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Via Electronic Submission (www.regulations.gov)

June 13, 2017

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
ATTN: CMS-1677-P
P.O. Box 8011
Baltimore, MD 21244-1850

Re: FY 2018 Inpatient Prospective Payment System Proposed Rule (RIN 0938-AS98)

Dear Administrator Verma:

The Association of American Medical College (AAMC) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services (CMS's) proposed rule entitled, *Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2018 Rates*, 82 Fed.Reg 19796 (April 28, 2017).

The Association of American Medical Colleges is a not-for-profit association dedicated to transforming health care through innovative medical education, cutting-edge patient care, and groundbreaking medical research. Its members comprise all 147 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and more than 80 academic societies. Through these institutions and organizations, the AAMC serves the leaders of America's medical schools and teaching hospitals and their nearly 160,000 faculty members, 83,000 medical students, and 115,000 resident physicians.

Summary of Major Issues on Which AAMC Provides Comments

Disproportionate Share and Uncompensated Care Payments

AAMC is concerned about the significant financial loss that some hospitals will experience as the Agency moves to the use of Worksheet S-10 data in the distribution of uncompensated care (UC) payments (Factor 3) and recommends that CMS implement a stop loss policy to mitigate the impact of the proposed changes. Our analysis of Worksheet S-10 data shows questionable values of uncompensated care costs that indicate that the data continues to lack accuracy, consistency and completeness. To mitigate the impact of flawed S-10 data, the AAMC urges CMS to undertake additional steps to validate the data and to limit the proportion of Factor 3 affected by S-10 until such time as the data are audited and reliable. In addition, eliminating Medicaid shortfalls from the calculation of uncompensated care would result in dramatic financial losses for hospitals that serve large Medicaid populations where Medicaid's rates do not cover a hospital's costs, causing a negative impact on the financial stability of many large academic medical centers and safety net providers. We urge CMS to take additional steps to ensure that the

methodology to distribute uncompensated care payments will not create financial hardships on teaching hospitals and hospitals that care for a higher proportion of Medicaid patients.

As the AAMC has expressed in previous comment letters, we remain concerned that CMS has not provided sufficient detail in prior year rules and this proposed rule about the calculation of disproportionate share (DSH) and aggregate uncompensated care payments. In the CMS' proposed rule supplemental file, we noticed significant fluctuation between years in the "Other" column. AAMC remains concerned that CMS' proposal does not sufficiently explain the determination of these figures. This alteration may have a significant impact on the projected DSH payment pool. We request that CMS provide an explanation of this figure and its impact on its FY 2018 DSH estimates to allow providers to understand and verify these projections.

To ensure fairness, the AAMC urges CMS to include costs associated with direct graduate medical education (DGME) in the numerator of the Worksheet S-10 cost-to-charge ratio (CCR) in the same manner that DGME costs are included in the denominator.

The AAMC supports CMS's decision to calculate Factor 2 based on CMS's Office of the Actuary's uninsured estimates.

Documentation and Coding

In the FY 2017 final rule, CMS adopted an additional 0.7 percent payment cut to IPPS rates because its analysis indicated that the actual amount recouped was lower than its original estimates. The AAMC believes that the additional 0.7 percentage point cut imposed in FY 2017 does not reflect Congressional intent. We urge CMS to restore the additional 0.7 percent documentation and coding payment cuts in FY 2018 using its "exceptions and adjustments" authority under statute. Failure to do so means that the cut will become a permanent part of the baseline calculation of the IPPS rates.

Hospital Quality Programs

The AAMC appreciates that CMS included a proposed methodology to implement the provisions of the 21st Century Cures Act into the Hospital Readmissions Reduction Program in the FY 2018 IPPS rule. The AAMC supports CMS's proposed recommendations to modify the HRRP payment penalties and recommends that Agency frequently review this methodology in the upcoming years to ensure that CMS's goals of reducing penalties for safety net hospitals is met. The Association also thanks the Agency for requesting feedback on accounting for social risk factors in the hospital reporting and performance programs. The nation's teaching hospitals disproportionately treat disadvantaged and vulnerable patient populations and are penalized by these programs in part due to the lack of adequate SDS adjustment.

Regarding specific measure recommendations, the AAMC strongly recommends that CMS not finalize inclusion of the pneumonia episode-of-care payments measure (proposed starting FY 2022) and the modified PSI-90 composite (proposed starting FY 2023) in the Value Based Purchasing program. Hospital Performance on these measures will not be publicly reported on the Hospital Compare website until after the deadline for comments has closed. Publicly reporting measures of these measures provides transparency on provider performance, allows hospitals to gain experience submitting the measures, and allows time to identify errors and unintended consequences with the measure methodology.

Requirement that Accrediting Organizations Post Survey Reports

The AAMC supports the public reporting of valid and reliable quality metrics assessing hospital safety and quality of care. The AAMC has concerns that the long form hospital survey reports are not an accurate or fair depiction of hospital quality. These reports lack sufficient context, are not written for public consumption, and may inadvertently identify specific patients or clinicians at the institution under review. CMS should not move forward with this proposal. We strongly recommend that the Agency convene a stakeholder group of patients, hospitals, Accrediting Organizations (AOs), and other relevant bodies to develop methods to display meaningful information in the future.

Payment Differentials for Services Based on Whether They Are Provided in an Inpatient or Outpatient Setting

As the 2-midnight rule finally made clear, where a patient should receive services should be left to the judgment of the patient's physician, depending on many factors including the health of the patient and the patient's needs for the more extensive and intensive services that are available in an inpatient setting. Hospitals should not be penalized for this decision when it is made in the best interests of the patient. Therefore, CMS should not implement a payment differential based on site of service.

Request for Information

The AAMC supports CMS's commitment to reduce burdens for hospitals, physicians, and patients. While regulation is necessary for safety and patient protection, hospitals, physicians and other providers spend too much time and too many resources on unnecessary regulatory paperwork and compliance that divert from patient care. The AAMC supports initiatives to reduce, simplify, modernize, and harmonize regulations and recommends that any newly needed regulations be applied prospectively and have clear objectives.

MEDICARE DISPROPORTIONATE SHARE AND UNCOMPENSATED CARE HOSPITAL PAYMENTS

The AAMC urges CMS to take additional steps to ensure that the methodology to distribute UC payments will not create financial hardships on teaching hospitals and hospitals that care for a higher proportion of Medicaid patients, and that all decisions will be based on audited, accurate data. The Association remains concerned about the accuracy of Worksheet S-10 data reporting and recommends the Agency undertake a separate Medicare Administrative Contractor (MAC) survey audit before the data is used. The AAMC also believes all unreimbursed and uncompensated care costs, such as Medicaid shortfalls and discounts for the uninsured, should be included in the definition of uncompensated care costs. Lastly, to ensure fairness, the AAMC urges CMS to include costs associated with direct graduate medical education (DGME) in the numerator of the Worksheet S-10 cost-to-charge ratio (CCR) in the same manner that DGME costs are included in the denominator.

Fluctuation in Key Factors Used to Project Medicare Disproportionate Share and Uncompensated Care Hospital Payments

In past rules, AAMC has commented that CMS has not provided sufficient detail about its calculation of estimated DSH and aggregate uncompensated care payments. In the CMS' proposed rule supplemental file, we noticed significant fluctuation between years in the "Other" column. AAMC remains concerned that CMS' proposal does not sufficiently explain the determination of these figures.

The “Other” column in CMS’s proposed rule supplemental file is meant to show the increase in various factors that contribute to the Medicare DSH estimates. These factors include the difference between total inpatient hospital discharges and the IPPS discharges, various adjustments to the payment rates that have been included over the years but are not reflected in the other columns, and a factor for the Medicaid expansion due to the Affordable Care Act (ACA). We noticed some significant fluctuation between years in the “Other” column. For example, between FY2015 and FY2017, CMS projects that annual growth due to “Other” factors between are between 4.9 percent and 6.9 percent, while in FY2018 CMS projects a 1 percent decrease. CMS did not provide an explanation for the change in the projection. This alteration may have a significant impact on the projected DSH payment pool. We request that CMS provide an explanation of this figure and its impact on its FY 2018 DSH estimates to allow providers to understand and verify these projections.

New Data Source to Determine Factor 2 Provides More Accurate Accounting of Uninsured

To calculate Factor 2 in FYs 2014 - 2017, the statute required CMS to use the Congressional Budget Office’s (CBO’s) estimate of the uninsured rate in the under 65 population from before enactment of the Affordable Care Act (ACA) for FY 2013. For FY 2018 and subsequent years, the statute provides flexibility in the choice of the data sources to be used in the estimate of the change in the percent of the uninsured. The Secretary has the ability to identify an appropriate data source which is then certified by the Chief Actuary of CMS. CMS has determined that the uninsured estimates produced by CMS’s Office of the Actuary as part of the development of the National Health Expenditure Accounts (NHEA) is the best data source and has decided to use it to calculate the uninsured rate for FY 2018. The AAMC supports CMS’s decision to use the NHEA as the data source to calculate the number of uninsured as it better reflects the rate of uninsurance in the U.S. across all age groups and residents.

