June 13, 2017

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: CMS-1677-P Medicare Program: Hospital Inpatient Prospective Payment System Proposed Rule for Fiscal Year (FY) 2018

Dear Ms.Verma:

On behalf of our 127 community hospitals in Kansas, we appreciate the opportunity to provide comments to the Centers for Medicare & Medicaid Services on CMS-1677-P, the Medicare Inpatient Prospective Payment System Proposed Rule for FY 2018. Our comments are listed below.

Disproportionate Share Hospital (DSH) Payment Changes

In the rule, CMS proposes to transition to the use of the Worksheet S-10 for the calculation of Medicare DSH beginning in Fiscal Year (FY) 2018. Generally speaking, the Kansas Hospital Association (KHA) believes that, if reported in an accurate and consistent manner, the Worksheet S-10 data have the potential to serve as a better measurement of hospital uncompensated care costs. However, as we have commented in previous years, we remain concerned about beginning the transition without the implementation of an audit process and detailed instructions for consistent hospital reporting of data on the Worksheet S-10. In the 2017 final IPPS rule (page 56965 of the August 22, 2016 *Federal Register*), CMS seemed to agree with comments from KHA and many others in the hospital industry, by saying, "We believe the postponing our decision regarding when to begin incorporating data from Worksheet S-10 is necessary to allow us time to consider what changes to the cost report may be necessary and to implement an audit process."

We agree with CMS's analysis that shows that the S-10 data have improved over time, however, we still have concerns over the accuracy and consistency of the data. As such, we urge the Agency to take the following actions:

- Delay by one year the use of the Worksheet S-10 in calculating DSH payments, and to begin using the S-10 data in FY 2019 rather than FY 2018. The Agency should use this one year to provide additional instructions to hospitals to provide for more accurate and concise data reporting, as well as a process to allow hospitals to correct their data retroactively if necessary. We recommend that the definition of uncompensated care be broad based and include all unreimbursed and uncompensated care costs, including not only charity care and bad debt, but also uninsured discounts for individuals without insurance. CMS states that it has developed a process for auditing S-10 data and instructions will be provided to the Medicare Administrative Contractors (MACs) as soon as possible.

- Furthermore, CMS must have an audit process for the Worksheet S-10 in place for FY 2019 DSH reporting period (using FY 2015 data) and begin by auditing hospitals that appear to have anomalies in their data. For example, the Agency could conduct a side audit to expedite the process, similar to audits for the occupational mix survey data.

- During the one year delay, CMS should continue to use Medicaid and Medicare SSI days from 2011-2013 (pre-Medicaid expansion) for purposes of calculating uncompensated care payments to hospitals, thereby postponing inclusion of the FY 2014 data in the DSH payment calculation for FY 2018. CMS should also continue using a three-year average of data reported on a hospital's cost reports to calculate the uncompensated care payment to limit unpredictable swings and anomalies in DSH payments.

- Implement a phase-in approach of at least three years when transitioning to the Worksheet S-10 data in order to help maintain predictability and reliability in the prospective payment system.

- Implement a stop-loss policy to protect hospitals that lose more than 10% DSH payments in any given year as a result of transition to the Worksheet S-10.

96-Hour Certification Requirement

As a condition of payment for inpatient services provided at a critical access hospital (CAH), current law requires that a physician certify that a patient may reasonable be expected to be discharged or transferred to a hospital with 96 hours of admission to the CAH. CAHs also are required to comply with a Medicare Condition of Participation (CoP) that requires CAHs to provide acute inpatient care for a period that does not exceed, on an annual basis, 96 hours per patient.

In response to concerns raised by rural hospitals across the nation, CMS is proposing in the rule that it will direct review organizations to make the 96-hour certification a low priority for medical record review conducted on or after October 1, 2017. KHA appreciates CMS's recognition that this condition of payment could stand in the way of promoting essential, and often lifesaving, health care services in the rural areas. **We urge CMS to finalize this proposal**.

