



Association of
American Medical Colleges
2450 N Street, N.W., Washington, D.C. 20037-1127
T 202 828 0460 F 202 862 6161
www.aamc.org

Darrell G. Kirch, M.D.
President and Chief Executive Officer

Via Electronic Submission (www.regulations.gov)

June 30, 2014

Ms. Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
ATTN: CMS-1607-P
7500 Security Blvd.
Baltimore, MD 21244-8013

Dear Ms. Tavenner:

Re: FY 2015 Inpatient Prospective Payment System Proposed Rule, File Code CMS-1607-P

The Association of American Medical Colleges (AAMC) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS' or the Agency's) proposed rule entitled "Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System and Proposed Fiscal Year 2015 Rates; Quality Reporting Requirements for Specific Providers; Reasonable Compensation Equivalents for Physician Services in Excluded Teaching Hospitals; Provider Administrative Appeals and Judicial Review; Enforcement Provisions for Organ Transplant Centers; and Electronic Health Record (EHR) Incentive Program," 79 *Fed. Reg.* 27978 (May 15, 2014). The AAMC is a not-for-profit association representing all 141 accredited U.S. medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and nearly 90 academic and scientific societies. Through these institutions and organizations, the AAMC represents 128,000 faculty members, 83,000 medical students, and 110,000 resident physicians.

The FY 2015 IPPS proposed rule includes a 1.3 percent hospital payment update. The overall impact on all hospitals is 0.8 percent, yet the impact on major teaching hospitals is -1.3 percent. Much of this negative impact is driven by the implementation of two Affordable Care Act (ACA) mandated provisions: the Medicare disproportionate share hospital (DSH) cuts and the Hospital Acquired Condition (HAC) Reduction Program. Given the disproportionate and negative impact of these and other proposals on teaching hospitals, the AAMC urges CMS to reconsider certain policies that are within the Agency's ability to reverse. In particular, the AAMC encourages changes to the Two-Midnight Rule and to the HAC Reduction Program methodology and payment application.

Two-Midnight Rule

The Two-Midnight Rule finalized in the FY 2014 rulemaking cycle continues to cause numerous problems and have damaging effects for teaching hospitals and Medicare beneficiaries. These include inadequate reimbursement for hospitalizations and complete loss of policy add-on payments that support physician training, care for low income patients, and provide other community benefits. The rule also has been a source of increased financial liability and confusion for Medicare beneficiaries. Further, the rule is a disincentive to efficient care, a source of administrative burden, and inappropriately creates a disconnect between a physician's complex medical judgment about the most appropriate site of care for the patient and reimbursement for medically necessary hospital services. **The AAMC urges CMS to revise or replace the Two-Midnight Rule with a policy that does not sacrifice the critical role of medical judgment and adequate reimbursement for medically necessary short hospitalizations. This policy should also be easily understood by patients and should not unreasonably increase their financial responsibility for short inpatient stays. An interim solution is needed now, with additional time being devoted to developing permanent policy in a later rulemaking cycle.**

The AAMC does not support using time as the permanent basis for determining which stays should be characterized and reimbursed as inpatient and which as outpatient instead of relying on the historical and appropriate deference to complex medical judgment. When determining whether to admit a patient, clinicians rely on their training, medical judgment, and clinical protocols to determine whether the patient's medical needs would be better served in the inpatient or outpatient setting. This judgment depends on factors such as the severity of the patient's condition, the risks of complications and adverse events, and the nature of the services needed. Given the factors that ultimately guide the admission process, the presumption that a short length of time in the hospital makes the care less clinically relevant or less worthy of full inpatient reimbursement is flawed.

Because CMS has not promulgated a sufficiently detailed proposal for a revised policy during this comment period, the AAMC strongly encourages CMS to adopt an interim policy in the FY 2015 final rule. The part of the Two-Midnight Rule that applies to medically necessary stays longer than two midnights should be maintained to ensure that these stays are appropriately paid as inpatient stays. At the same time, for stays shorter than two midnights, the interim policy should return to the policy before the Two-Midnight Rule went into effect (i.e., before 10/1/13). This would mean removing the documentation requirement for the expectation of a stay longer than two midnights and a return to the longstanding practice of relying on a physician's judgment about the inpatient admission supported by the medical record to determine when these

stays should be paid for under Part A. The AAMC also welcomes further engagement on broader policies to address the shortcomings of Medicare's current observation stay policy, RAC process, and other payment issues.

The AAMC looks forward to collaborating with CMS and the hospital community to ensure that short hospitalizations are appropriately reimbursed. In the meantime, the AAMC strongly urges CMS to finalize an interim policy that maintains the current presumption that hospital stays expected to exceed two midnights are to be paid under Part A, but return to CMS' previous policy of deferring to clinical judgment for hospital stays lasting fewer than two midnights.

HAC Reduction Program

CMS will implement the HAC Reduction Program for the first time in FY 2015. As this program begins, the AAMC is extremely concerned that CMS' policies for implementing the program disproportionately affect teaching hospitals in two ways. First, the HAC program is the only performance program where penalties could apply to add-on payments as well as base diagnoses-related group (DRG) payments. Second, the current measure scoring methodology disproportionately identifies teaching hospitals as poor performers, which may be because of technical issues related to measurement rather than true differences in quality. The AAMC urges CMS to use the Agency's administrative authority to ensure teaching hospital performance is appropriately measured and not disproportionately impacted. In particular, the AAMC requests that CMS use its administrative authority under section 1886(d)(5)(I)(i) of the Social Security Act to limit the HAC penalty to base operating DRG payments only, at least for a transition period. In addition, the AAMC asks CMS to consider hospital comparisons within peer cohorts to remove any systematic bias that could affect comparisons across different hospital provider types.

Our comments below focus on the following areas:

- Medicare Payments for Short Inpatient Hospital Stays (pp. 4-18)
- MS-DRG Recalibration Budget Neutrality Adjustment Factor (pp. 18-20)
- Graduate Medical Education Proposals (pp. 20-28)
 - Cap-setting Process for New Medical Residency Programs (pp. 20-24)
 - Rural Hospitals Redesignated as Urban (pp. 24-25)
 - Transition Period for Redesignated Hospitals and Rural Training Tracks (pp. 25-26)
 - Sec. 5506 Application Process for GME Positions from Closed Hospitals (pp. 26-28)

- Medicare Advantage Indirect Medical Education (IME) Payments to Sole Community Hospitals (pp. 28-29)
- Hospital Quality-Related Programs (pp. 29-48)
 - Hospital-Acquired Conditions (HAC) Reduction Program (pp. 31-34)
 - Hospital Readmissions Reduction Program (HRRP) (pp. 35-38)
 - Hospital Value-Based Purchasing (VBP) Program (pp. 38-43)
 - Inpatient Quality Reporting (IQR) Program (pp. 43-48)
- MS-DRG Documentation and Coding Adjustment (pp. 48-50)
- ACA Price Transparency Requirements (p. 50)
- Cost Reporting and Appeals Regulations (pp. 50-51)
- Outlier Payments (pp. 51-53)
- Medicare Disproportionate Share Hospital (DSH) Payments (pp. 53-57)
- Updates to the Reasonable Compensation Equivalent (RCE) limits on Compensation for Physician Services Provided in Providers (pp. 58)
- Survey, Certification, and Enforcement Procedures for Transplant Centers (p. 59)

MEDICARE PAYMENT FOR SHORT INPATIENT HOSPITAL STAYS

CMS Should Adopt an Interim Policy to Mitigate the Most Objectionable Effects of the Two-Midnight Rule Until a New Policy That Would Appropriately Defer to Clinical Judgment Can Be Proposed and Finalized

The AAMC urges CMS to revise or replace the Two-Midnight Rule with a policy that appropriately defers to the critical role of medical judgment and adequately reimburses hospitals for medically necessary short hospitalizations. Because CMS did not include a sufficiently detailed proposal in the FY 2015 IPPS proposed rule, the Association encourages CMS to adopt an interim policy to mitigate the Two-Midnight Rule's significant negative impact on patients and providers.

Under the Two-Midnight Rule finalized in the FY 2014 IPPS final rule, medically necessary stays that are expected to cross two midnights are presumed appropriate for Part A payment and, with minor exceptions, stays that are not expected to cross two midnights will be paid under Part

B. In response to the many concerns raised regarding the Two-Midnight Rule, CMS implemented a partial enforcement delay related solely to reviews by Recovery Audit Contractors (RACs). This partial enforcement delay has been in place since the rule took effect on October 1, 2013 and will remain in place until March 31, 2015, as mandated by the Protecting Access to Medicare Act of 2014. Despite this partial delay of recovery audits, hospitals are still expected to be in full compliance with the Two-Midnight Rule, and remain subject to prepayment review by Medicare Administrative Contractors (MACs) and “probe and educate” audits on this basis.

For hospitals, problems with the Two-Midnight Rule include inadequate -or in some cases no-reimbursement for medically necessary hospitalizations and the complete loss of policy add-on payments that support physician training, care for the uninsured, and provide other community benefits. The confusing nature of the rule and subsequent subregulatory guidance, as well as the dramatic departure from a reliance on clinical criteria, have required significant retraining of physicians and staff, modifications to health information technology systems, and major changes in billing practices. The rule has been a major source of confusion and increased financial burden for many Medicare beneficiaries who thought they were admitted as inpatients but later discovered that they only qualified as outpatients, thereby incurring substantial cost-sharing for Part B services. Additionally, beneficiaries are discovering that the time they spend in the hospital does not count toward the three-day inpatient stay needed to qualify for Skilled Nursing Facility (SNF) benefits.

Since the finalization of the FY 2014 IPPS rule, the hospital industry, patient advocates, and Members of Congress have exposed the myriad flaws in the Two-Midnight Rule and have urged CMS to significantly revise or reverse it. In the FY 2015 IPPS proposed rule, CMS responds to this criticism by soliciting public comment on how to define an inpatient stay and on potential alternative payment policies for short inpatient stays. However, CMS has made no specific proposals and has provided no regulatory language for comment, making it premature for the Agency to finalize either a definition of an inpatient or an alternative short stay payment policy during the current rulemaking cycle.

Although the Agency must consider the feedback it receives from this request for information, analyze data to understand the impact of any truly new policy, and continue to work with stakeholders as it develops a specific proposal that will be subject to notice and comment rulemaking in the future, action to address the burden of the Two-Midnight Rule on patients and providers cannot be further delayed. The AAMC urges CMS to finalize an interim policy that maintains the current “bright line” presumption that hospital stays expected to exceed two

midnights are to be paid under Part A, but returns to CMS' previous policy of deferring to clinical judgment for hospital stays lasting fewer than two midnights.

The comments below elaborate on this interim proposal, outline key principles and concerns regarding any new short stay payment policy, and highlight the wide range of policy and implementation issues making the current Two-Midnight Rule untenable.

New Short Stay Policy without Public Comment Is Premature, but Immediate Relief from the Most Onerous Aspects of the Two-Midnight Rule Should be Finalized Now

The AAMC appreciates that the Two-Midnight Rule originated as an attempt to provide clarity about the appropriate site of care, which was the source of many RAC audits. Because the Association believes the flaws in the current policy are numerous and its effects damaging to hospitals and beneficiaries alike, we support CMS' stated intention and hope to see a revised policy that provides needed clarity without sacrificing the critical role of medical judgment, adequate reimbursement for medically necessary short hospitalizations, and simplicity for patients who benefit from short inpatient stays. Unfortunately, CMS has not promulgated a sufficiently detailed proposal for such a revised payment policy upon which AAMC and other stakeholders can comment.

That said, the AAMC believes it is both possible and essential for CMS to finalize an interim policy during this rulemaking cycle that would alleviate the most burdensome aspects of the Two-Midnight Rule. To that end, and after much collaboration with our member institutions and fellow hospital associations, we propose the following:

- **Maintain “Two Midnights or Longer” as a Clear Indicator of an Inpatient Stay:** The AAMC supports the premise that patients who are hospitalized for medically necessary services lasting longer than two midnights should be considered inpatients and their care reimbursed through Part A. Though the Association is not convinced that a time-based measure ultimately will be the most appropriate method for determining inpatient status, the Association supports maintaining this portion of the Two-Midnight Rule as a way to eliminate excessive hospital stays under observation status and reduce some of the burden of excessive RAC review.
- **Return to Previous Short Stay Policy Based on Medical Judgment:** For medically necessary hospitalizations that are expected to last fewer than two midnights, the AAMC advocates for a simple return to the policy in place for short stays prior to October 1,

2013. In other words, these stays should be paid under the IPPS system, relying on medical judgment to determine appropriate site of care based on the clinical needs of individual patients. This return to a longstanding deference to the medical judgment of physicians for short hospital stays is simple, familiar to the industry, and a logical outgrowth of CMS' inquiry into appropriate short stay payment.

- **Implement Simple RAC Reforms:** These policies should be accompanied by straightforward, yet essential, reforms to the RAC process. CMS should eliminate or significantly extend the one-year “timely filing” window for Part B inpatient rebilling. This one-year window begins on the date patient care is delivered, but RACs can question payment significantly after that date, leaving hospitals with no ability to rebill the services under Part B if the Part A claim is denied; or if a hospital unsuccessfully challenges a RAC denial, the one-year deadline will have passed and no payment will have been received. At the very least, this rebilling clock should be tolled during a RAC appeals process, which is very lengthy due in large part to inadequate CMS resources.

Taken together, these policies provide an interim solution that would provide much needed immediate relief to hospitals, other providers, and patients. Yet the AAMC acknowledges that this straightforward proposal does not address all of the complexities of short stay reimbursement policy. The Association welcomes further engagement on broader policies to address the shortcomings of Medicare's current observation stay policy, RAC process, and other payment issues.

Given that no such proposals have been included in the FY 2015 IPPS proposed rule, the AAMC urges CMS to begin with this interim step, based on a policy with which hospitals nationwide are already familiar. CMS should implement this relief effective October 1, 2014, while continuing to engage with stakeholders and evaluating the specific impacts of other potential short stay policy changes.

In Future Rulemaking, Any New Short Stay Payment Policy Should Be Approached Cautiously, and Must Maintain Essential Elements of Current Inpatient Reimbursement

In the FY 2015 IPPS proposed rule CMS solicited feedback on potential definitions of and payments for short inpatient stays, and offered possible approaches to these issues. First, CMS asked whether the definition of a short or low-cost inpatient hospital stay should be based on an average length of stay for a Medicare Severity Diagnosis Related Group (MS-DRG). CMS also requested input regarding whether a per diem payment model (such as that used for transfer

cases) would be appropriate. Additionally, CMS requested input on the impact a per diem payment model or other payment methodology might have on payment for cases under the OPSS and IPPS.

As mentioned previously, none of these inquiries contained sufficient detail to offer stakeholders a meaningful opportunity to comment. They do, however, raise several notable concerns.

The suggestions for alternative payments for short stays mentioned in CMS' FY 2015 IPPS proposed rule have the potential to undermine the very basis of the MS-DRG system. The MS-DRG system is predicated on the understanding that there will be a diversity of treatment patterns and individual patient circumstances for any given clinical condition, and that this diversity balances out – high-intensity cases are balanced by low-intensity cases. A standardized payment amount encourages efficiency while maintaining the flexibility to meet individual patient needs. To create a new category of “short stays” and pay for them differently has the potential to dramatically upend this important balance in hospital reimbursement.

The AAMC also remains concerned that any “alternative short stay policy” that creates a claims classification other than inpatient would put at risk essential policy add-on payments such as DSH and indirect medical education (IME). These mission-driven payments support societal priorities that have real and fixed costs. Medically necessary care delivered in a hospital should continue to be designated as inpatient so that these essential community-benefit funding streams are not placed at risk.

Additionally, the AAMC does not support using time as the permanent basis for determining which stays should be characterized and reimbursed as inpatient and which as outpatient, instead of the long-standing and appropriate deference to complex medical judgment. Though maintaining the two-midnight designation is useful in the interim, the Association believes that framing this issue as one of “short stays” fundamentally misses the mark. Problems with the burden of RAC audits, excessive use of observation stays, or potential patterns of fraudulent submission of claims for care that cannot be justified by medical necessity should be addressed directly. The presumption that a short length of time in the hospital makes the care less clinically relevant or less worthy of full inpatient reimbursement is flawed.

To sufficiently clarify issues surrounding patient status, billing, and the review process, CMS must also work with providers, patient advocates, and other stakeholders to revise the Agency's observation stay policy, which has never been adequately defined and has exacerbated issues for hospitals and patients alike. Additionally, Medicare's outpatient PPS rates for reimbursing

observation care do not adequately cover hospital costs. These rates are based on the procedures a hospital provides and are not sensitive to the level or intensity of care, nor do they take into account room and board costs. As a result, the rates are historically low and often do not cover the costs of the services provided.

Finally, meaningful and fundamental reforms to the RAC process must be implemented quickly. Any new definition of ‘short stays’ or change in payment policy will be an insufficient solution; if RACs continue to be paid on volume, not accuracy. RACs are currently paid on a contingency fee basis, where they receive 9 to 12.5 percent of the supposedly improper payments they identify and collect. This structure increases the frequency of inappropriate RAC denials and prevents timely and accurate auditing and must be addressed by both CMS and Congress.

Inpatient Admission Decisions Are Necessarily Complex, and Should Rely on the Medical Expertise of the Treating Physicians

Medicare’s Benefit Policy Manual recognizes that the decision to admit is a “complex medical judgment” which can be made only once the physician has considered a number of factors including “the patient’s medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital’s by-laws and admissions policies and the relative appropriateness of treatment in each setting.”¹ CMS guidance provides additional factors for the physician to consider when making the decision to admit, including: the severity of the signs and symptoms exhibited by the patient; the medical predictability of an adverse event; the need for diagnostic studies that are appropriately outpatient services; and the availability of diagnostic procedures at the time when and at the location where the patient presents.² To the detriment of both providers and Medicare beneficiaries, the Two-Midnight Rule requires that at the time of admission, the physician make a determination about the length of stay that will be required, a guessing game at best, and an unreasonable rule that confuses both beneficiaries and physicians.