CMS Should Use Accurate and Verifiable Data to Determine the Uncompensated Care Payment

CMS is proposing the same general methodology as in prior years to determine the pool available for uncompensated care payments and reductions and redistribution of this pool based on each hospital’s relative share of uncompensated care. Factor 1 is equal to 75 percent of the amount that otherwise would have been paid as Medicare DSH payments. Factor 2 reduces that 75 percent to reflect changes in the percentage of individuals under age 65¹ who are insured because of ACA implementation. Factor 3, expressed as a percentage, represents a hospital’s uncompensated care amount for a given time period relative to the uncompensated care amount for that same time period for all hospitals that receive Medicare DSH payments in that fiscal year. In short, the product of Factors 1 and 2 determines the total pool available for UC payments. This product multiplied by Factor 3 determines the amount of UC payments each eligible hospital will receive.

In the FY 2017 final IPPS rule, CMS indicated that the move toward S-10 data would begin by FY 2021. The Agency noted that based on comments, additional quality control and data improvement measures were needed first. Therefore, the hospital community did not expect the Agency to propose that the S-10 transition should begin in FY 2018 as these data quality issues have yet to be resolved.

CMS’s Factor 3 methodology is computed using an average of data from three cost reporting periods instead of one cost reporting period. In the FY 2018 IPPS proposed rule, CMS is proposing to use S-10 data for the FY 2014 cost reporting period and the low-income insured days proxy data that are a blend of two cost reporting periods. If adopted as proposed, the calculation of Factor 3 would be solely

¹ For FY 2014 to FY 2017, the statute not only required CMS to use CBO data from before enactment of the ACA for the percent of the population that was uninsured in FY 2013, it also limited the uninsured population to those under age 65. Beginning with FY 2018, estimates of the change in the uninsured population is no longer restricted to those under age 65.

determined from Worksheet S-10 data by FY 2020. To support this move, CMS claims to have undertaken extensive analysis of the Worksheet S-10 data, benchmarking it against the data on uncompensated care costs reported to the Internal Revenue Service (IRS) on Form 990 by not-for-profit hospitals. Based on its findings, CMS believes there is a strong correlation between Worksheet S-10 and IRS Form 990 in the calculation of Factor 3 indicating that S-10 data would be a statistically valid source to use as part of the calculation of uncompensated care payments in FY 2018. For the reasons discussed below, the AAMC disagrees with this conclusion.

It is worth noting that because Schedule H reporting is done by Employer Identification Number (EIN), some filing organizations include non-hospital activities (e.g., foundations, physician clinics, home health agencies, and others), as hospitals may have these types of non-hospital entities under their single EIN. Cost reports are completed by each CMS Certification Number (CCN) which may or may not correlate to the EIN. Additionally, under IRS rules, some governmental (public) hospitals are not required to file a Schedule H, even if they have 501(c)(3) status. This would mean that none of these hospitals, many of which provide substantial amounts of uncompensated care, have been included in the Dobson-DaVanzo analysis.²

While it is possible that a correlation between S-10 and Schedule H data exists, CMS should not conclude that this means the S-10 data have been validated. We believe the Dobson-DaVanzo report underestimates the differences between information reported on the Worksheet S-10 and IRS Form 990 Schedule H, and any correlation of the data is incidental. For example, as the table below illustrates, information collected on the Schedule H may include non-hospital activities such as information on home health and rural health clinics that is not reported on Worksheet S-10. In addition, in Tax Year 2011 (which for many hospitals is the same as their fiscal year 2012), Schedule H changed such that bad debt expense no longer is to be reported “at cost.” As of that year, filing organizations no longer were instructed to multiply bad debt expenses by an RCC. It does not appear that the Dobson-DaVanzo report considered this change in Schedule H and its instructions.

Line Item	IRS Schedule H	Worksheet S-10
Financial Assistance (Charity Care)	Charges written off to charity multiplied by RCC	All charges (and patient responsibility amounts for insured patients) for accounts with any charity multiplied by RCC minus patient payments
Bad Debts	Bad debt expense (as of Tax Year 2011 no longer “at cost”)	Bad debt expense multiplied by RCC
Medicaid	Net patient revenue (including DSH, UPL) minus Medicaid charges multiplied by RCC minus provider taxes / assessments / fees	Net revenue from Medicaid minus Medicaid charges multiplied by RCC

Furthermore, the Dobson-DaVanzo’s report acknowledges that “[a]lthough the Factor 3s are highly correlated, large hospital-level differences in uncompensated care costs, charity care, bad debt, and Factors 3 exist between measures calculated using the S-10 and 990 data.” The analysis further shows that “For over 50 percent of the hospitals in 2011-2013, the differences between the S-10 and IRS 990 Factor 3s center around 40 percent.” Yet the report fails to explore these differences.

² <http://www.dobsondavanzo.com/clientuploads/CMS%20Improvements%20to%20DSH%20-%20Dobson%20DaVanzo%20&%20KNG%20Final%20Report%204.25.13.pdf>

The Tax Year 2011 change to how bad debt is reported on Schedule H was based on a recognition by the IRS that the actual financial loss associated with bad debt equals the amount of revenue hospitals intended but were unable to collect. The IRS also recognized that there is wide diversity in organizations’ policies that result in significant difference in amounts reported as bad debt expense. Bad debt expense reported by health care organizations is a mix of full charges, discounted charges, patient co-payments (a small subset of the full bill based on charges), and “actual revenue” determined to be uncollectible. Uniformly applying a ratio of cost to charges to bad debt expense reported both on Schedule H and on Worksheet S-10 leads to comparing apples and oranges.

S-10 Data Should Be Audited, and CMS Should Determine Whether the Instructions Need Additional Clarification

The AAMC’s analysis of Worksheet S-10 data shows questionable values of uncompensated care costs that indicate that the data continues to lack accuracy, consistency and completeness. By way of example, Titus Regional Medical Center in Texas – a 96-bed hospital with \$62 million (Worksheet A, line 200) in operating costs – reported \$535 million in uncompensated care costs. That is roughly 9 times the hospital’s annual operating expenses. According to CMS’s estimates in the FY 2018 IPPS proposed rule and the FY 2017 IPPS final rule, the hospital is expected to receive \$48 million in UC payments in FY 2018 as compared to less than half a million dollars in FY 2017. Furthermore, 23 hospitals, or one percent of hospitals that receive UC payments, report uncompensated care costs of more than 25 percent of their total net costs. This one percent of hospitals account for approximately 2 percent of total UC payments in FY 2017; this share would rise to 6 percent in FY 2018 as a result of CMS’s proposal to move to S-10. Should the UC payment be determined based only on Worksheet S-10 data, these hospitals’ share of the UC payment pool would be expected to be 14 percent in FY 2018. This raises serious questions about whether reliance on Worksheet S-10 data will result in an equitable distribution of the UC pool.

Some of the flawed data are the result of inconsistent reporting that arises because S-10 instructions need more clarification. Below is an example.

Example of Unclear Instructions on the Medicare Cost Report
<p>Line 20 of the cost report form is labeled and reads:</p> <p>“Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility”. [Emphasis added.]</p> <p>A contradiction of this occurs in the instructions to Worksheet S-10 for line 20 for column 2 which instructs providers to:</p> <p>“Enter in column 2, the deductible and coinsurance payments required by the payer for insured patients covered by a public program or private insurer with which the provider has a contractual relationship that were written off to charity care.”</p> <p>Full charges, and deductible and coinsurance amounts are two totally different amounts for a patient and there could be many hospitals reporting on line 20, column 2, full charges rather than coinsurance and deductible amounts. The instructions are explicitly clear that deductible and coinsurance amounts should only be reported, yet if a provider were not to reference the instructions to Worksheet S-10, they could be reporting full charges instead of deductibles and coinsurances.</p>

Example of Unclear Instructions on the Medicare Cost Report

The reported column 2, line 20, deductible and coinsurance amounts are reduced to cost on line 21 using a CCR. Deductible amounts are usually preset amounts specific to a patient's coverage that have no relation to the cost structure of a provider, and therefore applying a CCR to these amounts does not make sense. By reducing the same \$200 deductible that a patient has to cost based on a provider's CCR does not show the true cost of that charity care to the provider. CMS would need to develop a separate CCR applicable to deductible amounts to calculate the cost of charity care at each provider. A similar statement could be made about coinsurance amounts, which in many cases are not dependent upon a provider's charges. A patient's coinsurance responsibility reduced to cost by a CCR does not measure the cost of the patient's responsibility, creating an unconnected measure of charity care.

