June 16, 2015

Andrew M. Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1632-P
P.O. Box 8013
Baltimore, MD 21244-8013

REF: CMS-1632-P

Re: Fiscal Year 2016 Inpatient Prospective Payment System and Long-Term Care Hospital Prospective Payment System

Dear Mr. Slavitt,

Catholic Health Initiatives (CHI) appreciates the opportunity to provide comments to the Centers for Medicare and Medicaid Services (CMS) on the fiscal year (FY) 2016 inpatient prospective payment system (IPPS) and long-term care hospital (LTCH) prospective payment system policy changes. As one of the nation’s largest health systems, Colorado-based CHI operates in 19 states and comprises 104 hospitals, including four academic medical centers and 30 critical access hospitals, as well as numerous community health-services organizations, accredited nursing colleges, home-health agencies, and other facilities that span the inpatient and outpatient continuum of care.

CHI appreciates many of the changes made in this proposed rule, including changes to many of the quality measures. However, we have a number of areas that we believe can be improved before CMS finalizes this regulation.
DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

The Affordable Care Act (ACA) requires that, beginning in FY 2014, hospitals will receive only 25 percent of the disproportionate share hospital (DSH) funds they would have received under the pre-2014 formula, with the remaining 75 percent flowing into a separate funding pool for DSH hospitals. This pool will be reduced as the percentage of uninsured people declines and will be distributed based on the proportion of total uncompensated care each Medicare DSH hospital provides.

To make these calculations, CMS must first determine what the DSH payments to hospitals would have been without this ACA requirement and use three Factors to determine payments.

- Factor 1 equals 75 percent of the aggregate DSH payments that would otherwise be made without application of the DSH changes made by the ACA.
- Factor 2 is a ratio of the percent of the population who are insured now versus a base year prior to ACA implementation.
- Factor 3 is a single hospital’s amount of uncompensated care represented as a percent of all hospitals’ uncompensated care during the year.

In the FY 2014 IPPS rule, CMS finalized a new policy to address these significant changes to DSH payments. While this year’s proposal generally follows the same rules adopted in past years, CHI remains concerned that CMS is not including all relevant information in its calculation, is allocating DSH payments inappropriately, and is determining payment calculations without releasing all the significant details to hospitals.

Calculating Factor 1: Changes in Medicaid and CHIP enrollment

CMS uses an estimate—including cost report information and the FY 2013 IPPS final rule impact file, adjusted for inflation and assumptions for future changes in utilization and case mix—to calculate a number that equals 75 percent of the aggregate DSH payments that would otherwise be made without application of the DSH changes made by the ACA. CMS uses the most recent estimates available from the CMS Office of the Actuary.

Factor 1 is a dynamic component in the DSH reimbursement formula. While estimates are listed as a viable option in the statute, there are too many unknowns to accurately predict DSH in a future year, and Congress must have assumed that such estimates would be based on
complete and accurate data. We believe CMS has the authority to “true-up” all data inputs used for DSH/uncompensated care reimbursement. A true-up approach would resolve discrepancies between estimates and reality.

There is much at stake for providers. Particularly because the limitation of “no administrative or judicial review of the estimates developed for purposes of applying the three factors used to determine uncompensated care payments, or the periods selected in order to develop such estimates” does not provide a remedy in cases of error. Estimates should be revised and true-up when better data is available.

We urge CMS to specifically explain how Medicaid and CHIP expansion is accounted for in the Factor 1 DSH estimate. We believe CMS’s proposed DSH estimate understates the impact of the enrollment increases.

*Recommendation: We urge CMS to explain how Medicaid and CHIP expansion is accounted for in the Factor 1 DSH estimate.*

**Calculating Factor 3**

We are concerned with the accuracy and completeness of the data being used to calculate Factor 3, which is a single hospital’s uncompensated care number represented as a percent of all hospitals’ UC in a year. Currently, CMS uses a federal fiscal year calendar to determine supplemental security income (SSI) ratios and uses low-income days as a proxy for uncompensated care reimbursement. We believe both of these calculations are inaccurate.

