HAP Comments—Inpatient Prospective Payment System
Proposed Rule for Federal Fiscal Year 2017

Two-Midnight Policy Payment Adjustment

When the Centers for Medicare & Medicaid Services (CMS) implemented the two-midnight policy in federal fiscal year (FY) 2014, it also implemented at 0.2 percent payment cut because it estimated that the policy would increase Medicare spending by approximately $220 million due to projected shifts between inpatient and outpatient admissions. In the proposed rule, CMS includes its “final notice” in response to the federal court order in the consolidated federal challenge to the 0.2 percent reduction in inpatient PPS rates. Specifically, CMS proposes two adjustments that would reverse the effects of the 0.2 percent cut – a permanent adjustment of approximately 0.2 percent to remove the cut prospectively for FYs 2017 and onward; as well as a temporary, one-time adjustment of 0.6 percent to address the retroactive impacts of this cut for FYs 2014 – 2016.

HAP commends CMS’ proposal to reverse the effects of the 0.2 percent reduction. HAP also commends CMS on applying a retroactive fix to restore lawfully due resources to hospitals for the previous three years paid under the reduced rate. We await finalization of these adjustments with publication of the final rule and a formal resolution by the Court.

Medicare Disproportionate Share Hospital (DSH) Payment Reductions

The Affordable Care Act (ACA) required changes to the way in which DSH payments are made to hospitals. For FY 2017, CMS proposes that the amount in the 75 percent pool be further decreased to reflect additional decreases in the percentage of uninsured.

Despite strong efforts and ongoing success in reducing the number of uninsured, Pennsylvania has not yet realized the full benefit of increased insurance coverage originally envisioned in the ACA. These DSH cuts intensify already strained budgets as hospitals make investments in transforming the health care delivery system, while continuing to provide high-quality care for patients today.

Proposed Changes to DSH Payment Methodology Beginning in FY 2017

Beginning in FY 2017, CMS proposes to expand the time period for the data used to calculate hospitals’ Medicaid and Medicare Supplemental Security Income (SSI) inpatient days from one year to three years. CMS believes this change will address concerns raised by 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.

HAP supports this proposal.

Proposed Changes to DSH Payment Methodology Beginning in FY 2018—Future Use of Data from S-10 Worksheet for Determining Factor 3

CMS has been using Medicaid and Medicare SSI days as a proxy for uncompensated care in Factor 3 since FY 2014 and proposes to do so again for FY 2017, due to concerns regarding data variability and lack of reporting experience with the S-10 Worksheet. However, CMS is proposing to phase-in the use of data reported on Line 30 of Worksheet S-10 (Charity Care and Non-Medicare Bad Debt Expense) of the Medicare cost report in order to determine the Uncompensated Care (UCC) payment factor (Factor 3), starting with FY 2014 cost reports for DSH payments in FY 2018. The Worksheet S-10 data would be
phased-in as part of the three-year averaging process for Factor 3; i.e. an average of two years of proxy data (2012 and 2013) and one year of S-10 data (2014) for FY 2018 DSH payments, one year of proxy data (2013) and two years of S-10 data (2014, 2015) for FY 2019 DSH payments, and three years of S-10 data for FY 2020 DSH payments and thereafter.

**HAP is very concerned about the accuracy and consistency of the Worksheet S-10 data and we urge CMS to take additional steps to ensure the accuracy, consistency, and completeness of the data prior to their use. This entails auditing the S-10 data, as well as adopting a broad definition of uncompensated care costs to include all unreimbursed and uncompensated care costs, such as Medicaid shortfalls and discounts for uninsured. In addition, once CMS ensures the accuracy and consistency of the Worksheet S-10 data, we believe that transitioning to its use, either through a phase-in approach and/or a stoploss policy, is appropriate.**

**Auditing of Worksheet S-10**

While CMS' proposals would account for some anomalies in the cost-to-charge ratio (CCR), they do not improve the accuracy or ensure consistency of the S-10 charity care and bad debt data itself. Analysis of the Worksheet S-10 data identifies examples of missing and implausible data. Although the number of these anomalies are unknown, because the 75 percent pool is a fixed amount, inaccurately reported data by one hospital affects the DSH payments of all other hospitals.

**Simply starting to use the S-10 for payment and requiring its use going forward will not improve its accuracy. Therefore, we strongly urge CMS to audit the S-10 data prior to use to verify that they are correct and complete.**

**Definition of Uncompensated Care Costs**

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 the unreimbursed costs of Medicaid, the 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.