To mitigate the impact of flawed S-10 data on the distribution of UC payments, the AAMC urges CMS to do the following: (1) implement additional steps to eliminate data that represents unreasonable uncompensated care costs reported on Worksheet S-10 – operating costs, revenues, and discharges – are variables that could be used to identify anomalies and unreasonable data reporting; and (2) limit the proportion of Factor 3 affected by S-10 data before the audited FY 2017 S-10 data becomes available.

Finally, the Association encourages CMS to make clarifications regarding data reported on Worksheet S-10 to calculate Factor 3 to accurately determine each hospital's relative share of uncompensated care for purposes of distributing uncompensated care payments.

Medicaid Shortfall Should Be Included in the Uncompensated Care Costs

In the FY 2017 IPPS proposed rule, CMS proposed a definition of uncompensated care costs that included charity care and non-Medicare bad debt. At that time, CMS stated that the exclusion of Medicaid shortfalls from the definition of uncompensated care was warranted as a number of government agencies and key stakeholders do not consider Medicaid shortfalls in their definition of uncompensated care. The exclusion of these shortfalls from the definition, allowed Medicare UC payments to be targeted to hospitals that have a disproportionate share of uncompensated care due to patients with no insurance.

For FY 2018 CMS is again proposing that uncompensated care would include only charity care and non-Medicare bad debt costs. The AAMC opposes this proposal. Eliminating Medicaid shortfalls from the calculation of uncompensated care would result in dramatic financial losses for hospitals that serve large Medicaid populations where Medicaid's rates do not cover a hospital's costs, causing a negative impact on the financial stability of many large academic medical centers and safety net providers. Medicaid is the largest health insurance program in the United States, providing coverage to more than one in five Americans—more than 65 million beneficiaries. Teaching hospitals are core institutions in the health care safety net and serve a disproportionate number of Medicaid Children's Health Insurance Program (CHIP) beneficiaries. The CMS proposal would have a major impact on teaching hospitals and the access they provide to Medicaid enrollees. Therefore, AAMC strongly recommends that CMS include Medicaid shortfalls in the calculation of uncompensated care costs and also that the Agency revise the definition of uncompensated care to include unreimbursed and uncompensated care costs for Medicaid, CHIP, and other state and local government indigent care programs.

DGME Costs Should be Included in Both the Numerator and Denominator of the Worksheet S-10 Cost-to-Charge Ratio

Currently, DGME is included only in the denominator of the cost-to-charge ratio. By excluding DGME from the numerator, the cost-to-charge ratio for teaching hospitals is artificially reduced. CMS states that it is not appropriate to modify the calculation of the CCR to include DGME costs because uncompensated

care payments should not be used to provide additional payments to teaching hospitals that already receive DGME payments. The AAMC agrees that there should not be additional payments for teaching hospitals related to training residents but that is not the case here; rather, a teaching hospital's charges account for all its costs including DGME. For accuracy of data, the AAMC recommends limiting the use of Worksheet B based cost-to-charge ratios to only teaching hospitals that report DGME full-time equivalents (FTEs).

The problem occurs when the net revenue for Medicaid includes DGME-related payments, for example, services provided by residents. Applying a CCR that does not include DGME costs results in the exclusion of DGME Medicaid costs from hospital Medicaid costs, thereby artificially reducing Medicaid costs for teaching hospitals. Including DGME costs in the CCR also is consistent both with DGME being a Medicare allowable cost and Medicare's policy that allows other payers, such as Medicaid and state indigent care programs, to pay their share of DGME. As the Association has previously stated, including DGME costs in the cost-to-charge ratio is the simplest way to achieve alignment and consistency. However, CMS could choose the method that is most efficient operationally: either include DGME from both the numerator and denominator or exclude from both.

A Longer Transition Period is Necessary Before Worksheet S-10 Data Is Used; CMS Also Should Provide for a Stop Loss

The transition to Worksheet S-10 is likely to cause a large redistribution of uncompensated care payments. CMS should understand the impact of the redistribution and to the extent of its authority ensure that DSH and UC money goes to hospitals with higher rates of caring for poor, complex patients, as was Congress's intent. The AAMC recommends that CMS explore ways to mitigate the effect on hospitals by lengthening the transition to the Worksheet S-10 from the proposed 3 years. This would allow hospitals to prepare for potential losses due to policy changes. In addition, the Agency should consider imposing a stop loss policy to prevent significant financial harm to hospitals that would limit the amount a hospital can lose during any redistribution of UC funds.

DOCUMENTATION AND CODING

The Additional 0.7 Percent Documentation and Coding Payment Cut Must be Restored

The American Taxpayers Relief Act of 2012 required CMS to make a recoupment adjustment(s) totaling \$11 billion in order to recover overpayments from FY 2010 through FY 2012 attributed to changes in documentation and coding. ATRA required that the adjustment be completed by FY 2017. Once the necessary amount of overpayment was recovered, any adjustments made to reduce rates in one year eventually would be offset by a single, positive adjustment in FY 2018 to ensure the recoupment adjustments do not have a permanent effect on the rates. CMS anticipated a single, positive adjustment in FY 2018 to offset the recoupment reductions. However, MACRA provided for a 0.5 percent positive adjustment in FYs 2018 through 2023 instead of a one-time positive adjustment.

To comply with ATRA, CMS anticipated that a cumulative -3.2 percent adjustment to the rates would achieve the \$11 billion recoupment, and imposed a -0.8 percent payment adjustment in FY 2014 and an additional -0.8 percent on top of previous cuts each subsequent year through FY 2016. However, in the FY 2017 final rule, CMS adopted an additional 0.7 percent payment cut as well as the cumulative -3.2 percent adjustment because, according to the Agency's analysis, the actual amount recouped was lower than its original estimates.

At the time that MACRA was enacted, the expectation was that the cumulative reduction would be 3.2 percent—an expectation that was specifically referenced in the statute. It was only later that CMS

increased the recoupment adjustment from a cumulative 3.2 percent to 3.9 percent. This is inequitable to hospitals as it removes nearly a full percentage point is being removed from IPPS rates that will never be restored. AAMC urges CMS to use its authority under section 1886(d)(5)(I) of the Social Security Act to make “exceptions and adjustments to such payment amounts... as the Secretary deems appropriate” to restore the additional 0.7 percent payment documentation and coding payment cut to restore payment equity to hospitals.

HOSPITAL QUALITY PROGRAMS

CMS Must Take Additional Steps to Account for Sociodemographic Status (SDS) Factors in Hospital Quality Measurement

For each of the Medicare inpatient hospital quality reporting and performance programs, CMS has requested stakeholder feedback on a range of methods to account for social risk factors. Most outcome measures, particularly readmission measures, are affected by sociodemographic status (SDS) factors, which are beyond the control of the hospital. The nation’s teaching hospitals, which provide superior patient care³ and disproportionately treat disadvantaged and vulnerable patient populations, are penalized by the performance and penalty programs in part due to the lack of adequate SDS adjustment. Efforts by the National Quality Forum (NQF) to address these important issues through the recently concluded SDS trial period have been underwhelming. And while passage of the 21st Century Cures Act is a good first step in creating a fairer Hospital Readmissions Reduction Program (HRRP), it is not a panacea. The legislative requirement that the penalty adjustments be budget neutral will only result in slightly reduced penalties for those hospitals most in need of resources to treat underserved and complex patient populations. Most importantly, the Act does not immediately address the serious flaws in the risk adjustment methodology for the readmissions and other outcomes measures that are influenced by SDS.

The literature recognizing the impact of SDS factors on patient outcomes is substantial.^{4,5} Recent entities tasked with addressing this issue have also been clear. The reports released by the Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation (ASPE) and the National Academy of Medicine (NAM) on accounting for social risk factors in the Medicare performance programs have provided evidence-based confirmation that accounting for patients’ sociodemographic and other social risk factors is critical in validly assessing the quality of providers. The reports demonstrate that hospitals caring for large numbers of disadvantaged patients are more likely to receive penalties in the performance programs and that the lack of SDS adjustment can worsen health care disparities because the penalties divert resources away from hospitals and other providers treating large proportions of vulnerable patients. The failure to account for SDS variables also mislead and confuse patients, payers, and policymakers by shielding them from important community factors that contribute to poor health outcomes. Finally, as noted by ASPE, the cumulative effect of the penalties across the Medicare performance and penalty programs could significantly hinder the work of those institutions that disproportionately serve beneficiaries with social risk factors.⁶ Both reports clearly show that there are implementable mechanisms by which SDS data elements can be incorporated into quality measurement today. The AAMC urges CMS to incorporate the recommendations below to account for SDS factors and ensure that all hospitals are assessed on an even playing field. The AAMC is eager to work with CMS as the Agency implements these change.

