF #0215): Proportion of Patients Who Died from Cancer Not Admitted to Hospice (EOL-Hospice)
- (NQF #0216): Proportion of Patients Who Died from Cancer Admitted to Hospice for Less than Three Days (EOL-3DH)
- (NQF #0213): Proportion of Patients Who Died from Cancer Admitted to the ICU in the Last 30 Days of Life (EOL-ICU)

HFMA supports CMS’s efforts to improve end-of-life care for terminally ill patients. **However, at this time, we do not support incorporating these measures into the IQR at a future date.** First, HFMA’s members believe the focus of this activity should be with the oncologist or primary care physician who is responsible for the patient’s care. Performance (or performance improvement on these measures) is predicated on the physician who is responsible for the patient’s care discussing end-of-life issues with the patient and helping him or her document those choices in a transportable manner. In instances where the hospital does not employ the oncologist (or primary care physician), the ability to drive

¹⁹ Butcher, L. “The patient’s role in achieving value.” *Leadership*, Spring 2014.
<http://www.hfma.org/Content.aspx?id=22696&##>

performance improvement is limited. Therefore, all things being equal, this measure would disadvantage community hospitals that don't employ the oncologists in their community. Similar to the bonus points provided to physicians who report electronically or submit high priority measures, we strongly encourage CMS to award bonus points for the four proposed measures in MIPS.

Second, HFMA is concerned that the measures are not adjusted to remove patients from the numerator and denominator who have stated a desire to pursue aggressive treatment through the end of life. As such, we expect these measures disadvantage hospitals serving younger patient populations. Similarly, there is a policy flaw that may limit the uptake of hospice services for certain patients. To qualify for the hospice benefit, Medicare patients must elect to forgo curative services²⁰. And we believe a similar requirement exists for many other health plans. While the Center for Medicare & Medicaid Innovation has a number of experiments in field that are testing the impact of allowing a patient to receive parallel curative and palliative services, this is not yet common in the broader Medicare program or with other health plans. HFMA's members believe it is inappropriate to mandate reporting of measures related to hospice utilization while flaws exist with the selected palliative care measures and hospice coverage policies.

Nurse Staffing Measures: CMS believes there is opportunity for hospitals to develop nurse staffing strategies to improve quality and the value of care. Therefore, it is considering adding the following nurse staffing measures to the IQR in the future:

- (NQF #0204) Skill Mix (Registered Nurse [RN], Licensed Vocational/Practical Nurse [LVN/LPN], Unlicensed Assistive Personnel [UAP], and Contract) (Nursing Skill Mix) Measure
- (NQF #0205) Nursing Hours per Patient Day Measure

CMS suggests that, if adopted in the future, it would collect the data for the measures on a quarterly basis. CMS would collect data at the unit level, starting initially with adult and pediatric medical-surgical units. The proposed rule states that "approximately half of hospitals are reporting" this information to the National Database of Nursing Quality Indicators—a proprietary database.

HFMA's members currently do not support collection of the nurse staffing measures. We question the need for reporting on a quarterly basis. We believe the administrative burden of frequent reporting far exceeds its value and are concerned about the accuracy of quarterly reporting.

First, hospital and health system staffing models evolve over time and do not structurally change from quarter to quarter. Only patient volume and acuity would cause them to fluctuate this rapidly. And the measures shouldn't be impacted by these fluctuations if they are properly adjusted for volume and risk.

Second, HFMA's members believe reporting on a quarterly basis will impose a significant administrative burden. CMS collects the occupational mix wage index survey every three years. The information collected includes the data necessary to calculate NQF #0204 and #0205. Depending on the size of the hospital, our members suggest that collecting the necessary information to complete the occupational mix wage index requires between 40 and 160 hours of staff time. Given the administrative expense

²⁰ https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/hospice_pay_sys_fs.pdf

associated with these efforts, we question the value of quarterly collecting this metric, given that it shouldn't change that frequently.

