MISSOURI HOSPITAL ASSOCIATION

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Marilyn B. Tavenner, R.N.
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201-0007

RE: CMS-1607-P, Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Fiscal Year 2015 Rates

Dear Ms. Tavenner:

NATIONWIDE RURAL FLOOR BUDGET NEUTRALITY ADJUSTMENT

MHA continues to oppose the continued application of a nationwide rural floor budget neutrality adjustment as described in the proposed rule. CMS is well aware that this policy was instigated by the orchestrated conversion of a single facility in Massachusetts — Nantucket Cottage Hospital — from a critical access hospital to an inpatient prospective payment system hospital. Coupled with the application of nationwide budget neutrality through section 3141 of the Patient Protection and Affordable Care Act, the conversion initiated a policy that unfairly skews Medicare payments. Payments to thousands of hospitals across the nation are diverted to produce gains for hospitals predominately located in Massachusetts.

CMS recognizes the problems and inequities raised by this nationwide rural floor budget neutrality factor, which contradicts the agency's stated wishes in applying wage indexes. In its CY 2012 OPPS final rule (CMS-1525-FC), CMS expressed concern that allowing a change in hospital status as occurred in Massachusetts through the ACA distorts wage indexes across the nation:

> "…In recent years, we have become concerned that hospitals converting their status **significantly inflate wage indices** across a State…Hospitals in Massachusetts can expect an approximate **8.7 percent increase** in IPPS payments due to the conversion and the resulting increase of the rural floor. Our concern is that the **manipulation of the rural floor** is of sufficient magnitude that it requires all hospital wage indices to be reduced approximately 0.62 percent as a result of nationwide budget neutrality for the rural floor (or more than a 0.4 percent total payment reduction to all IPPS hospitals)." (emphasis added)

In its proposed rule, CMS publishes the projected state-specific effect of the nationwide rural floor budget neutrality standard in FY 2015. The agency notes that Massachusetts hospitals are estimated to receive approximately a 4.9 percent increase in IPPS payments due to the application of the proposed rural floor. The estimated amount of windfalls to Massachusetts from the manipulation of the wage index is $157.8 million for FY 2015. In addition to Massachusetts, California is now a large beneficiary of the manipulation and the agency estimates a windfall of more than $196 million.

MHA would like to thank CMS for its work to publish the state-specific impact table. MHA urges CMS to include in its final IPPS rule an updated detailed state-specific analysis of the effects of nationwide rural floor budget neutrality. Also, we ask that CMS build on its earlier analytical work on this topic by publishing tables showing the cumulative state-specific and aggregate inpatient and outpatient payment distortions produced by nationwide rural floor benefit neutrality in recent years and also projecting the estimated 10-year state-specific effects of continuing the current policy.

The adverse consequences of nationwide rural floor budget neutrality have been recognized and commented upon by CMS, the Medicare Payment Advisory Commission and many others over the past several years. That the policy continues into a fourth year is disconcerting at best. Until this policy is corrected, the Medicare wage index system cannot possibly accomplish its objective of ensuring that payments for the wage component of labor accurately reflect actual wage costs.

OUTLIERS

Outlier payments are reserved for high-cost outlier cases. Each year, CMS establishes a fixed-cost threshold that needs to be met before an outlier payment can be added to the base MS-DRG payment. CMS is proposing to increase this threshold by 18.6 percent, from $21,748 to $25,799. In order to continue this payment stream on which hospitals rely to care for high-cost outlier cases, hospitals are incentivized to increase their charges by the same rate of cost outlier change. In addition, the agency sets the fixed cost outlier threshold based on a percentage of total payments. Historically, the actual outlays have been lower than the estimation and no effort is made to correct the forecasting errors. The Missouri Hospital Association encourages CMS to re-evaluate and lower the final fixed outlier threshold so hospitals can keep charge inflation as neutral as possible and ensure that the estimated outlier payments from CMS are actually paid.

MEDICARE DISPROPORTIONATE SHARE PAYMENTS

The Medicare DSH payment mechanisms and calculations significantly changed in FFY 2014. CMS continues proposing changes for FFY 2015. Certain aspects of the calculation are beginning to undermine the vision and spirit of the Affordable Care Act in how Medicare DSH payments should be administered.

