June 17, 2016

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health & Human Services
200 Independence Avenue, SW, Room 314G
Washington, DC 20201-0007

Re: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System Policy Changes and Fiscal Year 2017 Rates; Quality Reporting Requirements for Specific Providers; Graduate Medical Education; Hospital Notification Procedures Applicable to Beneficiaries Receiving Observation Services; and Technical Changes Relating to Costs to Organizations and Medicare Cost Reports (CMS-1655-P)

Dear Acting Administrator Slavitt:

On behalf of our member hospitals and health systems in Kansas, the Kansas Hospital Association (KHA) offers the following comments regarding the Centers for Medicare & Medicaid Services (CMS) hospital inpatient prospective payment system and long-term care hospital prospective payment proposed rule for 2017.

MEDICARE DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

CMS proposes to change the time period for the data used to calculate hospitals' Medicaid and Medicare SSI inpatient days from one year to three years. CMS believes this change will address the concern from the hospital field that using only one year of data to determine a hospital's share of uncompensated care may result in unpredictable swings and anomalies. **KHA supports this proposal.**

Proposed Changes for FY 2018 DSH Payment Calculation

For several years, CMS has discussed the alternative of using Worksheet S-10 of the Medicare cost report to determine the amount of uncompensated care each hospital provides. This worksheet contains data on hospitals' charity care and bad debt and would be used in the place of their Medicaid and Medicare SSI days when distributing the 75-percent pool of DSH funds. For FY 2018, CMS proposes to begin a three-year phase in of incorporating hospitals' Worksheet S-10 data into the methodology for determining uncompensated care payments. CMS proposes to use FY 2014

Worksheet S-10 data in combination with FYs 2012 and 2013 Medicaid days and FYs 2014 and 2015 Medicare SSI days to determine the distribution of uncompensated care payments.

Generally speaking, KHA supports the use of Worksheet S-10 data to serve as a better measure of hospital uncompensated care costs. However, we remain concerned about the lack of accurate and consistent data being reported on the S-10, primarily due to lack of clear and concise instructions regarding its use. KHA encourages CMS to continue to refine the guidelines in reporting uncompensated care charges and costs in order to ensure the distribution of accuracy and consistency in reporting uncompensated care. **Once CMS ensures the accuracy and consistency of the S-10 data, KHA is supportive of the transition through a phase-in approach.**

CMS proposes that, beginning in FY 2018, uncompensated care costs would be defined to include line 30 of the Worksheet S-10, which includes the cost of charity care and non-Medicare bad debt. The Agency also proposes that Medicaid shortfalls (i.e. the unreimbursed costs of Medicaid, State Children's Health Insurance Program, and other state and local government indigent care programs) reported on line 19 of Worksheet S-10 would not be included in the definition of uncompensated care. **KHA continues to recommend that the definition of uncompensated care be broad based and include all unreimbursed and uncompensated care costs, including the Medicaid shortfalls. Consistent with this, KHA also recommends that discounts for uninsured individuals (regardless of whether they are called "discounts" or some other term) be included in the definition of uncompensated care in the Worksheet S-10.** These discounts are clearly costs that hospital incur in providing treatment to the uninsured. Not including these costs would inappropriately penalize these hospitals and runs contrary to the underlying intent of uncompensated care payments under the Affordable Care Act (ACA).

Timing of Reporting Charity Care and Bad Debt

CMS proposes to revise Worksheet S-10 cost report instructions concerning the timing of reporting charity care, such as charity care will be reported based on the date of write-off, not based on the date of service. **KHA supports this proposal.**

OBSERVATION NOTICE

The Notice of Observation Treatment and Implication for Care Eligibility (NOTICE) amended the Social Security Act to require a hospital or critical access hospital (CAH) to give each individual who receives observation services as an outpatient for more than 24 hours, an adequate oral and written notification of observation status. The NOTICE Act was enacted on August 6, 2015 and is scheduled to be effective August 6, 2016.