Consistent with their missions, teaching hospitals care for many high-acuity patients with complex medical issues and multiple comorbidities. Physicians and medical professionals at teaching hospitals have a longstanding commitment to delivering the highest quality medical care and to basing admission decisions on the most appropriate setting for every patient. When deciding whether to admit a patient, clinicians rely on their training, medical judgment, and clinical protocols to determine whether the patient’s medical needs would be better served in the

¹ Benefit Policy Manual (BPM) (CMS Pub. 100-02), ch. 1, § 10.

² *Id.*

inpatient or outpatient setting. This is a determination that comes down to factors such as the severity of the patient's medical condition, the risks of complications and adverse events, and the nature of the services needed.

CMS has established an exception to the Two-Midnight Rule for procedures defined as "inpatient-only," which may be appropriately provided on an inpatient basis, irrespective of length of the patient's stay. Otherwise, CMS explains that only "rare and unusual circumstances" could be considered appropriate for short inpatient stays.³

The inpatient only list is inadequate as a comprehensive list of short inpatient stays that should be exempted from the Two-Midnight Rule. It is extremely challenging to encapsulate each situation on an exceptions list or as "rare and unusual circumstances," because cases are highly dependent on many factors such as a patient's overall condition, age, and comorbidities. While there are numerous examples of short hospitalizations that are medically necessary and should be reimbursed as inpatient stays, these examples are illustrative:

- *Congestive Heart Failure (CHF)*: A patient may come to the hospital experiencing symptoms related to CHF and require short-term but intensive monitoring in an inpatient setting that includes interventions to reduce fluid on their lungs. These patients may have underlying cardiac and pulmonary disease (such as emphysema) that makes diagnosis and treatment more complex. In otherwise stable, healthy patients, fluid and electrolytes can be brought back into balance relatively quickly with aggressive treatment. Many patients can switch quickly from an intravenous to oral regimen and go home in short order without having to stay "two midnights." However, many CHF patients also suffer from renal disease requiring closer monitoring and careful fluid balancing to avoid having treatment for one disease (CHF) negatively affect another (renal disease). In such cases, patients may still fare well and be discharged before two midnights have elapsed but must be treated in an inpatient hospital setting. Not providing that level of care would endanger patient safety.
- *Acute Exacerbation of Asthma*: Some patients presenting with particularly acute asthma attacks may respond relatively quickly to IV steroids and nebulized inhaled medicines, yet it is difficult to predict who will suffer respiratory failure before the medications stabilize them. Often, these patients may be able to transition to home inhalers and oral

³ Inpatient Hospital Reviews, CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS), www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medical-Review/InpatientHospitalReviews.html.

steroids in under two midnights but not all will – and they may require intubation, use of a ventilator, and an extended hospital stay. Careful monitoring, in a setting equipped to respond quickly should the patient’s status worsen, is often essential, because it is impossible to always predict accurately which patients will recover quickly and which will remain critically ill.

Not all patients require inpatient care, but some require much more immediate and intensive interventions and careful monitoring that can only be provided in the inpatient setting. Others can be treated in the outpatient setting, and it should be left to the physician to use complex medical judgment to make this determination based on the needs of patient rather than based on how long the patient may stay. Whether CMS reimburses for an inpatient or outpatient stay should be aligned with how admission decisions are actually made, not using a clock, but rather deferring to the physician’s medical judgment and consideration of clinical factors.

The Two-Midnight Rule Inadequately Reimburses Hospitals for Short Stays and Discourages High-Quality, Efficient Care

In hospitals across the country, physicians continue to use their best medical judgment in making treatment and site of care decisions – risking their payments, instead of their patients. Patients continue to be hospitalized for stays shorter than two-midnights, for all of the reasons illustrated above and many others, but now hospitals are receiving dramatically reduced reimbursements for those medically necessary short stays. At Johns Hopkins, the number of patients admitted to the hospital but reimbursed only at outpatient rates has increased by 33 percent since the implementation of the Two-Midnight Rule. At University of Texas Southwestern, the shift to re-classifying clinically required inpatient hospitalizations as outpatient claims has led to over \$3 million in lost reimbursement across three specialties alone, with the true impact likely far greater. This experience is typical among AAMC members and results in both a dramatic payment cut for medically necessary hospital services and in huge increases in cost-sharing for patients.

The Two-Midnight Rule is particularly devastating to academic medical centers and safety-net hospitals. AAMC member institutions are dedicated to core social missions, in addition to providing the highest quality clinical care. These missions include serving the uninsured, maintaining costly trauma centers and burn units, conducting ground-breaking research, and training the next generation of medical professionals. Yet, when CMS’ two-midnight policy pays for necessary services delivered in a hospital as though they were outpatients, these hospitals lose their IME and DSH add-on payments and see decreases in their direct graduate

medical education (DGME) payments. Therefore, in addition to the inadequate reimbursement for necessary services that every hospital faces, teaching hospitals and safety net providers also face unwarranted cuts in payments that help support their vital missions, which continue to be national priorities.

The very fact that these medically necessary intensive stays can occur in such a relatively brief period of time is a testament to the innovation and achievement of high-performing institutions. With improved technology and efficiency, more patients are being evaluated, treated, and transitioned to an appropriate care setting in less than the two-midnight timeframe. In the past, these patients would have been expected to stay longer and, therefore, would be considered inpatients under the Two-Midnight Rule. This is the very medical efficiency CMS should be encouraging. If CMS has identified abusive practices, then policies should be developed to address those practices.

The Two-Midnight Rule Unfairly Shifts Costs of Hospital Care to Patients

Policies that inappropriately cut hospital payments affect patients in indirect but real and harmful ways. In the case of the Two-Midnight Rule, there is also a direct financial impact on Medicare beneficiaries.

If a patient's hospitalization is arbitrarily classified as outpatient based on the length of stay, Medicare will cover the care through Part B (instead of Part A used for inpatient hospital care). This means the patient will be billed separately for each procedure and test and will be responsible for up to 20 percent of the costs for each service – bills that can mount into the tens of thousands of dollars. Additionally, there is no coverage for self-administered drugs under Part B. Finally, a patient's "outpatient" hospitalization will not count toward the three-day inpatient stay needed for eligibility for Medicare coverage of a skilled nursing facility (SNF) after leaving the hospital, further exacerbating potential financial liability.

In addition to placing new and unpredictable financial burdens on patients, the Two-Midnight Rule creates confusion and threatens the doctor-patient relationship. Patients unaware of the policy are blindsided by unexpected costs. Physicians and hospital administrative staff – themselves perplexed by CMS' policy – can offer little clarity about likely financial obligations for patients, eroding the trust essential to delivering the highest quality care, because these providers cannot explain the policy or the reasoning behind an arbitrary time-based benchmark.

Implementing the Two-Midnight Rule Adds Significant Administrative Burden

Though the AAMC believes the Two-Midnight Rule to be deeply flawed, the Association has been working closely with our members to help them come into compliance with the new rule.

Across the country, our members are retraining staff at every level – from residents and physicians, administrative billing staff, compliance officers, and others – to shift from assessments of medical necessity to evaluations of predicted time estimates. Hospitals are making significant investments in reprogramming electronic medical records and claims processing systems to comply with the new rule. And still, these same institutions each continue to invest hundreds of thousands of dollars annually in responding to RAC audits – the issue the Two-Midnight Rule was intended to alleviate.

Another source of confusion and disruption for teaching hospitals arises from the fact that the CMS guidance implementing the Two-Midnight Rule entitled “Hospital Inpatient Admission Order and Certification”⁴ excludes most residents from the list of medical professionals who can furnish orders for admission. Specifically, CMS guidance provides:

Qualifications of the ordering/admitting practitioner: The order must be furnished by a physician or other practitioner (“ordering practitioner”) who is: (a) **licensed by the state to admit inpatients to hospitals**, (b) granted privileges by the hospital to admit inpatients to that specific facility, and (c) knowledgeable about the patient’s hospital course, medical plan of care, and current condition at the time of admission. The ordering practitioner makes the determination of medical necessity for inpatient care and renders the admission decision. The ordering practitioner is not required to write the order but must sign the order reflecting that he or she has made the decision to admit the patient for inpatient services.⁵ (*Emphasis added.*)

This requirement is onerous to teaching hospitals, because these hospitals’ by-laws allow residents to write orders on behalf of the attending physicians who supervise them, and residents rarely have their own admitting privileges as they are not considered to be part of the medical staff. CMS’ strict requirement that the order must be furnished only by those “licensed by the state to admit inpatients to hospitals” excludes the majority of residents without a reasonable justification for this requirement, demanding burdensome changes to longstanding hospital practices.

⁴ *Hospital Inpatient Order and Certification*, CMS, 1 (Jan. 30, 2014). <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/IP-Certification-and-Order-01-30-14.pdf>.

⁵ *Id.*

The AAMC urges CMS to change the guidance to the following:

Qualifications of the ordering/admitting practitioner: The order must be furnished by a physician or other practitioner (“ordering practitioner”) who is: (a) **licensed by the state to practice medicine**, (b) granted privileges by the hospital **to write inpatient admission orders**, and (c) knowledgeable about the patient’s hospital course, medical plan of care, and current condition at the time of admission.⁶ (*Emphasis added.*)

CMS guidance attempts to provide further clarification regarding how these requirements apply to residents, with the following paragraph:

Residents and non-physician practitioners authorized to make initial admission decisions- Certain non-physician practitioners and residents working within their residency program are authorized by the state in which the hospital is located to admit inpatients, and are allowed by hospital by-laws or policies to do the same. The ordering practitioner may allow these individuals to write inpatient admission orders on his or her behalf, if the ordering practitioner approves and accepts responsibility for the admission decision by counter-signing the order prior to discharge. (Please see (A)(2) for guidance regarding the definition of discharge time and (B)(3) for more guidance regarding knowledge of a patient’s hospital course). In countersigning the order, the ordering practitioner approves and accepts responsibility for the admission decision. This process may also be used for physicians (such as emergency department physicians) who do not have admitting privileges but are authorized by the hospital to issue temporary or “bridge” inpatient admission orders.⁷

Yet, this clarification does not resolve the problems that are preventing residents from furnishing orders without substantially burdensome changes to longstanding practices for teaching hospitals. This requirement means that supervising physicians must be tracked down prior to patient discharge for the sole purpose of ensuring that a countersignature is included on the resident’s order, even though there is no place in the electronic medical record to do this. This

⁶ *Id.*

⁷ *Id.*

disrupts hospital workflows and distracts physicians from patient care. The AAMC strongly urges CMS to revise the Agency's guidance so that the attending physician can allow the resident to write inpatient orders on his or her behalf, as long as the supervisor approves and accepts responsibility for the admission decision through some form of documentation in the medical record before the patient is discharged. This could be accomplished by using the following language to replace paragraph B.2.a of CMS' guidance:

Certain non-physician practitioners and residents working within their residency program are authorized by the state in which the hospital is located **to practice medicine**, and are allowed by hospital by-laws or policies to **furnish orders**. The admitting practitioner may allow these individuals to write inpatient admission orders on his or her behalf, if the admitting practitioner approves and accepts responsibility for the admission decision **as demonstrated by documentation in the medical record, such as progress note**, prior to discharge. **In this case a countersignature of the order is not needed.** (*Emphasis added.*)

CMS' inability to address this seemingly easy fix has been discouraging, and highlights that the problem with the current rule is both in its underlying policy and in its implementation.

The Two-Midnight Rule Does Not Address the Critical Need to Reform the Recovery Audit Contractor (RAC) Program

RAC reform is essential to ensure that RAC financial incentives do not encourage second-guessing of clinical judgment, deny payment for services that are medically necessary, or force hospitals to use resources to appeal RAC denials rather than to improve patient care. As the Two-Midnight Rule does nothing to resolve the fundamental flaws with the RAC auditing process, the AAMC urges CMS to adopt, at a minimum the RAC reforms described below.

To mitigate the effects of inappropriate incentives, the AAMC strongly encourages CMS to subject RACs to financial penalties if a denial is overturned on appeal. Additionally, CMS' assertion in the preamble of the FY 2014 IPPS final rule that RACs should be limited to using the medical documentation available at the time the admission decision was made when reviewing the medical necessity of an inpatient stay should be codified in regulations.

The AAMC also urges CMS to eliminate or waive the one-year timely filing requirement for Part B inpatient billing. In the FY 2014 IPPS final Rule, CMS finalized a policy allowing hospitals to rebill for an expanded list of services under Part B after a Part A claim is denied for lack of

medical necessity, or to self-audit by submitting a no pay/provider liable Part A claim before submitting Part B claims. In both cases the Part B billing must occur within twelve months of the date of service. If a hospital's short stay claim under Part A is denied, and the hospital subsequently is unsuccessful in appealing the denial, a process that generally takes several years, then the hospital is unable to rebill for any services, thereby receiving no payment at all. At a minimum, the twelve-month time limit for re-billing under Part B should be tolled during an ongoing RAC appeals process.

Other examples of necessary RAC reforms include, but are not limited to:

- Requiring expertise for review of complex services;
- Requiring the RAC to do a medical record review first to see if it has correctly interpreted the data before implementing an automated review;
- Allowing for communication with the RAC other than through US mail;
- Providing more time to do a telephone appeal;
- Having separate limits for inpatient versus outpatient reviews; and
- Creating a website that lists the RACs for each provider or group practice.

Finally, as CMS and stakeholders grapple with how best to replace the Two-Midnight Rule with a policy that appropriately defers to clinical judgment, adequately compensates hospitals for providing medically necessary services, and protects Medicare beneficiaries from increased financial liability, CMS should exempt this time period from RAC review and from future look back audits. Accordingly, the AAMC urges CMS to permanently exempt from RAC review all claims with dates of admission from October 1, 2013 through the effective date of a new policy to replace the Two-Midnight Rule.

The Unjustified \$220 Million Offset in FY 2014 Should Be Reversed

When CMS finalized the Agency's new time-based standard for distinguishing between appropriate inpatient and outpatient care, CMS assumed the net effect would be that more claims – previously classified as outpatient – would be reimbursed as inpatient hospitalizations. Based on this assumption, CMS predicted a net revenue increase in hospital payments and, to maintain budget neutrality, cut hospital reimbursement by \$220 million for FY 2014. Unless reversed, this payment cut remains in hospitals' base payment rate in perpetuity – resulting in over \$2 billion in cuts during the current 10-year budget window.

Independent reviewers have not been able to replicate CMS' findings. The Association and other stakeholders requested information about the assumptions CMS relied on to justify this cut,

but CMS never provided this information. Contrary to CMS' projections, outside research confirms the recent experiences reported by our individual member institutions: the Two-Midnight Rule results in fewer cases being classified as inpatient, not more. In a peer-reviewed article in *The Journal of Hospital Medicine*, University of Wisconsin School of Medicine and Public Health researchers stated, "Although CMS predicts that more patients will be classified as inpatients under the new rule, we determined the opposite."⁸ In their study applying both methodologies to the same set of historic claims, the Wisconsin researchers found that the Two-Midnight Rule would decrease the number of cases classified as inpatient by 7.4 percent.⁹ These results are consistent with those reported by the Department of Health and Human Services' Office of Inspector General (OIG), which found that the new two-midnights methodology would "significantly reduce" the number of cases classified as inpatient.¹⁰

CMS' faulty assumption that hospitals would see an increase in inpatient cases means hospitals are now taking a double hit: their volume of inpatient cases is declining (even without any change in services delivered) and CMS has cut their underlying payment rate for each remaining inpatient case. Any alternative to the Two-Midnight Rule must proactively reverse the cuts to hospital payment rates implemented in the FY 2014 IPPS Final Rule, as these cuts were meant to offset increases in inpatient volume which did not, and will not, occur as a result of the Two-Midnight Rule.

Conclusion Regarding Two Midnights

The AAMC recognizes the importance of ensuring that hospitals accurately bill for the services they provide and the seriousness of making wise and efficient use of Medicare funds. As currently drafted, the Two-Midnight Rule supports neither of these goals and places unnecessary burden on hospitals and the patients they serve. For all the reasons cited above, the AAMC urges CMS to adopt the interim policy that patients who are hospitalized for medically necessary services lasting longer than two midnights should generally be considered inpatients and their stays should be reimbursed accordingly. For stays lasting fewer than two midnights, the Association strongly urges CMS to return to the policy in place for short stays prior to October 1, 2013, that relied on physician medical judgment to determine appropriate site of care. This

⁸ Sheehy, A. M., Caponi, B., Gangireddy, S., Hamedani, A. G., Pothof, J. J., Siegal, E. and Graf, B. K. (2014), Observation and inpatient status: Clinical impact of the 2-midnight rule. *Journal of Hospital Medicine*. 9: 203–209, February, 2014.

⁹ Ibid.

¹⁰ Department of Health and Human Services Office of Inspector General. Hospitals' use of observation stays and short inpatient stays for Medicare Beneficiaries, OEI-02–12-00040. Issued July 29, 2013. Available at: <http://oig.hhs.gov/oei/reports/oei-02-12-00040.asp>. Accessed May 18, 2014.

interim solution is needed to provide hospitals and beneficiaries much needed immediate relief from the effects of the Two-Midnight Rule. It is premature to finalize an alternative short stay payment policy, particularly when CMS did not make a specific proposal, and any payment methodology that relies on length of stay instead of appropriately deferring to clinical judgment supported by the medical record would often underpay short stays for the sickest and most complex patients who are often treated by teaching hospitals. The AAMC welcomes the opportunity to continue to work with CMS and other stakeholders to consider other policy solutions in future rulemaking cycles.