First, we disagree with using SSI ratios based on a federal fiscal year end rather than the end of the cost reporting period. The change in the uncompensated care proxy due to an SSI recalculation could have a significant impact on a provider’s Factor 3 percentage. We believe providers should be allowed to request a recalculation of the SSI ratio based on the cost reporting period and that those recalculation should be incorporated into Factor 3.

Based on the analysis conducted by a consulting firm working with numerous health systems on DSH issues, we believe there are inaccuracies and anomalies in the data when CMS uses low-income days as a proxy for uncompensated care reimbursement. For example, some hospitals in the Factor 3 file have zero recorded Medicaid days, yet their latest cost report shows Medicaid days reported therein. There are other examples where Medicaid S-2 and S-3 days
vary significantly. Still other providers appear to have reported exempt unit days on S-2 and are being overpaid uncompensated care reimbursement.

We do not believe that hospitals are purposefully reporting erroneous information on their cost reports. However, due to the wide variety of state Medicaid eligibility determination timelines, Medicare audit preparation updates, and other legitimate amendments to cost reports, some information can be inaccurate if hospitals are not given the chance to make corrections. We urge CMS to put in place some mechanism that affords hospitals the opportunity to provide the most current and best available data for this purpose.

**Recommendation:** We urge CMS to put in place mechanisms to allow hospitals to update their cost reports with corrected information related to the calculation of Factor 3.

We concur with CMS’ stance that it is premature to use S-10 data for FY 2016 Factor 3 given the flaws in the reported data. CMS must consider the various factors at play in the data recorded on an S-10 worksheet, for example differences in hospital policies regarding charity care and bad debts as well as varying state laws, to ensure accurate reporting and creating a level playing field for all hospitals. If CMS intends to transition to using worksheet S-10 in the future, CHI recommends that CMS work toward the development and publication of clear and consistent instructions for the data elements to be captured on Worksheet S-10, which would result in a uniform calculation of the cost of uncompensated care across all hospitals.

**Recommendation:** CMS should create clear and uniform instructions for the S-10 worksheet before using it to determine Factor 3.

**Bundled Payment for Care Improvement**

CMS is seeking comment on an extensive list of questions affecting the future expansion of the Bundled Payments for Care Improvement (BPCI) Initiative. This initiative, currently in the testing and pilot phase, must be evaluated before CMS can expand its implementation. The BPCI initiative is comprised of four related payment models that link payments for multiple services that Medicare beneficiaries receive during an episode of care into a bundled payment. The models are:

**Model 1:** Retrospective acute care hospital stay only. Under Model 1, the episode of care is defined as the inpatient stay in the acute care hospital. Medicare will pay the
hospital a discounted amount based on the payment rates established under the Inpatient Prospective Payment System used in the original Medicare program. Medicare will continue to pay physicians separately for their services under the Medicare Physician Fee Schedule.

Model 2: Retrospective acute care hospital stay, plus post-acute care. In Model 2, the episode of care will include the inpatient stay in the acute care hospital and all related services during the episode. The episode will end either 30, 60, or 90 days after hospital discharge.

Model 3: Retrospective post-acute care only. For Model 3, the episode of care will be triggered by an acute care hospital stay and will begin at initiation of post-acute care services with a participating skilled nursing facility, inpatient rehabilitation facility, long-term care hospital or home health agency.

Model 4: Acute care hospital stay only. Under Model 4, CMS will make a single, prospectively determined bundled payment to the hospital that would encompass all services furnished during the inpatient stay by the hospital, physicians, and other practitioners.

Implementation of the BPCI initiative began with Model 1 in April 2013, with subsequent implementation of the other three models. CMS states that the forthcoming evaluation of the BPCI initiative for expansion is expected to include analyses based on a combination of qualitative and quantitative sources, including Medicare claims, patient surveys, awardee reports, interviews, and site visits. However, CMS also is seeking stakeholder feedback through this proposed rulemaking. We offer the following responses to CMS’s questions.

