June 17, 2016

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

Submitted electronically through www.regulations.gov.

RE: Comments on Proposed Rule CMS-1655-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 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; Centers for Medicare and Medicaid Services (CMS), HHA,; Proposed Rule (Vol. 81, No. 81), 4/27/2016

Dear Mr. Slavitt:

On behalf of our 137 member hospitals and health systems, the Minnesota Hospital Association (MHA) offers the following comments and suggestions regarding the Centers for Medicare & Medicaid Services’ (CMS) proposed rules for 2017 Inpatient Prospective Payment Systems for Acute and Long-Term Care Hospitals (Proposed Rule).

At the outset, MHA supports the recommendations and detailed comments submitted by the American Hospital Association (AHA). Instead of duplicating AHA’s analysis and suggestions, MHA’s comments will focus on the issues of most concern to Minnesota’s hospitals and health systems.

- Specifically, we are providing comments and recommendations in the following areas:
  - Documentation and coding adjustment
  - Disproportionate Share Hospital (DSH) payment changes
  - Two-Midnight policy
  - Proposed notification procedures for outpatients receiving observation services
  - Graduate Medical Education

Minnesota Hospital Association comment letter
• Hospital-Acquired Conditions (HAC) reduction program
• Hospital Readmissions Reduction Program (HRRP)
• Hospital Value-Based Purchasing program
• Hospital IQR Program

Documentation and coding adjustment

We are extremely troubled by the proposal for a 1.5% cut associated with the documentation and coding adjustment. This cut is almost double the cut anticipated by hospitals and should be reduced to what the agency originally estimated and planned – 0.8 percentage points for FY 2017. The American Taxpayer Relief Act of 2012 (ATRA) requires the Centers for Medicare & Medicaid Services (CMS) make adjustments to the standardized amount to recoup $11 billion that the agency claims is the effect of documentation and coding changes from FYs 2010 – 2012 that CMS says do not reflect real changes in case mix. However, we believe ATRA does not require CMS to reconcile its initial estimated amounts with actual discharges.

CMS indicates that this larger cut is necessary because inpatient PPS discharges have been less than its actuaries had anticipated, and an additional cut is necessary to fully account for the $11 billion. To be clear, ATRA allows CMS to continue using the analysis its actuaries prepared for the FY 2014 inpatient PPS final rule that was based on estimated discharges and projected a cut of 0.8 percentage points in FY 2017. Accordingly, we urge CMS to reduce this documentation and coding cut to what it originally estimated and planned – 0.8 percentage points for FY 2017.

If CMS implements a cut of 1.5 percentage points in FY 2017, the agency will, in total, remove 3.9 percentage points from the standardized amount. Yet, MACRA allows for only 3.0 percentage points to be returned to hospitals by FY 2023. Consequently, CMS’s proposed cut would leave hospitals with a permanent cut of 0.9 percentage points after the MACRA adjustments have been made, instead of the 0.2 percentage point cut that Congress intended. This additional 0.7 percentage point cut is inconsistent with Congress’s intent in the ATRA and MACRA, which, together, required restoration of the documentation and coding cuts.

Lastly, Congress did not intend for the recoupments to exceed $11 billion and any additional recoupment will unfairly penalize hospitals. ATRA limits CMS’s total documentation and coding recoupment to $11 billion. If CMS does not restore the 0.7 percentage points to the standardized amount, it will continue to recoup funds from hospitals each year going forward; resulting in recoupments that far exceed the $11 billion authorized by the ATRA. We, along with the AHA, have long argued that the documentation and coding cuts are unwarranted. For hospitals that are already financially strained, this additional reduction could result in a loss of health services and programs that are essential for Medicare beneficiaries, as well as other patients. Further, it penalizes hospitals for successfully doing what CMS and Congress have asked them to do – decrease admissions and reduce unnecessary admissions. To allow their ongoing effects to
continue indefinitely will significantly impact hospitals in a manner that was never intended by Congress. Therefore, as stated above, CMS should act in accordance with Congress’ intent in the ATRA and MACRA to ensure that the appropriate amount – 0.8 percentage points – is removed in FY 2017. If CMS removes more than this amount, we strongly urge CMS to ensure that any amount over 0.8 percentage points is returned to the standardized amount in FY 2018.