PROPOSED MS-DRG RECALIBRATION BUDGET NEUTRALITY ADJUSTMENT FACTOR

CMS Should Examine and Correct the Budget Neutrality Adjustment Factor in the Final Rule

The AAMC believes CMS has miscalculated the MS-DRG recalibration budget neutrality adjustment (BNA) factor for FY 2015. Specifically, Section 1886(d)(4)(C)(iii) of the Social Security Act states that, beginning in FY 1991, the annual DRG reclassification and recalibration of the relative weights must be made in a manner such that aggregate payments to hospitals are not affected. CMS normalizes the recalibrated MS-DRG relative weights by an adjustment factor so that the average case weight after recalibration is equal to the average case weight before recalibration. However, because payments to hospitals are affected by several factors other than just the average case weight, budget neutrality is not necessarily achieved by this normalization alone. To comply with the requirement that MS-DRG reclassification and recalibration of the relative weights be budget neutral for the Puerto Rico standardized amount and the hospital-specific rates, CMS used the FY 2013 MedPAR data to compare the following:

- Aggregate payments, net of the estimated FY 2015 Hospital Value-Based Purchasing (VBP) Program and Hospital Readmissions Reduction Program (HRRP) payment adjustments, using the new OMB labor market area delineations proposed for FY 2015 along with the FY 2014 pre-reclassified wage data and the FY 2014 relative weights; and
- Aggregate payments, net of the estimated FY 2015 hospital VBP and HRRP payment adjustments, using the new OMB labor market area delineations proposed for FY 2015 along with the FY 2014 pre-reclassified wage data and the FY 2015 relative weights.

Using the methodology above, CMS calculates a proposed MS-DRG recalibration budget neutrality adjustment factor of 0.992938, which is far lower than historical levels. In the last five years, BNA factors have ranged from between 0.996731 (FY 2011) and 0.998431 (FY 2013), as shown in the table below.

Table 1:

Historical Levels of the MS-DRG Recalibration Budget Neutrality Adjustment Factor

Year	Factor
FY 2015 - Proposed	0.992938
FY 2014	0.997989
FY 2013	0.998431
FY 2012	0.997903
FY 2011	0.996731
FY 2010	0.997941

The AAMC, through its contractor, The Moran Company (TMC), tried to replicate this budget neutrality factor, using the FY 2013 MedPAR data but was unable to do so. Specifically, TMC initially used the original MS-DRG weights that were published with the FY 2015 proposed rule and could not replicate the factor. CMS, in May 2014, published a revised set of MS-DRG weights, because a number of post-acute care transfer adjusted cases for certain MS-DRGs in the FY 2015 proposed rule were “inadvertently miscalculated.” Using the revised MS-DRG weights, TMC still could not replicate the budget neutrality adjustment factor of 0.992938. The table below shows the calculations of TMC and its subcontractor, Watson Policy Analysis Incorporated (WPA). Note that the TMC/WPA calculations result in a factor that is in line with historical levels.

Table 2:

MS-DRG Recalibration Budget Neutrality Adjustment Factor as Calculated by TMC/WPA

MS-DRG Weights Used	CMS	TMC/WPA
Original	0.992938	0.998587
Revised	N/A	1.000301

The AAMC strongly believes that, as a result of the post-acute care transfer calculation in the FY 2015 proposed rule, the MS-DRG recalibration budget neutrality adjustment factor has also been miscalculated, and urges CMS to examine and correct the budget neutrality adjustment factor in the FY 2015 final rule.

CAP-SETTING PROCESS FOR NEW MEDICAL RESIDENCY PROGRAMS

CMS Should Reconsider Synchronization Effective Date for the FTE Resident Cap, 3-Year Rolling Average, and Intern- and Resident-to-Bed Ratio Cap for New Programs; AAMC Urges CMS to Issue Guidance on Resident Rotators

CMS permits hospitals that do not have direct graduate medical education (DGME) or indirect medical education (IME) full time equivalent (FTE) caps, because they were not training residents when the caps were established in 1997, to start new programs and establish Medicare DGME and IME FTE caps during a five-year cap-building window. Rural hospitals are also permitted to increase their existing DGME and IME FTE caps at any time by starting new programs (though not by expanding existing programs).

The resident FTE counts CMS uses to make DGME and IME payments to teaching hospitals are not based on current year counts but rather on the 3-year rolling average of the DGME and IME FTE counts. Additionally, the intern- and resident-to-bed-ratio used to determine IME payments is not paid based on the current year's ratio, but rather is capped at the lower of the current or the prior year's ratio. (This is the so-called "IRB ratio cap".) Until now, the 3-year rolling average and the IRB ratio-cap have not gone into effect for a new program until the number of years equal to the minimum accredited length of each new program has passed.

CMS currently calculates a new urban teaching hospital's DGME and IME FTE caps (or the cap increases of a rural teaching hospital building a new program) based on the number of residents training in the fifth year of the cap-building window, and the caps take effect beginning the sixth year after the start of the first program at a new urban teaching hospital.

CMS proposes to begin "synchronizing" the effective date of the FTE resident caps with the effective dates and application of the 3-year rolling average and the IRB ratio cap, such that all three would go into effect at the start of the hospital cost reporting period that precedes the start of the sixth program year after the start of the first program. This proposal would apply to any urban hospital that first began training residents in its first new residency training program on or after October 1, 2012 and would apply to any new program at a rural hospital that was started on or after October 1, 2012.

The AAMC opposes the date CMS has selected for synchronizing these three events. Under current regulations governing new programs, CMS permits hospitals in their five-year cap building window to be reimbursed for "the actual number of residents participating in the new program" for each of the first five years, so long as that number does not exceed the number of accredited positions available to the hospital for that program year. *See* 42 C.F.R. § 413.79(e)(1)(ii). By setting the date the cap takes effect at the beginning of the cost reporting period that precedes the start of the sixth program year, CMS imposes the cap prior to the end of the cap-building window. In certain circumstances, this effectively denies hospitals the ability to be reimbursed for the "actual number of residents participating in the new program" in the fifth year.

The AAMC disagrees with CMS' statement that "barring unusual circumstances, the FTE resident caps that would take effect under the proposed policy at the beginning of the fiscal year that precedes the sixth program year should accommodate the FTE resident count training in the fifth and subsequent program years." The most likely situation in which the new policy would not accommodate the full complement of resident trainees in the fifth year is one in which residents rotate to more than one hospital, such that CMS' new program apportionment rules apply. Residents' rotating to more than one hospital for training is most certainly not an "unusual circumstance."

In CMS' very own example from the FY 2013 IPPS final rule (see 77 *Fed. Reg.* 53258, 53418-53419 (Aug. 31, 2012)), in which a hospital began a family medicine residency program in the first year it trained residents, and residents in that program rotated to an existing non-rural teaching hospital with an established cap, the total number of family medicine trainees in year

five was 10.70 FTEs; but the hospital's cap for family medicine was set at 9.41 FTEs. If that hospital had a fiscal year end of June 30, then under this proposal, CMS would fail to reimburse the new teaching hospital for 1.29 FTEs in the fifth training year. Surely the fact that CMS chose to use this as an example illustrates that such a scenario is typical, rather than "unusual."

Hospitals incur significant expense in establishing new training programs and should be permitted the benefit of the full five-year cap-building window to grow their caps and be paid for actual numbers of resident FTEs. The AAMC is sympathetic to CMS' desire for administrative simplicity. Thus, if CMS proceeds with the Agency's plan to synchronize the effective dates of the cap, three-year rolling average, and IRB ratio cap, the AAMC urges CMS to set the effective date as the start of the hospital cost reporting period that follows the start of the sixth program year after the start of the first program. This effective date would permit new teaching hospitals to retain the payments they are entitled to under the current regulations and would achieve CMS' desire for simplicity.

The AAMC also urges CMS to clarify a particularly vexing and ambiguous problem many new teaching hospitals have been facing that relates to the establishment of new programs and the cap-building window. To date, CMS has not offered any clear public guidance that would indicate whether the presence of a small number of FTE resident rotators triggers the setting of a hospital's per resident amount (PRA) for DGME purposes or DGME and IME caps under the new program regulations (42 C.F.R. § 413.79). Through this letter, the AAMC requests that CMS publish in the final rule a clear statement that neither a hospital's PRA nor its cap-building window is triggered by the presence of a small number of residents performing brief rotations at the hospital.

The AAMC believes that CMS has informally interpreted the new program regulations such that a hospital triggers its PRA anytime a single resident rotates to the hospital, no matter how short the rotation, and that the hospital begins to build a resident cap if it hosts rotating residents from any new medical residency training program, regardless of whether the hospital that sponsors the program and other participating hospitals are in a cap-building period, and no matter how fleeting the hospital's participation in the program.

The following two examples serve to illustrate the problem:

Example 1: Hospital A, an existing teaching hospital, has had an internal medicine program for 30 years. Hospital A decides to rotate two medical residents from that internal medicine program to Hospital B, a non-teaching community hospital, each for a 4-week rotation. Hospital A continues to pay the residents' stipends and benefits during the 4-week rotation.

Under CMS' informal interpretation, the fact that a resident rotated to a community hospital from an existing teaching program would trigger the establishment of a PRA for the community hospital. If the community hospital does not incur or record costs for those residents on the hospital's Medicare cost report, it will be assigned a PRA amount of \$0 and will *never* be eligible to receive Medicare DGME funding. This severely limits the non-teaching hospital's ability to become a teaching hospital and begin a community training program in future years.

Example 2: Hospital X, an existing teaching hospital, has never had a psychiatry residency program before but decides to open one on July 1, 2013 to help alleviate a psychiatry shortage in its region. One resident from the new psychiatry program rotates to Hospital Y, a non-teaching community hospital, for a two-month rotation in August 2015.

If Hospital Y only trained two months' worth of resident rotators in each of the remaining three years of the cap-building window, Hospital Y would be given a permanent cap of less than one FTE and would never be eligible to receive funding for a bigger residency training program.

Because of the lack of publicly available information on these informal interpretations, hospitals, through no fault of their own, have not been on notice that their ability to receive DGME and IME funding in the future was being curtailed. Hospitals that are just now discovering that their PRA and cap-building windows were apparently triggered, have been required to halt efforts to establish robust new teaching programs that are desperately needed to combat current and impending physician shortages.

There are important policy reasons to adopt rules that encourage community hospitals to host resident rotators. A policy that allows hospitals to test the waters by hosting brief rotations from established teaching institutions ensures they are fully prepared for and capable of undertaking a teaching mission and can remain viable over the long term. Additionally, a policy that allows a hospital to set its PRA only when it begins its cap-setting process – and not earlier – encourages resident rotations to take place at the most academically and clinically appropriate clinical training sites.

As CMS finalizes policies around establishing GME caps for new teaching hospitals in the final rule, the AAMC urges the Agency to clarify this ambiguity around the PRA- and cap-setting processes. The AAMC urges CMS to publish a formal interpretation that neither a hospital's per resident amount nor its cap-building window will be triggered by the presence of a small number of residents performing brief rotations at the hospital. The Social Security Act gives CMS broad discretion to adopt these clarifications, and they are critical to ensuring a sufficient physician workforce.

Finally, if CMS determines that hospitals have in the past inadvertently triggered a PRA or a cap adjustment based on CMS' unpublished, informal policy, the AAMC encourages CMS to offer these hospitals a one-time opportunity to set a PRA and obtain a future cap adjustment.

RURAL HOSPITALS REDESIGNATED AS URBAN

AAMC Supports Permitting Rural Hospitals Redesignated as Urban to Complete New Program Cap Adjustments Already in Progress; Additional Flexibility Needed for RRCs

Under current CMS regulations, a hospital located in a rural area may continue to increase its DGME and IME FTE caps to account for residents training in new programs at the rural hospital, even after permanent caps have already been established for that hospital. A hospital only receives the benefit of this exception to the Medicare caps if it is located in an area designated as "rural."

CMS proposes to implement new Office of Management and Budget (OMB) labor market area delineations that are based on the 2010 Census. These new delineations have the effect of changing some areas from being rural to being urban, and vice versa. Teaching hospitals that are redesignated from being located in a rural area to being located in an urban area lose their ability to increase their DGME and IME FTE resident caps when they start new residency training programs.

In this rule, CMS proposes to permit hospitals that were already actively training residents in a new program at the time they were redesignated as urban to continue to increase their caps for that new program. The AAMC strongly supports this proposal. Rural hospitals that are in the midst of building new programs already have committed to these programs' growth and made plans for developing the programs based on an expectation of having five years to build their new program caps. CMS' proposal is fair and equitable to these hospitals and supports efforts to address the critical nationwide shortage of physicians practicing in rural areas.

The AAMC requests that CMS take this support for rural training one step further and propose a policy (through an interim final rule) that would permit hospitals that remain rural referral centers (RRCs) – even if they are no longer in a labor market area designated as rural – to increase their DGME and IME FTE caps to account for residents training in new programs. Generally speaking, RRCs are high-volume hospitals that treat complex cases, many of which are referred to them from great geographic distances. *See* 42 C.F.R. § 412.96.

RRCs meet important health care needs of rural communities and are training sites that can promote the development of physicians who are equipped to deal with rural populations. In adopting this policy, CMS should specify that grandfathered RRCs should be able to increase their GME caps for new programs, so long as during the current federal fiscal year, they continue to meet all RRC requirements other than being located in a rural area.

TRANSITION PERIOD FOR REDESIGNATED HOSPITALS AND RURAL TRAINING TRACKS

AAMC Supports CMS' Proposed 2-Year Transition for Redesignated Hospitals and Rural Training Tracks; Urges CMS to Provide Opportunity for Cap Increase to New Rural Partners

If an urban hospital meets certain criteria, it may establish a separate “rural track FTE limitation” or rural training track (RTT) cap. The cap-building window for an RTT program is three years. A hospital only receives the benefit of this separate cap if residents in the accredited rural training track program train for more than half of their time at a rural hospital or at rural non-hospital sites.

Because CMS proposes to implement new OMB labor market area delineations, urban hospitals that are in the three-year cap-building window for establishing an RTT program with a particular rural hospital may find that their rural hospital partner has been redesignated as urban. In this rule, CMS proposes that in this situation, the urban hospital’s opportunity to build an RTT cap would not be affected by this redesignation. The urban hospital may continue to build its RTT cap and have that cap take effect at the end of the three-year cap-building window. The AAMC fully supports this proposal, which recognizes that significant planning and resources have already been invested in establishing the new RTT at the time the redesignations take effect.

CMS also proposes that the urban hospital will have a two-year transition period to seek a new partner and continue to count residents under its RTT cap after that two-year period ends. At the

end of this two-year transition period, the urban hospital may only count its RTT residents if: (1) the newly-redesignated hospital reclassifies back to being rural (in which case the urban hospital may only receive IME payments, not DGME payments, for residents in the RTT program), or (2) it must seek out a new rural hospital partner where residents in the RTT program can train.

The AAMC supports CMS' proposed two-year transition period. The Association urges CMS to consider, however, that an urban hospital that seeks a new rural partner for an existing RTT program may have difficulty doing, so unless that rural partner is able to expand its DGME and IME caps to accommodate the RTT program. Given the severe shortage of rural physicians and limited rural hospital partnership options, the AAMC encourages CMS to consider that the RTT program is in fact brand new to the new rural partner and should use the Agency's discretion granted to it under Section 1886(h)(4)(H)(i) of the Social Security Act ("In promulgating such rules for purposes of subparagraph (F), the Secretary shall give special consideration to facilities that meet the needs of underserved rural areas.") to permit new rural hospital partners to increase their FTE resident caps for RTT programs.

SECTION 5506 APPLICATION PROCESS FOR GME POSITIONS FROM CLOSED HOSPITALS

AAMC Opposes Eliminating the Cap Relief Option from the Affordable Care Act Section 5506 Application Process for GME Positions from Closed Hospitals

Under Section 5506 of the ACA, the DGME and IME residency slots from any hospital that closed or closes on or after March 23, 2008, must be redistributed on a permanent basis to other hospitals. To date, CMS has announced seven rounds of slots available for redistribution and has made award announcements for five of these rounds. CMS now proposes to make several changes to the closed hospital redistribution program.

Under CMS' current application rules, teaching hospitals are permitted to apply for FTE slots for purposes of general cap relief. This option is the last ranking criterion, used only after all available positions have been distributed for other reasons. In the rule, CMS proposes to eliminate this option, citing the relatively small number of slots that have been awarded specifically for cap relief and the administrative burden of reviewing applications. While the AAMC appreciates the complicated nature of the application process and the effort CMS has put into administering this program, the Association strongly disagrees with CMS' proposal to eliminate the cap-relief option from the Section 5506 application process.

Since the Balanced Budget Act (BBA) imposed limits on Medicare-funded residency positions in 1997, teaching hospitals have been required to bear the entire cost of training any residents in excess of their DGME and IME caps. Throughout the country, hospitals are being asked to grow residency positions in response to impending physician shortages, but are asked to do this without any additional funding. CMS should not take away over-the-cap hospitals' one and only opportunity to receive some funding for these positions. Though a small number, some positions have in fact been awarded for cap relief to date, and the Agency cannot predict what hospital closures will take place in the future. The AAMC urges CMS not to preclude this option but instead to work collaboratively with the teaching hospital community to determine ways that applications might be reviewed in a more efficient and expeditious manner.