CMS is decreasing the 75 percent pool by the national change in the uninsured rate. The decrease is justified by the thought that uninsured rates would decrease throughout the nation as a result of the marketplace and Medicaid expansion. However, CMS is once again using Medicare SSI and Medicaid days to distribute the 75 percent pool. In doing so, states that expand Medicaid eligibility will receive a greater portion of the pool than states in which Medicaid eligibility is not expanded. For those states that do not expand coverage, they will receive a reduction to the national pool based on the national change in the uninsured rate and be penalized a second time due to the number of Medicaid days remaining relatively flat.

MHA supports the use of the Medicare cost report, worksheet S-10 to determine the redistribution rate for the 75 percent pool. At this time, it is wise to ensure that the newly developed schedule is used in a consistent manner. MHA encourages CMS to tighten the guidelines in reporting uncompensated care charges and cost. MHA also encourages CMS to transition from Medicaid and Medicare SSI days over a period of time. This will allow some time for hospitals to improve the reporting and the Medicare contractors to perform audits to ensure accuracy.

ALTERNATIVE PAYMENT APPROACHES FOR SHORT HOSPITAL STAYS

The two-midnight standard was developed by CMS to bring clarity to the process of determining the need for inpatient or outpatient hospital services. For those cases which meet the two-midnight standard, the standard is clear. However, for those cases in which the patient is not expected to stay over two midnights, CMS' regulatory standards remain murky and generate unnecessary cost and administrative burden. For these cases, hospitals fall back on proprietary indicia of medical necessity such as Milliman or Interqual but find themselves second-guessed by the Medicare Recovery Audit Contractors, whose contingency fee reimbursement system gives them strong incentives to challenge health care provider claims.

The two-midnight standard acknowledges that those services designated as "inpatient-only" under Addendum B of the Medicare outpatient prospective payment system should be exempt from the two-midnight standard. However, the current billing and reimbursement system does not capture the CPT or other data needed to identify whether a particular admission qualifies as an "inpatient-only" course of treatment. Without that data, hospitals and regulators are compelled to return to the costly and subjective practice of compiling and reviewing medical record case files.

Beyond the challenges of addressing designated "inpatient-only" procedures, the Missouri Hospital Association welcomes the opportunity to work with CMS and others to explore the potential of adapting the Medicare payment standards for short-stays to address the issues that gave rise to the two-midnight standard. In applying this short-stay methodology, it is crucial that full weight be given to the medical judgment of the ordering physician. Failing to do so will create a system focused on subjective disputes over medical necessity that will do nothing to improve the complexity and administrative burden of the current system.

HOSPITAL PRICE TRANSPARENCY

As proposed, MHA supports the flexibility for hospitals in determining how to make a list of standard charges available to the public. Specifically, MHA supports the flexibility of allowing a hospital to meet the ACA requirement by providing a "policy for allowing the public to view a list of those charges in response to an inquiry."

As stated in the proposed rule, hospitals "are in the best position to determine the exact manner and method by which to make those charges available to the public." Often times, it takes education and additional communication with patients to understand charges. Due to this, MHA supports the two-prong approach of either making public a list of their standard charges or their policies for allowing the public to view a list of those charges in response to an inquiry.

BUDGET NEUTRALITY REDUCTION FOR MS-DRG RECALIBRATION

When CMS released the proposed rule, the operating rate for FY 2015 included a significant budget neutrality reduction for MS-DRG recalibration. Since the proposed rule was published, the agency released a correction to the DRG weights on May 21. The new file contains a reduction of 0.26 percent for the majority of DRG's. Due to the release of corrected DRG weights, MHA recommends that the agency recalibrate and decrease the budget neutrality reduction for MS-DRG recalibration.

INPATIENT QUALITY REPORTING

In this proposal, CMS has stated its intention "to promote higher quality and more efficient health care for Medicare beneficiaries. This effort is supported by the adoption of widely agreed-upon quality measures. We have worked with relevant stakeholders to define quality measures for most settings and to measure various aspects of care..." MHA does not believe the objective mentioned above by CMS to promote higher quality and defining the appropriate measures for each setting has been met.