**Disproportionate Share Hospital (DSH) payment changes**

The Affordable Care Act (ACA) requires that, beginning in FY 2014, hospitals initially receive 25 percent of the Medicare DSH funds they would have received under the pre-FY 2014 formula, known as “empirically justified DSH payments.” The remaining 75 percent flows into a separate funding pool for DSH hospitals, known as “uncompensated care DSH payments.” This pool is reduced as the percentage of uninsured individuals declines and distributed based on the proportion of total uncompensated care each Medicare DSH hospital provides relative to the national total.

For FY 2017, CMS estimates that the total amount of Medicare DSH payments that would have been made under the pre-FY 2014 formula is $14.227 billion. Therefore, the agency estimates that the empirically justified DSH payments, or 25 percent of the Medicare DSH payments hospitals would initially receive is $3.556 billion. The remaining $10.670 billion flows into the 75-percent pool. To calculate what portion of the 75-percent pool is retained, CMS determines that the percentage of uninsured for FY 2017 would be 10.25 percent. After inputting that rate into the statutory formula, CMS proposes to retain 56.74 percent – or $6.054 billion – of the 75-percent pool in FY 2017. This amounts to a reduction of about $134 million in Medicare DSH payments in FY 2017 compared to FY 2016.

We, along with the entire hospital industry, are concerned about the agency’s lack of transparency with regard to how CMS and the Office of the Actuary (OACT) are calculating DSH payments. This is particularly troubling because Congress has generally foreclosed subsequent review, making the adequacy and completeness of notice-and-comment rulemaking that much more important from a constitutional due process perspective. The AHA highlights some examples of improvements that could be made to promote transparency related to the DSH calculation; however, this list is not inclusive, and we urge CMS to provide any additional information possible related to this complex calculation.

We request clarification from CMS regarding this significant discrepancy. We also request that CMS include a detailed explanation, including calculations, of how this factor and the “other” values for all years have been calculated by OACT. In addition, the AHA would like to see detailed calculations of the discharge and case mix values for all years. We remain concerned regarding OACT’s calculations and these inconsistencies, and request that CMS address these concerns in the FY 2017 inpatient PPS final rule.
MHA supports the proposed change to the DSH methodology 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 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.

CMS’s 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 place of their Medicaid and Medicare SSI days when distributing the 75-percent pool. However, because of concerns regarding variations in the data reported on Worksheet S-10 and the completeness of these data, CMS had indicated it was premature to propose the use of Worksheet S-10 for purposes of determining uncompensated care payments in each of those years.

CMS reiterates that assessment for FY 2017; but, for a variety of reasons, proposes to, starting in FY 2018, begin a three-year phase-in of incorporating hospitals’ Worksheet S-10 data into the methodology for determining uncompensated care payments. Therefore, for FY 2018, 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.

MHA members are concerned about the accuracy and consistency of the Worksheet S-10 data. We ask that CMS to take additional steps to ensure the accuracy, consistency and completeness of these data prior to their use. This entails auditing the S-10 data, as well as making other modifications to the S-10 worksheet, including, but not limited to, adopting a broad definition of uncompensated care costs to include all unreimbursed and uncompensated care costs, such as Medicaid shortfalls and costs associated with discounts for uninsured. Furthermore, we ask CMS to direct that Medicare Administrative Contractors accept Worksheet S-10 changes due to any revised instructions that materialize.

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 all charity care and non-Medicare bad debt; we support uncompensated care costs including these costs. However, 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. The AHA recommends, and MHA supports, that the definition of uncompensated care be broad based and include all unreimbursed and uncompensated care costs, including the unreimbursed costs of Medicaid, State Children’s Health Insurance Program (SCHIP), and other state and local government indigent care.

Minnesota Hospital Association comment letter
programs) reported on line 19 of Worksheet S-10. This broad definition of uncompensated care costs will be important in accurately measuring a hospital’s unreimbursed costs, and it will ensure the most appropriate basis for calculating future uncompensated care payments.