In the FY 2017 proposed rule, CMS requests comments on their recently published Medicare Outpatient Observation Notice (MOON) and instructions. **KHA applauds CMS's efforts to develop the MOON and the corresponding instructions, however, we are concerned with the lack of transition period for hospitals to implement the standards established by the NOTICE Act.** CMS will likely issue the final IPPS rule for FY 2017 around August 1, which allows no time for hospitals and CAHs to develop and implement their observation notification processes to meet the August 6, 2016 timeline. **KHA recommends CMS provide a transition period for the implementation of the NOTICE Act that begins with the publication of the IPPS final rule for 2017 and ends at the time the FY 2017 payment updates occur, which is October 1, 2017.**

TWO-MIDNIGHT RULE AND DOCUMENTATION AND CODING ADJUSTMENT

In the IPPS proposed rule, CMS reversed its 0.2 percent payment reduction for inpatient services that was implemented as part of the original "two-midnight" policy beginning in 2017. In addition, CMS is proposing a one-time temporary adjustment of 0.6% to reverse the reductions taken for FYs 2014, 2015, and 2016. This was an appropriate action to take.

KHA is concerned with the 1.5% reduction proposed by CMS which the Agency indicates is required to fulfill the $11 billion requirement of American Taxpayer Relief Act. CMS believes this proposed cut, combined with the effects of previous cuts of 0.8% in 2014, 2015 and 2016 is needed. Although a cut to hospital payments was mandated by ATRA, CMS's proposal is significantly larger than Congress estimated and the hospital field anticipated. Congress was clear in its passage of the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 that it expected this cut to be 0.8% for 2017. However, CMS is ignoring this directive and proposes to almost double the planned reduction. **We strongly urge CMS to reduce the amount of this cut in the final rule.**

WAGE INDEX

KHA continues to oppose the application of a nationwide rural floor budget neutrality adjustment as described in the proposed rule. CMS recognizes the problems and inequities raised by this nationwide rural floor budget neutrality standard. In the Agency's CY 2012 outpatient prospective payment system final rule (CMS-1525-FC), CMS expressed concern that allowing a change in hospital status as occurred in Massachusetts through the ACA distorts wage indices across the nation.

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 fifth 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.

QUALITY REPORTING

Hospital-Acquired Conditions (HAC)

As demonstrated by our long-established quality improvement initiatives, KHA continues to support quality measurement and pay-for-performance programs that effectively promote improvement, especially value-based approaches that measure both a hospital's actual performance, as well as how much it has improved over a baseline period. For this reason, KHA opposes the arbitrary statutory design of the HAC Reduction Program, which imposes penalties on 25 percent of hospitals each year, regardless of whether hospitals have improved performance, and regardless of whether performance across the field is consistently good. This methodology unfairly places teaching hospitals, large hospitals, small hospitals and hospitals caring for larger number of poor patients at greater risk of a penalty as a result of faulty measurement, and not bad performance.

The majority of our Kansas hospitals are rural and small. When volume is low enough, measures within the HAC program are excluded. In some cases, a single measure can determine whether a hospital will incur the HAC penalty. The PSI-90 measure is significantly affected by coding classifications and guidelines, documentation requirements and clinical definitions, rather than realized outcomes. The KHA urges CMS to phase out the PSI 90 composite measure altogether.

The KHA appreciates CMS's willingness to consider program changes within its statutory authority. However, we do not believe the proposed policy changes are sufficient to remedy the fundamental flaws with the program. PSI 90 should be replaced with alternative measures that address a variety of quality and safety issues. We recommend that CMS 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

In addition, KHA recommends that CMS eliminate the measure overlap between the HAC and value-based purchasing (VBP) programs. The VBP program uses all three of the current HAC measures but employs a different methodology to delineate good and bad performance. The measure overlap has created "double penalties" for some hospitals, while assessing disparate scores on the same measures for other hospitals.

<u>Electronic Clinical Quality Measure Reporting</u>

For FY 2019, CMS proposes a significant expansion of the requirement that hospitals report certain electronic clinical quality measures (eCQMs). Currently, hospitals must report on four of the 28 eCQMs available. The agency is proposing to reduce the number of eCQMs available to 15, but to require hospitals to report a full year of data on all 15 eCQMs in the IQR program. New software, changes to workflows, training staff and testing are required for any additional measure. These transitions take time and require substantial resources of both vendors and providers. As one of our hospitals has pointed out, they are required to submit 16 measure-centric data for the Meaningful Use EHR Incentive requirements and attest or submit numerator/denominator data for each. In 2016, they are required to submit 4 eCQMs for the IQR program through Quality Net. However, they are required to be in completely disparate formats. The IQR requires patient-centric measures, so that each patient only has one file, even if they are counted in multiple measures. The Meaningful Use submission requires data organized by measure. The vendor has promised that they will be ready for IQR by 4th quarter, but they have no written assurance of that and it will leave very little time for validation testing. *At the time in which this final rule for 2017 would be released, hospitals will still not have submitted data for 2016.* We simply do not know enough to expand requirements to the extent they are proposed. **KHA recommends that CMS remain with the four measures for 2017, to share additional information from the validation pilot and to continue education and outreach programs relative to eCQM reporting.** Our hospitals need examples of implementation best practices. Reliance on vendors is an issue, putting vendors and providers at varying states of readiness. KHA encourages CMS to build requirements on experience, and that experience has not yet been established.

