HAP Comments—Inpatient Prospective Payment System
Proposed Rule for Federal Fiscal Year 2016

MS-DRG Documentation and Coding Adjustment

The Hospital & Healthsystem Association of Pennsylvania (HAP) believes reduction in payments for documentation and coding adjustments for perceived coding practices under Medicare Severity Diagnosis Related Groups (MS-DRG) is unwarranted. HAP continues to believe that much of this change relates to the acuity of the patients that are being served, not “coding creep.”

Although HAP appreciates that the Centers for Medicare & Medicaid Services (CMS) has implemented these congressionally mandated cuts over time, we note that this coding adjustment will have a significant impact on Pennsylvania hospitals, reducing payments by $32 million for federal fiscal year (FFY) 2016.

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 FFY 2016, CMS proposes that the amount in the 75 percent pool be further decreased to reflect additional decreases in the percentage of uninsured. It also proposes to continue to use inpatient days of Medicaid beneficiaries and Medicare supplemental security income beneficiaries as a proxy for measuring uncompensated care.

Due to these changes, Pennsylvania hospitals will see nearly $48 million in losses when compared to FFY 2015.

Despite strong efforts and 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.

HAP urges CMS to work with us in asking Congress to delay implementation of these cuts until the full impact of coverage expansion is measured and understood. Additionally, with the potential for very significant impacts to the insurance market resulting from the U.S. Supreme Court’s forthcoming decision in King v. Burwell, No. 14-114 (U.S. Oral Argument held Mar. 4, 2015), HAP urges CMS to commit to reassess the calculation of the uninsured population after the ruling and consider approaches to mitigate the impact of DSH cuts.

S-10 Worksheet

CMS continues to express concern regarding variations in data reported on the S-10 Worksheet and indicates that it would be premature to use such data for calculating uncompensated care.
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HAP agrees with CMS that the S-10 Worksheet is currently not a reliable source of data about uncompensated care, and urges CMS to work with stakeholders as it pursues use of the Worksheet S-10 data in the future.

Elimination of the Simplified Cost Allocation Method

CMS has proposed eliminating the simplified cost allocation method for hospitals. Elimination of the simplified cost allocation method would create a significant and unnecessary administrative burden for hospitals. HAP urges CMS to withdraw the proposal.

Two-Midnight Policy and Short Inpatient Hospital Stays

As previously expressed to CMS, HAP has concerns about the two-midnight policy. The two-midnight policy fails to provide adequate reimbursement for beneficiaries who require an inpatient level of care, but who do not meet the two-midnight benchmark for admission.

HAP does not believe that a short-stay payment policy in isolation would address the issues adversely affecting providers, physicians, and beneficiaries. We hope forthcoming discussion of the two-midnight policy will include consideration of: short inpatient hospital stay payment, the adequacy of the outpatient prospective payment systems (PPS) rates Medicare pays for observation care, a reversal of the negative 0.2 percent inpatient PPS payment adjustment, and fundamental reforms to the recovery audit contractor (RAC) program. Additionally, HAP recommends that any time spent in observation should count towards the three-day stay prior hospitalization skilled nursing facility requirement.

HAP also believes exemptions from the two-midnight policy should be granted to Critical Access Hospitals (CAH) and Inpatient Psychiatric Facilities (IPF). The time-based policy does not make sense for either subset, as CAHs already are subject to a 96-hour condition of payment and IPFs are paid on a per-day basis under the IPF PPS.

In anticipation of changes to the two-midnight policy in the calendar year 2016 OPPS proposed rule, which would take effect January 1, 2016, we ask CMS to continue the partial enforcement delay to at least March 31, 2016, and preferably through the fiscal year (September 30, 2016) to provide sufficient time for CMS to issue guidance and allow hospitals to implement any new policies.

Recovery Audit Contractor Reform

Misaligned financial incentives that encourage RACs to deny claims inappropriately must be addressed to deal with the underlying issues motivating the audit program and backlogs in the appeals process. HAP supports:

- Eliminating the RACs contingency fee structure.
- Establishing a transparent methodology to review RAC performance.
- Adjusting payments based on RAC performance.
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- Allowing hospitals to rebill for medically necessary care.
- Ensuring claims are reviewed based on the medical documentation available when the patient was being treated.