Timing of Reporting Charity Care and Bad Debt. 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. MHA members do not believe that hospitals would have identified and resolved all of the charity and bad debt accounts related to services provided in the current cost-reporting year by the time the cost report is due five months after the close of the hospital’s fiscal year. CMS now proposes 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. The MHA very much supports this clarification which brings the reporting into better alignment with generally accepted accounting standards.

Revisions to the 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. MHA supports GME costs be included in the formula calculating the CCR for Worksheet S-10 because they are a significant part of the overhead for teaching hospitals. In the proposed rule, however, CMS states that it does not believe that it is appropriate to modify the calculation of the CCR on line 1 of Worksheet S-10 to include GME costs. The MHA continues to recommend that the formula calculating the CCR for Worksheet S-10 be modified to include GME costs. This could be accomplished easily by using costs from Worksheet B, column 24, line 118.

Medicaid Reporting. The MHA supports AHA’s three recommendations related to the reporting of Medicaid DSH data on lines 2-6 of the Worksheet S-10. Specifically, we have indicated that hospitals should be required to report Medicaid DSH on a separate line, rather than having the options of including DSH in total Medicaid revenues (Line 2) without breaking it out separately. In addition, non-DSH supplemental payments (e.g., upper payment limit) should be reported on a separate line from Medicaid revenue and Medicaid DSH and the instructions for Medicaid lines should be revised to indicate that stand-alone S-CHIP should not be included in Medicaid line items. SCHIP is difficult to interpret from a DSH perspective given the various forms of implementation across states. CMS has taken no action related to these recommendations; therefore, the AHA renews its request for CMS to address these issues related to Medicaid reporting on Worksheet S-10.

Private Grants, Donations, Endowments and Government Grants, Appropriations and Transfers. The AHA has requested, on numerous occasions, that CMS clarify the purpose of Lines 17 and 18 on the Worksheet S-10, both in the near term and for the future. Line 17 requires the reporting of
grants, gifts and investment income that are related to uncompensated care. Line 18 requires reporting of a very broad scope of data related to the general operation of the hospital, whether or not they relate to uncompensated care. Both lines appear to be informational only, since they are not included in any of the totals elsewhere on Worksheet S-10. The MHA supports the AHA’s requests for CMS to make clarifications related to Lines 17 and 18. In the absence of such clarification, we recommend these lines be deleted.

Two-Midnight policy

MHA appreciates that CMS has decided to reverse the 0.2 percent payment reduction and supports the agency’s proposals to restore the resources that hospitals are lawfully due. We eagerly await finalization of these adjustments with publication of the final rule and a formal resolution by the Court.

Proposed notification procedures for outpatients receiving observation services

CMS proposes to implement the provisions of the Notice of Observation Treatment and Implication for Care Eligibility (NOTICE) Act, which requires hospitals and critical access hospitals (CAHs) to provide Medicare beneficiaries receiving observation services for more than 24 hours a written notice – the Medicare Outpatient Observation Notice (MOON) – and an oral explanation that the beneficiary is an outpatient receiving observation services and the implications of that status.

Implementation Timeline. MHA believes that hospitals and practitioners should communicate clearly with Medicare beneficiaries and their families about their status in the hospital. CMS will not issue a final rule with its inpatient policies until around Aug. 1. However, while we understand that the law requires the notice procedures to be effective starting on Aug. 6, we are concerned that it is unrealistic to expect hospitals and CAHs to have fully implemented these policies only a few days after the final rule is issued, particularly if there are changes made to the agency’s proposed policies.

Hospitals and health systems will need adequate time to develop and operationalize policies and procedures for the NOTICE Act requirements, update and test their medical record system to include the notice requirements and provide extensive education to their staff on the requirements. For hospitals and health systems that intend to integrate the requirements of the NOTICE Act into their information technology (IT) infrastructure and workflow, the process would involve critical and time-consuming tasks including:

We urge CMS to delay implementation to October 1 to coincide with other aspects of the rule and to institute a six-month enforcement grace period in order to provide hospitals and health systems with the opportunity to operationalize this new policy. This implementation
period also would have the additional benefit of giving CMS time to issue clear and detailed guidance to hospitals and Medicare contractors.