**HAP recommends that the definition of uncompensated care be broad based and include all unreimbursed and uncompensated care costs, including the unreimbursed costs of Medicaid, the State Children’s Health Insurance Program, and other state and local government indigent care programs reported on line 19 of Worksheet S-10.**

In addition, the ACA directed this pool to account for the uncompensated costs of the “uninsured.” Hospitals incur costs of treating uninsured patients that are not categorized as either charity care or non-Medicare bad debt and, therefore, are not appropriately captured on the S-10. For example, some, as a matter of course, provide discounts to uninsured individuals.

**Consistent with HAP’s recommendation for a broad definition of uncompensated care costs, we also recommend that these discounts (regardless of whether they are called “discounts” or**
some other term) for uninsured individuals be included in the definition of uncompensated care on the Worksheet S-10.

Timing of Reporting Charity Care
Historically, CMS required that the amounts claimed on line 20 and lines 26–29 of the Worksheet S-10 relate to services rendered in the cost reporting year. CMS now proposes that it intends to revise the Worksheet S-10 cost report instructions concerning the timing of reporting charity care, such that charity care will be reported based on the date of write-off, and not based on the date of service.

HAP supports this proposal.

Revisions to the cost-to-charge ratio (CCR) for Worksheet S-10
The ratio of cost to charges calculation on line 1 of Worksheet S-10 flows from Worksheet C, column 3 (costs) and column 8 (charges). Column 3 costs do not include the cost of training residents (direct graduate medical education [GME] costs), but column 8 charges do inherently include the cost of training residents. Therefore, the numerator and denominator of the CCR are not consistent.

HAP is recommending that the formula for calculating the CCR for Worksheet S-10 be modified to include GME costs.

Documentation and Coding Adjustment
The American Taxpayers Relief Act of 2012 (ATRA) requires adjustments totaling $11 billion during FY 2014 through 2017 to recover overpayments from FY 2010 through FY 2012 as a result of coding and documentation changes. CMS is proposing to increase the 0.8 percent cut expected by hospitals to 1.5 percent as CMS’ Office of the Actuary analysis estimates that an additional 0.7 percent point cut will be necessary to fulfill its legislative mandate due to decreasing inpatient admissions.

HAP is disappointed that the adjustment does not reflect the expected and intended payment cut of 0.8 percent.

While CMS anticipated a single, positive adjustment in FY 2018 to offset the recoupment reductions, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) replaced the one-time adjustment with 0.5 percent positive adjustments for FYs 2018 through 2023. This replacement will restore 3.0 percent, however, it does not include the additional 0.7 percent proposed in FY 2017’s rule.

HAP urges CMS to consider the Congressional intent of both ATRA and MACRA and ensure that the appropriate amount is fully restored to the hospital community.
Notification Procedures for Outpatients Receiving Observation Services

In August of 2015, the federal NOTICE Act was signed into law (P.L. 114-42). Per the federal statute, the notification process must consist of written notice, an oral explanation of notification, and documentation of notification.

The law requires both oral and written communication to Medicare patients placed into observation status for longer than 24 hours. The law requires hospitals to provide the notification no later than 36 hours after observation services are initiated, or sooner if the individual is transferred, discharged, or admitted as an inpatient.

CMS is proposing a standardized written notice (MOON) to be used by all applicable hospitals and critical access hospitals. The MOON will explain to patients that they are receiving observation services, the reasons for such status, and the implications. CMS will issue Medicare manual provisions regarding oral notification in conjunction with the delivery of the MOON.

HAP has particular interest in this issue because Pennsylvania has enacted its own law, Act 169 of 2014, the Hospital Observation Status Consumer Notification Act, that requires hospitals to provide notice to a patient (or the patient’s designee) of the patient’s outpatient status, and the impact of the outpatient status regarding insurance coverage. Pennsylvania’s law took effect on April 20, 2015.

HAP requests CMS consider the following:

- The NOTICE Act is intended to go into effect on August 6, 2016, likely before the FY 2017 final rule is released. In order to operationalize the federal requirements, many providers may need to make changes to their information technology infrastructure, revise their policies and procedures, and educate staff. As a result, HAP requests that CMS provide at least a six-month period for providers to comply following implementation of the new regulatory requirements.
- Under the regulation, observation begins “when treatment starts pursuant to the order.” HAP recommends that time spent in the emergency room should not be considered as part of the 24-hour notice calculation.
- As it pertains to the MOON, HAP recommends:
  - Removing the Quality Improvement Organization (QIO) name and phone number as it appears to indicate that this would be an appropriate channel for patients to appeal their discharge status. We believe this is misleading because the MOON does not afford Medicare beneficiaries any appeal rights. Accordingly, we recommend the removal of this language.
  - Adding language to the form to clarify that patient status may change throughout the course of a patient’s hospitalization if it becomes medically necessary.
  - Allowing states to tailor the MOON to meet state requirements and be used for the entire patient population, not just Medicare beneficiaries.
  - Making the MOON available in at least the top 15 languages to allow providers to download and use as appropriate.
Inpatient Quality Reporting (IQR) Program