Additionally, EHR vendors and third-party data submission vendors generate the QRDA-I file for some hospitals. It is not known if vendors will have the ability to support their hospital customers with successful submissions of a full year of data for CY 2017 immediately following the close of the CY 2016 reporting period. Please consider, all hospitals participating in the EHR Incentive Program will be required to implement the 2015 edition certified EHR in CY 2017. Experience indicates that

upgrading to a new edition of certified EHR results in unforeseen implementation challenges. The KHA urges CMS to refrain from increasing the amount of eCQM data reported for CY 2017 and recommends retaining the current requirement that hospitals electronically submit eCQM data for one calendar quarter for either Q3 or Q4. We also recommend that CMS use the experience from the 2016 data submission to inform proposals to increase in the amount of eCQM data to be submitted and to increase the number in an incremental manner.

Public Reporting of eCQMs. CMS proposes to continue the policy to not publically report the eCQM data submitted. The KHA supports the continuation of this policy. One quarter's worth of data would not provide a statistically valid sample from which to assess a hospital's performance, and the ongoing challenges with the reliability and validity of the electronically submitted eCQM data make public reporting premature.

Extraordinary Circumstances Extensions/Exemptions (ECE) Policy. CMS proposes to establish a submission deadline of April 1 following the end of the reporting calendar year for ECEs related to eCQMs. This timeframe also aligns with the Medicare and Medicaid EHR Incentive Programs' typical annual hardship request deadline. The KHA supports this proposal, as it provides certainty in the ECE policy. We also recommend that CMS recognize an expansive definition of extraordinary circumstances that would support favorable consideration for an extension or waiver of the eCQM data submission requirement to include technology difficulties that present a barrier to compliance, including switching EHR or third-party data eCQM submission vendors during the reporting period.

Hospital Readmissions Reduction Program (HRRP) Inclusion of Social Economic Status
Absence of adjustment for Social Economic Status (SES) in risk adjustment methodologies for the Value Based Purchasing program remains a concern. There are compelling reasons to include SES factor in the hospital risk adjustment models and KHA encourages CMS to consider economic status, particularly relative to readmissions. Research continues to show that factors that have nothing to do with the quality of care patients received while hospitalized increase the likelihood that patients will be readmitted. These factors include: living alone; the lack of primary care, home health and rehabilitation services in the community; a lack of transportation options, particularly in rural areas, that enable patients to go to follow up appointments; and challenges adhering to dietary restrictions or health promoting activities; among others. We remain concerned that hospitals caring for patients from poorer communities, where these kinds of sociodemographic factors are more common, will be disproportionately penalized.

CRITICAL ACCESS HOSPITALS

Kansas, like other predominantly rural states, faces challenges in many areas. Rural Kansans and their communities are critical to sustaining the overall resources of the state. They support and protect our environment; produce food and fiber, are often a laboratory of social innovation, and produce healthy, well-educated future citizens. In smaller communities, hospitals are a critical piece of the economic engine and a symbol of continued community cohesion. They are important not only for the health care services they deliver, but for maintaining the overall economic vitality and viability of the communities they serve. In today's health care environment, rural hospitals are facing federal and state reimbursement shortfalls, low population service areas, high community expectations and difficulties recruiting and retaining physicians and other highly trained staff. The need to consider new models of care is great. Towards that end, the Kansas Hospital Association supports CMS's efforts regarding the

Frontier Communities Health Integration Project Demonstration. While this program is not available to the 84 Kansas CAHs, we do have concerns that it may impact our hospitals and communities. CMS has stated in the proposed rule that as a contingency to ensure budget neutrality under the FCHIP demonstration, any expenditures not sufficiently offset by savings elsewhere will be recouped through a reduction in Medicare payments to all CAHs nationwide. KHA disagrees with this approach and believes it unfairly penalizes the 84 Kansas CAHs.

Thank you for the opportunity to provide comments to the proposed rule.

Sincerely,

Tom Bell
President and CEO