Area Wage Index

CMS finalized applying the most recent Office of Management and Budget (OMB) labor market delineations that reflected the OMB’s new 2010 standards and 2010 Census data in FFY 2015. These changes have had a direct impact on the Medicare wage index and other factors used for payment purposes under the inpatient PPS.

HAP supports the continued application of transition periods to help reduce the impact of significant financial shifts due to the core-based statistical area (CBSA) changes.

Inpatient Quality Reporting and Electronic Clinical Quality Measures

CMS proposes a number of changes to the Inpatient Quality Reporting (IQR) program that would require, beginning in FFY 2018, that hospitals report patient-level data when submitting electronic clinical quality measures (eCQM) in order to avoid a payment penalty. Reporting would be required in the last two quarters of calendar year 2016 for PPS hospitals to avoid such a penalty. This goes beyond what is required under Stage 2 or 3 of meaningful use. HAP opposes mandatory implementation of eCQM reporting in the IQR program.

Of concern, the IQR program does not provide a hardship exemption for providers that are unable to report eCQMs, similar to the process provided in the meaningful use program. Failure to provide an exception process will unfairly expose hospitals to risk for payment penalties. Additionally, greater consideration should be given to the due process protections to allow hospitals that disagree with CMS’ determinations to appeal, and a waiver in the event of a disaster that precludes timely reporting.

HAP supports aligning quality reporting under the IQR and the Medicare Electronic Health Record (EHR) Incentive programs, and as stated above, believes the current proposal for required IQR reporting for FFY 2018 essentially would mandate electronic reporting in IQR before it is required for meaningful use.

HAP opposes mandatory implementation of eCQM reporting in the IQR program and urges CMS to continue voluntary reporting. Hospitals and health systems first need to gain experience with voluntary electronic reporting for IQR program purposes and address operational issues. CMS should sufficiently test its ability to receive and process the electronic measures before such reporting is made mandatory for all hospitals participating in the IQR program.
CMS has proposed to modify two pneumonia-related, claims-based measures beginning in FFY 2018:

- Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Pneumonia Hospitalization.
- Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate Following Pneumonia Hospitalization.

Specifically, in each case the cohort of patients included in the measure—currently defined to include patients with a principal discharge of pneumonia indicating viral or bacterial pneumonia—would be expanded to also include patients with a principal diagnosis of aspirational pneumonia, and those with a principal diagnosis of sepsis or respiratory failure, who also have a secondary diagnosis of pneumonia present on admission.

HAP urges CMS to reconsider adoption of this measure until it has gone through review by the National Quality Forum (NQF). Of concern, analysis indicates expansion of the readmission measure will significantly expand the patients included in the measure.

**Hospital Value-Based Purchasing (VBP) Program**

As we have commented in the past, we believe that the VBP program should include a mix of measures such as measures that test adherence to evidence-based interventions. We support prioritizing the use of outcome rather than process measures but urge CMS to ensure measures comprising particular measure domains reliably assess hospital performance. Measures should be carefully crafted to ensure they accurately reflect hospital performance, and are appropriately risk-adjusted for issues outside of the control of the organization being measured.

**ICD-10-CM/PCS Transition**

HAP is concerned that the proposed rule does not address issues related to how the transition to ICD-10 may affect the VBP program measures, benchmarks, baseline, and performance periods. With the implementation of ICD-10 approaching on October 1, we urge greater transparency regarding the transition of quality programs, in particular the VBP program, from ICD-9 to ICD-10.

**Hospital Readmissions Reduction Program (HRRP)**

HAP continues to be concerned that the readmissions reduction program makes excessive payment reductions to hospitals and that the payment methodology disadvantages hospitals serving a high percentage of low-income patients. A single excess readmission can cause a hospital to face a payment reduction that is several times greater than Medicare’s payment amount for that one admission.

HAP is 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.

Immediate adoption of the Medicare Payment Advisory Commission (MedPAC) recommendation to assess the HRRP penalty based on peer group comparisons—e.g., tiers based on the proportion of dual eligible patients—would avoid penalizing providers who are serving a high percentage of low-income patients and thus trying to eliminate disparities in health care.