In addition, while this moratorium offers some comfort, it does not remove the 96-hour certification requirement from the statute, and KHA remains concerned that CAHs may still be at risk for penalties. For example, noncompliance with this payment requirement could trigger liability under the False Claims Act – leaving CAHs subject to unscrupulous relators in those cases. There also is potential for auditors outside CMS's control to use this requirement to target and penalize CAHs. As a result, KHA

will continue to advocate for a legislative solution that permanently removes the 96-hour physician certification requirement as a condition of payment for CAHs and we urge CMS to work with us to support that effort.

Extension of Rural Community Hospital (RCH) Demonstration Program

The RCH Demonstration Program was established to test the feasibility and advisability of reasonable cost reimbursement for rural hospitals with fewer than 51 beds. This program has provided stability to certain rural hospitals that are too large to qualify for CAH status, but too small to remain financially viable under Medicare's inpatient hospital PPS. While originally authorized for five years, the program was extended by the Affordable Care Act (ACA) for an additional five years. The 21st Century Cures Act expanded this program for an additional five years.

CMS proposes to begin implementation of the 21st Century Cures Act extension on a hospital's first cost-reporting period beginning on or after Oct. 1, 2017, following the announcement of the selection of additional hospitals to the RCH Demonstration Program. However, this would result in a gap in the reasonable cost-based payment methodology paid to hospitals that previously participated in the program. While the length of the gap in payment will vary for each previously participating hospital, all ended their performance long before Oct. 1, 2017.

We are concerned that CMS's proposal to implement the 21st Century Cures Act extension is inconsistent with both congressional intent and past CMS approaches. Specifically, Section 15003 of the 21st Century Cures Act changed the language in the ACA regarding length of the extension from "five years" to "ten years." The language also explicitly states that this extension is to begin on the date *immediately following* the last day of the initial five-year period. Further, CMS's proposal is inconsistent with its previous approach – the agency implemented the first five-year extension of this program continuously without a gap in the reasonable cost payment methodology. In addition, CMS has implemented extensions of other critical rural payment programs, including the Medicare-Dependent Hospital program and the enhanced Low-Volume Adjustment, in a seamless manner.

In addition, this proposal would cause financial hardship for the hospitals that have been participating in the RCH Demonstration Program. For example, a gap in reasonable cost-based payments would harm these hospitals' ability to recruit specialty health care services, prevent development of virtual care and transportation services and force them to reevaluate ongoing capital projects. As a result, we are concerned that they would be forced to reduce or eliminate the services they offer to their communities, thereby further threatening access to health care services for individuals living in these rural communities.

CMS acknowledges this gap in payment in the proposed rule and indicates that it also considered an "alternative approach" where each previously participating hospital would begin the second five years of the 10-year extension period immediately following the end of their first five-year period. For example, if a hospital's first five-year period ended on June 30, 2015, the extension period would begin July 1, 2015. Accordingly, under this alternative approach, there would be no gap in the reasonable cost-based payment methodology.

KHA urges CMS to implement the "alternative approach" instead of its proposal, thereby continuing the RCH Demonstration Program in a seamless manner. Doing so would align with

congressional intent, remain consistent with CMS's past practice and help allow previously participating hospitals to continue delivering essential health care services to their communities.

eCQMs in the IQR program

For the FY2019 and the FY2020 IQR program, CMS proposes to decrease the number of eCQMs for which hospitals must submit data and proposes to decrease the number of calendar quarters for which hospitals are required to submit data.