Perhaps the most important question CMS asks is whether the BPCI initiative is ripe for mandatory participation. While we believe BPCI is a valuable program and support smart expansion, CHI is against mandatory participation in BPCI at this time.

CMS queries whether model expansion should focus on one or more of the four models or one or more specific episodes, or should target specific geographic regions of the country. We urge CMS to reduce restrictions to participation in the testing models as a first step toward expansion. There are many providers and provider groups who are interested in BPCI.
participation, but some groups who only recently were ready to enter the program have been shut out from testing the models since CMS has frozen entry. **CMS should increase the number of voluntary BPCI participants by re-opening entry to the program.**

As for which model to expand, **CHI believes Model 2 is the most appropriate for immediate expansion.** Model 2, which includes a 90-day episode of care, requires intense collaboration between hospitals, physicians, and post-acute providers that cover the entire continuum of care. In addition, Model 2 is a retrospective payment model that does not require the intense infrastructure changes that Model 4 requires. In our experience, it is easier to get all providers engaged in bundled payment reforms as they continue to receive normal reimbursement.

**As CMS prepares to move toward mandatory participation in bundled payment, we urge it to move slowly.** In future years, CMS should start with one Diagnostic Related Group (DRG) at a time for mandatory bundled payment. We believe the starting point should be with a DRG that has been heavily tested—total joint replacement of the lower extremity, for example—and teams should be allowed to enter the program with no downside risk for at least 12 months. Teams will require training and preparation time to be successful in BPCI, and they will need a risk-free period to implement required care model redesigns and to transition away from fee-for-service.

CMS seeks feedback on how to best define episodes of care, including what care should be excluded from the definition or bundle. **CHI urges CMS to expand the exclusion lists for each BPCI DRG to include routine medical care needs, preventative care, and wellness care that are in the best interest of the patient.** In the current model, the bundle is negatively impacted by each of these categories, even though the care is routine, medically necessary, and beneficial to the patient. We would recommend that these types of care be excluded from the bundle costs.

CMS seeks comment on the roles that organizations, including health care providers and suppliers and other entities, should serve under an expanded model, including the types of relationships and arrangements, financial or otherwise, that would assist participants with care transformation in an expanded model. **CHI believes that the current ability to have both a physician convener entity and a health system convener entity functioning in the same hospital at the same time is problematic and does not provide the best outcomes for patients.** In addition, having a physician convener entity functioning independently without the collaboration of the hospital in which patients are having care delivered is inefficient. **To eliminate these issues, CMS should require that only one convener can be allowed for each**
hospital. In addition, if that convener is a physician convener entity, we urge CMS to require co-leadership from the hospital to ensure that patient outcomes are coordinated with all providers.

CMS seeks input on setting bundled payment amounts, including target trending. In our experience, constant movement of the target prices and the quarterly changes in the national and regional trend factors that impact the reconciliation process create an administrative burden for program management and program administration. We believe CMS could remedy the situation by keeping targets steady for a year after they are set by historical episode experience. **We urge CMS to set baseline pricing prior to program entry and to keep it constant for a year before an annual reset.**

CMS seeks comment on administering bundled payments, including prospective vs. retrospective payment. In CHI’s experience, prospective payment is an enormous administrative burden that most would-be BPCI participants see as a barrier to entry to the initiative. **We recommend CMS utilize retrospective payment.** With retrospective payment, CMS would continue to pay providers under fee for service, with a bundle reconciliation completed retrospectively at the completion of the bundle.

CMS requests comments on a number of technological issues, including data needs and health information technology. **Overall, CHI believes that providers need access to and funding for more technology and better data, and CMS needs to enhance their capabilities to provide data feedback in real-time.** Best practices require BPCI teams to have real-time data systems in place to follow patients across the care continuum, but most teams do not have the funds available to invest in this part of the project. We urge CMS to provide additional funds, such as infrastructure bonus payments, to help BPCI teams defray the costs of data integration and analysis required by the initiative.