³ Laura Burke, MD, et al. *Association Between Teaching Status and Mortality in US Hospitals*. *JAMA*, 2017. Retrieved from: <http://jamanetwork.com/journals/jama/article-abstract/2627971%20>

⁴ Michael Barnett, MD, et al. *Patient Characteristics and Differences in Hospital Readmission Rates*. *JAMA*, 2015. Retrieved from: <http://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2434813>

⁵ Jianhui Hu, et al. *Socioeconomic status and readmissions: evidence from an urban teaching hospital*. *Health Affairs*, 2014. Retrieved from: <http://content.healthaffairs.org/content/33/5/778.full>

⁶ “Office of the Assistant Secretary for Planning and Evaluation.” *Report to Congress: Social Risk Factors and Performance Under Medicare’s Value-Based Purchasing Program*. December, 2016. Pg. 92 Retried from <https://aspe.hhs.gov/system/files/pdf/253971/ASPESESRTCfull.pdf>

AAMC Recommendations to Account for SDS Factors in the Medicare Hospital Reporting and Performance Programs

- Require measure developers to test a range of national-level sociodemographic data elements, identified in the ASPE⁷ and NAM⁸ reports, into the risk adjustment methodology of accountability metrics. Both reports discuss in detail data elements that are publicly available and could be immediately tested to determine whether an empirical relationship exists between SDS and the measure's outcomes. Such elements could include income, education, neighborhood deprivation, and marital status.
- Within the next year, provide hospitals with confidential reports of performance on accountability measures stratified by dual eligible status or other nationally available data elements.
- Once hospitals have had sufficient opportunity to review and understand their performance on these stratified measures through their confidential reports, CMS should work with stakeholders to publicly report this data in a manner that is accurate and understandable to patients.
- CMS should implement demonstration projects to encourage hospitals to collect SDS data through their electronic health records (EHR). These elements could be used to supplement the claims data already captured by CMS to greatly improve the measure's risk adjustment methodology. It is essential that CMS include vendors in these discussions.
- Where meaningful and comprehensive neighborhood level SDS-data currently exist, CMS should encourage empirical tests of quality metrics adjusted for those factors to assess the impact of the adjustments on local provider performance metrics. Based on the results of these tests CMS and other agencies will be able to prioritize the national collection of data that are most essential for valid risk adjustment methodologies.

HOSPITAL READMISSIONS REDUCTION PROGRAM

In the rule, CMS outlined a proposed methodology to implement the provisions of the 21st Century Cures Act regarding the Hospital Readmission Reduction Program (HRRP). Beginning FY 2019, a hospital's payment penalties under the HRRP will be adjusted to account for the proportion of dual-eligible patients served. In addition, similar to the other reporting and performance programs, CMS requested stakeholder feedback on potential methods to account for social risk factors in the HRRP. No new readmissions measures were proposed.

Implementation of 21st Century Cures Adjustment to the HRRP

The 21st Century Cures Act, signed into law in December 2016, requires CMS to account for a hospital's proportion of full benefit Medicare and Medicaid dual-eligible patients [hereafter referred to as dual-eligible or dual-eligibility] in determining payment penalties starting FY 2019. To calculate these adjustments, hospitals will be placed into cohorts based upon their proportion of inpatient stays for dual-eligible patients and will be compared to the performance of other hospitals within the dual-eligible assigned group. The Act also mandates these payment adjustments be implemented in a budget neutral fashion, and allows for future adjustment of the HRRP based upon recommendations of reports required by the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014.

The AAMC thanks CMS for including language in this year's rule outlining the proposed adjustment methodology. This gives hospitals time to understand and predict potential payment adjustments before

⁷ *ibid*

⁸ "National Academies of Medicine." *Accounting for Social Risk Factors in Medicare Payment: Criteria, Factors, and Methods*. 2016. Retrieved from <https://www.nap.edu/download/23513#>

the FY 2019 start date. CMS's primary proposals – along with alternative proposals - to implement the modifications required under the 21st Century Cures Act are summarized below:

Data Sources Used to Determine Dual-Eligibility

CMS proposes to identify a patient's dual-eligibility status using data from the state Medicare Modernization Act (MMA) file of dual eligibility. A beneficiary would be counted if he/she was identified as having dual-eligibility status in the state MMA file for the month in which they were discharged. States submit the MMA files to CMS on a monthly basis.

Proportion of Dual-Eligible Inpatient Stays

CMS proposes to determine the hospital's proportion of dual-eligible inpatient stays by dividing the total number of dual-eligible hospital stays (numerator) by the total number of inpatient stays by all beneficiaries enrolled in either fee-for-service (FFS) Medicare or Medicare Advantage (denominator). CMS also requested feedback on using only FFS Medicare patients in the denominator. Under either approach, CMS proposes to use Medicare Provider and Analysis Review (MedPAR) files to identify hospital stays. As an alternative proposal, the Agency considered using integrated data repository (IDR) files to identify hospital stays.

Data Period to Determine Dual-Eligibility

To calculate the proportion of dual-eligible stays, CMS proposes to use the number of dual-eligible patients discharged during the three year data period that is applicable to the HRRP performance period. For example, in FY 2018 the data period would include dual-eligible patient discharges between July 1, 2013 and June 30, 2016. CMS also considered using the most recent one year of data.

Methodology for Assigning Hospitals to Peer Groups

CMS proposes to cluster hospitals into five groups (quintiles). The Agency also considered placing hospitals into two or ten separate groups.

Payment Adjustment Formula Calculation Methodology

CMS proposes to use a peer group determined threshold – in place of the current formula - to calculate the hospital's payment adjustment. In the current formula, the hospital's excess readmissions ratio (ERR) is compared to a threshold of 1.000. The Agency's recommended approach is to replace the threshold of 1.000 with the median ERR for each hospital's peer group. CMS also considered replacing the 1.000 threshold with the mean ERR, using a percentile ERR, or using a standardized ERR to compare hospitals within each peer group.

AAMC Supports CMS's Recommended Approach for Each Proposal; However More Work is Necessary to Ensure Readmissions Measures are Appropriately Adjusted

The AAMC supports each of CMS's primary recommendations to modify the HRRP payment penalties to account for the proportion of dual eligible patients treated in our nation's hospitals. We ask that the Agency frequently review this methodology in the upcoming years to ensure that CMS's goals of reducing penalties for safety net hospitals is met. The AAMC also requests that CMS immediately release the state MMA files of dual eligibility to allow stakeholders to review the Agency's calculations of the data.

While the changes mandated by the 21st Century Cures Act are a commendable first step in this process, the AAMC believes that more work is necessary to ensure the readmissions measures are appropriately adjusted so that hospitals are assessed on an even playing field. Readmissions measures, which are especially sensitive to patient demographics, must be adjusted at the measure level to ensure that certain

hospitals treating vulnerable patient populations are not unfairly disadvantaged. The AAMC urges CMS to incorporate the recommendations listed at the start of this section in help alleviate these concerns.

AAMC Recommends Removal of Certain Measures from the HRRP Program

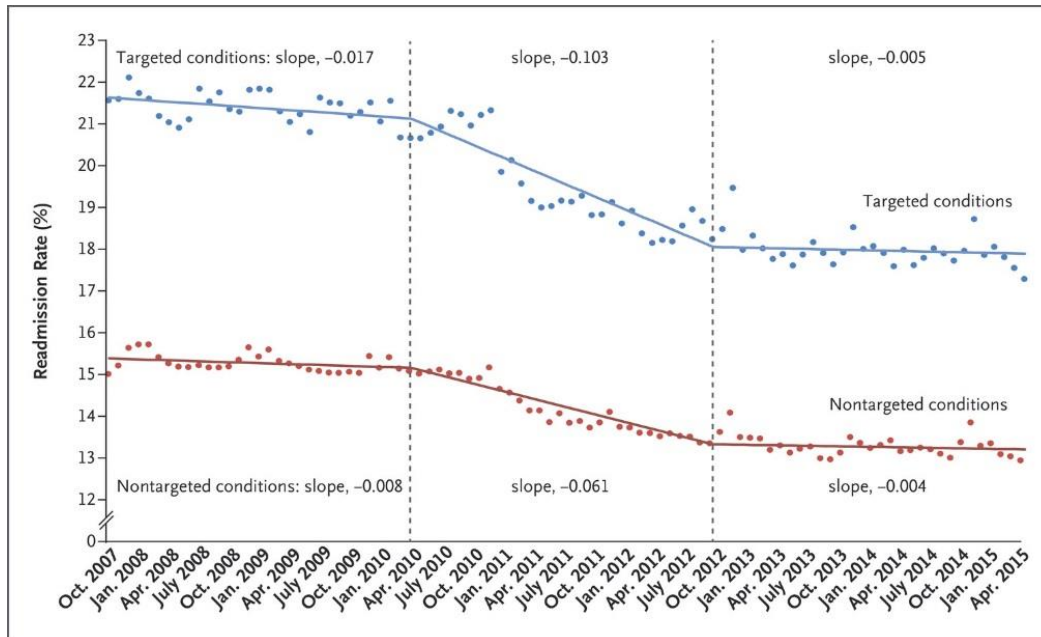
The AAMC recommends that CMS undertake a comprehensive review of the readmission measures in the HRRP to determine whether the readmission rates on any of these conditions have not significantly changed from the previous performance year. Hospitals are assessed on six conditions in FY 2018, three of which have been in the program since FY 2013. These three conditions are acute myocardial infarction (AMI), heart failure (HF), and pneumonia (PN). A recent article in the *New England Journal of Medicine* titled “Readmissions, Observations, and the Hospital Readmissions Reduction Program” shows that HRRP-targeted conditions declined significantly following passage of the Affordable Care Act in March 2010, but have declined much more slowly starting in late 2012.⁹ Please see **Figure 1** from NEJM article below that highlights performance on these conditions between 2007 through 2015. Hospitals have undertaken significant efforts to implement care improvement strategies to address excess readmissions in their communities. As displayed in the graph below, the gains from the readmissions program could be reaching a peak for certain conditions with hospitals no longer being able to move the needle on further readmissions reductions.