Written Notification via the MOON. CMS proposes that hospitals furnish a new CMS-developed standardized notice, the MOON, to a Medicare beneficiary or enrollee who has been receiving observation services for more than 24 hours. The MOON would include all the required elements specified in the NOTICE Act. **MHA supports the use of a standardized CMS notice for hospitals’ use and appreciates the agency’s assistance in designing this form.** However, we recommend that CMS clarify that the hospital may list either the physician who ordered the observation services or the patient’s attending physician on the MOON. Observation services are often initiated in a hospital’s emergency department by an emergency physician, prior to an attending physician being assigned to the patient. Allowing the hospital to list the ordering physician or the attending would help ensure the timely completion of the MOON.

In addition, we are concerned that supplying specific dates and times in three separate fields on the MOON is unnecessary. The first incidence is the date and time that the MOON was provided to the patient, which should be the same as the date and time of the patient’s signature. The second incidence is the date and time at which observation services are initiated. As CMS notes in the proposed rule, this information should already be contained in the patient’s medical record and so it is unnecessarily redundant to provide it on the MOON. **We urge CMS to delete these two fields for date and time from the MOON.**

Timing of the Required Notification. CMS would require that, for beneficiaries receiving outpatient observation services for more than 24 hours, the hospital must provide the written notification and oral explanation no later than 36 hours after observation began (or upon discharge). While it is not clear from the proposed rule, one interpretation of this requirement would be that the hospital could only present and explain the MOON within a 12-hour period between 24 and 36 (or less) hours after observation services have been initiated. Delivering the notice within this window of time could pose significant logistical and operational challenges for hospitals – observation beds can be located in many different units across the hospital, observation care patients are often taken off the unit for purposes of testing and treatment and the appropriate hospital personnel required to present the notice may not be available within this timeframe.

**MHA supports the AHA’s recommendation that CMS clarify that hospitals are permitted to provide the beneficiary with the MOON and its explanation at any point after outpatient observation services are initiated, as long as it takes place within 36 hours or, if earlier, prior to discharge, transfer or inpatient admission.** This would be helpful for both the beneficiary and the hospital. Specifically, it would permit beneficiaries to learn about their status as outpatients and the implications of that status earlier in their stay. For the hospital, it would allow the notice to be provided in a timely manner that is in accordance with the workflow of the facility.
ORAL EXPLANATION. In the proposed rule, CMS provides virtually no information about what is required with regard to the oral explanation of the written notice. Instead, the agency states it will provide guidance for the oral notification in forthcoming Medicare manual provisions. MHA, along with the AHA, are concerned that the agency plans to issue this critical guidance outside of a notice-and-comment rulemaking process and, therefore, without an opportunity for public comment. We encourage CMS to develop the manual section in a transparent manner that allows for public review and comment prior to it being finalized. Further, we note that CMS does not propose to limit which hospital staff may provide the written MOON and its oral explanation to the beneficiary. We agree that hospitals should be permitted to determine which staff are best equipped to provide the notice to beneficiaries in the most appropriate and timely manner.

BENEFICIARY SIGNATURE REQUIREMENT. The Act provides that, if a beneficiary refuses to provide a signature on the MOON, the notification must be signed and dated by the hospital staff member who presented the written notification. We recommend that CMS also apply this process in other similar situations – such as when a beneficiary is unable, due to his or her medical or mental condition, to comprehend and sign the notification and there is no family or patient representative available in a timely manner. In these circumstances, hospitals’ ability to obtain a signature is out of their control. They should be able to document that an attempt was made to provide the notice, including efforts to reach family or the patient’s representative, and allow the staff member to sign the MOON.

OVERLAP WITH SIMILAR STATE LAWS AND/OR REGULATIONS. In Minnesota, we have a regulation that mandates notification similar to those in the NOTICE Act for outpatients receiving observation services. We urge CMS to clarify whether state or federal requirements would take precedence or if both requirements must be met simultaneously. In addition, we recommend that CMS address whether a hospital that complies with substantially equivalent requirements imposed by its state could be considered to also be in compliance with the requirements of the NOTICE Act. We believe that it would be confusing and counter-productive to require hospitals in these states to give patients two somewhat different notifications, potentially provided at different times, informing them about generally the same thing.