Additionally, HFMA's members are concerned about the accuracy of the metrics from both a measure construction and potential payment adjustment perspective. Before these measures are incorporated into the VBP, HFMA's members demand that CMS develop a methodology to adjust the measure to account for state-level staffing mandates. Failing to do so could disadvantage hospitals in states without staffing mandates. From a reporting perspective, our members are deeply concerned about the accuracy of data currently reported on a quarterly basis, given the effort involved reporting data tri-annually for the occupational mix.

HFMA's members strongly encourage CMS to resolve the issues discussed above before implementing the nurse staffing measure. If these measures are implemented, HFMA's members ask CMS to refine the occupational mix wage index survey to incorporate the data reported for NQF #0204 and #0205. If implemented properly, this could minimize the administrative burden posed to hospitals by two overlapping CMS programs.

Ideas for Regulatory, Policy, Practice and Procedural Changes to Better Achieve Transparency, Flexibility, Program Simplification and Innovation

HFMA's members, along with members of numerous other associations, believe there is significant need for regulatory relief in the Medicare program. Below, please find a list of areas where we believe the need is greatest.

Quality Measure Reporting and Charge Posting

- 1) *Suspend Hospital Star Ratings*: Despite objections from a majority of the Congress, CMS published a set of deeply flawed hospital star ratings on its website this fall. The ratings were broadly criticized by quality experts and Congress as being inaccurate and misleading to consumers seeking to know which hospitals were more likely to provide safer, higher quality care. **HFMA asks CMS to remove the star ratings from the Hospital Compare website.**
- 2) *Cancel "Stage 3" of Meaningful Use*: Hospitals and physicians face extensive, burdensome, and unnecessary "meaningful use" regulations from CMS that require significant reporting on the use of electronic health records (EHRs) with no clear benefit to patient care. These excessive requirements are set to become even more onerous when Stage 3 begins in 2018. They also will raise costs by forcing hospitals and physicians to spend large sums upgrading their EHRs solely for the purpose of meeting regulatory requirements. **HFMA's members urge CMS to cancel Stage 3 of meaningful use by removing the 2018 start date from the regulation. The Administration also should institute a 90-day reporting period in every future year of the program, and gather input from stakeholders on ways to further reduce the burden of the meaningful use program from current requirements.**
- 3) *Remove Faulty Quality Measures*: Improvements in quality and patient safety are accelerating, but (as discussed above and in prior IPPS proposed rule comment letters) the ever-increasing number of conflicting, overlapping measures in CMS programs take time and resources away from what matters the most – improving care. Most recent additions to the inpatient quality reporting (IQR) and outpatient quality reporting (OQR) programs provide inaccurate data, and

do not focus on the most important opportunities to improve care. **We urge the Administration to remove all IQR and OQR measures added to the programs on or after Aug. 1, 2014. These measures also should be removed from CMS pay-for-performance programs, such as readmissions and hospital value-based purchasing.**

- 4) *Work with Other Purchasers to Develop a Coherent National Hospital Quality Measurement Strategy that Will Lead to Improved Outcomes for Patients at a Lower Cost:* HFMA would like to reiterate that its members' organizations are struggling to manage the vast array of public and private sector reporting programs for hospitals, physicians, and ambulatory care sites. In the 2012 report, *Defining and Delivering Value*, HFMA's members found that only 45 percent of hospitals agreed that quality metrics were either "very consistently" or "somewhat consistently" defined across payers. And we believe that if we resurveyed our members the percentage would decrease sharply given the proliferation of programs that attempt to measure and base payment on quality since that time. **Inconsistently defined quality measures increase the administrative cost of collecting data. And, given the potential for conflicting results, such measures make it harder for organizations to rally around improvement opportunities that have the greatest potential to improve quality for the patients they serve.**

Further, as discussed above, HFMA's members are concerned that many of the measures CMS and other purchasers have included in their programs are not focused on the greatest areas of opportunity to improve the quality or the efficiency of care they deliver. And when these metrics are focused on valuable activities that could improve patient outcomes, it's questionable whether the hospital or physician can meaningfully improve the measure, as much of the clinical care pathway is beyond their control. **This increases the risk of measurement fatigue and physician burnout.**

Given its leadership role in the Core Measures Collaborative, HFMA asks CMS to continue to work with other purchasers and stakeholders to develop more harmonized measure sets.