Studies have also shown that there is a direct correlation between higher readmission rates and lower mortality for HF, PN, and AMI.¹⁰ Hospitals with low mortality rates for patients with HF also have higher readmission rates. This is likely due to the fact that these hospitals are successful at keeping the patient alive, thereby resulting in more readmissions. In addition, interventions to improve care coordination and access to follow-up treatments also result in higher readmissions. For these reasons, a certain level of readmissions are necessary for patient care. If hospital performance on these measures has reached a natural plateau, CMS should take steps to remove the conditions from the program.

⁹ Rachel Zuckerman, et al. *Readmissions, Observation, and the Hospital Readmissions Reduction Program*. The New England Journal of Medicine.” *NEJM*, 2016. Retrieved from: <http://www.nejm.org/doi/full/10.1056/NEJMs1513024#t=article>

¹⁰ Jha, Ashish and Karen Joynt Karen. *Thirty-Day Readmissions – Truth and Consequences*. The New England Journal of Medicine. June, 2012 Retrieved from: <http://www.nejm.org/doi/pdf/10.1056/NEJMp1201598>.

Figure 1: Change in Readmission Rates for Targeted Conditions and Non-targeted Conditions within 30 Days after Discharge.



HOSPITAL VALUE-BASED PURCHASING PROGRAM

CMS proposes to remove one measure, the PSI-90 patient safety composite, from the VBP program starting FY 2019, and to bring back a modified version of this measure (renamed the Patient Safety and Adverse Events Composite and referred to as the modified PSI-90 composite) to the VBP program starting FY 2023. In addition, the Agency plans to add a 30 day pneumonia payment episode of care measure to the program starting FY 2021. CMS also proposes weighting changes to the Efficiency and Cost Reduction Domain. Finally, CMS sought feedback on incorporating social risk factors in the VBP Program.

Individual Measure Recommendations

Measure to be removed in FY 2019

In FY 2019, CMS proposes to remove one measure from the Safety Domain

- PSI-90 Patient Safety Composite

The PSI-90 Patient Safety Composite assesses hospitals on eight different patient safety events and conditions. An ICD-10 version of the current measure has not been developed and therefore CMS is unable to continue to calculate performance scores for hospitals under this measure in the VBP program. A modified version of this measure is proposed for VBP starting FY 2023, which is discussed below. The AAMC strongly supports removal of the composite from the VBP program in FY 2019 and urges CMS to postpone the reintroduction of the measure as discussed in more detail below.

Measure Proposed to Be Added in FY 2022

In FY 2022, CMS proposes to add one new measure to the Efficiency and Cost Reduction Domain:

- Pneumonia Episode-of-Care Payments Measure

This measure calculates risk-standardized payments for patients admitted with pneumonia over a 30-day episode-of-care period using claims data. While an earlier version of this metric was NQF endorsed, the measure cohort has since been expanded to include patients with a principal discharge diagnosis of aspiration pneumonia and patients with a principal discharge diagnosis of sepsis with a secondary diagnosis of pneumonia coded as present on admission. The AAMC continues to have serious concerns that this change to the measure cohort could make hospitals who care for the most complex patients look worse unless there is appropriate risk adjustment for social risk factors.

In addition, hospital performance on this measure will not be publicly reported on the Hospital Compare website until July 26, 2017, which is after the deadline for comments has closed. The AAMC strongly believes that all measures should be publicly reported in the Inpatient Quality Reporting (IQR) program for one year before being considered for a performance or penalty program. Publicly reporting measures in the IQR program provides transparency on provider performance, allows hospitals to gain experience submitting the measures, and allows time to identify errors, unintended consequences, or other concerns with the measure methodology. Stakeholders are unable to provide sufficient feedback on this measure without this data.

Moreover, CMS has failed to adequately address the concerns raised by the Measure Applications Partnership (MAP), which did not support the use of this measure in the VBP program. The MAP specifically cited the overlap and double counting of services already captured by the Medicare Spending per Beneficiary (MSPB) measure, which could penalize hospitals twice for the same episode. For all of the reasons noted above, we urge CMS to postpone inclusion of this measure in the VBP program at this time.

Measure Proposed to Be Added in FY 2023

In FY 2023, CMS proposes to add one new measure to the Safety Domain:

- PSI-90 Patient Safety and Adverse Events Composite (also referred to as the modified PSI-90 composite)

The AAMC has serious concerns that the modified PSI-90 composite has been proposed for inclusion into the VBP program before the measure has been publicly reported on the Hospital Compare website for at least one year. CMS has noted that performance data will be posted on the website in October 2017, at the earliest. The AAMC strongly believes that hospital performance on all quality measures should be publicly reported for at least one year before being considered for inclusion in a performance or penalty program. Stakeholders are unable to provide sufficient feedback on this measure without having access to this data.

In addition to the lack of data, the AAMC has numerous concerns with the current components of the PSI-90 composite. Some of the components focus on surgical care, which disadvantages teaching institutions that tend to have a larger volume of surgical cases. Other components are susceptible to surveillance bias. For example, teaching institutions tend to have robust infection control programs, which means the harder you look for a patient safety event, the more likely you are to find one. In addition, the components are based on administrative claims data so cannot capture the full scope of patient-level risk

factors.^{11,12,13} While the modified composite may be an improvement over the previous version, many of the issues previously cited will continue to apply. For all of the reasons listed, the AAMC urges CMS to postpone finalizing this measure for the VBP Program until stakeholders have sufficient data to review this measure to determine the appropriateness of the modified PSI-90 composite in this performance program.

AAMC Recommends Changes to Proposed Weighting of VBP Efficiency and Cost Reduction Domain

In the rule, CMS proposes to adjust the weights of the measures in the Efficiency and Cost Reduction domain starting FY 2021. Under the proposal, the MSPB measure would be weighted at 50 percent and the other condition-specific payment measures in this domain would encompass the remaining 50 percent. As justification for this change, CMS cites hospital's experience with MSPB and the ability of the measure to "incentivize greater coordination among hospitals, physicians, and providers of post-acute services..."¹⁴

The AAMC's concerns with MSPB have been echoed by the MAP. Above all else, this measure overlaps and double counts payments already captured by the condition specific episode of care measures in this domain, essentially penalizing hospitals twice for the same payment. In addition, the comprehensiveness of the measure makes it difficult for hospitals to "move the needle" on performance. Finally, the recent ASPE report noted deficiencies in the measure's current risk adjustment and found that "frailty is in part responsible for the observed higher spending in dually enrolled beneficiaries. This finding suggests that some of the effect currently captured by the indicator of dual enrollment may be picking up differences in medical risk – including frailty – which are beyond providers' control and should be adjusted for."¹⁵

For all of the reasons discussed above, the AAMC strongly recommends that CMS not finalize its proposal to weight the MSPB measure at 50 percent of the Efficiency and Cost Reduction domain. Instead, the AAMC believes that the MSPB measure should be removed from the program starting FY 2021, which is the first year that the AMI and HF episode of care payment measures will be included in this domain. A reliance on condition specific measures will ensure that payments are not double counted and will make it easier for providers to implement targeted strategies to improve performance. At a minimum, the MSPB measure should be equally weighted with the other episode of care payment measures, as is the case for the other others in the four domains that encompass the VBP program.

AAMC Urges CMS to Account for SDS for Specific VBP Domains

In addition to the recommendations listed at the beginning of this section, the AAMC requests that CMS take steps to ensure that the VBP program appropriately accounts for differences in patient populations served. Two domains in the VBP program contain measures that are influenced by factors outside of the hospital's direct control: the Clinical Care domain and the Efficiency and Cost Reduction domain. The AAMC recommends that CMS consider a stratification approach for these domains similar to the approach taken for the HRRP outlined in the 21st Century Cures Act.