There is a general concern about the pattern of measure development—measures being included in proposed rulemaking and moved to final rule without field testing, National Quality Forum (NQF)-endorsement, or modification based on input garnered during the public comment period.

HAP recommends that CMS meaningfully engage provider stakeholders in measure development, place a priority on Measure Applications Partnership (MAP) input, and secure NQF-endorsement of measures prior to inserting measures into the rulemaking process.

Modified Patient Safety Indicator (PSI)-90

As a result of recent NQF maintenance review processes, refinements were made to the PSI-90 measure. CMS proposes to include the modified version of the PSI-90, which includes changes in the component indicators and reweighting of the indicators to include assessment of the patient harm from adverse events, as well as the volume of these events, in the Hospital-Acquired Condition Reduction Program (HACRP) and IQR program starting with FY 2018 payment determination.

While HAP appreciates the attempt to control for the variability in the preventability and importance of safety events, the proposed modifications will not improve the general concern of reliability and accuracy of the individual component PSI measures.

Electronic Clinical Quality Measures

CMS is proposing significant changes to the electronic reporting requirements for the FY 2019 IQR program. The rule proposes to remove 13 electronic clinical quality measures (eCQM), however, it also proposes to require hospitals to electronically submit data for the remaining 15 eCQMs for a full year rather than four out of a possible 28 eCQMs for one quarter as finalized in the FY 2016 rule.

Hospitals in Pennsylvania are at varying levels of maturity technologically. Less advanced organizations will be challenged by this requirement, especially due to the proposed timing of the requirement.

Pennsylvania hospitals remain committed and supportive of the shift to electronic reporting. In order to allow hospitals appropriate time to deal with cumbersome data mapping, value-set downloads, and developing a successful submission process, HAP urges CMS to consider, as it once had, the phasing of requiring electronic data submission for the remaining 15 eCQMs across a two-year period, with data collected during calendar year (CY) 2017 and 2018 reporting periods.

Hospital Readmissions Reduction Program (HRRP)

The rule proposes only minor updates to the HRRP and will continue to impose a maximum payment penalty of 3 percent of base Medicare payments in FY 2017, as required by the ACA.
HAP continues to be concerned that the readmissions measures do not recognize that patient characteristics beyond those of medical diagnosis, age, and gender greatly affect health status, potentially leading to unintended consequences for providers and patients when used in the HRRP.

**HAP supports risk adjustment to account for socioeconomic factors when calculating readmissions penalties.**

**Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program**

CMS is proposing several changes to the IPFQR program including two new quality measures beginning with the FY 2019 payment determination:

- SUB-3 Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge (NQF #1664)
- Thirty-day all-cause unplanned readmission following psychiatric hospitalization in an IPF

HAP is concerned that the SUB suite of measures does not appropriately address the needs of inpatient psychiatric patients. The suite of measures was developed to screen general patient populations for use in primary and general acute care settings. SUB measures are an inappropriate use of resources within IPF settings, as psychiatric providers perform more in depth assessment of their patients' alcohol and substance abuse history and use, and provide effective, usually multi-disciplinary, substance and alcohol abuse treatment as part of standard care practice.

**HAP recommends that CMS test the value of applying SUB measures in inpatient psychiatric units prior to extending the number of SUB measures.**

HAP is also concerned with the broad characterization of readmissions as a direct reflection of the quality of care received in an IPF. Due to inadequacies in access to appropriate, community-based, mental health services, we know that patients (and well-meaning providers) are too often severely limited in moving within the continuum of mental health services—making an inpatient readmission a life-saving safety net.

HAP is also concerned that the unplanned readmission measure does not account for the complexity of the patient population in IPF—65 percent less than 65 years old who qualify for Medicare due to disability; 58 percent are dually Medicare and Medicaid eligible due to poverty status.

**HAP recommends that CMS, at least, put forth risk adjustment methodologies to better acknowledge the impact of patients’ socioeconomic status on IPFs’ ability to manage patients’ chronic psychiatric conditions within the community setting and prevent readmissions.**

# # # #