eCQM Reporting for the FY2019 IQR Program. For FY 2019, CMS proposes that hospitals electronically submit data for a minimum of six of the 15 eCQMs available for the IQR program, a reduction from the current FY 2019 requirement to submit data for eight eCQMs. CMS also proposes that hospitals report on two self-selected calendar quarters of data, a reduction from the current requirement to report four quarters of data. **KHA supports the proposal for FY 2019 to decrease the number of eCQMs for which hospitals must submit data and a reduction in the number of calendar quarters for which data is reported and urges CMS to finalize additional flexibility for FY 2019. We recommend that CMS retain the FY 2018 reporting requirement, permitting hospitals to submit data for a minimum of four eCQMs and do so for a minimum of one self-selected calendar quarter**. Maintaining the FY 2018 eCQM reporting requirements will provide hospitals, certified health IT vendors and CMS with additional time to work on measure specification, data validation, technology readiness and system issues. As CMS sites in the proposed rule, the process of mapping the data, taking on code, updating software, producing test and production files takes a tremendous amount of time, energy and resource. We believe additional relief is appropriate for both the 2017 and 2018 reporting periods. Particularly considering the current trajectory of providers taking on the new Certified Electronic Health Records. Historically, when there is a transition year for a new certification of EHR, there are substantial delays. Failure to successfully electronically submit eCQMs places hospitals at risk for an annual payment reduction equal to the applicable market basket update in a future payment year (25 percent reduction under the IQR program and 75 percent reduction under Medicare EHR Incentive Program). **Additionally, KHA recommends that CMS finalize the FY 2019 requirements as soon as possible to provide clarity for hospitals concerning the current CY2017 reporting year requirements.**

eCQM Reporting for FY 2020 IQR Program. For FY 2020, CMS proposes that hospitals electronically submit data for a minimum of six eCQMs of the 15 eCQMs available for Hospital IQR, a reduction from the current FY 2020 requirement to submit data for eight eCQMs. CMS also proposes that hospitals report on the first three calendar quarters of CY 2018, a reduction from the current FY 2020 requirement to report four quarters of data. **KHA recommends that CMS retain the FY 2018 reporting requirement, permitting hospitals to submit data for a minimum of four eCQMs and do so for a minimum of one self-selected calendar quarter. While KHA strongly supports the long-term goal of using EHRs to streamline and reduce the burden of quality reporting, there remain far too many questions about eCQM for CMS to mandate an expanded reporting requirement in the IQR for FY 2020.** The long-term challenges associated with eCQMs – accuracy, reliability and efficiency when compared to manual abstraction and the value delivered to the organization when compared to outcome-based measures – will not be resolved by the start of or during the CY 2018 reporting period. The entire eCQM process – from measure specifications updates through data file submission – must mature and provide evidence that eCQMs are feasible and valid measures of the quality of care before a mandatory increase in eCQM data reporting requirements.

Additionally, a reporting period of one calendar quarter will align the eCQM reporting requirement in the IQR with a 90-day reporting period proposed for the Medicare and Medicaid EHR Incentive Programs for CY 2018. Hospitals will be transitioning to the 2015 edition of certified EHR technology, and the process to transition to a new edition or a new technology takes 19 months to conduct safely. At this time, the certified health IT product list reflects a scarcity of available 2015 edition certified EHRs for the inpatient setting, which makes data gathering and reporting eCQMs for the first three calendar quarters of 2018 extremely unlikely.

Hospital experience with the use of EHRs for eCQM reporting indicates significant work has occurred, yet more work is necessary before eCQMs represent data that is reliable and valid for use in hospital quality reporting programs. As an independent 69-bed hospital reports*, "Our vendor has not completed all of the certification requirements at the present time and is actively working to do so. Rolling out a new certified version to the entire client base by end of the year is ambitious at best, impossible at worst. Even if each client is somehow able to receive the new version, implementing the processes to support the measures will take another several months of work. Rolling out newly minted software in such an accelerated timeline is not in the best interest of safe, quality patient care. To illuminate this concept, the rapidly deployed software fixes sent by our vendor just before the eCQM IQR program submission deadline inadvertently caused unintended system issues."* **KHA urges CMS to help build the knowledge base about eCQM reporting by collaborating with hospitals in the identification and sharing of successful practices in data mapping, data validation, and test production file submission.**

KHA also recommends that CMS address the diverse challenges to successful eCQM reporting. Relative to issues encountered with QRDA-1 file submission, KHA urges CMS to improve the capacity of the QualityNet system to receive QRDA-1 files and to send submission summary and performance reports before increasing the number of QRDA-1 data files hospitals must submit. To ensure that EHR vendors support any proposed requirement that hospitals use EHRs certified to all eCQMs.