The National Quality Forum has been selected to assist CMS in the development of quality measures to be used in the hospital quality reporting programs. However, CMS is not following the recommendations provided by NQF and NQF's Measure Application Partnership related to specific measures.

Overall, MHA has significant concerns on some of the proposed changes in the inpatient quality reporting program. Our concerns include measures that are not endorsed by NQF and measures that are not receiving recommendation from the NQF MAP. In addition, MHA is concerned about the aggressive time line for use of electronic measures in lieu of chart-abstracted measures and the major changes in the validation process, as well as lack of validation for eMeasures. MHA believes CMS is unnecessarily adding more complexity to an already complex IQR program.

Removal of Measures

MHA understands CMS' rationale removing 15 chart-abstracted "topped out" measures. As MHA has previously stated, there is value in collecting data on all the recommended interventions for a specific condition, regardless of the national scores. Yet, this is not the approach CMS has chosen.

CMS has stated if it is determined that hospital adherence to practices has unacceptably declined, CMS would propose to resume data collection in future rulemaking for "topped out" measures that are retired. CMS has not provided any information on how it would be determined that adherence to practices has declined.

MHA agrees with the removal of the structural measure — "Participation in a Systematic Database for Cardiac Surgery" — from the hospital quality reporting, as recommended by the NQF MAP. We believe the structural measures add little, if any, additional information on the actual quality of patient care in hospitals.

In the rule, CMS proposes to adopt quantitative criteria for identifying "topped out" measures that are very similar to those used in the hospital value-based purchasing program. CMS proposes to remove measures from the IQR if national measure data meet two specific criteria.

- The difference in performance between the 75th and 90th percentile is statistically insignificant.
- The coefficient of variation is less than or equal to 0.10.

MHA agrees with establishing quantitative criteria that can be used as part of the decision making regarding whether a measure is "topped out" for national scoring.

CMS used these statistical criteria to recommend the removal of 15 "topped out" measures for fiscal year 2017 payment determination. However, CMS includes 10 of these "topped out" measures in the voluntary electronic data collection that may be used to meet both the IQR program and meaningful use requirements. MHA finds this logic difficult to understand. If quality measures are determined not to be of value for the IQR program, what additional value do they add to the MU electronic clinical quality measures? MHA does not understand how these measures would add to the expansion of the knowledge base or affect the quality of patient care in hospitals.

In addition, CMS is proposing to bring back two previously retired IQR measures — aspirin prescribed at discharge and statin prescribed at discharge for acute myocardial infarction. Again, MHA does not understand why measures that meet the proposed criteria for being "topped out" are being proposed for inclusion in the electronic CQM. MHA opposes the usage of measures in the eCQM program that have previously been removed from the IQR program and meet the removal criteria proposed by CMS.

FY 2017 Proposed IQR Measures

CMS proposes to add 11 measures to the IQR program for FY 2017. NQF has been selected to assist hospital quality reporting with measure development. However, the NQF MAP has not endorsed five of the proposed measures and also recommended four additional measures obtain endorsement before their use in the IQR program. Nine of the 11 measures do not meet the criteria for full NQF endorsement and MAP recommendation for use in IQR. MHA is very concerned that CMS is not following the recommendations of the measure partnership working with NQF on the development of quality measures.

In addition, six of the proposed 11 measures for FY 2017 are only available through the IQR's voluntary electronic reporting option. MHA does not understand the rationale for implementing these proposals under the IQR program voluntary electronic reporting. MHA supports the transition to eMeasures, but we have concerns when the data collection overlaps between the two programs. The IQR program is already very complex without adding additional layers of complexity.

FY 2017 Proposed Claim Measures

- CABG Readmissions (not endorsed by NQF)
- CABG Mortality (not endorsed by NQF)
- Pneumonia Payment Per Episode of Care (not endorsed by NQF)
- Heart Failure Payment Per Episode of Care (not endorsed by NQF)

MHA is opposed to measures being implemented for the IQR program that have not been endorsed or have lost endorsement by NQF. We believe CMS should follow the recommendations of the NQF, a public/private organization that has been designated as assisting with quality measures for all CMS' programs.