Graduate Medical Education

CMS proposes to revise the GME regulations related to rural training track programs (RTT), a change the agency indicates it inadvertently failed to make when it previously amended regulations to provide for a five-year new program growth period and cap-building window. Specifically, the agency proposes to increase, from three to five years, the period of time that urban hospitals are granted to establish RTT direct GME and indirect medical education caps. Under the proposed revisions, an urban hospital's RTT cap would take effect beginning with the hospital’s cost-
reporting period that coincides with or follows the start of the sixth program year of the RTT’s existence. **MHA supports this proposal.**

**Hospital-Acquired Conditions (HAC) reduction program**

MHA members are deeply committed to eliminating avoidable harm, and data show that we are making care safer. We continue 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, we have long opposed 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. In addition, we are concerned that CMS’s implementation of the program has unfairly placed 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.

MHA does not support CMS’s proposal to use Winsorized z-scores to calculate points on HAC measures starting in FY 2018. While we applaud CMS’s willingness to explore changes to its current scoring methodology, we do not believe the z-score approach meaningfully improves the fairness of the HAC program based on the research findings from an AHA-commissioned study. **Our biggest concern with either the decile or the Winsorized approaches is that there should be a clinically and statistically significant difference between scores of worse performers.** Unfortunately, the current methodologies identified appear to penalize some hospitals based on random variation.

**Updated Version of PSI 90 for FY 2018.** MHA does not object to CMS’s proposal to incorporate an updated version of the PSI 90 measure in the HAC Reduction Program starting in FY 2018. However, we strongly urge the agency to phase the measure out of the HAC Reduction Program and other programs altogether. CMS proposes to adopt the version of PSI 90 that was recently endorsed by the National Quality Forum (NQF). We appreciate that the revised measure re-weights individual component PSIs so they better reflect the importance and preventability of particular safety events. We certainly agree that there is variability in the preventability and importance of safety events, and appreciate the attempt to improve the measure. Nevertheless, these changes are not sufficient to improve the underlying lack of reliability and accuracy with individual component PSI measures.

Given the claims-base nature of PSI-90, claims data cannot and do not fully reflect the details of a patient’s history, course of care and clinical risk factors. As a result, the rates derived from the measures are highly inexact. PSI data may assist hospitals in identifying patients whose particular cases merit deeper investigation with the benefit of the full medical record. But, the measures are
poorly suited to drawing meaningful conclusions about hospital performance on safety issues. In other words, PSI 90 may help hospitals determine what “haystack” to look in for potential safety issues. But the ability of the measure to consistently and accurately identify the “needle” (i.e., the safety event) is far too suspect to deem it worthy of NQF endorsement, let alone use in public reporting and pay-for-performance applications.

PSI 90 Performance Period for FYs 2018 and 2019. MHA supports the AHA’s concern over CMS’s proposal to shorten the performance periods of the PSI 90 measure to 15 months in FY 2018 and 21 months in FY 2019. While the performance period for PSI 90 generally is 24 months, the agency proposes shorter performance periods to account for the transition from ICD-9 to ICD-10 coding on Oct. 1, 2015. CMS is developing an ICD-10 version of PSI 90, but it will not be finalized until late 2017. Moreover, CMS believes it is not feasible to calculate PSI 90 using a combination of data collected under ICD-9 and ICD-10.

While we agree it is likely inappropriate to mix performance data collected under ICD-9 with data collected under ICD-10, we note that the PSI measure’s reliability is compromised when the reporting periods are shortened. We are especially concerned by the 15-month performance period proposed for FY 2018. At a minimum, we would encourage the agency to reduce the domain weight of the PSI 90 measure for FYs 2018 and 2019. CMS also should consider whether it would be feasible to suspend the use of the PSI measure for FY 2018. In addition, the agency could determine whether there are any other available measures that could be incorporated into the program for FY 2018.