Finally, CMS seeks input on quality measurements and payment for value for future expansion of the BPCI initiative, including what quality measures are most appropriate for teams and how they can be measured. In our experience with BPCI and overall acute and post-acute care, **we recommend that any quality metrics used to evaluate BPCI participants utilize quality measures already in place for other CMS programs,** such as hospital-acquired conditions or skilled nursing facility quality reporting. In essence, CMS does not need to create new quality metrics, but rather rely on those already in place. However, BPCI participants are different from an inpatient hospital and will have different reporting needs. As such, **we recommend CMS**
allow BPCI teams to determine which quality metrics are most appropriate for their bundle and program, since each program will have different needs. We also recommend CMS provide bonuses for high quality performance and, only after a year or more in the program, implement payment reductions for low quality performance.

QUALITY MEASURES

CHI appreciates many of the changes CMS proposes to its numerous quality programs. We support the expansion of the hospital-acquired condition measures for catheter-associated urinary tract infection (CAUTI) and central line-associated bloodstream infection (CLABSI). We also appreciate CMS’s proposed extraordinary circumstances exception process.

We are concerned, however, that CMS continues to disregard its own rules to only implement quality measures that are endorsed by the National Quality Forum (NQF). NQF provides an extra layer of testing and reliability for quality measures used in health settings and is an important “stamp of approval” before CMS uses a measure to determine hospital reimbursements or penalties. Unfortunately, throughout the myriad quality programs amended in this proposed rule, CMS proposes to add measures that are not NQF endorsed or that are only conditionally endorsed. This is in direct violation of CMS’s own policies.

Recommendation: CMS should include only NQF-endorsed quality metrics in all quality programs.

In the Hospital-Acquired Conditions (HAC) Reduction Program, CHI is pleased that CMS is moving away from Patient Safety Indicator (PSI) measures and toward hospital-acquired infection (HAI) measures in determining a facility’s HAC performance. PSI measures are epidemiological and provide no real value on a hospital-specific level. In addition, these measures have basic methodological problems, such as inadequate risk adjustment and inconsistent reliability, which render them inappropriate for the HAC program. We urge CMS to continue to move away from PSI measures in the HAC reduction program.

Recommendation: CMS should eliminate PSI measures from the HAC reduction program.

CMS is proposing a significant expansion of the pneumonia measure for the Hospital Readmissions Reduction Program. While CHI supports the expansion generally, although the
expanded measure is not NQF endorsed, we are concerned that CMS fails to take into account the many factors beyond a PPS facility’s control that can contribute to pneumonia. For example, intubation by pre-hospital services can lead to an exceedingly higher risk for ventilator-associated pneumonia prior to when the patient is admitted or transferred to a PPS facility. We would suggest CMS instead look at a measure that assesses whether a PPS facility complies with evidence-based standards of care for assessment and management of pneumonia, similar to the measure(s) used to assess for PPS facility compliance with evidenced-based standards of care for assessment and management of venous thromboembolism.

**Recommendation: CMS should consider outside factors that affect pneumonia before expanding the pneumonia measure for the Hospital Readmissions Reduction Program.**

For the Value-Based Purchasing Program, CHI supports the removal of two topped-out measures and the proposed addition of additional care transition measures. We do not agree with CMS’s proposal to add chronic obstructive pulmonary disease (COPD) mortality measure for FY 2021, which will calculate risk-adjusted hospital mortality rates within 30 days of hospital admission for patients with either a principal discharge diagnosis of COPD or a principle discharge diagnosis of respiratory failure with a secondary diagnosis of acute exacerbation of COPD. In our experience, mortality is not a good measure of a hospital’s evidence-based quality practices for COPD. In addition, the COPD mortality measure is claims based, which leads to an overall low level of reliability. We urge CMS to reconsider adding this measure to the value-based purchasing metrics for FY 2021.