Again, as MHA stated in last year's comment letter, we oppose measures such as the AMI episode of care measure and now the proposed pneumonia and heart failure episode of care measures that reflect the broad spectrum of care inside and outside of the hospital. We do not believe measures that encompass a range of services from admission until 30 days post-discharge should be used as an indicator of hospital-specific care. MHA believes this is a more appropriate measure for continuity of care that would include the physician's quality reporting program, as well as long-term care, post-acute care, home health and the other potential entities that participated in the patient's care.

FY 2017 Chart-Abstracted Measure

- Quality of Sepsis Care (endorsed by NQF)

MHA supports this chart-abstracted measure because it is endorsed by NQF and has undergone review by the NQF MAP.

Electronic Health Record Based (voluntary reporting)

- Hearing Screening — Newborns (recommended by NQF MAP)
- PC-05 Exclusive Breast Milk Feeding and the subset measure PC-05a Exclusive Breast Milk Feeding Considering Mother's Choice (endorsed by NQF, recommended by MAP)
- CAC-3 (Children's Asthma Care-3) Home Management Plan of Care document given to patient/caregiver (no longer endorsed by NQF, not recommended by MAP)
- Healthy Term Newborn — claim (endorsed by NQF, not recommended by MAP)

MHA is confused about adding measures to the IQR program that are electronic voluntary measures only. We do not understand the goal or the value of this proposal.

If CMS wanted to propose a voluntary dual data collection between chart-abstracted measures and electronic measures, we would support that proposal. That is not the case here. Many of the measures being proposed for IQR as voluntary eMeasures are no longer part of the chart-abstracted IQR program because they have been retired, which does not allow for comparisons between chart-abstracted data and eMeasure data. Would it not make more sense to do dual data collection for validation and reliability? This is what MHA was expecting to see with the implementation of eMeasures.

The breast feeding measure is actually two measures related to breast feeding. Both are based on the mother's ability or plan to breast feed. There are no exclusions for newborn's medical conditions that may warrant the need for supplemental feedings. Because this measure is endorsed by NQF and recommended by MAP, MHA would support the inclusion of this measure as a chart-abstracted measure and not an eMeasure.

MHA opposes the children's asthma home management plan as NQF has removed its endorsement, and MAP has not recommended this measure. MAP actually recently removed its recommendation of this measure.

"Healthy term newborn" is a claim-based measure using ICD-9 coding to remove cases with complications or multi-fetus cases such as twins. This measure is endorsed by NQF. After review, MAP removed its recommendation of this measure because of significant technical issues with the electronic technical specifications. MHA cannot support this measure's implementation and it is in the category for voluntary eMeasures only reporting.

Acute Myocardial Infarction Measures (voluntary reporting — eCQM)

- AMI-2 Aspirin Prescribed at Discharge for AMI (endorsed by NQF, MAP recommended retirement)
- AMI-10 Statin Prescribed at Discharge (endorsed by NQF, MAP recommended retirement)

Both of these AMI measures have been removed from the IQR program and placed into what CMS categorizes as "reserve status." In the proposal, CMS states that reserve status is to retain endorsement of reliable and valid quality performance measures that have overall high level of performance with little variability. The NQF MAP did not recommend these two measures as eMeasures for this reason. MHA does not understand why these measures would be recommended in the IQR program as an eMeasure when they have already been retired in the chart-abstracted IQR program.

In summary, CMS' proposed additions and removals for measures have taken on greater complexity because CMS also proposes to retain and expand the option for hospitals to report electronic versions of IQR measures, thereby receiving credit in both the IQR and Medicare electronic health records incentive programs. Although CMS proposes to remove 15 chart-abstracted measures for the FY 2017 IQR program because their performance is "topped out," it also proposes to retain the electronic versions of 10 of them to support the voluntary electronic reporting option. Moreover, six of the 11 proposed measures only would be part of the voluntary electronic reporting option. Of those six electronic measures, two are actually electronic versions of measures that were previously retired from the program because they were "topped out."

Alignment Time Periods

CMS proposes a time line of alignment between the process of care chart-abstracted measures and the electronic clinical quality measures for meaningful use. MHA agrees alignment would be beneficial in the future and believes it is premature to attempt alignment at this time. This alignment would require the chart-abstracted measures data submission to be shortened by 90 days, from August 15 to May 15.