CMS also proposes to change Ranking Criteria One and Three, which give preferences for Section 5506 slots to hospitals that assume an entire program or part of a program from the closed hospital. CMS currently requires hospitals applying under these ranking criteria to show that they are "seamlessly" replacing displaced FTE residents with new FTE residents once the displaced residents graduate. The Agency now proposes to eliminate the "seamless" requirement, effective for application rounds announced after October 1, 2014.

The AAMC is fully supportive of CMS' proposal to eliminate a requirement that has proved extremely complicated and burdensome for hospitals that legitimately intend to continue training residents in that program, even after the displaced residents have graduated. The AAMC requests that CMS clarify, however, what documentation requirements will be different under the new rules. CMS indicates that hospitals applying for Section 5506 slots under Ranking Criteria One and Three "would continue to be required to submit supporting document when applying...that indicates that they have made a commitment to take over the closed hospital's program or that they have made the commitment to permanently expand their own residency training program resulting from taking over part of a closed hospital's program." The AAMC asks CMS to explain what type of supporting documentation would meet this new requirement.

Additionally, CMS proposes to change its interpretation of the Agency's policy to avoid slot duplication through the Section 5506 slot redistribution program. Currently, CMS ensures no Section 5506 slots are duplicated on a national basis; the Agency proposes to change its policy to ensure there is no duplication on a hospital-specific basis. More specifically, CMS' proposal would mean that a hospital awarded slots under Ranking Criteria Four through Eight would have to wait to receive those slots until any temporary slots the hospital had under 42 C.F.R. §413.79(h) are used, even though the Section 5506 cap increases would be awarded for a completely different purpose (and, possibly for a different specialty program).

The AAMC urges CMS to modify this proposal to state that the “no duplication of slots” policy will apply for all hospitals on a hospital-specific basis when evaluating applications under Ranking Criteria Four through Eight. Additionally, for these ranking criteria, Section 5506 slots should be awarded when the hospital can demonstrate to its Medicare Administrative Contractor that the slots needed for a new program or program expansion are actually filled and, therefore, are needed as of a particular date. The Association strongly believes that CMS has the discretion to apply the policy in this manner in compliance with the language of Section 5506(d) of the ACA.

Finally, CMS proposes to permit hospitals that were members of an emergency Medicare GME affiliation agreement with the closed hospital prior to its closure to be considered under Ranking Criterion Two. The current application only expressly permits the application of Ranking Criterion Two to hospitals that received slots from the closed hospital through a Medicare GME affiliation agreement. The AAMC supports this proposal.

MEDICARE ADVANTAGE IME PAYMENTS TO SOLE COMMUNITY HOSPITALS

AAMC Supports Including Medicare Advantage (MA) IME Payments to Sole Community Hospitals Paid under the Hospital-Specific Rate; CMS Should Adopt the Prior Policy of Including MA IME Payments in Determining Which Payment Rate to Use

Sole community hospitals (SCHs) are reimbursed the higher of the federal payment rate or their own hospital specific rate. Under current CMS policy, SCHs that are teaching hospitals and that are paid based on the hospital-specific rate are ineligible to receive IME payments for their Medicare Part C discharges (also referred to as MA IME payments). Only SCHs that are paid under the federal rate are eligible for these payments.

In this rule, CMS proposes to change the Agency’s interpretation of the statute to permit all SCHs that are teaching hospitals to receive MA IME payments, regardless of whether they are paid based on the federal rate or the hospital-specific rate. Additionally, for purposes of comparing payments based on the federal rate and payments based on the hospital-specific rate to determine which payment the SCH should receive, CMS proposes that IME payments for Medicare Part C patients will no longer be included as part of the Federal rate payment. These proposals would take effect for discharges occurring in cost reporting periods beginning on or after October 1, 2014.

The AAMC supports CMS’ proposal to begin making MA IME payments to SCHs paid based on the hospital-specific rate. The AAMC does not, however, support CMS’ second proposal to

discontinue considering MA IME payments for purposes of determining which rate is higher. Because SCHs are only eligible for disproportionate share hospital (DSH) and uncompensated care (UC) payments if they are paid under the federal rate, this policy proposal would have the unintended consequence of disqualifying a subset of SCHs that otherwise would have qualified for DSH and UC payments.

The AAMC urges CMS to adopt the Agency's proposed change to make Medicare Advantage IME payments to SCHs that are paid based on the hospital-specific rate but to retain the Agency's prior policy of including MA IME payments in the determination of which rate should be used for payment. SCHs that care for uninsured patients and otherwise would have qualified for DSH and UC payments should not be disadvantaged by CMS' proposed policy change.

HOSPITAL QUALITY-RELATED PROGRAMS

In FY 2015, hospitals will have at least 5.5 percent of their base DRG payments at risk for pay-for-performance programs:

- **Hospital Value-Based Purchasing (VBP) Program** – up to 1.5 percent of base DRG payments at risk in a pay-for-performance program.
- **Hospital Readmissions Reduction Program (HRRP)** – up to 3 percent of base DRG payments at risk for excess readmissions.
- **Hospital-Acquired Condition (HAC) Reduction Program** – 1 percent of all payments for hospitals in the worst quartile for performance.

The AAMC is very concerned about the disproportionate impact of these programs on teaching hospitals. Of particular concern is the HAC Reduction Program, which starts in FY 2015 and could affect add-on payments, such as IME, DSH and UC, as well as base operating DRG payments. Teaching hospitals that are penalized will experience millions of dollars in cuts, which could affect their ability to make investments in quality improvements as well as their missions to deliver unique services, teach the next generation of health professionals, and conduct research. The Association is particularly worried that hospitals are being penalized because of measurement, data collection, and risk adjustment limitations, rather than true differences in quality.

Because so much of a hospital's revenue stream is at risk, CMS has an obligation to continually review these performance programs, evaluate the appropriateness of the measures in each program, and ensure the results are fairly compared. In addition, if the programs are to be fair and actionable, hospitals need rapid feedback on their performance and the opportunity to

improve before their revenues are affected. Providers and stakeholders also need time to ensure that there are not unexpected issues with measure implementation before the measures are included in a performance program.

The AAMC understands that the hospital performance programs have certain legislative requirements that cannot be modified without Congressional action, but the Association has several recommendations that CMS can implement within the Agency's regulatory authority:

- **Restrict the HAC Penalty to Base Operating DRG Payments Only**
CMS should use its administrative authority under section 1886(d)(5)(I)(i) of the Social Security Act to limit the HAC penalty to base operating DRG payments, or at a minimum, implement a transition policy.
- **Create Fair Comparisons Among Hospitals**
CMS should use peer cohorts and sociodemographic adjustments to ensure appropriate comparisons of outcome, efficiency, and safety measures for hospital accountability in all pay-for-performance programs.
- **Ensure Hospitals Have Access to Validated Performance Results BEFORE Incorporating Measures Into a Payment Program**
Hospitals need to receive feedback and have sufficient time to improve performance before their payment is affected. In addition, stakeholders need an opportunity to identify and resolve any implementation issues with the measures that could affect performance measurement. AAMC believes all measures need to be publicly reported a minimum of one year before the performance period begins in a pay-for-performance program.
- **Provide Feedback to Hospitals on a Timely Basis**
Only Medicare has complete information on which patients experience a readmission, and other claims-based outcomes. CMS can help hospitals improve their performance by sharing more real-time data with hospitals.
- **Delay Mandatory Reporting of Electronic Measures (E-Measures) until the Issues with that Reporting Mechanism Have Been Resolved**
The AAMC has heard from multiple hospitals that wanted to submit e-measures through the IQR voluntary electronic reporting, but were unable due to data concerns and technical issues.

- **Remove Overlapping Measures Between VBP and HAC Program**
Hospitals should not be penalized twice by the same measure in two different performance programs.

The AAMC provides detailed comments below for each of the quality-related programs. For a full list of the proposed measures, along with AAMC's recommendations, please see Appendix A.

HOSPITAL-ACQUIRED CONDITIONS (HAC) REDUCTION PROGRAM

The AAMC is extremely concerned about the impact of the HAC Reduction Program on major teaching hospitals. While teaching hospitals across the nation are working on innovative quality improvement and patient safety initiatives, the program, as currently designed, disproportionately affects teaching hospitals in two ways. First, unlike VBP and HRRP which limit payment adjustments to base operating DRG payments, the HAC penalty could be applied to all payments. Because teaching hospitals receive additional payments for providing unique services, caring for disadvantaged patients, and for teaching, the impact on these hospitals would be much greater than on other hospitals. Second, the current measure scoring methodology disproportionately identifies teaching hospitals as poor performers, which may be because of technical issues related to measurement rather than true differences in quality. The AAMC believes that CMS can use the Agency's administrative authority to ensure teaching hospital performance is appropriately measured and not disproportionately impacted.

CMS Should Use Its Administrative Authority to Limit the HAC Penalty to Base DRG Payments

CMS should use its authority for general exceptions and adjustments to IPPS payments under section 1886(d)(5)(I)(i) of the Social Security Act to limit the HAC penalty to base operating DRG payments only, at least for a transition period. This section reads: "*(I)(i) The Secretary shall provide by regulation for such other exceptions and adjustments to such payment amounts under this subsection as the Secretary deems appropriate.*" The AAMC understands that the statutory provision in Section 1886(p) of the Social Security Act, also known as the HAC payment provision, references the 1 percent payment reduction as "the amount of payment under this section," which admittedly could be interpreted to include all payments such as IME, DSH, UC, capital, and outlier payments. Conversations with Congressional staff confirm, however, that this was a drafting error, and it was not Congress' intent to have this penalty affect other policy payments. Both VBP and HRRP apply the adjustments to the operating base DRG

payment only; restricting the penalty to the base operating DRG will ensure consistency across the programs and reduce confusion.

AAMC analysis estimates that applying the penalty to these payments increases major teaching hospitals' penalties by 62 percent compared to 14 percent for non-teaching hospitals, a four-fold differential. For some teaching hospitals, the total penalty is millions of dollars. Penalties, particularly when they are applied to policy payments such as IME payments, can have an immediate effect on a teaching hospital's ability to fulfill its mission to teach, provide special care services, and do research.

The AAMC strongly urges CMS to apply the HAC penalty only to the operating base DRG amount on a permanent basis. If the Agency concludes that this is not feasible, then CMS should apply the penalty to base DRG payments as a transition policy. A transition policy is justified in this situation given the disproportionately large negative payment impact the HAC penalty has on teaching hospitals. The Association believes a transition period is warranted, given that CMS has traditionally provided for a transition period when adopting changes, including statutory changes, which have significant payment implications, particularly large negative impacts. All hospitals would benefit from such a transition, which would also allow time for both hospitals and CMS to better understand the measurement and how to address any measurement flaws. During this time, the AAMC suggests that CMS investigate steps, such as those described in the following section, to ensure the HAC measurement and scoring system is fair for all hospital types.

CMS Needs to Ensure Fair Comparison of Hospitals

One major flaw with the HAC Reduction Program is that it automatically penalizes a quarter of all hospitals, even if there are improvements in reducing infections within the institution or across the nation. Because the legislation that created the HAC program requires that one quarter of all hospitals be penalized, it is essential that CMS ensure that the measurement is as fair as possible and does not create a systematic bias that disadvantages a particular type of hospital.

Based on the current methodology, over half of large teaching hospitals are identified as poor performers for FY 2015, more than twice the rate of hospitals nationally. The AAMC is very concerned that some hospitals are identified as poor performers because of limitations in data collection, risk adjustment, measure methodology, and the size of teaching facilities rather than true differences in the quality of care. The AAMC asks CMS to review the performance rates to see if there are systematic biases or other reasons that could affect performance. For example, some measures are based on claims data and performance can vary based on how

comprehensively a hospital searches, documents, and codes for the complication. Some events are rare and therefore difficult, if not impossible, to measure in smaller samples. Additionally, the complexity of patients and types of services provided at academic centers is considerably different than those at small hospitals. While measures are risk-adjusted, the adjustment may not account for all the variation.

The AAMC recommends that CMS measure performance within specific hospital peer cohorts to address any potential bias. The AAMC would be happy to work with CMS staff to identify potential biases and potential cohorts.

AAMC Supports Increasing the Weight for Clinically-Validated Measures (Domain 2) and Reporting a Consolidated Surgical Site Infection (SSI) Rate

In the FY 2014 IPPS final rule, CMS finalized using two measure domains, based on different data sources, for the HAC Reduction Program. Domain 1 is a composite of eight Agency for Healthcare Research and Quality (AHRQ) patient safety indicators (PSIs) derived from claims data. Domain 2 consists of measures from the Centers for Disease Control National Healthcare Safety Network (CDC NHSN). For FY 2015, Domain 2 has only two measures, however, for FY 2016, CMS finalized the addition of a new measure: surgical site infection (SSI) standardized infection rate (SIR) for colon surgeries and hysterectomies. The AAMC supported CMS' decision in the FY 2014 IPPS final rule to weight the clinically validated Domain 2 measures more than claims measures in Domain 1 (65 percent to 35 percent respectively for FY 2015).

In the FY 2015 IPPS proposed rule, CMS outlines how the Agency will create a single infection rate for the two types of surgical procedures for FY 2016. Also, because Domain 2 will have one more measure, CMS proposed to increase the Domain 2 weight to 75 percent and decrease the Domain 1 weight to 25 percent for FY 2016.

The AAMC strongly supports increasing the weight of Domain 2 to 75 percent. The CDC NHSN has a rigorous methodology for collecting information on safety events which is more reliable than claims. If there is a discrepancy in performance, then the measures based on clinical data should take precedence.

The AAMC also supports the proposal to create a single consolidated standardized infection rate for colon surgeries and hysterectomies. The Association asks CMS and the CDC to monitor the impact of the consolidated rate for hospitals that have higher rates of hysterectomies. Based on Hospital Compare data, where the SSI rates for the two procedures are reported separately, hysterectomies have a higher infection rate compared to colon surgeries, and fewer hospitals have a reported hysterectomy SIR. If the consolidated rate adversely impacts hospitals that

perform more hysterectomies, then the rate should be modified to account for the different mix of services.

Remove Measure Overlap from the HAC Reduction Program and VBP

The AAMC firmly believes that hospitals should not be penalized twice for the same measure in two different performance programs. Currently, several measures in the HAC program are also in VBP. While both programs are important, they serve different functions. The HAC program penalizes relatively poor performance and does not reward improvement, while VBP offers the opportunity to obtain credit for improvement as well as achievement. As CMS implements more safety measures, the measures should move into VBP first to allow hospitals the opportunity to understand and improve performance. Once there are established protocols to improve performance, the measure could then move into the HAC program where a hospital is measured on performance alone.

Several of the FY 2016 HAC Reduction Program measures are also in the FY 2016 VBP. For this reason, the AAMC asks CMS to remove the FY 2016 HAC measures (PSI-90, CLABSI, CAUTI, and SSI for colon surgery and hysterectomy) from VBP.

Remove Methicillin-resistant Staphylococcus aureus (MRSA) from HAC and VBP Programs

The AAMC does not support the MRSA measure for either the FY 2017 HAC or the FY 2017 VBP programs. The main issue with the MRSA measurement is the inability to accurately distinguish community versus hospital-acquired infections. With variations in community MRSA rates, the AAMC is concerned about the potential noise, or random variation, in this measure for a payment program and urges CMS to remove the measure from the FY 2017 HAC Reduction Program.

Remove *Clostridium difficile* (*C. difficile*) from HAC and Add to VBP for FY 2017

CMS is proposing the *C. difficile* measure for VBP in 2017. As this measure is relatively new (first posted on Hospital Compare in December 2013), the AAMC supports its inclusion in VBP, where improvements can be credited, as long as the measure is also removed from the HAC Reduction Program.

HOSPITAL READMISSIONS REDUCTION PROGRAM (HRRP)

CMS previously finalized changes to HRRP that start in FY 2015. First, the maximum penalty increases to 3 percent of base DRG payments. In addition, readmissions for Chronic Obstructive Pulmonary Disease (COPD) and Total Hip Arthroplasty/Total Knee Arthroplasty (THA/TKA) were added to the HRRP, which in turn increases the amount of penalties that can affect a hospital.

For FY 2017, CMS is proposing to add a new measure and to make updates to the planned readmissions algorithm. In addition, CMS proposes a minor change to the THA/TKA readmission calculation which would start in FY 2015.

Readmission Rates Need to be Adjusted for Sociodemographic Factors

The AAMC is concerned that CMS' current policy for readmissions for the HRRP payment program does not account for sociodemographic factors for the patients and community that a hospital serves, despite mounting evidence about the relationship of sociodemographic factors and readmissions. For example, the May 2014 issue of *Health Affairs*, researchers Hu, *et al* reported:

Patients living in high-poverty neighborhoods were 24 percent more likely to be readmitted than others, after demographic characteristics and clinical conditions were adjusted for. Married patients were at significantly reduced risk of readmissions, which suggests that they had more social support than unmarried patients. These and previous findings that document socioeconomic disparities in readmissions raise the question of whether CMS' readmission measures and associated financial penalties should be adjusted for the effects of factors beyond hospital influence at the individual or neighborhood level, such as poverty and lack of social support.¹¹

Similarly, Nagasako, *et al* found that risk-adjustment models that are inclusive of poverty level, educational attainment, and housing vacancy rate significantly reduced observed variation in hospital readmission rates.¹² These findings only continue to build the body of evidence on the

¹¹ Hu, J., Gonsahn, M., and Nerenz, D. (2014), Socioeconomic Status And Readmissions: Evidence From An Urban Teaching Hospital. *Health Affairs*. Vol. 33: No. 5: 778-785, May, 2014.

¹² Nagasako, E., Reidhead, M., Waterman, B., and Dunagan, W.C., (2014), Adding Socioeconomic Data To Hospital Readmissions Calculations May Produce More Useful Results. *Health Affairs*. Vol 33: No. 5: 786-791, May, 2014.

importance and appropriateness of adjusting for sociodemographic variables for readmissions and other outcome variables.