¹¹ "MedPAC Comments on FY 2014 IPPS Proposed Rule." June 25, 2013. Retrieved from: <http://www.medpac.gov/documents/comment-letters/medpac-s-comment-on-cms-s-acute-and-long-term-care-hospitals-proposed-rule.pdf?sfvrsn=0>

¹² Rajaram, Ravi et al. *Concerns About Using the Patient Safety Indicator-90 Composite in Pay-for-Performance Programs*. *JAMA*. Vol 313, No. 9. March 3, 2015. Retrieved from: <http://jama.jamanetwork.com/article.aspx?articleid=2109967>

¹³ *Medicare's Hospital-Acquired Condition Reduction Program*. *Health Affairs*: Health Policy Briefs. August 6, 2015. Retrieved from http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=142

¹⁴ Inpatient Prospective Payment System Proposed Rule. *Federal Register*, Vol. 82, No. 81. Friday, April 28, 2017. Pg. 19985

¹⁵ "Office of the Assistant Secretary for Planning and Evaluation." *Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Program*. December, 2016. Pg. 92 Retried from <https://aspe.hhs.gov/system/files/pdf/253971/ASPESESRTCfull.pdf>

Under the 21st Century Cures Act, CMS is required to account for SDS in the readmissions program by stratifying HRRP penalties by the hospital's number of dual-eligible patients. In order to determine the size of the penalties, hospitals would be divided into equal groups (based on the overall proportion of dual-eligible patients) and compared to those in their cohort. Utilizing a similar approach for the VBP program, hospitals in the Clinical Care and Efficiency and Cost Reduction domains would be divided into different cohorts based on their overall percentage of dual eligible patients, or other appropriate data element. Hospitals would then be directly compared to those in their cohort to determine the domain level score. The AAMC believes that this is a temporary solution, and strongly recommends that CMS take steps to ensure that the individual measures in VBP account for SDS in the measure level risk adjustment model. The AAMC is happy to discuss these details with CMS in the months ahead.

HOSPITAL ACQUIRED CONDITIONS REDUCTION PROGRAM

CMS requests feedback on future measure topics to include in Domain 1, and adjusting certain measures in Domain 2 for disability and medical complexity. No new measures were proposed for this program.

AAMC Urges CMS to Improve Risk Adjustment for Domain 2 Measures

The AAMC continues to be extremely concerned that the HACRP disproportionately penalizes the nation's major teaching hospitals. This disparity in penalties is likely due to factors that do not reflect true differences in the quality of care, such as limitations in the scoring methodology, data collection, inconsistent reporting of data, and measure risk adjustment. Because this program penalizes 25 percent of all hospitals – and includes penalties for add-on policy payments - it is especially important that CMS ensure that the measures used are as fair and accurate as possible and do not create a systematic bias that disadvantages any particular type of hospital.

The AAMC is pleased that CMS is taking initial steps to address these concerns by requesting feedback on adjusting the Centers for Disease Control National Health Safety Network (CDC NHSN) measures (which encompass all of Domain 2) to account for disability and medical complexity. CMS cites ASPE's recommendations outlined in their IMPACT report that additional risk adjustment may be necessary to better account for differences in clinical risk. CMS specifically requested feedback on whether measures should be adjusted for "frailty, functional limitations, prior hospitals or nursing home residence, or other markers of immune system deficiencies or unmeasured medical complexity." Given the penalties associated with these programs and the importance of ensuring that the risk adjustment methodology for these measure is as fair as possible, the AAMC strongly recommends that CMS take steps to incorporate these adjustments as soon as possible. We also ask CMS to take steps to determine whether frailty and medical complexity should be used to improve the risk methodology for other accountability measures as well.

All Measures Proposed for the HACRP Should Be NQF Endorsed, Approved by the MAP, and Publicly Reported

CMS also requests stakeholder feedback on future inclusion of safety measure topics for Domain 1 of the HACRP. Currently, the only measure in Domain 1, which is weighted at 15 percent of the total HACRP score, is the modified PSI-90 patient safety composite (starting FY 2018). The Agency specifically noted the following topic areas under consideration: falls with injury, adverse drug events, glycemic events, and ventilator associated events.

The AAMC will provide feedback on new HACRP measures once they are proposed. We strongly recommend that all new measures be NQF endorsed to ensure that the measure is scientifically valid, reliable, and feasible, and determine whether it is appropriate for review in the NQF SDS trial period.

Any new measure for the HACRP should also be included in IQR and reported on Hospital Compare for one year and approved by the MAP before the measure the measure is proposed. Until this occurs, relevant stakeholders do not have the necessary information to make a critical assessment as to whether a measure is appropriate for the HAC reporting program.

The AAMC is very concerned that the modified PSI-90 composite, finalized for inclusion into the HACRP starting FY 2018, does not meet the criteria outlined above. The modified composite has not yet been publicly reported on Hospital Compare, and will not be reported until October 2017 at the earliest. The AAMC urges CMS to remove this measure from the HACRP and to re-propose the measure when the data has been publicly reported for at least one year.

INPATIENT QUALITY REPORTING PROGRAM (IQR)

Hospital quality measures are typically reported through the IQR program and publicly reported on the Hospital Compare website before they are included in the hospital performance and penalty programs and should therefore meet a certain standard. These measures, with very few exceptions, should be NQF-endorsed and approved by the Measure Applications Partnership (MAP) before they are proposed for the IQR program.

In the FY 2018 proposed rule, CMS proposed inclusion of two revised measures and the addition of one voluntary hybrid measure. No measures were proposed for removal. CMS also revised the requirements for the eCQM measures starting FY 2019. The measure recommendations are below:

Individual Measure Recommendations

Revised Measures to be Implemented Starting FY 2019

- HCAHPS Pain Management Survey Questions

In the CY 2017 OPSS rule, CMS finalized its proposal to remove the HCAHPS pain management questions from the HCAHPS survey for purposes of calculating VBP performance starting FY 2018. The AAMC appreciated that the Agency took this step to address stakeholder concerns on this issue of national importance. Starting FY 2020, CMS proposes updates to the wording of the pain management questions that are currently used on the HCAHPS survey and publicly reported on the Hospital Compare website. The current and proposed revised questions are shown below:

Current “Pain Management”	Proposed “Communication about Pain”
<p>12. During this hospital stay, did you need medicine for pain?</p> <p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No → If No, Go to Question 15</p> <p>13. During this hospital stay, how often was your pain well controlled?</p> <p>1 <input type="checkbox"/> Never</p> <p>2 <input type="checkbox"/> Sometimes</p> <p>3 <input type="checkbox"/> Usually</p> <p>4 <input type="checkbox"/> Always</p> <p>14. During this hospital stay, how often did the hospital staff do everything they could to help you with your pain?</p> <p>1 <input type="checkbox"/> Never</p> <p>2 <input type="checkbox"/> Sometimes</p> <p>3 <input type="checkbox"/> Usually</p> <p>4 <input type="checkbox"/> Always</p>	<p>• HP1: “During this hospital stay, did you have any pain?”</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No → If No, Go to Question __</p> <p>• “During this hospital stay, how often did hospital staff talk with you about how much pain you had?”</p> <p><input type="checkbox"/> Never</p> <p><input type="checkbox"/> Sometimes</p> <p><input type="checkbox"/> Usually</p> <p><input type="checkbox"/> Always</p> <p>• “During this hospital stay, how often did hospital staff talk with you about how to treat your pain?”</p> <p><input type="checkbox"/> Never</p> <p><input type="checkbox"/> Sometimes</p> <p><input type="checkbox"/> Usually</p> <p><input type="checkbox"/> Always</p>

The AAMC believes that pain management experience measures are an important aspect of patient care, and appreciate that CMS has taken steps to develop alternative pain management questions for the HCAHPS survey. While the Association agrees that the revised questions are an improvement, we have concerns that the revisions have not been NQF endorsed and that CMS’s testing results have not been shared with the public with sufficient time to review. Since the consequences of HCAHPS’ pain management questions are highly significant for both providers and patients, we urge the Agency to move cautiously. While the revisions are a step in the right direction, more work must be done to ensure that the new HCAHPS questions sufficiently address the concerns of stakeholders. Until such time, we do not believe that the pain management questions should be publicly reported on the Hospital Compare website or move forward for inclusion in the Value Based Purchasing Program.

As CMS works to improve the language of these questions on the survey, we ask that the Agency consider the work that the National Institutes of Health is undertaking on chronic pain treatment. NIH researchers are examining new and innovative treatments for people with moderate-to-severe chronic pain, with the ultimate goal of moving away from subjective pain assessments to individualized clinical management of pain.¹⁶ Such research may be beneficial in shaping how questions are presented to the public.