MHA strongly opposes such a significant decrease in time allocated for chart abstraction to occur. It is not reasonable to assume hospitals can successfully meet this time line. Coding and billing is allowed 30 days to complete this process, and then hospitals would have only 30 additional days to abstract all the records for the last month of the quarter. This significant change could adversely affect a hospital's ability to have an opportunity to successfully meet the stringent IQR abstraction requirements.

Claim-based Data

CMS proposes to use three years of claim-based data for all currently adopted and future condition-specific, claims-based measures, beginning with FY 2017 payment determination. MHA supports the use of three years of data.

NQF List of Measures Under Consideration

MHA appreciates CMS working with NQF to provide a list of measures under consideration for future implementation in the hospital quality reporting programs. An issue with this process is the release of a high volume of potential proposed measures for consideration at one time. For example, the list for calendar year 2012 had more than 500 measures, and at least 200 of the measures related to hospitals. It is unrealistic to think organizations that are on the operational side of implementing measures have the resources to thoroughly review such a large volume of measures within a 45 to 60 days turn around period.

MHA recommends that CMS and NQF provide a smaller volume of measures and prioritize the measures that are closer to use in the field. This would allow hospitals and hospital associations an opportunity to more closely review impending measures.

Validation Changes

There are significant changes in the proposal related to validation of chart-abstracted measures. CMS proposes to decrease the reabstraction of medical records from 96 records to 72 charts per facility annually, which is a 25 percent decrease. The distribution of records selected for process of care measures will decrease from 60 to 32 charts annually, which is a 47 percent reduction.

MHA recognizes that it may be labor intensive to reabstract medical records, but we believe it is a fundamental step in ensuring the accuracy of the hospital quality reporting data. Hospitals have invested enormous resources to ensure the documentation and abstraction for the hospital IQR program is as accurate as possible. MHA believes the process of care measures used for the IQR program and the value-based purchasing program requires validation of the abstracted records. The data affect the hospital's reimbursement, and we believe this abstraction warrants a continued validation of a higher volume of records.

In addition, decreasing the volume of the number of records selected may significantly increase the possibility of failed validation. One poorly documented record by a physician or clinical staff may result in failed validation. MHA would like to see statistical studies to show how this may affect the outcome of the validation results. MHA encourages CMS to maintain the current volume of review of these measures.

CMS proposes to remove the initial four core measures from the validation process. MHA suggests the measures be removed from the IQR and value-based purchasing programs if CMS believes these measures no longer warrant review. MHA highly encourages CMS to continue validation for all measure sets that are part of the IQR and value-based purchasing programs.

In addition to dropping four measure sets from validation, CMS is proposing to change the validation process to a "random systematic" process for case selection. Cases would be randomly selected across all measures submitted instead of each measure set having a specific number randomly selected. The immunization measure for influenza vaccine would have a higher weighing than other process of care measures because three of the eight records randomly selected will always be from this measure set.

MHA strongly opposes CMS' proposal to change the validation process. The immunization measure for influenza vaccine is only abstracted six months of each calendar year, carrying a higher proportion of records to validate. This means for six months of each year, the validation score for this measure will be based on the discharge disposition being accurately abstracted, as this is the only data point submitted to CMS during the non-flu season.

Mandatory Reporting of eCQM

MHA believes it is premature to consider implementing mandatory reporting of eMeasures for meaningful use by FY 2018 for IQR reporting requirements. There have been no validity and reliability studies to demonstrate the capture of equivalent data between chart-abstracted measures and electronically captured measures.

The electronic medical records were not developed with the purpose of capturing data to be used for measurement or comparison of data. When electronic measures were initially presented for potential future use of measures in lieu of chart-abstracted measures, CMS said there would be intensive comparison studies between the two programs to ensure the validity and reliability of these measures. MHA is not aware that this work has been scheduled or planned in the future. We believe this is a critical step in the transition to eMeasures.

MHA is aware of the proposed pilot of as many as 100 volunteer hospitals to participate in submitting data to a secure website. Because this initial pilot has not started, we believe it is very premature to establish a time line that is only three years away.