Additionally, KHA encourages that CMS ensure that EHR vendors support any proposed requirement that hospitals use EHRs certified to all eCQMs. CMS proposes to require hospitals to have their EHR technology certified to all eCQMs that are available for hospitals to report in order to meet the eCQM reporting requirements. This would be applicable for the CYs 2017 and 2018 reporting periods and applicable for 2014 Edition and 2015 Edition certified technology. KHA urges CMS not to require hospitals to have 2014 edition EHRs that are certified to support all of the eCQMs available for IQR reporting for FY 2019. This places an unreasonable burden on hospitals to identify health IT vendor solutions solely because the certified EHRs do not support all reporting options within this CMS program. We recommend that CMS work with ONC and health IT vendors to ensure that the 2015 edition certified EHRs are capable of supporting hospitals eCQM reporting, including reporting any of the eCQMs that are available to report in IQR.

***Communicate plans for eCQMs including public reporting of eCQMs*.** Hospitals that report eCQMs also are reporting the manually chart-abstracted counterpart measures. As a result, they have processes and documentation workflows for chart-abstracted measures and eCQM guidelines. To minimize the potential interruption in vetted and quality workflows, hospitals are spending significant time in reviewing and including flexibility in data collection. However, this process is time intensive, particularly as eCQM measure specifications can change in substantive ways from one year to the next

and multi-disciplinary teams are engaged in the data mapping and data capture. Given limited time and resources, hospitals would benefit from the ability to focus on measures expected to be retained and publically reported.

Medicare and Medicaid EHR Incentive Program

CMS proposes to modify the Medicare and Medicaid EHR Incentive Program reporting period in CY 2018 to a minimum of any continuous 90-day period within CY 2018. This is a reduction in the current requirement that participants attest for a full year. The proposed reduction would be applicable for new and returning participants attesting to CMS or their state Medicaid agency.

KHA strongly supports the proposal for a reporting period of any continuous 90-day period within CY 2018. We share CMS' view that eligible hospitals (EHs), CAHs and eligible professionals will benefit from additional time to implement and optimize the 2015 edition certified EHR and review workflows. Experience to date indicates that the transition to new editions of certified EHRs is challenging due to lack of vendor readiness, the necessity to update other systems to support the new data requirements, mandates to use immature standards, an insufficient information exchange infrastructure and a timeline that is too compressed to support successful change management. Additionally, each new certification edition has corresponded with a decline in the number of vendors offering certified products. Provider decisions to switch vendors within a shrinking marketplace may intensify the lack of certified product readiness seen in prior years. To address some of these challenges, **KHA recommends a reporting period of any continuous 90-day period for CY 2018 and subsequent reporting periods**.

Hospitals require greater flexibility to meet CY2018 reporting requirements. To increase the opportunities for hospitals to successfully meet Medicare and Medicaid EHR Incentive Program requirements, KHA recommends several additional program changes for CY 2018:

Cancel Stage 3 by removing the 2018 start date from the regulation. Hospitals face extensive, burdensome and unnecessary "meaningful use" regulations from CMS that require significant reporting on the use of EHRs with no clear benefit to patient care. These excessive requirements are set to become even more onerous when stage 3 begins in 2018. We believe the level of difficulty associated with meeting all of the stage 3 current measures is overly burdensome. Some of the measures require the use of certified EHRs in a manner that is not supported by mature standards, technology functionality or an available infrastructure. They also will raise costs by forcing hospitals to spend large sums upgrading their EHRs solely for the purpose of meeting regulatory requirements. For example, a 14-bed critical access hospital in Kansas reports that the major obstacle for them is the cost of the Stage 3 software. Their vendor has quoted them $100,000.00 for the new module without a guarantee that the new software will meet requirements. Additionally, they are working to meet requirements for clinical data registries, but they must rely on other agencies to develop. *"For a small rural hospital like ours we need time, money and flexibility from the Feds on this if they want it done."*

Expand the reporting options by allowing EHs, CAHs and eligible providers (EPs) to choose the certified technology to use to meet meaningful use in CY 2018. Specifically, permit the choice to use 2014 edition certified EHR to report modified stage 2 or use a combination of the 2014 and 2015 edition certified EHR to report modified stage 2. KHA urges CMS to offer comparable flexibility for the CY 2018 reporting year and recommend that CMS finalize the CY 2018 requirements in a timeframe that enables EHs, CAHs and EPs to take advantage of the flexibility finalized.