In addition to published literature, the National Quality Forum (NQF) convened an expert panel report on the topic of risk adjustment and sociodemographic factors. This group of esteemed academic researchers and stakeholders from across the health care industry nearly unanimously agreed that measures of health outcomes and resource use should be adjusted for sociodemographic factors in certain circumstances for provider accountability.

The AAMC strongly encourages CMS to implement a sociodemographic adjustment for all readmission measures. In previous comments, the AAMC outlined multiple approaches that CMS can employ to use the NQF-endorsed measures and still account for sociodemographic variables.¹³ Options include running separate models for dual-eligible patients or comparing readmission rates within peer cohorts. The AAMC would be happy to discuss these options further with CMS staff.

AAMC Urges CMS Not to Include Coronary Artery Bypass Graft (CABG) Readmission Measure in FY 2017 HRRP

Starting FY 2017, CMS proposes to expand the applicable conditions in HRRP to include patients readmitted following coronary artery bypass graft (CABG). This measure was first recommended for inclusion in the program by the Medicare Payment Advisory Commission (MedPAC) in its June 2007 Report to Congress. CABG would be the sixth condition added to the HRRP program.

The AAMC has three concerns with the CABG readmissions measure:

- The CABG readmissions measure is proposed for the Inpatient Quality Reporting Program at the same time as the Readmissions Reduction Program.
- This measure has not been endorsed by NQF. The Measure Applications Partnership (MAP) only approved the measure contingent on NQF endorsement.
- This measure has not been risk-adjusted to account for sociodemographic factors.

CMS proposes to include the CABG measure in the Readmission Program starting in FY 2017, which is the same time that the measure has been proposed for the IQR Program. The AAMC strongly believes that all measures should be reported first in the IQR program for one year before the performance period in a payment program begins. Publicly reporting measures in the IQR program provides transparency, allows stakeholders to gain experience submitting the

¹³ <https://www.aamc.org/download/295512/data/aamccommentletteronfy2013ippsproposedrule.pdf>.

measures, and allows time to identify errors, unintended consequences, or other concerns with the measure methodology. The CABG readmissions measure should also be endorsed by the NQF, which ensures that the measure is tested, reliable, and can be used in a specific setting. The AAMC recommends implementing the CABG readmission measure in the IQR Program starting in FY 2017, contingent on NQF endorsement and adjustment for sociodemographic status. Because it takes up to 18 months for data processing and reporting, if these measures are reported in IQR in FY 2017, they should not be considered for the readmission program until FY 2019, at the earliest. The AAMC also urges CMS to incorporate sociodemographic factors into the risk-adjustment methodology and to exclude unrelated readmissions for these measures.

The AAMC notes that the ACA requires CMS “to the extent possible” to expand the number of readmissions measures to include four conditions, including CABG. The AAMC believes that this language provides an opportunity for CMS to delay implementation of the CABG readmission measure until after the measure has NQF endorsement and has been reported through IQR.

Revisions to the Planned Readmission Algorithm Need NQF Review

The AAMC does not support the proposal to use the new CMS Planned Readmission Algorithm 3.0 in HRRP for FY 2017, because this algorithm has not yet been reviewed by NQF. By statute, HRRP is required to exclude planned readmissions from the calculation. The planned readmission algorithm is important, as it affects the readmission rates for all rates in HRRP, and the AAMC believes that revisions to the algorithm logic need to go through NQF review and stakeholder comment.

Last year, the AAMC supported implementation of the 2.1 version of the algorithm, which was reviewed by an NQF expert panel. For FY 2017, CMS is proposing to use a new algorithm (version 3.0) that includes some suggested changes based on the validation study that CMS conducted. The size of the study was limited, looking at a sample of charts for only seven hospitals. Making recommendations based on this information, without external review from NQF, could create unintended consequences. For example, the readmission rates for cancer chemotherapy would not be considered planned unless the principal diagnosis for the admission was “Maintenance Chemotherapy.” The AAMC is unconvinced that this coding practice holds true for all hospitals and therefore hospitals that deliver a large amount of cancer services could be affected by this change. For these reasons, the AAMC urges CMS to have the new algorithm reviewed by NQF before implementation.

Support Use of Secondary Diagnosis to Identify Fractures for Total Hip Arthroplasty and Total Knee Arthroplasty (THA/TKA) Readmission Rate

The AAMC supports CMS' proposal to look in the principal and secondary diagnosis fields of the admission index to identify femur, hip, or pelvic fractures. The THA/TKA readmission rate is supposed to be restricted to elective procedures, so the measure excludes patients who have fractures on their index admission. Previously, the measure only excluded fractures if the fracture was recorded as the principal diagnosis in the index admission. Starting in FY 2015, CMS proposes to expand this search to exclude fractures recorded in the secondary diagnosis as well. Because this is a minor change that improves accuracy without changing the clinical logic, the AAMC supports making this change immediately.

CMS Should Grant Access for Real Time Reporting on Readmission Rates

The CMS Office of Information Products and Data Analytics (OIPDA) has been implementing logic to track unadjusted readmission rates using more recent data.¹⁴ This data is not risk-adjusted and cannot be publicly reported by hospitals, but the AAMC believes it would be useful to grant hospitals access to this information.

Only Medicare has complete information on which patients experience a readmission. A prior AAMC analysis estimated that up to 37 percent of AMI readmissions at COTH hospitals are readmitted to other hospitals, which means that teaching hospitals often are missing important information about their patients. It is crucial that CMS provide data to fill that data gap. The AAMC requests that this real-time readmission data be made available, in a confidential manner, to hospitals.

HOSPITAL VALUE-BASED PURCHASING (VBP) PROGRAM

Summary of VBP Proposals

Starting FY 2017, CMS proposes to adopt three new measures, re-adopt one measure that was previously finalized, and remove six "topped out" process measures from the VBP Program. Because of the removal of so many process measures, CMS is proposing to reduce the weights for process measures from 10 percent to 5 percent and increase the weights for the safety domain from 15 percent to 20 percent. Starting FY 2019, CMS proposes to add a complications measure and re-adopt a measure that is finalized for the VBP program through FY 2018.

¹⁴ <http://www.academyhealth.org/files/2014/monday/brennan.pdf>.

Domain Weight for “Clinical Care-Process” Should Not Be Changed

The AAMC does not support lowering the domain weights for process measures. The AAMC agrees that outcome and safety measures should take a higher priority over process measures, but the current domain weights (25 percent for outcomes and 15 percent for safety) reflect that goal.

In addition, good process measures have value, in that they can be used to identify gaps that may not be immediately apparent from outcome measures, because not every poor process automatically results in a bad outcome. However, measuring processes gives hospitals the data they need to improve performance. And a good process measure will result in better outcomes. The key is to identify good process measures that are not burdensome to collect.

CMS should acknowledge the need for a limited number for good process measures and keep the current domain weight for those measures at 10 percent.

Individual Measure Recommendations

Measures Proposed to Be Removed in FY 2017

Starting in FY 2017, CMS proposes to remove six topped out process of care measures in the VBP Program. The AAMC agrees that topped out measures, or those measures where “performance among hospitals is so high and unvarying that meaningful distinctions and improvements in performance can no longer be made,” should not be included in the VBP program. As described above, the AAMC does not believe that the domain weights should be changed.

Measures Proposed to Be Added in FY 2017

Hospital-onset Methicillin-Resistant Staphylococcus Aureus (MRSA) and C. Difficile

CMS proposes that two CDC NHSN infection measures be added to the Safety Domain in the VBP program starting in FY 2017:

- Hospital-onset Methicillin-Resistant Staphylococcus Aureus (MRSA), and
- *Clostridium difficile* (*C. difficile*)

While the AAMC agrees it is important to monitor and measure MRSA and *C. difficile* infection rates, the Association has two serious concerns with these measures:

- *C. difficile* is already finalized in the HAC Reduction Program. The AAMC does not support having the same measure in multiple performance programs. As this measure is relatively new (first posted on Hospital Compare in December 2013), the AAMC supports its inclusion in VBP, where improvements can be credited. However, AAMC support for inclusion in VBP is contingent on removal of the measure from the HAC Reduction Program.
- The AAMC does not support the MRSA measure for either the FY 2017 VBP program or the FY 2017 HAC Reduction Program. The main issue with the MRSA measurement is the ability to accurately distinguish community versus hospital-acquired infections. With variations in community MRSA rates, the AAMC is concerned about the potential noise in this measure for a payment program and urges CMS to remove these measures from the FY 2017 HAC Reduction Program.

Elective Deliveries Prior to 39 Completed Weeks Gestation

The AAMC supports the proposal to include a measure assessing “elective deliveries prior to 39 completed weeks gestation” for the VBP Program starting in FY 2017.

Central Line Associated Blood Stream Infection (CLABSI)

CMS also proposes to re-adopt the CLABSI measure for FY 2017 that was previously adopted in FY 2015, but was not subject to immediate re-adoption. The Agency continues to re-propose this measure, with the intention of adopting the CDC’s reliability-adjusted version of the CLABSI measure in the future. The reliability-adjusted measure has not yet been reviewed by the NQF or adopted for the IQR Program. In addition to being proposed for VBP, this measure has also been finalized for the HAC Reduction Program. The AAMC believes that measuring rates of CLABSI is a critical aspect of managing hospital-acquired infections; however, the Association strongly believes that CLABSI should not be reported in both the HAC Reduction Program and VBP, because hospitals may be unfairly penalized twice on the same measures. Because hospitals are already measured on CLABSI in the HAC Reduction Program, the AAMC urges CMS to remove this measure from VBP.

Proposed Measures for FY 2019

Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and Total Knee Arthroplasty (TKA)

CMS proposes to include the THA/TKA complications outcome measure, which assesses complications following THA/TKA surgery 90 days post index admission. The AAMC support for this measure is conditional on CMS' adding a sociodemographic adjustment.

AHRQ PSI-90 Claims-Based Composite

In the FY 2014 IPPS final rule, CMS declined to finalize the PSI-90 Composite, unintentionally signaling that the measure would not be finalized for the VBP Program in FY 2019. CMS has said the Agency intended to keep the measure in the program, but withheld re-adoption at the time to obtain a more recent baseline period. To clarify the measure's status, the Agency is re-proposing the measure for FY 2019.

For several years, the AAMC has noted concerns with the use of the AHRQ PSI measure in hospital quality programs. This measure is calculated using administrative claims data that have significant limitations, because they were designed for billing purposes and are less accurate in identifying a patient's severity level than clinical data abstracted from the medical record. Performance can vary based on how well a hospital looks for and codes a complication. In addition, the measures lack a robust risk-adjustment methodology and were originally developed for internal quality improvement and not for public reporting and payment purposes. Finally, the AAMC is concerned that the PSI measures tend to penalize hospitals with larger case volumes, as compared to those with smaller case volumes.

This measure should not be re-adopted for the VBP Program. The PSI-90 Composite is currently undergoing NQF maintenance review but has not been recommended for continued endorsement at this time. The NQF's Patient Safety Standing Committee, tasked with reviewing the composite, cited concerns with the measure's weighting scheme. Moreover, the PSI-90 Composite has already been finalized for the HAC Reduction Program starting in FY 2015. Despite PSI-90's faults, the AAMC recognizes that the HAC Reduction Program needs to measure all hospitals, specifically those not reporting infection data through the CDC NHSN, and therefore needs to include a claims-based measures on a temporary basis. Because the AHRQ PSI-90 Composite was finalized for the HAC Reduction Program, CMS should avoid penalizing hospitals twice for the same measures in two different performance programs and remove this measure from the VBP Program.

Future Measures/Conceptual Measures

In addition to the proposed measures, CMS asked for feedback on measures under consideration for future years.

3-Item Care Transition Tool

CMS is considering adding the 3-Item Care Transition Tool (CTM-3) to the VBP program in FY 2018. The measure will be first reported on Hospital Compare in October 2014. The AAMC has supported the inclusion of patient experience measures and will be pleased to evaluate the inclusion of CTM-3 after it has been publicly reported.

Future Efficiency and Cost Reduction Domain Topics

CMS seeks feedback on several new efficiency measures that would supplement the Medicare Spending per Beneficiary (MSPB) measure in the VBP efficiency domain. Specifically, CMS is seeking feedback on three medical episodes (kidney/urinary tract infection; cellulitis; and gastrointestinal hemorrhage) and three surgical episodes (hip replacement/revision; knee replacement/revision; and lumbar spine fusion/refusion). These episodes would use logic similar to the MSPB measure, such as utilizing a 3-days prior to 30-days post discharge methodology.

The AAMC questions the value of adding these bundles as efficiency measures in VBP, if they are similar to the MSBP measure, as MSBP likely already incorporates the admission. In addition, the Association is worried that specifications and episode construction rules are not aligned with the Bundled Payments for Care Improvement (BPCI) initiative. For example, BPCI has a bundle based on hip/knee repair and another bundle for hip/knee revision, and the episode above is hip repair/revision and knee repair/revision - a completely different construct than BPCI. Similarly, most bundlers in BPCI have a 90-day episode period, rather than the 30-days in the measures above. At the Fourth National Bundled Payment Summit (June 16-20, 2014) in Washington, DC, CMS indicated that approximately 5,000 episode-initiating entities are enrolled in BPCI at this time. Reporting new measures that do not align with that project will add confusion and marginal utility.

The AAMC appreciates that a VBP efficiency measure needs to meet different requirements than an alternative payment model; however, the AAMC recommends that CMS revisit the Agency's logic and see how any new efficiency measures can align with BPCI. In addition, the AAMC

recommends that all efficiency measures, including MSPB, should be adjusted for sociodemographic status.

CMS Should Take Proactive Steps to Prepare for ICD-10-CM/PCS Transition

CMS' transition from ICD-9-CM/PCS to ICD-10-CM/PCS was delayed one year due to passage of the Protecting Access to Medicare Act of 2014, and is now scheduled to start October 1, 2015. The AAMC has concerns that the transition to ICD-10-CM/PCS coding could significantly alter how measures are specified, creating a disconnect between a measure's score in the baseline period compared to the same measure's score in the performance period. It would be unfair and impractical to compare a hospital's measurement results using ICD-9-CM/PCS in the baseline period and ICD-10-CM/PCS in the performance period. The AAMC appreciates that the Agency is requesting feedback on potential options to address this concern. In the rule, CMS discusses various corrective steps, including retrospectively adjusting performance standards, measure rates, or total performance scores (if there is a need), or only using achievement points to calculate performance for measures affected by this transition.

The AAMC recommends that CMS do the following:

1. Running both the baseline data and the performance data using ICD-9-CM (using crosswalk software) and making the results of the testing publicly available.
2. CMS should rule out the possibility of only using achievement points for measures affected by this transition. Improvement points are a statutory requirement for VBP, and actions taken by hospitals to improve care processes should continue to be rewarded.

CMS must work closely with national hospital associations and other stakeholders affected by this transition, all of which welcome the opportunity to contribute to this important effort.

INPATIENT QUALITY REPORTING (IQR) PROGRAM

All Performance Program Measures Should Be Publicly Reported in IQR First

The AAMC strongly believes that all quality measures need to be publicly reported before being proposed, and providers should have their performance reported at least one year prior to the beginning of a performance period. Publicly reporting measures in the IQR program allows stakeholders to gain experience submitting the measures, and allows time to identify errors,

unintended consequences, or other concerns with measure methodology. The VBP statutory language requires all measures in the program first to be publicly reported in IQR for the reasons outlined above. The AAMC believes this is good policy, and CMS should apply this requirement for measures proposed for the HRRP and HAC Reduction Program as well.

IQR Quality Measure Recommendations

Measures Proposed for Removal in FY 2017

CMS proposes to remove 20 measures from the IQR program starting in FY 2017, while retaining 10 of these measures for use as voluntary EHR measures. The measures proposed for removal are as follows:

Measures Proposed to Be Removed from the IQR Program for FY 2017

- AMI-1: Aspirin at Arrival (Previously Suspended)
- AMI-3: ACEI or ARB for Left Ventricular Systolic Dysfunction- Acute Myocardial Infarction (AMI) Patients
- AMI-5: Beta-Blocker Prescribed at Discharge for AMI (Previously Suspended)
- HF-2: Evaluation of Left Ventricular Systolic Function
- SCIP-Inf-3: Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time (48 Hours for Cardiac Surgery)
- SCIP-Inf-4: Cardiac Surgery Patients with Controlled Postoperative Blood Glucose
- SCIP-Inf-6: Surgery Patients with Appropriate Hair Removal (Previously Suspended)
- SCIP-Card-2: Surgery Patients on Beta Blocker Therapy Prior to Arrival Who Received a Beta Blocker During the Perioperative Period
- SCIP-VTE-2: Surgery Patients Who Received Appropriate Venous Thromboembolism (VTE) Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery
- Participation in a Systematic Database for Cardiac Surgery

Measures Proposed to Be Removed as Required Measures in the IQR Program, But Retained as Voluntary EHR Measures for FY 2017

- AMI-8a: Primary PCI Received Within 90 Minutes of Hospital Arrival
- PN-6: Initial Antibiotic Selection for Community-acquired Pneumonia (CAP) in Immunocompetent Patients
- SCIP-Inf-1: Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision

- SCIP-Inf-2: Prophylactic Antibiotic Selection for Surgical Patients
- SCIP-Inf-9: Urinary Catheter Removed on Postoperative Day 1 (POD1) or Postoperative Day 2 (POD2) With Day of Surgery Being Day Zero
- STK-2: Discharged on Antithrombotic Therapy
- STK-3: Anticoagulation Therapy for Atrial Fibrillation/flutter
- STK-5: Antithrombotic Therapy by the End of Hospital Day Two
- STK-10: Assessed for Rehabilitation
- VTE-4: Patients Receiving un-fractionated Heparin with Doses/labs Monitored by Protocol

The AAMC supports the removal of measures that are topped out, do not lead to improved outcomes, or cannot be feasibly implemented. As noted in our VBP comments, the AAMC would be interested in identifying good process measures to replace some of the removed measures.