**Hospital Readmissions Reduction Program (HRRP)**

MHA’s major concerns with the HRRP are that it is a penalty-only program and that there continues to be a lack of recognition by CMS to make adjustments for sociodemographic issues which clearly impact certain large and small hospitals in poor urban and rural areas. We believe the measures should not be expanded without first making adjustments that correct the deficiencies of the existing HRRP program. Again, we suggest there needs to be clinical and statistical significance applied to the program to avoid the random chance that some hospitals are penalized while others are not with no meaningful differences.

We remain concerned that hospitals caring for patients from poorer communities, where these kinds of sociodemographic factors are more common, will be disproportionately penalized. In addition, we believe hospitals that are performing better than others in a statistically and clinically meaningful way should be rewarded with an upside incentive.

**Sociodemographic Adjustment.** MHA is disappointed that the agency has once again failed to propose any sociodemographic adjustment for the HRRP. 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 dearth of transportation options that enable patients to go to follow up appointments; and challenges adhering to dietary restrictions or health promoting activities; among others.

**Timeline for Public Reporting on Hospital Compare.** CMS clarifies that excess readmission ratios will be posted on an annual basis to the Hospital Compare website as soon as is feasible following the review period. CMS notes that this could, but may not always, occur as early as October. We urge CMS to continue to ensure there is an adequate review period of at least 30 days, and to ensure there is adequate time to make necessary corrections between the review period and the public display of data.

**Hospital Value-Based Purchasing program**

MHA has been an ongoing supporter of the value-based purchasing program with its goal to improve overall value. Though we realize this is an evolving process, we have been concerned about hospitals’ having to chase a moving target. With a greater emphasis being focused on outcomes, we would caution implementing new measures without conclusive evidence that the measurement is clinically and statistically fair and meaningful.

**MHA does not support CMS’s proposal to add the acute myocardial infarction (AMI) and heart failure (HF) condition-specific episode-based payment measures to the FY 2021 VBP.** While we agree that well-designed measures of cost and resource use can assist with assessing the value of care, we are concerned that the overlap between these condition-specific measures and Medicare spending per beneficiary (MSPB) measure may lead to unnecessary confusion among hospitals.

MHA urges CMS to improve the reliability of the coronary artery bypass graft (CABG) mortality measure it proposes for the FY 2022 VBP program before finalizing it.

MHA supports CMS’s proposal to incorporate CAUTI and CLABSI measure data collected from non-ICU locations into hospitals’ VBP performance beginning with the FY 2019 program year.

**Hospital IQR Program**

Hospitals are required to report measures and meet the administrative requirements of the IQR program to avoid having their annual market basket reduced by one quarter. While the IQR program is “pay-for-reporting” only, the measures used in the IQR are foundational to CMS’s pay-for-performance programs, including VBP, HRRP and the HAC Reduction Program.
CMS proposes several significant changes to the IQR program. For FY 2019 IQR, CMS proposes to remove two registry participation measures, 13 electronic clinical quality measures (eCQMs), and two chart-abstracted measures, while adding four new Medicare claims-based measures. CMS also proposes refinements to two IQR measures for the FY 2018 IQR program. Lastly, CMS proposes a significant expansion of the requirement that hospitals report certain eCQMs.

MHA supports the comments and suggestions made by the AHA to improve the effectiveness of the program. We are concerned that the IQR is not achieving its foundational goals – that it, to provide the public and hospitals with accurate and comparable information for improving quality on the most important areas. to urge CMS to consider using the National Academy of Medicine’s (NAM) Vital Signs report as a unifying framework that will help make all stakeholders be more accountable and engaged in measurement and improvement. The report recommends 15 “Core Measure” areas, with 39 associated priority measures. Each stakeholder would be measured on the areas most relevant to their role in achieving common goals and objectives.

With respect to other issues and details of the 2017 IPPS Proposed Rule, MHA largely supports the concerns and suggestions contained in AHA’s related comment letter.

As always, we appreciate the opportunity to comment on CMS’s proposed rules. If you have any questions, please feel free to contact me at (651) 659-1415 or jschindler@mnhospitals.org.

Sincerely,

Joseph A. Schindler
Vice President, Finance