Make reporting stage 3 voluntary should CMS decide to move forward with the final stage of meaningful use in CY 2018. A voluntary start of stage 3 in CY 2018 would be available for those EHs, CAHs and EPs that have 2015 edition certified EHRs implemented and optimized to meet stage 3 requirements reporting requirements. EHs, CAHs and EPs should retain the option to report modified stage 2.

Align the eligible hospital and CAH required start of stage 3 and requirements in other programs to use 2015 edition certified EHRs. The CMS quality payment program (QPP) includes the advancing care information category, a set of requirements derived from the objectives and measures included in stage 3 that require the use of 2015 edition certified EHRs. KHA recommends that CMS align the timeline for required use of 2015 edition certified EHRs in the Merit Based Incentive Program, the Advanced Payment Model program and other CMS programs that have objectives, measures or reporting requirements that are dependent on the use of implemented 2015 edition certified EHRs in CY 2018 with the Medicare and Medicaid EHR Incentive Programs timelines for required use of 2015 edition certified EHRs. Specifically, we recommend that these programs also allow flexibility in technology used and make any requirements derived from Stage 3 voluntary. The barriers cited earlier to a safe and successful implementation of 2015 edition certified EHRs exist for eligible clinicians. Alignment is essential to the effective exchange of clinical information in support of care coordination across the continuum and the engagement of patients.

Permit CAHs to attest to eCQM reporting requirements in the CY 2018 reporting period. Under the current regulation, CAHs will be required to electronically submit eCQM data to CMS for the CY 2018 reporting period to meet Medicare meaningful use. Some CAHs attempted to electronically submit eCQMs in 2016 but others were unable to do so because their certified EHRs did not support QRDA-I file generation necessary for electronic submission of eCQMs. In all instances, the effort to validate the eCQM data due to the small number of patient cases is not minimal. KHA recommends that CMS not require CAHs to electronically submit eCQMs in CY 2018 and provide additional time for the validation necessary to successfully submit eCQMs data.

Updated HCAHPS Pain Management Questions

For FY 2020 payment determination and onward, CMS proposes to change the existing pain-related questions in the HCAHPS survey. A composite measure of three questions that emphasize communication about pain would become part of the survey and be publicly reported beginning in October of 2019. Specifically, the proposed questions ask:

- "During this hospital stay, did you have any pain?"
- "During this hospital stay, how often did hospital staff talk with you about how much pain you had?" and
- "During this hospital stay, how often did hospital staff talk with you about how to treat your pain?"

Pain management is an important part of patient experience and the healing process. Under-treatment of pain can have a significant impact on individuals' quality of life even during a short-term hospital stay. KHA believes the HCAHPS survey should include a component on pain management.

We commend CMS for its responsiveness to stakeholder concerns about the current pain-related questions. In light of opioid epidemic, we wholeheartedly agreed with CMS's decision last year to remove the pain questions from the VBP calculations. We appreciate that the agency has worked to develop and test new questions that focus less on pharmacotherapy to address pain.

The urgency and tragic outcomes associated with the opioid crisis necessitate careful review of the newly proposed pain questions. **CMS should complete the multi-stakeholder, consensus-based review process for this composite measure before incorporating it into the HCAHPS survey and the IQR program.** Although the law envisions a robust evaluation of measures before their inclusion in pay-for-reporting programs, a comprehensive analysis has yet to occur for this measure due to the unavailability of testing data. The MAP briefly discussed the proposed questions in December of 2016, but it recommended that they be refined and resubmitted prior to rulemaking. Additionally, these questions have not been reviewed or endorsed by the NQF. We note that the testing results were not included in the proposed rule, further complicating the ability of stakeholders to provide comprehensive feedback on the measure through the notice-and-comment rulemaking process.

At the very least, the MAP and NQF should have the opportunity to examine the testing data on reliability and validity, which could help them understand:

- how the questions will be perceived by patients and providers;
- whether CMS's proposal will ultimately provide accurate data about pain management or improve outcomes;
- whether the new composite could potentially have unintended consequences; and
- how these questions compare to others CMS may have tested, including further explanation about the incorporation of the term "how often" in two of the questions.