Pneumonia Readmission Measure Changes
Consistent with the comments above, with respect to the IQR program, HAP opposes CMS’ proposal to refine the pneumonia readmissions measure to expand the measure cohort for FFY 2017 payment determination and subsequent years. This measure is not NQF-endorsed, yet the ACA requires that all measures included in the readmissions program be NQF-endorsed. Such an expansion of the measure is a material difference that warrants NQF review prior to inclusion in this program.

Proposed Extraordinary Circumstances Exception (ECE) Policy
HAP supports CMS’ proposal to adopt an extraordinary circumstance exception policy to address hospitals that experience a disaster or other extraordinary circumstance beginning in FFY 2016. The proposed policy—that a hospital submit an extraordinary circumstance exception request form within 90 calendar days of the natural disaster or other extraordinary circumstance—is consistent with other waivers and reconsideration processes currently in place for other programs.

Hospital-Acquired Condition (HAC) Reduction Program

HAP has ongoing concerns about the HAC Reduction Program although we recognize that the statute imposes constraints on the design of this program. Of particular concern is that all the measures finalized for the HAC Reduction program are duplicated in the VBP program safety domain. Unlike the VBP program, however, the HAC Reduction program draws a bright line in determining which hospitals receive a one percent payment penalty and which receive no penalty, without any recognition of whether a hospital is making improvements in reducing HACs.

HAP is pleased CMS has not added any new measures to the program however we remain opposed to the inclusion of the PSI-90 composite measure. CMS acknowledges that the Agency for Healthcare Research and Quality (AHRQ) claims-based patient safety indicator composite, PSI-90, is undergoing maintenance review at NQF. New component measures are under consideration for addition to the composite. CMS indicates that it would consider the addition of one of the measures to be a significant change, requiring notice and comment rulemaking prior to requiring reporting of the revised composite.
Additionally, central line-associated blood stream infection (CLABSI) and catheter-associated urinary tract infection (CAUTI) measures have undergone NQF maintenance review, and modified versions of the measures were re-endorsed by NQF during November 2014. The new versions include a new statistical option (Adjusted Ranking Metric, or ARM) for calculating the measure result. CMS indicates any proposed change will be pursued through notice and comment rulemaking.

HAP supports CMS' commitment to pursue the changes above through rulemaking.

CMS proposes changes to the domain weights beginning in FFY 2017, on the basis that the National Health Safety Network (NHSN) measures are a more reliable and valid set of measures as compared to the PSI-90 composite. HAP supports the change in the domain weights for FFY 2017 to apply greater weight for Domain 2 because the chart-abstracted NHSN measures are more actionable than the Domain 1 claims-based composite measure, PSI-90.

Proposed Extraordinary Circumstances Exception (ECE) Policy

HAP supports CMS’ proposal to establish an extraordinary circumstances exception policy beginning in FFY 2016, which would allow a hospital to apply for relief if its ability to collect or report accurate quality measure data has been negatively affected as a direct result of a significant disaster or other extraordinary disaster or circumstance. This would allow a hospital to request a HAC Reduction program exception at the same time it requests a similar exception under the IQR program, the Hospital VBP program, and the HRRP.

Expanding the Bundled Payments for Care Improvement (BPCI) Initiative

Pennsylvania has had more than 500 individual BPCI initiative projects underway throughout the state.

Fundamental recommendations include:
- Allow voluntary participation in all four models.
- Facilitate additional rounds of voluntary participation.
- Continue voluntary selection of clinical conditions by participating providers which will allow providers to ensure they have sufficient patient volume.
- Continue to allow participants to choose the episode length, and allow for longer episode periods, where outcomes may not be realized for six to 12 months.
- Lift Medicare regulations that prevent BPCI participants from fully testing bundled payments for post-acute services, including the inpatient rehabilitation facility (IRF) three-hour rule, IRF 60 percent rule, Long-term Care Hospital (LTCH) average length of stay of greater than 25 days, and LTCH 25 percent rule.
- Continue with retrospective payment both for operational reasons and to allow for claims data to provide insight into trends in utilization and spending.
- Conduct additional testing and evaluation—examining a longer time period and more participants and episode types.