Measures Proposed to be Added Starting FY 2017

Severe Sepsis and Septic Shock Management Bundle

CMS proposes a Sepsis Shock Management Bundle for inclusion in the IQR Program starting FY 2017. This measure was endorsed by the NQF (# 0500) and conditionally supported by the MAP. Sepsis is a dangerous occurrence, and it is important to manage such situations as soon as symptoms appear. The AAMC supports the concept of measuring sepsis, but has concerns with the measure's readiness for implementation, including the ability of hospital quality staff to accurately collect this information and the required invasive procedures that may lead to additional infections. The AAMC is also worried that the measure, as defined, may have a high rate of false positives.

The AAMC believes this measure is not suitable for IQR in FY 2017 as specified. This measure is currently under NQF review, and the NQF Patient Safety Standing Committee has recommended changes to the measure. The AAMC recommends that CMS consider a streamlined version of the measure that is evidence-based and can be collected consistently and reliably, with minimal burden, and has a high degree of accuracy.

Hospital-Level, Risk Standardized 30-Day Episode-of-Care Payment Measures for Heart Failure and Pneumonia

These measures assess hospital risk-standardized payments associated with 30-day episodes of care for patients with heart failure and pneumonia. The heart failure episode-of-care measure

was initially reviewed by the NQF's Resource Use Steering Committee in March 2014. Multiple members of the Steering Committee expressed concerns that the measure's risk adjustment model does not properly account for differences in patient case mix and severity, which may lead to the misinterpretation of differences in episode cost performance. Additionally, concerns were raised about the lack of sociodemographic adjustment in the measure methodology. The AAMC does not support the heart failure measure due to the above concerns regarding the risk-adjustment methodology.

The pneumonia episode-of-care measure was reviewed by the NQF Resource Use Steering Committee at the end of June 2014. The measure is early in the review process, and the AAMC believes it is premature to finalize the measure for the FY 2017 IQR Program. Instead, CMS should re-propose the measure next year if it receives NQF endorsement.

Coronary Artery Bypass Graft (CABG) 30-day Mortality

This measure assesses a hospital's 30-day, all-cause risk-standardized rate of mortality following admission for a CABG procedure. This mortality measure has not yet been reviewed by the NQF. All measures proposed for the hospital performance and reporting programs should be first endorsed by the NQF, which ensures that the measure is tested, reliable, and can be used in a specific setting. The AAMC recommends that CMS withdraw this measure, and re-propose it upon receiving NQF endorsement.

Coronary Artery Bypass Graft (CABG) 30-day Readmission

This CABG readmission measure is currently undergoing the NQF consensus development process, and has been recommended for endorsement by the Admissions and Readmissions Standing Committee. The Committee also noted that their "recommendations...should be revisited following final recommendations from the NQF expert panel charged with developing new guidance on risk-adjustment for outcome measures." As discussed in the HRRP section, the AAMC supports this measure in IQR contingent on NQF endorsement and the application of an appropriate sociodemographic adjustment.

Mandatory E-Measure Reporting Should Not Be Incorporated into IQR at This Time

Starting in FY 2017, CMS proposes a total of 16 voluntary e-specified measures for the IQR program. Ten of these measures, listed earlier in this section, were previously required measures; CMS proposed to remove these ten as required measures in FY 2017, while

simultaneously retaining them as voluntary reportable EHR measures. The additional six voluntary EHR measures are:

- Hearing Screening Prior to Hospital Discharge
- PC-05 Exclusive Breast Milk Feeding and the subset 1042 measure PC-05a Exclusive Breast Milk Feeding Considering Mother's Choice
- CAC-3 Home Management Plan of Care (HMPC) Document Given to Patient/Caregiver
- Healthy Term Newborn
- AMI-2 Aspirin Prescribed at Discharge for AMI
- AMI-10 Statin Prescribed at Discharge

CMS proposes these 16 voluntary e-specified measures to promote alignment between the IQR and EHR Incentive Programs. The 16 voluntary measures are among the 29 eligible e-measures that hospitals can report to receive credit under Meaningful Use (MU), Stage 2. CMS also notes that many of these measures are topped out, which will allow hospitals an opportunity to test the accuracy of their electronic health record reporting system. CMS also stated the Agency's intention to require reporting of clinical quality measures beginning with the CY 2016 reporting period or FY 2018 payment determination.

The AAMC appreciates that CMS has not yet taken steps to mandate electronic reporting of measures for the IQR Program. Through discussions with our member institutions, the AAMC has not identified any hospitals that have chosen voluntarily to submit electronic measures at this time. Our members have noted that this decision is not the result of a lack of interest, but lack of capacity. The AAMC has spoken to members who pursued the voluntary submission of electronic measures, but have not been able to do so because the EHR vendor is incapable of collecting and transmitting this data to CMS, or because the data is invalid. Before CMS takes additional steps towards mandatory electronic reporting, the AAMC strongly recommends that the Agency reach out to EHR vendors, hospital quality staff, and other affected stakeholders to identify underlying structural problems and barriers to reporting these measures. The AAMC also requests that CMS publicly report how many hospitals are able to successfully report e-measures for IQR.

The AAMC also continues to have concerns with the validity of e-measures, particularly if they are to be used for public reporting or in a performance program. Before any e-measure data is reported on Hospital Compare, CMS should ensure that there is a robust validation process in place and should establish a process for hospitals to review their data and correct any errors. CMS should also identify how differences in measure rates by different data sources could affect integration of those measures in performance programs such as VBP.

AAMC Does Not Support the CDC NHSN Data Sharing Proposal

CMS proposes to access patient-level information from the CDC NHSN database for “monitoring and evaluation activities including validation, appeals review, program impact evaluation and development of quality measurement specifications.” The CDC NHSN is a valuable, clinically rich data source. CDC has been working with hospitals to ensure data is captured in a rigorous (and confidential) way. The CDC staff also understand the nuances of data collection, measure specifications, and limitations, which is important for using the information in a scientifically valid way.

The AAMC does not support the current proposal. NHSN contains detailed information on non-Medicare patients. It is unclear why CMS has need for such a broad database. CMS should be more specific about the individual data elements the Agency needs and for what purposes, particularly for development of quality measure specifications and validation. The AAMC encourages CMS to work with CDC to maximize the value of the NHSN data set and minimize reporting burdens to hospitals, rather than accessing the information directly.

THE MS-DRG DOCUMENTATION AND CODING ADJUSTMENT

CMS Should Continue Gradual Implementation of the Documentation and Coding Adjustments Required by the American Taxpayers Relief Act of 2012 (ATRA)

The purpose of the transition from CMS diagnosis-related groups (CMS-DRGs) to Medicare-severity DRGs (MS-DRGs) was to better account for severity of illness in Medicare hospital payment rates. When this process began, the MS-DRG relative weights for FY 2008 were calibrated with the intention that this transition would be budget neutral. The goal was for Medicare payments to increase only if there was an actual increase in patient severity (“real” case-mix change). CMS believes the Agency should recoup any higher payments that result from more cases being assigned higher weights without evidence of a change in a hospital’s real case mix. The AAMC continues to strongly oppose the documentation and coding adjustments the Agency has made, because the Association believes that higher-weighted DRGs can in fact result from increases in patient severity. The AAMC urges CMS to examine medical records data to distinguish documentation and coding changes from real case mix change and reduce the documentation and coding offset accordingly. Alternatively, the Agency should use a methodology that reflects historical trends in case mix index changes.

Congress passed the American Taxpayers Relief Act of 2012 (ATRA) to avert the “fiscal cliff.” Sec. 631 of ATRA requires the Secretary of the Department of Health and Human Services (HHS) to make a recoupment adjustment or adjustments totaling \$11 billion, to recover overstated payments from FY 2010 through FY 2012. The adjustment is required to be completed by FY 2017. The ATRA requires a one-time recovery of prior overpayments, such that once the necessary amount of overpayment is recovered, any adjustment made to reduce rates in one year eventually will be offset by a positive adjustment.

CMS proposes a second year of a -0.8 percent recoupment adjustment to continue recovering the \$11 billion required by the ATRA. CMS estimates that last year’s adjustment recovered almost \$1 billion in FY 2014 and that this year’s adjustment would recover approximately \$2 billion in FY 2015. While CMS does not propose a prospective adjustment, the proposed rule states that if CMS were to apply an additional prospective adjustment, it would be -0.55 percent.

In the FY 2013 final rule, CMS reduced the FY 2013 standardized amounts by 1.9 percentage points. This adjustment was intended to complete the adjustments determined to be necessary to account for coding changes occurring in FY 2008 and FY 2009. In previous IPPS proposed rule comment letters, the AAMC found fault with the methodology used to determine prospective documentation and coding adjustments related to the FY 2008/FY 2009 case mix changes. In the AAMC’s comment letter on the FY 2011 inpatient proposed rule, the Association discussed analysis that we, the American Hospital Association (AHA), and Federation of American Hospitals (FAH) conducted showing that the reduction due to documentation and coding should be much smaller than CMS’ methodology indicated, because the documentation and coding effect is substantially lower than CMS’ results. (*See* AAMC letter to Ms. Marilyn Tavenner, June 18, 2010.) The following year, we performed additional analyses to respond to issues CMS raised in the FY 2012 IPPS final rule, and our results continued to indicate that a smaller documentation and coding adjustment was warranted. (*See* AAMC Letter to Mr. Donald Berwick, June 20, 2011.) Accordingly, the Association disagrees with Congress’ rationale for requiring a recoupment adjustment in the ATRA, based on the reasoning that delaying prospective adjustments from the FY 2008/FY 2009 transition through FY 2013 resulted in IPPS payments in FY 2010, 2011, and 2012 that were overstated.

At the same time, the AAMC understands that CMS has been directed by Congress to make an \$11 billion recoupment adjustment over a four year period. Recognizing this, the AAMC appreciates CMS’ proposal to phase in this adjustment and strongly encourages CMS to continue to implement this adjustment gradually through FY 2017.

ACA PRICE TRANSPARENCY REQUIREMENTS

CMS Provides Appropriate Guidance to Hospitals on ACA Price Transparency Requirements

The ACA requires hospitals to make public lists of their standard charges for items and services they provide, in accordance with guidelines developed by the Secretary of Health and Human Services (HHS). In the proposed rule, CMS reminds hospitals of their obligation to comply with this requirement and notes that “hospitals are in the best position to determine the exact manner and method by which to make those charges available to the public.” CMS states that the Agency’s guidelines require hospitals to make public either (1) a list of standard charges (whether that be the chargemaster itself or in another form of their choice), or (2) their policies for allowing the public to view a list of those charges in response to an inquiry.

The nation’s teaching hospitals are supportive of transparency efforts and believe these guidelines represent a rational implementation of the ACA’s requirements. The AAMC appreciates the flexibility CMS has granted hospitals in this complex arena and urges the Agency to retain the current guidelines. The AAMC also encourages CMS to help in clarifying to the public that while the ACA may have required transparency of hospital chargemaster data, the chargemaster represents an inaccurate reflection of the prices hospitals actually are paid and is of limited value in helping patients understand their true out-of-pocket costs. The AAMC is engaging in efforts to help our member hospitals find more meaningful ways of communicating important and relevant price information to patients and the public.

COST REPORTING AND APPEALS REGULATIONS

AAMC Opposes CMS’ Proposed Changes to the Hospital Cost Reporting and Appeals Regulations

CMS proposes to amend the Agency’s cost reporting regulations to require a provider to include an appropriate claim for a specific item in its cost report to receive or potentially qualify for payment for the specific item. Failure to include an appropriate claim for a specific item in the hospital’s cost report would result in the exclusion from the notice of program reimbursement (NPR) issued by the Medicare Administrative Contractor (MAC) or in any decision or order issued by a reviewing entity in an administrative appeal.

CMS also proposes to amend the appeals regulations such that a provider's failure to include a specific claim in its cost report would no longer be a jurisdictional issue, but a substantive one. In short, any items the hospital did not specifically claim in an originally filed, amended, or reopened cost report would not be permitted to be appealed. These proposals would take effect for cost reporting periods beginning on or after October 1, 2014.

AAMC opposes these changes as proposed, because CMS offers no safeguard that would prohibit MACs from arbitrarily exercising their incredibly broad discretion to refuse to accept an amended cost report. A hospital is currently required to submit its Medicare cost report to its MAC five months after the end of its cost reporting year. This period of time is simply too short to accurately capture all data required for pass-through payments like DSH, DGME, IME, and bad debt, that are captured solely through the cost reporting process. For example, hospitals continue to receive information from their states about Medicaid eligible inpatient days used to calculate DSH payments well after that five-month period has ended. Similarly, hospitals may not know all of their bad debt accounts at the time they initially file their cost reports and rely on the ability to file amendments to ensure accurate reimbursement. While it may be true that today, MACs typically exercise their discretion in favor of accepting amended cost reports, there is no guarantee that they will continue doing so.

If CMS adopts these cost reporting and appeals changes, the AAMC urges the Agency to significantly limit the MAC's discretion to refuse to accept amended cost reports to well-defined and narrow circumstances, so that a hospital's reimbursement and appeal rights are not precluded by an arbitrary decision of the MAC not to accept an amended cost report.

OUTLIER PAYMENTS

CMS Should Use the Most Current Data Available to Calculate the Outlier Threshold

The AAMC encourages CMS to use the most current data possible when calculating the outlier threshold to address longstanding problems with underpayment resulting from inaccuracy in these calculations. Under the Medicare IPPS, a hospital will receive an outlier payment if the costs of a particular Medicare case exceed the sum of the prospective payment rate for the DRG, any IME and DSH payments, any new technology add-on payments and an outlier threshold. The sum of all these components is also referred to as the fixed-loss cost threshold (FLT). When determining if a case qualifies for outlier payments because the costs of the case exceed the FLT, a hospital's total covered charges are converted to estimated costs using the hospital's cost to

charge ratio (CCR). For cases that qualify, outlier payments are 80 percent of the case's costs above the FLT.

CMS proposes to continue to set the target for total outlier payments at 5.1 percent of total operating DRG payments (excluding adjustments for value-based purchasing and the readmissions reduction program). Therefore, CMS will again finance the outlier payment pool by reducing the inpatient standardized amount by 5.1 percent and estimating a cost threshold that should result in outlier payments that equal 5.1 percent. Additionally, CMS proposes to continue the policy adopted in the FY 2014 final rule to include the Uncompensated Care DSH payments in determining the outlier threshold and in calculating outlier payments.

The proposed rule would set the outlier threshold at \$25,799. CMS attributes the higher FY 2015 threshold to the charge inflation factor's being higher for FY 2015 than for FY 2014. As CMS has not released the claim data from the first quarter of FY 2014, it is not possible to check CMS' reported charge inflation figure, which limits stakeholders' ability to make meaningful comments. The AAMC urges CMS to release the first quarter of FY 2014 claim data with the FY2015 final rule. While CMS projects that the proposed outlier threshold of \$25,799 for FY 2015 will result in outlier payments equal to 5.1 percent of operating DRG payments and 6.26 percent of capital payments, the AAMC is concerned about the ongoing inaccuracy in CMS' estimation of outlier payments.

CMS' current estimate is that actual outlier payments for FY 2013 were 4.81 percent of actual total MS-DRG payments.¹⁵ Because CMS reduces the standardized amount by 5.1 percent and does not make retroactive adjustments to outlier payments when outlier payments total less than 5.1 percent of the total DRG payments, providers repeatedly have been shortchanged by the Agency's incorrect estimations. Moran's analysis shows that the aggregate underpayment of outlier payments between 2010 and 2012 is around \$1.5 billion. (See Appendix B.)

Each year, CMS tends to finalize a substantially lower outlier threshold than the Agency proposes in the proposed rule for that year. This is likely because CMS does not use the most recent data available when calculating the proposed outlier threshold. CMS should calculate the outlier threshold using the most recently available data. For the FY 2015 rulemaking cycle, this

¹⁵ Note: When the Moran Company used actual outlier payments from the MedPAR and calculated operating DRG payments using proposed rule adjustment factors, the outlier payment percentage was 4.86 percent. See Appendix B, "Modeling Fiscal Year 2015 Inpatient Prospective Payment System Outlier Payments," The Moran Company (June 9, 2014), at 5.

would mean using the March 2014 update of the Provider-Specific File (PSF) instead of the December 2013 update of the PSF.

CMS establishes the proposed FY 2015 outlier threshold using hospital CCRs from the December 2013 update to the PSF. Moran matching statistics over the last seven years show that only 64.8 percent of the CCRs in the impact file matched the March 2014 update of the PSF while 98.8 percent of the CCRs in the Impact File matched the December 2013 update of the PSF.¹⁶ Using the most recent March 2014 update of the PSF, Moran analyses produced an outlier threshold of \$25,375 when targeting an outlier payment percentage of 5.1 percent (compared to CMS' proposed outlier threshold of \$25,799).¹⁷ This demonstrates that the use of more current data should enable CMS to set a threshold that is closer to the 5.1 percent target. For these reasons, the AAMC urges CMS to use the most current available data (the March 2014 update of the PSF) to calculate the FY 2015 outlier threshold.