- Stroke Mortality Measure

Starting FY 2023, CMS proposes to adopt a refined 30 day stroke mortality measure. The revised measure’s risk adjustment would incorporate the National Institutes of Health (NIH) Stroke Scale, a 15-item neurologic examination scale to assess stroke severity. CMS worked with the American Heart Association (AHA) and the American Stroke Association (ASA) to develop the refinements. The Agency proposes to include measure dry run results in confidential hospital feedback reports in 2021, prior to the measure being used for payment determination. The revised measure was reviewed by the NQF in 2016

¹⁶ Volkow, Nora and Collins, Francis. *The Role of Science in Addressing the Opioid Crisis*. *NEJM*, 2017. Retrieved from: <http://www.nejm.org/doi/full/10.1056/NEJMsr1706626#t=article>

but was not endorsed due to the inability of the organization to test the validity of the Stroke Scale elements using ICD-10 codes. CMS plans to resubmit the measure to NQF following the dry run.

The AAMC thanks CMS for working to improve the risk adjustment methodology, and supports the steps that CMS has outlined to revise the measure and provide hospitals with necessary data before the results are publicly posted. The AAMC asks that CMS resubmit this measure to NQF as soon as possible. If the measure is endorsed, CMS should solicit stakeholder feedback before it is included in the IQR program.

- Voluntary Hybrid Hospital Wide Readmissions Measure

CMS proposes to include a voluntary hybrid hospital wide readmissions (HWR) measure, which would encompass reporting of data on discharges over a 6 month period in the first two quarters of CY 2018. Under the proposal, patient data extracted from the hospital EHR would be used to supplement the claims data collected by CMS. Hospitals taking part in the voluntary submission of this data would receive confidential feedback reports; this data would not be publicly reported and would not be used for payment purposes. The hybrid measure is also NQF endorsed (NQF# 2879). CMS has signaled their intention to require the measure in the IQR program as early as FY 2023.

The AAMC thanks CMS for taking steps to improve the risk adjustment methodology for these measures and believes integrating EHR data with claims data is a positive step. The AAMC also appreciates that CMS is proposing the hybrid HWR as a voluntary measure to allow hospitals to become comfortable submitting this data before it is publicly reported or used for payment purposes. That being said, the AAMC recommends that the Agency focus its efforts on adjusting condition specific measures that are currently being used in the Medicare performance or penalty programs. The Agency should also take steps to test the feasibility of using non-clinical EHR-derived elements, such as education, location, and other factors, to develop appropriate SDS adjustments.

Modify the Proposed Requirements for the Electronic Clinical Quality Measures (eCQMs)

CMS had previously finalized a requirement that hospital submit eight eCQMs for CYs 2017 and 2018 (FYs 2019 and 2020 payment determination). Due to a number of concerns raised by stakeholders, CMS has proposed to modify these requirements for FY 2019 and 2020 payment. Specifically, the number of required eCQMs for both years would be reduced from eight to six. In addition, the data reporting period for CY 2017 would be changed to two self-selected quarters of data instead of one full year. For CY 2018, hospitals would be required to first three quarters of CY 2018.

The AAMC appreciates CMS's recognition and responding to the challenges regarding the feasibility and electronically-submitted measures. That being said, the Association continues to have concerns that hospitals and vendors may not be sufficiently prepared to fully implement this change. There is considerable burden required to map the necessary data elements from the EHR to the appropriate Quality Reporting Data Architecture (QRDA) format, and some vendors are not properly equipped to collect and transmit such data through the CMS portal. In addition, mandatory eCQM reporting depends on hospitals using the correct version of specifications, which is generally in the control of the EHR vendors, not the hospitals. The AAMC urges CMS to continue outreach to EHR vendors, hospital quality staff, and other affected stakeholders to identify underlying structural problems and barriers to successful reporting of these measures.

Until these issues are sufficiently addressed, the AAMC recommends that CMS reduce the number of required measures for FYs 2019 and 2020 payment determination from the proposed six measures to four measures with a requirement that hospitals submit one quarter of data for both of these years. Reducing

the number of required measures will provide hospitals with additional time and bandwidth to address the considerable challenges of electronic data reporting.

CMS SHOULD NOT FINALIZE THE PROPOSAL TO REQUIRE ACCREDITING AGENCIES TO POST SURVEY REPORTS

In the rule, CMS proposes to require Accrediting Organizations (AOs) to post final accreditation survey reports and acceptable plans of corrections (PoCs) on their websites within 90 days after such information is made available to those facilities for the most recent 3 years, on an ongoing basis. This proposal includes all triennial, full, follow-up, focused, and complaint surveys, regardless of whether they are performed onsite or offsite.

The AAMC supports the public reporting of valid and reliable quality metrics assessing hospital safety and quality of care. However the proposal, as outlined by CMS, does not achieve this goal and could result in unforeseen consequences for both patients and providers. The AAMC does not believe that the long form hospital survey reports are an accurate or fair depiction of hospital quality. These reports lack sufficient context, are not written for public consumption, and may inadvertently identify specific patients or clinicians at the institution under review. In addition, the rule does not specify whether survey reports can be adjusted before being posted to account for immediate corrections undertaken by the institution and which are no longer relevant to the public. The AAMC urges CMS not to move forward with this proposal and strongly recommends that the Agency convene a stakeholder group of patients, hospitals, AOs, and other relevant bodies to develop methods to display meaningful information in the future.

AAMC REQUESTS PUBLIC REPORTING OF TIMELY AND COMPREHENSIVE DATA

In an effort to promote transparency and to inform quality improvement, since 2015 the Association has made requests for more comprehensive, timely, and coordinated data release related to the three Medicare pay-for-performance programs. We sincerely appreciate the changes CMS has incorporated to improve the reporting of this data, as they have enabled us to provide more accurate and complete information to our member hospitals in support of their ongoing effort to drive quality improvement. In the FY2017 data release, we were pleased to see that CMS made available additional data related to the VBP program, including baseline data, benchmark data, and thresholds for each measure, as we requested in a letter to the Agency on November 9, 2016. We also took note of the additional digits and specificity in the HRRP download for the observed and predicted readmission rates for FY2017.

The AAMC is now following up on remaining issues identified in our previous letters that have not been addressed by the Agency, as well as emerging issues for the Agency to consider as they are updating data and methods used in the quality programs are being updated. We have developed a model which uses the public data files to demonstrate, in a step-by-step format, how a hospital's performance on quality measures is converted to payment adjustments and thereby assists hospitals in assessing which areas they need to target for improvement. We rely on data released by CMS to populate the report, which the AAMC regularly sends to our hospital members to help inform their quality improvement strategies and understand the financial implications of their quality performance. As a result, the accuracy of our report relies on the accuracy and completeness of CMS's data release. In service of those goals, we are requesting the following items:

1. For the **HACRP program**, the current Hospital Compare quarterly release rounds the Patient Safety Indicator (PSI)-90 measure to 2-digits which causes discrepancies when replicating the HACRP methodology. In FY2018, the new scoring methodology will pose a further problem, since we will be unable to match the Winsorized PSI-90 scores CMS uses for ranking hospitals'

HAC scores. The AAMC requests that the CMS releases the same number of digits that the agency uses for computing PSI-90 scores in HACRP.

2. For the **HVBP program**, the HVBP supplemental data file released on Hospital Compare uses rounded HCAHPS baseline and performance period rates, instead of the unrounded rates which would be required to duplicate the same scores that CMS uses to compute HVBP adjustment rates. In addition to the rates for the HCAHPS dimension, the Clinical Process of Care measures also uses a greater unrounded precision of rates for the calculation of improvement and achievement rates. The other measures within the Hospital VBP Program (Mortality Measures, AHRQ PSI-90, HAIs, and MSPB) use the same precision in the calculations and public reporting. The AAMC requests that the CMS releases the unrounded rates for HCAHPS and the Clinical Care domain in the HVBP data.
3. For **HACRP**, Hospital Compare releases only 12-month reporting periods for hospital-acquired infection (HAI) measures, while HACRP uses HAI measures based on two year reporting periods. In response to our previous request for HAI measures based on two year reporting periods, CMS suggested we aggregate two years' of HAI performance for the HACRP program. We were able to replicate HACRP scores for FY2017 following CMS's recommendation. However, in FY2018, CMS published an error in the data for one of the HAIs (CDI) and a subsequently posted an acknowledgement on Hospital Compare explaining the error. The rereleased data did not match the data used to compute the FY2018 HACRP penalty. As a result, we cannot match the HACRP penalties released by CMS. The AAMC requests that CMS replaces incorrect HAI data from Hospital Compare with the data used to compute HACRP penalty as soon as possible. We also recommend that CMS adopt a general practice of correcting and replacing erroneous data whenever the corrected data becomes available.
4. For HACRP, the re-basing of the HAI data in the past year will pose a problem for re-computing HACRP scores for FY2018. Since HACRP uses two consecutive calendar years of HAI data to score each measure, there will be a mismatch when aggregating two years' of data from Hospital Compare from both the pre- and post-baseline data. The AAMC requests that CMS provide both calendar years' data for each HAI under the methodology used in the HACRP for FY2018 and future fiscal years.
5. When CMS revises, re-calibrates, or redefines quality measures, or makes major changes to program methodologies (e.g. changes to the risk adjustment), it is challenging for hospitals to keep track of their quality performance and monitor performance improvement. The AAMC recommends that CMS provides at least one previous performance period of data when measures have been significantly revised or updated, where the exclusion criteria have changed, or the rate has been set to a new baseline.