**Recommendation: CMS should not finalize the inclusion of the COPD mortality measure in the value-based purchasing program quality metrics.**

For the FY 2018 Inpatient Quality Reporting (IQR) program, CMS proposes to remove the chart-abstracted versions of nine measures, while retaining the electronic Clinical Quality Measure (eCQM) version of six of them for use in the proposed mandatory eCQM reporting process. CMS also is proposing numerous changes to the eCQM reporting requirements. Given these changes, and the myriad changes CMS proposes in other rulemaking recently closed for comment, we are firmly opposed to mandatory eCQM reporting.

CHI understands that electronic reporting of clinical quality measures is the direction CMS is heading. However, we are concerned that CMS is proposing to adopt a mandatory submission
of eCQMs while proposing additional changes to eCQM reporting in a separate rule, the Stage 3 electronic health record incentive program (meaningful use) rule. CMS has proposed many changes to eCQM reporting requirements for Stage 3 meaningful use, including a change to the reporting period, the format of reporting, and version of the eCQMs reported. CMS also proposes in the Stage 3 regulation to require electronic submission of eCQMs in calendar year (CY) 2018, while attestation is still available for CY 2017. Further, CMS seeks comment in the IPPS proposal on the appropriate frequency for requiring retesting and recertification of EHRs, and intends to address these comments in the proposed Physician Fee Schedule rule expected later this summer.

It is exceedingly difficult for hospitals to navigate these myriad changes, especially when the proposed changes are not cohesive. If CMS finalizes changes in the Stage 3 proposed rule, will it be sure to match those changes to the finalized language of the IPPS? And will those changes be incorporated into the Physician Fee Schedule, or other proposed rules, in the future? It is not feasible for hospitals to work toward mandatory electronic submission of eCQMs as proposed in this rule, while also planning for changes to eCQM reporting proposed in other rules.

**Recommendation: CMS should harmonize all eCQM reporting requirements and timelines before finalizing them in any regulation.**

**LONG-TERM CARE HOSPITAL**

CMS is implementing a statutory requirement borne of the Bipartisan Budget Act of 2013 to use “site neutral” IPPS-equivalent payment rates for LTCHs under certain conditions. The law establishes the following patient-level clinical criteria in order for the standard LTCH PPS payment to be made:

- The stay in the LTCH is immediately preceded by a discharge from an acute care hospital that included at least 3 days in an intensive care unit; or the stay in the LTCH is immediately preceded by a discharge from an acute care hospital and the patient’s LTCH stay was assigned to an Medicare Severity-Long-Term Care-Diagnosis Related Group (MS-LTC-DRG) based on the receipt of ventilator services of at least 96 hours; and
- The LTCH discharge does not have a principal diagnosis relating to a psychiatric diagnosis or to rehabilitation.
All other clinical criteria will lead to IPPS-level reimbursement.
The addition of a site-neutral payment component to the LTCH PPS is a major transformation for the LTCH field, but CHI is pleased CMS is moving forward in a thoughtful way. We seek clarification on one area of proposed rulemaking regarding the so-called “25 percent rule.”

Since 2005, legislative and regulatory action has delayed full application of the 25 percent payment adjustment threshold for most LTCHs. The 25 percent rule would reduce LTCH payment amounts to the inpatient PPS amount for LTCHs that admit more than 25 percent of Medicare cases from an onsite or neighboring inpatient acute care hospital. The Bipartisan Budget Act further delayed implementation of this policy through cost reporting periods that begin on or after July 1, or October 1, 2016, depending on the LTCH type.

CMS is proposing to apply the 25 percent rule policies to site-neutral cases. CMS provides significant detail for applying a different policy to site-neutral cases (the “interrupted stay” policy), but does not provide equal explanation for application of the 25 percent rule. We are unclear how CMS will implement these proposed policies and we seek further clarification.

**Recommendation: CMs should clarify why and how it plans to implement the 25 percent rule for site-neutral payments to long-term care hospitals.**

Thank you for considering our comments on these very important issues. If you would like additional information, please contact me at 720-298-9100.

Thank you,

Colleen Scanlon, RN, JD
Senior Vice President and Chief Advocacy Officer