MEDICARE DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS

CMS' Proposals Related to Changes to Medicare Disproportionate Share Hospital (DSH) Payments Required by Section 3133 of the Affordable Care Act (ACA) Are Acceptable Given Statutory Requirements

The AAMC supports CMS' proposals to implement changes in the DSH payment formula given that these changes are required by Section 3133 of the ACA, and CMS' proposals to implement this statutory requirement are reasonable at this point in time. The Association does not support these DSH cuts on principle, particularly given that they disproportionately affect teaching hospitals and safety net hospitals that routinely provide medically necessary services to all comers in keeping with their missions. Additionally, because the Supreme Court's opinion in *National Federation of Independent Business v. Sebelius; Florida, et al., v. Department of Health and Human Services* made Medicaid expansion optional for the states, these cuts are not adequately counterbalanced by coverage expansions as Congress intended when passing the ACA. The AAMC recognizes that these modifications to DSH payments are statutory and outside the scope of CMS' rulemaking authority. Accordingly, the AAMC appreciates that CMS is maintaining some level of continuity in the methodology used to reduce and redistribute Medicare DSH payments and has not proposed to use Worksheet S-10 (WS S-10) data in this

¹⁶ *Id.* at Table 3.

¹⁷ *Id.* at 1.

context, given that the WS S-10 needs to be modified, improved, and audited before it is used for these purposes.

CMS proposes to continue to implement the statutory requirement that 75 percent of current DSH payments be reduced and applied toward “uncompensated care” payments (UC DSH payments). Additionally, the proposed rule would continue to make these payments to hospitals that are currently eligible for DSH payments using three (3) factors. Factor 1 is 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 65 who are insured because of ACA implementation (*i.e.*, a ratio of the percentage of people who are insured in the most recent period following ACA implementation to the percentage of the population who were insured in a base year prior to ACA implementation). Factor 3 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, expressed as a percent. 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.

CMS proposes to estimate total Medicare DSH payments for FY 2014 using the most recently available projections of Medicare DSH payments as calculated by CMS’ Office of the Actuary (OACT). For the proposed rule, CMS used the February 2014 OACT estimate for Medicare DSH payments for FY 2015 and came up with an estimate of \$14.205 billion. Factor 1 is 75 percent of this estimate, which equals \$10.654 billion.

To calculate Factor 2, CMS proposed to use CBO estimates of the uninsurance percentage for the baseline year of 2013 (18 percent), the most recent estimate of the rate of uninsurance in CY 2014 (16 percent) and the most recent estimate of the rate of uninsurance in 2014 (14 percent). CMS then proposes to normalize the estimates for the CYs to correspond with the appropriate FYs, which results in the percentage of individuals without insurance for FY 2015 equaling 14.5 percent. When this is entered into the formula proposed to calculate Factor 2 (1 minus the percent change in the percent of individuals under 65 who are uninsured, determined by comparing the percent of such individuals uninsured in 2013, and those who are uninsured in the most recent period for which data are available, minus 0.2 percentage points), the proposed rule calculates Factor 2 to equal 80.36 percent.

CMS again proposes to use Medicaid inpatient days plus Medicare SSI inpatient days as a proxy for measuring the amount of uncompensated care a hospital provides. The AAMC supports

CMS' proposed methodology to implement Section 3133 of the ACA, but the Association encourages CMS to use the most recent available cost report information to update the most recent dataset used to calculate additional DSH payments. Additionally, CMS should allow hospitals 30 days after the final rule is published to submit corrections regarding any errors resulting from extracting the cost report data. The AAMC also supports the Agency's proposed proxy for the costs of treating the uninsured until a better source of data is identified and validated.

Worksheet S-10 Needs Significant Modification and Improvement Before It Can Be Used to Redistribute UC DSH Payments

The AAMC appreciates CMS' recognition that WS S-10 still needs to be modified and improved before it is potentially used to collect data on hospitals' relative share of uncompensated care for purposes of redistributing the new UC DSH payments. The Association remains concerned about the use of WS S-10 in this context and believes that significant threshold problems must be resolved before it is used to collect data for payment purposes. The AAMC participated in a stakeholder discussion group led by Dobson DaVanzo & Associates on January 30, 2014 and provided a detailed account of our recommendations regarding modifying and improving WS S-10. A summary of these concerns and suggestions is also included below. The AAMC strongly urges CMS to adopt these changes, provide an opportunity for stakeholder input on revisions to WS S-10, and then to allow time for education and validation of the data before using WS S-10 to determine hospitals' relative share of uncompensated care to distribute UC DSH payments.

Cost-to-Charge Ratio (Line 1)

The Association is primarily concerned with Line 1 (Cost-to-Charge Ratio (CCR)) of WS S-10. There are two inconsistencies in this line that must be addressed. First is in calculating the Cost-to-Charge Ratio (CCR). The numerator of the CCR is cost and the denominator is charges. The numerator currently excludes direct graduate medical education (DGME) costs, and the denominator currently includes all hospital charges. There is no explicit charge for DGME, so it is impossible to remove it and make the numerator and the denominator consistent. DGME costs are a substantial part of the overhead of teaching hospitals. Hospital charges are established to help cover DGME costs, and payment rates are negotiated to reflect the higher costs teaching hospitals incur by providing graduate medical education. Therefore, DGME costs must be taken into account by including these costs on WS S-10. This is the only way to match charges and costs to accurately calculate non-Medicare uncompensated care costs.

Second, revenues and costs must be aligned. Another inconsistency arises when comparing revenue that includes DGME payments with costs that exclude DGME costs. Including DGME costs in the CCR would be the simplest way to correct this problem and align revenues and costs. This is consistent both with DGME's being a Medicare allowable cost and with the fact that on WS S-10, the net revenue from Medicaid includes DGME payments. Including DGME in the CCR would only require a minor change in the cost report, because hospitals already report DGME costs on Worksheet B. This solution will eliminate further complication and confusion around S-10 data reporting.

Purpose of Lines 17- 18

The purpose of Lines 17 and 18 of WS S-10 are unclear. Hospitals have trouble understanding what data needs to be reported on these lines. Additionally, these lines do not seem necessary to report the revenues, costs, and payments related to uncompensated care. Given that these lines are unclear and extraneous, the AAMC encourages CMS to remove them from WS S-10 until the Agency clarifies the purpose of these lines, the data that should be reported on them, and how that data will be used.

Cost of Charity Care (Lines 20-23)

CMS must clarify what can be reported as charity care, because the term can vary significantly among providers and states. To make reporting more uniform, the AAMC believes that CMS' instructions should be to take the charity care write-offs reported in a year (regardless of the date of the service), multiply by the CCR, then subtract any payment received that year through collections.

Bad Debt Expense (Lines 26-29)

Similar to the recommendation regarding the cost of charity care, the AAMC believes that bad debt expenses should be reported on the S-10 by multiplying direct write-offs by the CCR. Therefore, this methodology would reflect total bad debt written off during the cost reporting period regardless of the date of service.

Ensuring the Accuracy of the Data

Before the S-10 can be used as a data source for the costs of treating the uninsured, hospitals need more explicit instructions and guidance regarding how to report on this form. Even after

necessary modifications are made, it will take at least three years before the data collected from the S-10 is sufficiently accurate to use for payment purposes. The AAMC also recommends that CMS do a separate Medicare Administrative Contractor (MAC) survey audit before the data is used, to ensure its accuracy.

The AAMC would welcome the opportunity to continue to work with CMS to develop a WS S-10 that is more accurate and can be better used to collect data on hospitals' costs associated with treating the uninsured.

CMS Should Finalize Policies Related to UC DSH Payments for Hospitals that Merge

The AAMC appreciates that CMS proposed new policies to address how UC DSH payments will be made in the context of hospital mergers. CMS proposes for FY 2015 to incorporate data from both merged hospitals' separate CMS Certification Numbers (CCNs) until data for the merged hospital become available under the surviving CCN.

This differs from the policy included in the FY 2014 IPPS final rule, in which CMS stated that Factor 3 would be calculated based on the Medicaid days and Medicare SSI days under only the surviving CCN based on the most recent available data for that CCN (for FY 2014 the cost report for 2011 or 2010).

CMS also proposes to identify hospitals that merged after the period from which data are being used to calculate Factor 3 (for FY 2015, after 2012 and 2011 cost reports) but before publication of the final rule. CMS will publish a table of known mergers with both the proposed and final rules so that hospitals can comment on the accuracy of these tables.

With respect to hospitals that merge after the development of the final rule, CMS proposes to treat these hospitals as the Agency treats new hospitals. Specifically, CMS proposes that interim UC payments would be based only on the data of the surviving hospital's CCN at the time of the preparation of the final rule. Then at cost report settlement, CMS would determine the newly merged hospital's final UC payments based on the Medicaid days and SSI days reported on the cost report used for the applicable fiscal year (revising the numerator of Factor 3 to reflect the low income days reported on the cost report). The AAMC urges CMS to allow hospitals an additional 60 days after the publication of the FY 2015 IPPS final rule to send the Agency comments regarding the accuracy of updated merger information included in the final rule. Otherwise, the Association supports these proposals that resolve problems with current policy as it pertains to making UC DSH payments to hospitals that merge.

UPDATES TO THE REASONABLE COMPENSATION EQUIVALENT (RCE) LIMITS ON COMPENSATION FOR PHYSICIAN SERVICES

CMS Should Not Eliminate the Location Adjustment to RCE Data as Proposed

CMS proposes to update and revise the methodology the Agency uses to calculate the reasonable compensation equivalent (RCE) limits for providers that are subject to those limits. Under the methodology, CMS considers physician income by specialty and type of location using the best available data. CMS proposes to: use the most recent Medicare Economic Index (MEI) data to update the RCE limits; replace the RCE limits in effect since January 2004; and eliminate the location adjustment to the RCE data.

When updating the RCE limits, CMS encountered challenges in applying a locality adjustment because of mismatched data—the physician salary data from the American Medical Association (AMA) Periodic Survey of Physicians (PSP) uses geographic classifications based on the Metropolitan Statistical Areas (MSAs) defined by the Office of Management and Budget (OMB), which are no longer updated. Because there are relatively few providers “currently affected” by the RCE limits and few with GME expenses paid on a reasonable cost basis, CMS proposes to eliminate the location adjustment to the RCE data, while continuing to adjust the RCE limits by specialty.

While CMS is correct that few hospitals receive payment for GME that is directly tied to the RCE limits, RCE limits continue to be an important part of reporting accurate GME costs. All teaching hospitals—not just those whose GME expenses are reimbursed on a reasonable cost basis—apply RCE limits to physician salaries in Worksheet A-8-2 of the Medicare Cost Report. Additionally, GME costs would likely be a cornerstone of any rebasing of DGME payments that could take place in the future, and accurate calculations of GME costs are important to Worksheet S-10 calculations, which ultimately may be used to calculate uncompensated care payments.

Because of the importance of recording accurate data for all teaching hospitals, the AAMC urges CMS not to eliminate the use of a location adjustment from the RCE calculation. The AAMC understands CMS’ concerns about the mismatch of the statistical geographic delineations but encourages CMS to develop and implement an alternative method of establishing a location adjustment moving forward.

SURVEY, CERTIFICATION, AND ENFORCEMENT PROCEDURES FOR TRANSPLANT CENTERS

CMS Should Allow Transplant Centers Additional Time to Respond to Mitigating Factor Requests

CMS proposes several improvements to the survey, certification, and enforcement procedures under 42 C.F.R. § 488.61 for transplant centers that request approval or re-approval for participation in the Medicare program. Specifically, CMS addresses situations when transplant centers have not met one or more of the conditions of participation but wish to have certain mitigating factors taken into consideration. With one notable exception, the AAMC views CMS' proposals as a positive step that will help achieve the goals of strengthening, clarifying, and providing additional transparency.

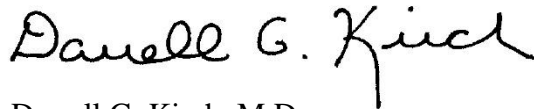
Of concern is the proposal that a transplant program would have to submit a request for mitigating factors within 10 days after CMS issues formal written notice of a condition-level deficiency, and provide all information within 30 days of the initial notification of deficiency. The AAMC believes that the 10- and 30-day timeframes are much too short. While a timeline provides assurance that issues will be resolved in a timely way, it is essential that sufficient time be provided to allow those affected to understand the issue, make an informed decision about how to address it, and ample opportunity to collect all necessary information. Therefore, the AAMC urges the Agency to allow 20 days to submit a request for mitigating factors and 45 days from the date of the formal written notice to submit additional information.

Administrator Tavenner
June 30, 2014
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CONCLUSION

Thank you for the opportunity to present our views. We would be happy to work with CMS on any of the issues discussed above or other topics that involve the academic medical center community. If you have questions regarding hospital payment issues please feel free to contact Lori Mihalich-Levin, J.D., at 202-828-0599 or at lmlevin@aamc.org or Allison Cohen, J.D. at 202-862-6085 or at acohen@aamc.org. For questions regarding the quality provisions please contact Mary Wheatley at 202-862-6297 or at mwheatley@aamc.org.

Sincerely,

A handwritten signature in black ink that reads "Darrell G. Kirch". The signature is written in a cursive style with a large, prominent "K".

Darrell G. Kirch, M.D.
President and CEO

cc: Janis Orłowski, M.D., AAMC
Ivy Baer, J.D., AAMC
Allison Cohen, J.D., AAMC
Lori Mihalich-Levin, J.D., AAMC
Scott Wetzell, AAMC
Mary Wheatley, M.S., AAMC

Appendix A



Association of
American Medical Colleges
2450 N Street, N.W., Washington, D.C. 20037-1127
T 202 828 0400 F 202 828 1125
www.aamc.org

Appendix A
FY 2015 IPPS Proposed Rule – Proposed Quality Measures Summary
June 2014

Measure Categories	Measures	NQF Endorsed	CMS Proposal	Additional Issues to Consider	AAMC Recommendation
HAI	<ul style="list-style-type: none"> Central Line Associated Blood Stream Infection (CLABSI) 	Yes	FY 2017: <ul style="list-style-type: none"> Re-proposed for VBP Finalized for HAC Finalized for IQR 	<ul style="list-style-type: none"> Measure in HAC starting FY 2015, and re-proposed for VBP in FY 2017 Data collection expansion (beyond ICU) starting CY 2015 	<ul style="list-style-type: none"> Because already finalized for HAC, do not finalize for VBP
Healthcare Associated Infections (HAI)	<ul style="list-style-type: none"> <i>Clostridium difficile</i> (C. diff) 	Yes	FY 2017: <ul style="list-style-type: none"> Proposed for VBP Finalized for HAC Finalized for IQR 	<ul style="list-style-type: none"> Measure in HAC starting FY 2017 	<ul style="list-style-type: none"> Support for VBP, as long as measure removed from HAC
HAI	<ul style="list-style-type: none"> Methicillin-resistant Staphylococcus aureus (MRSA) 	Yes	FY 2017: <ul style="list-style-type: none"> Proposed for VBP Finalized for HAC Finalized for IQR 	<ul style="list-style-type: none"> Measure in HAC starting FY 2017 Concern that providers cannot always distinguish between community and hospital-acquired MRSA 	<ul style="list-style-type: none"> Remove from HAC for FY 2017, and do not finalize for VBP

Quality Programs:

HAC – Hospital-Acquired Conditions Reduction Program; **IQR** – Inpatient Quality Reporting;

VBP – Hospital Value-Based Purchasing Program; **HRRP** – Hospital Readmissions Reduction Program

Measure Categories	Measures	NQF Endorsed	CMS Proposal	Additional Issues to Consider	AAMC Recommendation
Perinatal Care	<ul style="list-style-type: none"> Elective Delivery Prior to 39 Completed Weeks Gestation 	Yes	FY 2017: <ul style="list-style-type: none"> Proposed for VBP Finalized for IQR 		<ul style="list-style-type: none"> Support for VBP
Patient Safety Indicator	<ul style="list-style-type: none"> AHRQ Composite PSI-90 	Yes	FY 2019: <ul style="list-style-type: none"> Re-proposed for VBP Finalized for HAC Finalized for IQR 	<ul style="list-style-type: none"> Measure in HAC starting FY 2015, re-proposed for VBP in FY 2019 Measure undergoing NQF maintenance review 	<ul style="list-style-type: none"> Because already finalized for HAC, do not finalize for VBP Measure has reliability issues
Complications	<ul style="list-style-type: none"> Hospital-level Risk-standardized Complication Rate (RSCR) following Elective Hip and Knee Arthroplasty 	Yes	FY 2019: <ul style="list-style-type: none"> Proposed for VBP Finalized for IQR 		<ul style="list-style-type: none"> Support measure for VBP contingent on inclusion of sociodemographic adjustment
Readmissions	<ul style="list-style-type: none"> Coronary Artery Bypass Graft (CABG) 30-Day Readmissions 	Under NQF review	FY 2017: <ul style="list-style-type: none"> Proposed for IQR Proposed for HRRP 	<ul style="list-style-type: none"> Measure rates have not been publicly reported on Hospital Compare Not adjusted for sociodemographic status 	<ul style="list-style-type: none"> Support for IQR contingent on NQF endorsement and sociodemographic adjustment Do not support for HRRP, because the measure has not been publicly reported at least one year before the performance period for HRRP begins

Quality Programs:

HAC – Hospital-Acquired Conditions Reduction Program; **IQR** – Inpatient Quality Reporting;

VBP – Hospital Value-Based Purchasing Program; **Readmissions** – Hospital Readmissions Reduction Program