However, developing these sets is not enough. We ask CMS to take steps that would strongly encourage adoption of harmonized measure sets in programs using federal funds to purchase health care. If CMS could effect this, it would:

- Greatly reduce the administrative burden on hospitals and physicians
- Facilitate the transition to accountable care models
- Give CMS's efforts to collect Electronic Clinical Quality Measures (ECQMs) much-needed focus on areas that will drive improved patient outcomes

- 5) *Simplify Post-Acute Care Quality Measurement:* Recent laws and regulations are rapidly expanding the quality and patient assessment data reporting requirements for post-acute care providers. The requirements have been implemented aggressively, and without adequate time for stakeholder input. The result is duplicative reporting requirements – such as two different mandated ways of collecting patient functional status data for inpatient rehabilitation facilities (IRFs) – and enormous confusion in the field. **We urge the Administration to suspend any post-acute care quality reporting requirements finalized on or after Aug. 1, 2015, and to work with the post-acute care community to develop requirements that strike a more appropriate balance between value and burden.**

- 6) *Make Medicare Cost-Sharing Amounts Explicitly Available with Charge and Payment Data:* Annually, CMS makes hospital and physician charge data available to the public for common services. While cost sharing data is included in the total payment amount, the information necessary for an average Medicare beneficiary to understand their cost sharing isn't readily apparent. For example in the outpatient hospital services file, cost sharing data is included in the average total payments. For inpatient hospital services, there are two columns – one that provides “average total payments,” which includes cost sharing, and a column “average Medicare payments” that details the average amount Medicare pays a hospital. In theory a Medicare beneficiary could calculate their outpatient or inpatient cost sharing using this data. However, the information necessary to do so requires a level of sophistication far beyond what is possessed by the average Medicare beneficiary.

HFMA advocates for providing both quality and cost sharing information to consumers and patients. We believe empowering patient and consumers to make informed decisions about where to receive their care will improve individual patient outcomes but lead to a more sustainable healthcare system

To further the goal of transparency we convened a taskforce that included groups and individuals representing consumers, hospitals, health plans, and physicians. The resulting whitepaper “Price Transparency in Health Care²¹” suggested consensus best practices for providers and purchasers. One of those purchasers was Medicare and Medicaid. The report recommends CMS (and its administrative contractors) and state Medicaid programs (and their managed care organizations) make user-friendly tools available to their beneficiaries. These tools should provide beneficiaries with individualized cost sharing information based on their benefit design and the medical service required. For CMS, we believe this information should be available on the hospital compare website so that a beneficiary can evaluate both cost and quality to make a truly informed decision.

Reduce Administrative Burden Across the Care Continuum:

- 1) *Eliminate Redundant LTCH “25 Percent” Rule:* With the implementation of site-neutral payments for LTCHs, which began in October 2015 (as mandated by the Bipartisan Budget Act of 2013), the LTCH “25 Percent Rule” has become outdated, excessive, and unnecessary. The purpose of the 25 Percent Rule is to reduce overall payments to LTCHs by applying a penalty to selected admissions exceeding a specified threshold, even if the patient meets LTCH medical necessity guidelines. Given the magnitude of the LTCH site-neutral payment cut – a 54 percent reduction, on average, to one out of two current cases – **CMS should rescind the 25 Percent Rule and instead rely on the site-neutral payment policy to bring transformative change to the LTCH field.**
- 2) *Restore Compliant Codes for IRFs:* During the transition to ICD-10-CM, CMS reduced the number of conditions that qualify toward compliance under the IRF “60 Percent Rule,” which is a criterion that must be met for a hospital or unit to maintain its payment classification as an IRF. Yet, certain codes that qualified under ICD-9-CM were inadvertently omitted as a result of the conversion to ICD-10-CM. **We urge the Administration to restore those codes that counted**

²¹ HFMA Price Transparency Taskforce, HFMA, (2014), Price Transparency in Health Care

toward the 60 Percent Rule presumptive compliance test, but lost their eligibility as of June 1, 2016, during the transition to the new coding system.