Put simply, given the compelling need for a more comprehensive review of the proposed pain-related questions, **we ask CMS to not to finalize the proposed Communication About Pain composite at this time.** CMS should give the MAP and NQF time to review and deliberate the appropriateness of the new questions for the long-term.

We also urge CMS to do more to address the current pain questions in the HCAHPS survey. De-coupling the current pain management questions from VBP payments was a vitally important step to mitigating the potential pressure to use opioids to manage pain. However, concern remains about the negative unintended consequences of publicly reporting the current pain management composite. KHA recommends CMS suspend the reporting of individual facility performance on the pain management composite on *Hospital Compare.* This approach would enable hospitals to use any collected HCAHPS survey data to inform their internal pain management efforts if they choose to, but without the pressure of implementing pharmacological interventions that may be created from using the current questions for public accountability purposes.

Updated Stroke Mortality Measure for FY 2023

KHA applauds CMS for proposing to incorporate an adjustment for stroke severity into the stroke mortality measure. However, we urge CMS not to finalize the revised measure until it has been endorsed by the NQF. Given that stroke severity is perhaps the most important predictor of stroke

outcomes, KHA and numerous other stakeholders have long urged that CMS incorporate an adjustment for stroke severity into its 30-day stroke mortality measure. However, because the field only transitioned to ICD-10 on Oct. 1, 2015, CMS has not yet had the opportunity to complete field testing of the measure using the new codes. We urge that such testing be completed, and that the measure changes are reviewed and endorsed by the NQF prior to its inclusion in the IQR.

Accrediting Organization with Deeming Status

CMS proposes to require that accrediting organizations with deeming status publish the survey reports and health care facilities' plans of corrections for addressing any violations that have been found during the survey. These reports and corrective action plans would be published on the accrediting organization's website. CMS indicates that this proposal is in further support of its initiative to promote transparency about quality in health care delivery.

KHA fully supports the need for transparency around quality and safety. In fact, in 2003, KHA first proposed the coordinated voluntary effort to publicly report a set of valid and reliable quality measures that led to the creation of the *Hospital Compare* website that is now the foundation of CMS's transparency and value-based purchasing programs for hospitals. Since 2003, we have sought to work closely with CMS and others to identify the most useful, valid and reliable information for the public to have in assessing the quality provided by hospitals and other organizations, and we will continue that work.

We agree with CMS that compliance with standards, such as the CoPs or the even more demanding standards of some of the accrediting organizations, are an important part of ensuring the quality in hospitals, but believe the publication of the survey reports and plans of correction is not the right mechanism to help members of the public gain better insight into quality.

KHA does not support CMS's proposal to require the accrediting bodies to publish on their own websites the survey reports and corrective action plans for all surveyed organizations:

First, CMS's Proposal is Contrary to Congress's Limits on Public Disclosure of Accrediting Organization reports. The proposal is directly at odds with the limited authority Congress granted the HHS Secretary to disclose accrediting organization reports. The HHS Secretary must treat accrediting organization reports as confidential, with two narrowly drawn exceptions (accrediting organization reports related to a home health agency or disclosure in connection with an enforcement action), neither of which is relevant here or justifies CMS's proposal.

KHA concurs with the thorough and well-reasoned legal analysis in The Joint Commission's comment letter. We want to underscore several points. Section 1865(b) of the Social Security Act focuses specifically and exclusively on the confidentiality of accrediting organization reports. CMS contends that it has the authority to require public reporting of accreditation surveys by accrediting organizations because section 1865(a)(2) permits the Secretary to consider "other factors" when determining whether an accrediting organization should be granted deeming authority. CMS's defense of its proposal effectively and impermissibly treats 1865(b) as superfluous. It claims authority – to regulate the confidentiality of accrediting organization reports – under a provision focused on whether an accrediting organization can carry out the functions of surveying and monitoring the performance of a provider (Section 1865(a)(2)).