MHA suggests that CMS propose a systematic process to evaluate the validity and reliability of the electronic data. We believe it is critical this occur before any mandatory reporting of data that affects hospital reimbursement significantly through the quality reporting programs and value-based purchasing. MHA believes moving ahead with a program that is untested may unjustly penalize hospitals.

MHA highly supports the transition to the EHR measures and believes it will improve communication and documentation, as well as decrease resources currently needed for chart-abstracted core measures. However, we are very concerned about the aggressive time line CMS is proposing for the adoption of eMeasures for the IQR program.

MHA is concerned there is no proposed validation process for the eMeasures. We believe the use of electronic data that has not been validated and proven to be reliable should not be used for public reporting.

VALUE-BASED PURCHASING FY 2017

CMS proposes to remove six chart-abstracted process of care measures that are "topped out" from value-based purchasing. Again, these measures are proposed to be retained in the voluntary eMeasures for meaningful use.

Three measures are being proposed for adoption — *Methicillin Resistant Staphylococcus Aureas* bacteremia, *Clostridium Difficile* infection and early elective delivery.

Aggregate data for "Perinatal Care 01, early elective delivery," has been manually entered into QualityNet. Because CMS has no patient level data, it has no mechanism to validate the accuracy of this data.

MHA strongly opposes using any data that are not validated for inclusion in the value-based purchasing program. At this time, CMS has no way to ensure the data has consistently been collected from one hospital to another. It is quite possible to see a phenomenon that has occurred in the early days of collecting adverse events. Hospitals that collect data the most accurately and devote resources to the data collection may actually have the poorest scores. MHA believes hospitals are working very diligently to ensure the accuracy of the data. However, without a process in place to ensure a level playing field, it is difficult to determine what we do not know.

CRITICAL ACCESS HOSPITALS

We applaud CMS's willingness to revise its regulations at 412.103 and 485.610 to allow a two-year transition period for any CAH that changes designation from a rural area to an urban area due to OMB labor market delineation. This proposal will automatically provide the two-year transition period and will allow CAHs an opportunity to seek reclassification to maintain CAH status.

We appreciate CMS's proposal to allow greater flexibility for physician certification of expected discharge or transfer within 96 hours of admission. However, this policy is misguided. The issue at hand concerns the impossible task physicians have been given with regards to CAH inpatient admissions. When the 96 hour certification is coordinated with the two-midnight policy, a physician admitting an inpatient to a CAH must certify their "prediction" that the patient will require a stay encompassing two midnights, but will not exceed 96 hours. In some cases, the physician must certify that the patient will be transferred or discharged within a 49 hour time frame. We recommend that CMS pursue authority that aligns the physician certification in a way that the current Condition of Participation requirement of an annual average length of stay not to exceed 96 hours remains the standard. We believe this can be accomplished by requiring the physician to certify the CAH has the appropriate staff and resources to care for the inpatient.

LONG-TERM CARE HOSPITAL PPS PROPOSED RULE FOR FY 2015

FY 2018 Quality Reporting Measurement Proposals

CMS proposes three new measures for the Long-Term Care Hospital Quality Reporting program beginning in FY 2018 — two measures assessing functional status, and a healthcare-associated infection measure of ventilator-associated events. MHA is concerned that the three measures are not yet endorsed by the National Quality Forum. However, the Measure Applications Partnership has lent its full support to the VAE measure.

MHA, recognizing that LTCHs care for a significant number of patients requiring long-term ventilator care, supports adding the VAE measure to the LTCHQR in the future. However, NHSN did not implement surveillance for VAE until January 2013 and hospitals voluntarily submitting data are still learning the new VAE algorithm. We urge CMS to wait until the NQF endorses the VAE measure for LTCHs or at least the data submitted under the new VAE algorithm is reviewed for reliability and then evaluate the timing of implementation to allow for adequate training and resources for VAE data collection.

For the FY 2016 LTCHQR program, CMS proposes to establish, for the first time, data completeness standards and a measure validation process for the LTCHQR. MHA believes that this is a fundamental step to ensure the accuracy of the LTCH quality reporting data.

Sincerely,

Herb B. Kuhn
President and CEO

hbk/cml