- 3) *Expand Coverage for Telehealth Services:* Hospitals are embracing the use of telehealth technologies because they offer benefits such as virtual consultations with distant specialists, the ability to perform high-tech monitoring without requiring patients to leave their homes, and less expensive and more convenient care options for patients. However, coverage and payment for telehealth services remain major obstacles for providers seeking to improve patient care. Medicare, in particular, lags far behind other payers due to its restrictive statutes and regulations. For example, CMS approves new telehealth services on a case-by-case basis, with the result that Medicare pays for only a small percentage of services when they are delivered via telehealth. **HFMA urges the Administration to expand Medicare coverage, such as by a presumption that Medicare-covered services also are covered when delivered via telehealth unless CMS determines on a case-by-case basis that such coverage is inappropriate.**
- 4) *Prohibit Enforcement of Direct Supervision Requirements:* In the 2009 OPPS final rule, CMS mandated a new policy for “direct supervision” of outpatient therapeutic services that hospitals and physicians recognized as a burdensome and unnecessary policy change that could harm access to care in rural and underserved communities. Because CMS characterized the change as a “restatement and clarification” of existing policy in place since 2001, hospitals, particularly small and rural hospitals and critical access hospitals (CAHs), found themselves at increased risk of unwarranted enforcement actions. For CYs 2010-2013, in response to hospital concerns, the agency prohibited its contractors from enforcing the direct supervision policy. While Congress has extended this enforcement moratorium annually since 2014, this annual reconsideration of the misguided direct supervision policy places these hospitals in an uncertain and untenable position. **HFMA urges the Administration to permanently prohibit its contractors from enforcing the direct supervision regulations in CAHs and small and rural hospitals.**
- 5) *96 Hour Rule:* CMS has indicated it would begin enforcing a condition of payment for CAHs that requires a physician to certify that a beneficiary may reasonably be expected to be discharged or transferred to another hospital within 96 hours of admission. While CAHs must maintain an annual average length of stay of 96 hours, they may offer some critical medical services that have standard lengths of stay greater than 96 hours. Enforcing the condition of payment will force CAHs to eliminate these “96-hour-plus” services. **CMS should not enforce this provision.**

Reform Fraud and Abuse Programs to Make Them More Effective:

- 1) *Reform the RAC Program to Hold Contractors Accountable:* Medicare RACs are paid a contingency fee that financially rewards them for denying payments to hospitals, even when their denials are found to be in error. We believe that CMS’s two rounds of settlements with hospitals for cases inappropriately denied by the RAC is more than sufficient proof of the program’s substantial flaws. In the 2014 settlement, over 2,000 hospitals settled approximately 350,000 disputed claims for \$1.47 billion. Despite the sheer size of the settlement, it did not make a dent in the administrative backlog due to inappropriately denied claims necessitating another settlement. **HFMA urges the Administration to revise the RAC contracts to incorporate a financial penalty for poor performance by RACs, as measured by Administrative Law Judge**

appeal overturn rates. HFMA's members believe the RAC Program is plagued by additional issues and encourages CMS to review its previously submitted comment letters.

Barriers to Improving Patient Outcomes:

- 1) *Provide More Regulatory Flexibility for APMs:* CMS's continued application of fee-for-service (FFS) regulatory barriers within payment reform models often hinders providers' ability to identify and place beneficiaries in the most clinically appropriate setting. It also inhibits their ability to test new, more patient-centered and streamlined clinical pathways. Testing new approaches in an environment free from artificial barriers to care coordination, such as the IRF 60 Percent Rule and the home health homebound rule, will more effectively advance solutions that improve clinical outcomes and reduce overall costs and variation. **As such, HFMA encourages the Administration, to the greatest extent of its authority, to waive the regulations that CMS or Congress established for use in FFS reimbursement, but that inhibit the redesign of care episodes across provider settings.**
- 2) *Modify CoPs to Allow Hospitals to Recommend Post-Acute Providers:* CMS's discharge planning regulations have been interpreted to prevent a hospital from offering advice to a patient on the selection of a provider for post-hospital care. However, efforts to prevent unnecessary readmissions and to improve the health of individuals with chronic medical conditions have shown that coordination of care makes a difference in patient outcomes. This kind of coordinated care is essential to meeting the goals of the new payment models and would benefit all patients. **HFMA urges the Administration to amend the CoPs to establish that, while the choice must always be up to the patient, a hospital may make recommendations about post-acute care providers.**
- 3) *Create Stark Exemptions for Clinical Integration Arrangements:* Hospitals cannot succeed in their efforts to coordinate care and participate in new payment models because of outdated regulations, such as the Anti-Kickback Statute and the "Stark" law. **A new exception should be created that protects any arrangement that meets the terms of the newly created Anti-Kickback safe harbor for clinical integration arrangements.**
- 4) *Create Anti-Kickback Safe Harbor for Clinical Integration Agreements:* **The Office of the Inspector General should create an Anti-Kickback safe harbor for clinical integration arrangements that establishes the basic accountabilities for the use of incentive payment or shared savings programs among hospitals, physicians, and other providers:**
 - a. A program must be documented.
 - b. Performance practices must use an objective methodology, be verifiable, and be supported by credible medical evidence. They must be individually tracked, in the aggregate be reasonable for patient care purposes, and be monitored throughout the term of the arrangement to protect against reductions or limitations in medically necessary patient care services.
 - c. Payments must reflect the achievements of a physician, a physician practice, or the program, and be auditable through documentation retained to support the program as established and implemented.

The safe harbor should not try to supplant, duplicate, or recreate existing quality improvement processes or the mechanisms for monitoring quality of care in hospitals.

Currently, there is both internal and external oversight. State licensing agencies and accrediting organizations have an ongoing role. The Medicare Quality Improvement Organizations (QIOs) continuously review the quality of care for beneficiaries. Other Medicare program oversight includes the hospital inpatient and outpatient quality reporting programs, readmissions program, and value-based purchasing program.

The safe harbor would cover arrangements established for one or more of these purposes:

- a. Promoting accountability for the quality, cost, and overall care for patients
- b. Managing and coordinating care for patients
- c. Encouraging investment in infrastructure and redesigned care processes for high-quality and efficient care delivery for patients

The safe harbor would protect remuneration, including any program start-up or support contribution, in cash or in-kind.

- 5) *Create Anti-Kickback Safe Harbor for Assistance to Patients:* **This type of safe harbor is necessary so that hospitals can help patients realize the benefits of their discharge plan and maintain themselves in the community. Arrangements protected under the safe harbor also would be protected from financial penalties under the Civil Monetary Penalties (CMPs) for providing an inducement to a patient. The safe harbor should do all of the following:**
 - a. Protect encouraging, supporting, or helping patients to access care or make access more convenient
 - b. Permit support that is financial (such as transportation vouchers) or in-kind (such as scales or meal preparation)
 - c. Recognize that access to care goes beyond medical or clinical care, and include the range of support important to maintaining health such as social services, counseling, or meal preparation
 - d. Remove the regulatory prohibition on a hospital offering advice to a patient on the selection of a provider for post-hospital care or suggesting a specific facility (or through other legislation)
- 6) *Remove HIPAA Barriers to Integrated Care:* The HIPAA regulation currently restricts the sharing of a patient's medical information for "health care operations" like quality assessment and improvement, including outcomes evaluation, or activities that relate to the evaluation of provider qualifications, competence, or performance, to information about those patients with whom both the disclosing and receiving providers have – or have had – a patient relationship. The challenge that strict regulatory prohibition poses in the integrated care setting is that frequently patients do not have a relationship with all of the providers among whom information should be coordinated. A clinically integrated setting and each of its participating providers must focus on and be accountable for all patients. Moreover, achieving the meaningful quality and efficiency improvements that a clinically integrated setting promises