PAYMENT DIFFERENTIALS BETWEEN INPATIENT AND OUTPATIENT

The AAMC's fundamental policy priority is that clinical judgment should determine whether to admit a patient as an inpatient or perform a procedure in the outpatient setting. Procedures performed on the outpatient basis may be appropriate for Medicare beneficiaries who are younger and healthier. However, close to half of all Medicare beneficiaries live with four or more chronic conditions and one-third have one or more limitations in activities of daily living that limit their ability to function independently which can make even a simple procedure more complicated.

Compared to other hospitals, major teaching hospitals care for patients that are sicker, poorer, and more likely to be disabled. Teaching hospitals are committed to missions of providing critical services, serving

vulnerable populations and educating the next generation of physicians. However, these missions carry heavy expenses that are often under reimbursed by payers with these costs being absorbed by the hospitals themselves.

Site neutral proposals would pay hospitals the same amount for similar procedures performed in the outpatient setting. The AAMC is concerned that reductions in inpatient hospital reimbursement will lead to a reduction of services that affect vulnerable patient populations – especially those with complex medical conditions. Teaching hospitals incur significant costs associated with training new physicians and other health care professionals. They also have costs associated with using newly developed devices and technologies, maintaining standby services, treating patients with complex conditions, providing unfunded and underfunded health services, being sites for clinical research, and serving as safety net providers. These activities impose substantial financial burdens on teaching hospitals. When CMS pays for necessary services delivered in a hospital as though they were outpatients, these hospitals lose their indirect medical education (IME) and disproportionate share hospital add-on payments and see decreases in their direct graduate medical education payments. Therefore, in addition to the inadequate reimbursement for necessary services that every hospital faces unwarranted cuts in payments that help support their vital missions, which continue to be national priorities.

ELECTRONIC HEALTH RECORD INCENTIVE PROGRAM

AAMC Supports a 90-day Reporting Period for EHRs

CMS proposes to modify the electronic health record (EHR) reporting period for 2018 for all participants – new and returning – attesting to CMS or to a State Medicaid agency to a minimum of any continuous 90-day period within calendar year (CY) 2018. The applicable incentive payment year and payment adjustment years for the 2018 EHR reporting period, and attestation deadlines and other related program requirements, would remain the same. The AAMC supports the proposal and encourages CMS to finalize the change to the reporting period.

LABOR-RELATED SHARE REBASING

CMS Should Release Additional Information to Allow for Stakeholder Verification of Labor-Related Share Rebasing

The labor-related share is used to determine the proportion of the national prospective payment system base payment to rate to which the area wage index is applied. HHS periodically estimates the proportion of payments that are labor-related. In the FY 2018 IPPS, CMS is proposing to rebase the labor-related share. The AAMC cannot replicate or verify the labor share estimate included in the FY 2018 IPPS. We understand the need for rebasing the labor share but request that CMS release additional information on how they determined the rebasing and the data used in that rebasing process that will better enable stakeholders to verify CMS's estimate. To that end, examples of data that would be helpful include greater clarity of data sources, case counts at different points (*e.g.*, providers included after each step of data trimming), and provider level data like the impact file that shows what information is used.

REQUEST FOR INFORMATION

The AAMC supports CMS's commitment to reduce burdens for hospitals, physicians, and patients. Identifying and revising or removing regulations that divert time and resources from patient care, care improvement, safety and quality will benefit providers, patients, and CMS. Many regulations were developed decades ago when reimbursement was strictly fee for service and delivery models did not rely on team-based care and other innovations. The AAMC supports initiatives to reduce, simplify,

modernize, and harmonize regulations and recommends that any newly needed regulations be applied prospectively and have clear objectives and would be pleased to work with CMS.

To Reduce Burdens on Providers, Further Major Changes to IPPS, OPSS, and MPFS Should Not Be Implemented for Several Years

In recent years hospitals and physicians have experienced a wide array of regulatory changes that have an impact on delivery system reform, reimbursement and reporting requirements. To date, we do not yet understand the interaction of these numerous changes. For example, under the new payment system finalized by CMS in the Outpatient Prospective Payment System (OPSS) Interim Final Rule, CMS does not specify how to apply OPSS payment policy when items and services are bundled into a comprehensive ambulatory payment classification (APC) that are provided in locations that will be reimbursed differently under the new payment system. This raises the question of how CMS will reimburse for services if the primary services are provided by a nonexcepted, off-campus physician-based department (PBD) and a portion of the packaged services are provided at an excepted hospital outpatient department (HOPD).

The AAMC is very concerned that the rapid pace of these changes exceeds both hospitals' adaptive capacity and the Agency's ability to accurately model and sufficiently explain the impact of either past or current proposals. In most cases, these changes interact with each other. Also of concern is that the rapidity with which new policies are being adopted leaves inadequate time to identify and address implementation issues and that data collection requirements impose a significant administrative burden. The Association urges CMS to review ongoing regulatory activity and to allow for sufficient time to fully understand the impact of such changes including analyzing data and seeing stakeholder feedback to measure the impact on hospitals and physicians.

The Skilled Nursing Facility (SNF) 3-Day Hospital Stay Should be Eliminated and Pay for Telehealth Services Should be Expanded to More Locations

To better coordinate and improve care for patients, CMS should work with Congress to eliminate or modify the requirement that a patient must spend three days as a hospital inpatient before being eligible for SNF services. While we recognize that complete removal of the requirement would require legislative action, at a minimum we recommend CMS use its administrative flexibility to create additional waivers of the SNF 3 day stay for alternative payment models (APMs). Many patients who are not in APMs would benefit from an inpatient stay that is shorter than 3 days, followed by care in a SNF. Eliminating the 3-day stay would assist all physicians to ensure that their patients receive the most appropriate care in the most appropriate settings, without creating the possibility of an unforeseen financial burden on the patient.

The general Medicare rules related to payment for telehealth services are that the services must be provided to a patient in a rural area and at an originating site specified in statute. The home is not included as the originating site. Patients in urban and other areas who do not have convenient access to a provider also could benefit from telehealth. Certain APMs, such as Next Generation ACOs, have telehealth waivers available, but such waivers should be provided to other APMs. As Medicare payments move toward having a strong quality component, there is little risk that these services will be used for other than the best quality, most cost efficient care. CMS should encourage the use of telemedicine beyond rural areas and outside of APMs, as many patients would benefit from the availability of telemedicine services.

Align Quality Measures Across Payers

The number of quality measures that providers must report to CMS and other payers is increasing rapidly in the inpatient and outpatient quality programs. CMS should align the measures used by both the Medicare and Medicaid programs as well as commercial payers to reduce burden and prevent confusion. A key step would be development of a national core measure set, with measures that apply across health settings and across payers. CMS should focus on measures that are critical to driving the best possible outcomes for patients.

Prevent Inconsistent and Duplicative Audits

Medicare subjects providers to claims review by multiple entities including Medicare Administrative Contractors (MACs), Recovery Audit Contractors (RACs), Zone Program Integrity Contractors (ZPICs), and Comprehensive Error Rate Testing Contractors (CERT). These redundant and overlapping audits place an enormous burden on providers and have resulted in inappropriate denials. There is a need to streamline and eliminate these duplicative audits.

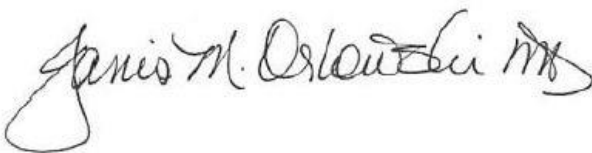
Include Page Numbers in the Table of Contents in CMS Regulations

CMS includes a Table of Contents in both the display copy of its proposed and final rules as well as in the version that appears in the *Federal Register*. However, the table of contents does not include page numbers. As CMS' regulations are lengthy, it would facilitate navigation of its regulations if both the display and *Federal Register* copies of its regulations were to include page numbers. This would be a simple and non-controversial change that CMS could make that would be very much appreciated by the many parties that read its regulations.

CONCLUSION

We appreciate your attention to these matters of significance to our nation's teaching hospitals and medical schools and would welcome the opportunity to meet with you to discuss them further. If you have questions regarding the issues discussed in this letter please feel free to contact Ivy Baer, ibaer@amc.org or 202-828-0499 or Mary Mullaney, mmullaney@aamc.org or 202.909.2084.

Sincerely,



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Chief Health Care Officer

cc: Ivy Baer, AAMC
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