The legislative history reinforces the limitation on the Secretary's authority to regulate disclosure. Prior to section 1865, the Secretary did not have access to accrediting organization reports. The trade-off for obtaining access was the duty of the Secretary to maintain confidentiality. The existence of the provision and its continued presence through many years and various amendments makes sense only if Congress intended that accrediting organizations be able to keep reports confidential. Thus, CMS's proposal contravenes Congress's clear intent to protect the confidentiality of accrediting organization reports from broad public disclosure. CMS's proposal would unlawfully deprive section 1865(b) of any meaningful effect.

Second, CMS's Proposal Will Not Provide Meaningful Transparency. To achieve transparency, information must be presented to the public in a clear, understandable and useable manner that would support the decisions patients and their family members are trying to make. However, the survey reports are not designed to communicate to patients. The length and nature of the survey reports is likely to obscure rather than enlighten patient decision-making. The survey reports focus on issues of keen interest to those who operate health care organizations and are responsible for the day to day operations, but not on issues identified by patients or their families as critical to decision-making.

Moreover, the reports are written to communicate effectively with an internal audience that is knowledgeable about both the standards and the organization being surveyed. Further, they are written in a manner that requires sufficient context in which to understand the implications of the citation for the patients and community served. In the alternative, some might try to use the number of citations as a proxy for quality, but the number of citations can vary depending on the nature and size of the organization, the age of the physical plant, the number of different services provided, and the composition and training of the survey team rather than differences in quality. Thus, we believe this approach is likely to mislead patients and families.

Further, CMS's proposal would mean that the surveys for hospitals and other providers would appear on various accrediting organization websites. This will make it hard for the public to find information on the organization(s) in which they have an interest. Anyone wanting to locate the survey for a particular hospital or other organization would have to know the names and websites of the organizations to which CMS has granted deeming authority for that type of provider and be willing to search each of those organizations' websites to discover which organization accredits the hospital or hospitals in which the patient has an interest.

Finally, the survey reports may be out of date very quickly. Every hospital and other organization that seeks accreditation does so because it wants to be in compliance with the standards. As soon as defects are identified on a survey, the hospital will launch efforts to correct them. In many cases, hospitals fix issues spotted during the survey within days or weeks of the survey – even before the official survey report is received. This means the survey report could be obsolete even before it is posted. Yet, the majority of hospitals will not be surveyed again for three years or longer. The public should not be misled by out-of-date surveys as if they were current reflections of the care provided.

Third, the Mandated Publication of Survey Reports Could Have a Chilling Effect on Quality and Safety Improvement. Since the publication of the Institute of Medicine Report *To Err is Human* in 1999, some accrediting organizations have undertaken major efforts to change from simply looking at compliance with standards to partnering with health care provider organizations in their efforts to fundamentally improve quality and safety. This work involves creating a culture in which every

member of the staff trusts that he or she can raise questions or identify areas where risks are present and can be mitigated. Surveyors contribute to this work in many ways, including noting areas where no standard has been violated, but there may be an opportunity for a different approach that is safer or more likely to lead to high-quality results. Creating that culture of trust takes immense effort and time, but it can evaporate instantly if confidential inquiries are disclosed. The kind of public disclosure proposed by CMS is likely to have a chilling effect on conversations between hospital staff and surveyors – conversations that lead to safer, more effective care for the public. The survey reports prepared by accrediting bodies provide a confidential, detailed assessment of opportunities for improvement that are of great value to the hospitals that contract for the surveys and to the communities they serve.

For these reasons, KHA strongly urges CMS not to finalize its proposal to require accrediting organizations to publish survey reports and corrective action plans. Instead, we urge CMS to work with accrediting organizations, hospitals and other health care provider organizations, and experts on transparency to determine what information, if any, can be derived from surveys that would be useful to patient and family decision-making and how it might best be added to the vast amount of data and other information CMS provides on *Hospital Compare* and other similar websites to create a more complete picture of quality for the public without violating the statute or impinging on the culture of safety.

We appreciate your consideration of these issues. Please contact me or Tish Hollingsworth, KHA Vice President of Reimbursement at 785-276-3132 or thollingsworth@kha-net.org should you have any questions.

Sincerely,

Tom Bel1
CEO and President