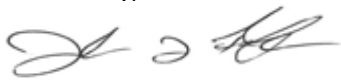
requires that all participating providers be able to share and conduct population-based data analyses. **The HIPAA medical privacy regulation enforced by the Office for Civil Rights should permit a patient's medical information to be used by and shared with all participating providers in an integrated care setting without requiring that individual patients have a direct relationship with all of the organizations and providers that technically "use" and have access to the data.**

- 7) *Allow Treating Providers Access to Their Patient's Substance Use Disorder Records*: Requiring individual patient consent for access to addiction records from federally funded substance use treatment programs, as current requirements do, is an obstacle to an integrated approach to patient care. It also may unknowingly endanger a person's recovery and his or her life. **The Administration should fully align requirements for sharing patients' substance use records with the requirements in the HIPAA regulation that allow the use and disclosure of patient information for treatment, payment, and healthcare operations.** Doing so would improve patient care by ensuring that providers and organizations who have a direct treatment relationship with a patient have access to his or her complete medical record.

HFMA looks forward to any opportunity to provide assistance or comments to support CMS's efforts to refine and improve the 2018 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:

[HFMA Comments on CMS's FY17 IPPS Proposed Rule \(CMS 1665-P\), June 15, 2016](#)
[HFMA Comment Letter: CMS' FY2016 Hospital IPPS Proposed Rule \(CMS- 1632-P\), June 29, 2015](#)
[Comment Letter to CMS: FY14 IPPS Proposed Rule \(CMS-1599-P\), June 24, 2013](#)
[HFMA Comments on Medicare DSH Payment Reductions, March 10, 2014](#)

Readmissions:

[HFMA Comment Letter: CMS' FY2016 Hospital IPPS Proposed Rule \(CMS- 1632-P\), June 29, 2015](#)
[HFMA Comments on CMS's Proposed Inpatient Hospital PPS Rule for FY15 \(CMS-1607-P\), June 30, 2014](#)
[Comment Letter to CMS: FY14 IPPS Proposed Rule \(CMS-1599-P\), June 24, 2013](#)
[HFMA Proactively Comments on the CMS Hospital Readmissions Reduction Program \(CMS 3239-P\), January 30, 2012](#)
[HFMA's Comment Letter to CMS on Hospital Value-Based Purchasing, October 17, 2012](#)

Value-Based Purchasing:

[HFMA Comment Letter: CMS' FY2016 Hospital IPPS Proposed Rule \(CMS- 1632-P\), June 29, 2015](#)
[HFMA Comments on CMS's Proposed Inpatient Hospital PPS Rule for FY15 \(CMS-1607-P\), June 30, 2014](#)
[Comment Letter to CMS: FY14 IPPS Proposed Rule \(CMS-1599-P\), June 24, 2013](#)
[HFMA Comments on the CMS Hospital Inpatient Value-Based Purchasing Program, \(CMS-3239-P\), March 8, 2011](#)
[HFMA's Comment Letter to CMS on Hospital Value-Based Purchasing, October 17, 2012](#)

HAC Penalty:

[HFMA Comment Letter: CMS' FY2016 Hospital IPPS Proposed Rule \(CMS-1632-P\), June 29, 2015](#)
[HFMA Comments on CMS's Proposed Inpatient Hospital PPS Rule for FY15 \(CMS-1607-P\), June 30, 2014](#)
[Comment Letter to CMS: FY14 IPPS Proposed Rule \(CMS-1599-P\), June 24, 2013](#)

RAC Policy:

[HFMA comments on the Senate Finance Committee Chairmen's Audit & Appeal Bill, June 18, 2015](#)
[HFMA Comments on Medicare Short Stay Payment Policy, April 21, 2015](#)
[HFMA comments on the Delay of RAC Appeals assigned to Administrative Law Judges, March 24, 2014](#)
[HFMA Comments on the Medicare Recovery Audit Contractor Program, October 11, 2013](#)
[HFMA Comments on Medicare Part B Inpatient Hospital Billing and the RAC Program \(CMS-1455-P\), May 17, 2013](#)