Measure Categories	Measures	NQF Endorsed	CMS Proposal	Additional Issues to Consider	AAMC Recommendation
Mortality	<ul style="list-style-type: none"> Coronary Artery Bypass Graft (CABG) 30-day mortality 	No	FY 2017: <ul style="list-style-type: none"> Proposed for IQR 	<ul style="list-style-type: none"> Measure has not undergone NQF review process 	<ul style="list-style-type: none"> Measure must first be NQF endorsed before being considered for IQR
Cost Efficiency	<ul style="list-style-type: none"> 30 –day episode of care measure for heart failure 	Under NQF review	FY 2017: <ul style="list-style-type: none"> Proposed for IQR 		<ul style="list-style-type: none"> Do not support for IQR Concern about missing necessary clinical data needed to risk adjust episodes
Cost Efficiency	<ul style="list-style-type: none"> 30 day episode of care measure for pneumonia 	Under NQF review	FY 2017: <ul style="list-style-type: none"> Proposed for IQR 		<ul style="list-style-type: none"> Initial NQF review of measure occurred in June 2014; premature to include in IQR at this time Recommend that CMS re-propose next year, if measure receives NQF endorsement
Sepsis	<ul style="list-style-type: none"> Severe Sepsis and Septic Shock Management Bundle 	Yes	FY 2017: <ul style="list-style-type: none"> Proposed for IQR 		<ul style="list-style-type: none"> Important topic area Do not support current sepsis measure for IQR due to concerns about the data collection burden of this measure, among other issues

Quality Programs:

HAC – Hospital-Acquired Conditions Reduction Program; **IQR** – Inpatient Quality Reporting;

VBP – Hospital Value-Based Purchasing Program; **Readmissions** – Hospital Readmissions Reduction Program

Measures Under Consideration for Future Rulemaking					
Patient Experience	<ul style="list-style-type: none"> Care Transition Measure (CTM) 	Yes	<ul style="list-style-type: none"> Under future consideration for VBP Finalized for IQR 	<ul style="list-style-type: none"> Measure will be publicly reported starting October, 2014 	<ul style="list-style-type: none"> AAMC will consider this measure once it has been proposed for VBP
Cost Efficiency	<ul style="list-style-type: none"> Medical/surgical 30-day episodes: Kidney/urinary tract infection, cellulitis, gastrointestinal hemorrhage, hip replacement/revision, Knee replacement/revision, Lumbar spine fusion/refusion 	No	<ul style="list-style-type: none"> Under future consideration for VBP 		<ul style="list-style-type: none"> Measures need to be NQF endorsed, reviewed by the MAP, and publicly reported before inclusion Episodes need to align with the CMMI bundling project. Questions about the marginal value of the measures if they are based on MSPB, which is already in the measure set. Resource measures need sociodemographic adjustment

Quality Programs:

HAC – Hospital-Acquired Conditions Reduction Program; **IQR** – Inpatient Quality Reporting;

VBP – Hospital Value-Based Purchasing Program; **Readmissions** – Hospital Readmissions Reduction Program

Appendix B

Modeling Fiscal Year 2015 Inpatient Prospective Payment System Outlier Payments

June 23, 2014

Modeling Fiscal Year 2015 Inpatient Prospective Payment System Outlier Payments

This report summarizes our findings from the replication of outlier payments from the Centers for Medicare & Medicaid Services (CMS) Fiscal Year (FY) 2015 Inpatient Prospective Payment System (IPPS) proposed rule and other associated analyses. CMS describes its methodology and logic starting on page 28321 of the Federal Register.¹ We attempted to replicate the CMS logic and then compared our results. In addition, we conducted additional analyses, modifying some of the CMS logic and parameters to assess the impact of using different parameters on outlier payments.

Summary of Findings

- In the rule, CMS proposed a fixed loss threshold (FLT) of \$25,799 to achieve an outlier operating payment level of 5.1 percent. Our replication of the CMS methodology and logic produced a FLT of \$26,149, which is \$350 more than CMS' estimate. Both our calculation and CMS' calculation are significantly higher than the FLT for FY2014, and we have not yet been able to determine a cause for this dramatic increase, such as an error in different factors used in the calculations. Please note that CMS released updated weights due to an issue in their calculations in the proposed rule.² CMS' FLT was calculated with the original weights, while our calculation is based on the revised weights. We expect that using the revised weights would change their results slightly. We assume that the issue will also not be repeated in the final rule.
 - If the Budget Neutrality for DRG system level changes (reported in the rule as 0.992938) is also inaccurate due to the weight calculation, this would also have an effect on the standardized amount and the fixed loss threshold. Using a number close to the historical trend of 0.998 for that budget neutrality factor, we calculate a fixed loss threshold of: \$25,894.
- We also must note that we cannot replicate all factors used to calculate the FLT. Changing some of these elements could lead to differences in our estimate. In particular, it is not possible to replicate and check CMS' reported charge inflation figure because the agency has not released the claims data from the first quarter of FY2014 used to calculate it.³
- CMS estimated actual outlier payments for FY 2013 at 4.81 percent using actual claims data. Using the FY 2013 Final Rule Impact File and 2013 Medicare Provider Analysis

¹ "Proposed Outlier Payments, Proposed Rule." *Federal Register* 79 (15 May 2014): 28321-28324.

² CMS did not release a correction notice, but published the new weights on their website, available from <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FY2015-NPRM-Revised-AORv31v32andDRGWeights.zip>. Accessed on 6/12/14.

³ "Proposed Outlier Payments, Proposed Rule." *Federal Register* 79 (15 May 2014): 28321.

and Review (MedPAR) claims, we calculated actual outlier payments at 4.86 percent. Both CMS' and our calculations are less than the 5.1% target for operating outlier payments.

- CMS used cost-to-charge ratios (CCRs) from the December 2013 update of the Provider-Specific File (PSF). Using the most recent March 2014 update of the PSF produced a FLT of \$25,375 when aiming for an operating outlier payment percentage of 5.1 percent.
 - Similarly here, if instead we use a budget neutrality factor of 0.998, which is closer to the historical trend, we calculate a fixed loss threshold of: \$25,124.
- The amounts paid out in outlier payments have continued to be lower than the 5.1% target.

Analysis 1: Replication of the CMS estimated 2015 outlier payment levels from the IPPS FY2015 Proposed Rule

We estimated regular and outlier payments using the 2013 MedPAR file, the FY 2015 Proposed Rule Impact File and other factors from the FY 2015 Proposed Rule, such as the Diagnosis-Related Group (DRG) weights. DRG payments were calculated using the proposed standardized amount, proposed DRG weights, transfer adjustments, and other hospital specific payment adjustments, such as wage index, cost of living adjustment, Indirect Medical Education (IME), and Disproportionate Share Hospitals (DSH). The hospital specific parameters were obtained from the FY 2015 Proposed Rule Impact File. We adjusted for Sole Community Hospitals (SCHs) paid hospital specific rates.

Outlier payments were calculated after inflating the FY 2013 charges by approximately 11.5 percent as CMS specified in the rule. The average annualized rate of change over two years and the one year adjustment factor were applied to account for charge inflation as reported in the FY 2015 Proposed Rule. The inflated charges were then converted to costs and compared to the projected FY 2015 FLT.⁴

We calculated a FLT of \$26,149 at the proposed operating outlier target of 5.1 percent, which is \$350 above the CMS proposed FLT. However, CMS' proposed FLT may have been calculated on the original weights, and so could have changed with the release of new weights. Using our calculated FLT, we estimated operating outlier payments for FY 2015 at \$4.30 billion.

⁴ *Ibid.*

Analysis 2: Comparison of cost-to-charge ratios between the FY 2015 Proposed Rule Impact File and the most recent cost-to-charge ratios from the Provider-Specific File

CMS used hospital CCRs from the December 2013 update to the PSF to establish the proposed FY 2015 outlier threshold. Since the most recent available PSF is from the March 2014 update, we compared CCRs from the FY 2015 Proposed Rule Impact File with both the December 2013 update and the March 2014 update of the PSF. This was our attempt to be comparable to CMS' analysis in the Proposed Rule with the most recently available PSF. CCRs were considered matched if both operating and capital Impact File CCRs were matched with the respective CCRs from at least one record of the PSF.

We included 3,388 providers subject to IPPS from the FY 2015 Proposed Rule Impact File for the comparison with the PSFs. This provider count excluded Maryland and Indian Health Service hospitals. The matching rates between the PSF's CCRs and the FY 2015 Proposed Impact File are shown in Table 1 and Table 2. Table 3, which provides the matching statistics for the last seven years, showed that only 64.8% of the CCRs in the Impact File matched the March 2014 update of the PSF while 98.8% of the CCRs in the Impact File matched the December 2013 update of the PSF. We recognize that the development of the rule occurs over a period of months, and observe that in between the time of the development of the rule and the rule's publication, more recent data may become available. We show the comparison to the most recent data to highlight the continuing evolution of the data. Simulating the CMS FY 2015 outlier methodology using the most recent March 2014 PSF CCRs (as opposed to the December ones), and using the revised CMS proposed rule weights, while keeping all the other parameters the same, resulted in an estimated FLT of \$25,375.

Table 1: Matching Proposed FY 2015 Impact File and PSF Cost-to-Charge Ratios

	PSF December 2013 Update	PSF March 2014 Update
Number of IPPS hospitals in the Impact File	3,388	3,388
Hospitals with Impact File CCRs not matching any PSF CCRs	126	102
Hospitals with Impact File CCRs matching PSF CCRs (both Operating and Capital Ratios Match)	3,262	3,286
Hospitals with Impact File CCRs matching most recent CCRs	3,255	2,210
Hospitals with Impact File CCRs matching earlier CCRs	7	1,076
Hospitals with Impact File Operating CCR greater than most recent CCRs	3	673
Hospitals with Impact File Operating CCR equal or less than most recent CCRs	4	403

Table 2: Statistical Measures of the Percent Difference between Impact File Operating CCR and the Most Recent PSF Operating CCR

Statistics	IMPACT FILE OPERATING CCR - Percent Difference From the Most Recent PSF Operating CCR of the Same Hospital	
	PSF - December 2013 Update	PSF - March 2014 Update
Count	3,388	3,388
Mean	-0.15%	0.64%
Standard Deviation	3.18	9.62
Weighted Mean (by Medicare Discharges)	-2.70%	1.04%
Minimum	-92.97%	-87.53%
25th Percentile	0.00%	0.00%
Median	0.00%	0.00%
75th Percentile	0.00%	0.00%
Maximum	12.34%	257.85%

The difference in mean appears to be largely due to distributional characteristics of the data, in that there are particular outliers pulling the average down. For the December release, the majority of the providers had no difference in CCRs, but certain providers shifted the mean difference in CCR noticeably. Although an extremely high percentage of providers matched using the December 2013 update, the average percent difference is much higher than any other comparison. That difference could lead to differences in the calculated FLT.

Table 3: FY 2015 Proposed Rule and Historical Matching Rate between Impact File and Most Recent PSF CCRs

Final Rule for FY	Matching Rate Between Impact file and Most recent PSF CCRs^b	Average Percent Difference Between the Impact File and Most Recent PSF Operating CCR of the Same Hospital (weighted By Discharges)
2010*	93.2%	0.4%
2011*	96.4%	0.1%
2012 - Dec 2010 Update	96.9%	0.2%
2012 - March 2011 Update	65.3%	1.6%
2013	92.1%	0.0%
2014	97.2%	-0.1%
2015 ^a - Dec 2013 Update	98.8%	-2.7%
2015 ^a - March 2014 Update	64.8%	1.0%

* Vaida Health Data Consulting, Modeling FY 2013 IPPS Outlier Payment. June 11, 2012

^a Proposed Rule

^b March PSF updates available at the time the FY 2010-2013 Final Rules were issued; December 2012 PSF update for the 2014 Proposed Rule and December 2013 Update for the 2015 Proposed Rule

Analysis 3: FY 2013 Outlier Payments using 2013 MedPAR data

FY 2013 actual outlier payments were calculated using the 2013 MedPAR claims data, FY 2013 payments rules, FY 2013 DRG weights and the FY 2013 Final Rule Impact File. The operating DRG payments were calculated using the CMS standardized amount, MS-DRG weights and wage indices for FY 2013 and other payment factors. The actual outlier payments were calculated using discharges from the MedPAR 2013 file and the outlier adjustment factor from the FY 2013 Final Rule Impact File. We adjusted for SCHs paid hospital specific rates. We did not adjust for Medicare Dependent Hospitals (MDHs). Alternatively, we also calculated the outlier percentage using actual outlier and Medicare operating payments from the MedPAR 2013 file. Finally, we calculated the outlier percentage using a combination of the methodologies described above. We extracted actual outlier payments from the MedPAR 2013 data, and then calculated the operating DRG payments using the FY 2013 Proposed Rule Impact File adjustment factors. In all cases, the outlier payment level was calculated by dividing the total outlier amount by the operating DRG payment plus outlier payments

As shown in Table 4 below, we used actual outlier payments from MedPAR and calculate operating DRG payments using proposed rule adjustment factors, the outlier payment percentage was 4.86 percent while CMS calculated an outlier payment percentage of 4.81.

Table 4: FY 2013 Outlier Payments Using MedPAR 2013 File and FY 2013 Final Rule Impact File

Data Source	Total Providers	Operating IPPS Payments Net of IME, DSH and Outlier Amounts (\$) (Does not include Capital)	Outlier Payments (\$)	Outlier Payment Level (%)	Total Medicare Payment (\$)
MedPAR 2013 Actual Outlier Payments, FY 2013 Final Rule Impact File Adjustment Factors. ³	3,315	79,292,337,014	4,048,712,402	4.858	106,021,141,075

³This calculates the payments from the Impact File, and uses the reported outlier payment amount from MedPAR.

Analysis 4: Outlier Payments from Medicare Cost Reports, 2014 Update

We calculated historical outlier payments and regular DRG payments using the 2014 update of hospital cost reports. Since different providers have different reporting periods and MedPAR data are reported based on Federal FY (October 1-September 30), we aggregated cost reports if the reporting beginning dates were in a particular FFY. For example, cost reports in “2010” were obtained by aggregating cost reports beginning in FY 2010. We reported operating outlier payments and operating DRG amounts net of IME, DSH and outlier amounts. We then calculated the percentage of outlier payments and the shortfall in achieving the 5.1% target. The results are shown in Table 5. Outlier payments from 2010-2013 have been consistently lower than the projected CMS target of 5.1 percent, which may indicate a structural issue in the methodology for projecting the fixed loss threshold. Given the low number of cost reports from 2013 submitted so far, the estimates for 2013 will adjust dramatically with more data.

Table 5: Historical Outlier Payments Using the 2014 March Update of the Medicare Cost Report

Federal Fiscal Year	Number of Cost Reports Beginning in FFY	IPPS Payments Net of IME, DSH and Outlier Amounts (\$)	Outlier Payments (\$)	Outlier Payment Level (%)	Target Outlier Payments (5.1%)	Shortfall in Outlier Payments (\$)
2010	3,072	79,733,087,154	3,660,488,700	4.39	4,284,918,277	(624,429,577)
2011	2,973	77,197,362,245	3,707,407,929	4.58	4,148,646,443	(441,238,514)
2012	2,716	67,461,311,753	3,137,279,264	4.44	3,625,423,498	(488,144,234)
2013	43	431,689,902	13,367,119	3.00	23,199,352	(9,832,233)
Total (2009-2013)	8,804	224,823,451,054	10,518,543,012	4.47	12,082,187,570	(1,563,644,558)

Analysis 5: Historical Outlier Reconciliation Payments from the 1996 Healthcare Cost Reporting Information System (HCRIS) File

We calculated historical outlier reconciliation amounts for FY 2003-2010 using the 1996 Healthcare Cost Reporting Information System (HCRIS) data. We aggregated cost reports if the reporting beginning dates were in a particular FY. For example, cost reports in “2003” were obtained by aggregating cost reports beginning in FY 2003. We reported total reconciliation amounts for each FY. The results are shown in Table 6. Outlier reconciliation amounts varied across years, with the highest reconciliation amount occurring in FY 2006 and the lowest in FY 2003. We are also uncertain of the positive amounts we found in the data from 2010.

We also attempted to calculate outlier reconciliation amounts for 2010-2013 using the March 2014 update of the HCRIS file and the CMS 2010 Hospital Complex Cost Report Instruction Manual. Following the instructions on page 176 of the instruction manual,⁵ we tried to extract outlier reconciliation payments. However, none of the cost reports had the payment information populated in these fields.

Table 6: Historical Outlier Reconciliation Payments Using the 1996 HCRIS File

Federal Fiscal Year (FFY)	Total Number of Cost Reports	Outlier Reconciliation Payments (\$)
2003	4,044	(351,892)
2004	3,877	(19,082,757)
2005	3,651	(5,358,217)
2006	3,517	(61,204,479)
2007	3,524	(11,403,869)
2008	3,489	(6,967,494)
2009	3,471	(5,102,232)
2010	2,248	536,515
Yearly Avg. (2003-2010)	3,478	(13,616,803)
Total (2003-2010)	27,821	(108,934,425)

⁵ Centers for Medicare and Medicaid Services. Medicare Provider Reimbursement Manual: Part 2, Provider Cost Reporting Forms and Instructions, Chapter 40, Form CMS 2552-10. December 2010 40-176. Transmittal 1 Available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1P240.pdf> Last accessed on 06/13/2014.

Data Sources

1. The MedPAR 2013 file obtained from CMS.
2. CMS FY 2015 Proposed Rule Impact File. This file includes hospital-specific parameters used to calculate IPPS payments, such as IME, DSH, wage index, CCRs, among others. Maryland providers and Indian Health Services are excluded from the outlier calculation.
3. The March 2014 update of the Provider-Specific File (PSF). This file contains information used by the Fiscal Intermediaries to determine IPPS payments.
4. The 1996 and March 2014 update of the Healthcare Cost Report Information System (HCRIS) database. HCRIS contains the most recent version of hospitals' Medicare cost reports.