PREMIER

June 21, 2013

Ms. Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1518-P
Hubert H. Humphrey Building
200 Independence Avenue, SW,
Room 445-G
Washington, DC 20201

RE: CMS-1599-P, Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2014 Rates; Quality Reporting Requirements for Specific Providers; Hospital Conditions of Participation.

Dear Ms. Tavenner:

On behalf of the Premier healthcare alliance serving more than 2,800 leading hospitals and health systems and nearly 100,000 other healthcare sites, we appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) fiscal year (FY) 2014 hospital inpatient prospective payment system (PPS) proposed rule. Premier, a 2006 Malcolm Baldrige National Quality Award recipient, maintains the nation's most comprehensive repository of hospital clinical, financial and operational information and operates one of the leading healthcare purchasing networks. Our comments primarily reflect the concerns of our owner hospitals and health systems which, as service providers, have a vested interest in the effective operation of the inpatient PPS.

Below, the Premier healthcare alliance provides detailed comments with suggested modifications to the policies proposed by CMS. We urge CMS to issue an interim final rule and accept comments on select issues that warrant further stakeholder input.

DOCUMENTATION AND CODING ADJUSTMENT

Recoupment Related to FYs 2008 and 2009

Section 631 of the American Taxpayer Relief Act (ATRA) of 2013 requires the Secretary to make a recoupment documentation and coding adjustment or adjustments totaling $11 billion in FYs 2014 through 2017 to account for the increase in aggregate payments as a result of delaying prospective adjustments related to FY 2008 and FY 2009 case-mix change until FY 2013. This resulted in overstated payment rates in FYs 2010, 2011 and 2012 that CMS was not authorized to recoup in future years because its statutory recoupment authority was limited to overpayments made in FY 2008 and FY 2009. The recoupment adjustment required by ATRA is a one-time recovery of prior overpayments, not a permanent reduction to payment rates. Therefore, any adjustment made to reduce rates in one year would eventually be offset by a positive adjustment, once the necessary amount of overpayments is recovered.

CMS actuaries estimate that a -9.3 percent adjustment to the standardized amount would be necessary if CMS were to fully recover the full $11 billion required recoupment in FY 2014. As it has done in the past, CMS proposes to phase in the adjustment beginning with a -0.8 percent recoupment adjustment to the standardized amount in FY 2014. If adjustments of approximately -0.8 percent are implemented in FYs 2014, 2015, 2016 and 2017, using standard inflation factors, CMS estimates that the entire $11 billion would be accounted for by the end of the statutory four-year timeline. The FY 2014 proposed rule does not, however, propose specific adjustments for FYs 2015, 2016 or 2017.

The Premier alliance appreciates CMS' proposal to apply only a 0.8 percent to payments in FY 2014 with expected 0.8 percent reductions each year through 2017. The Medicare payment Advisory Commission (MedPAC) recommended a 1 percent net increase in payment for inpatient hospitals in FY 2014 given an estimated *negative* 6.0 percent profit margin in FY 2013 and other factors. As it stands under the proposed rule, hospitals will receive a net update of 0.8 percent. If CMS were to implement an even greater adjustment in FY 2014 it would jeopardize hospitals' ability to continue providing the high-quality services we expect. **Premier supports CMS' proposal to reduce payments by 0.8 percent as its first step in recouping the require $11 billion required under ATRA.**

Prospective Adjustment Related to FY 2010

In FY 2013, CMS proposed but did not finalize an additional -0.8 percent prospective adjustment to the standardized amount to account for documentation and coding changes occurring in FY 2010. After further analysis of public comments, including MedPAC's, CMS states that it believes a reduction of 0.55 percent would be more appropriate, but does not propose to implement it in FY 2014. **We support CMS postponing the cuts related to 2010 services until a future date and reducing them to 0.55 percent given the extent of the existing cuts proposed for FY 2014.**

DISCHARGE STATUS CODES

CMS proposes to add 16 new discharge status codes to the CMS GROUPER and the MCE logic effective October 1, 2013. One code would identify patients being discharged or transferred to an alternative site that will provide basic patient care during a disaster response (69, Discharged/transferred to a designated disaster alternative care site). The other 15 codes correspond with identifying planned acute hospital inpatient readmissions (for example, code 81, Discharged to home or self-care with a planned acute care hospital inpatient readmission).

We appreciate that CMS has taken our previous comments into consideration and proposed a process to track planned readmissions. We believe that systematically tracking such readmissions is an important step in determining if such planned readmissions should be removed from the Hospital Inpatient Quality Reporting (IQR) readmission measures and the Hospital Readmission Reduction Program (HRRP). We remain concerned that certain hospitals that treat conditions requiring planned or staged admissions may be disadvantaged by the existing measures, although to a lesser extent under the proposed revisions to the measures. **We support CMS' efforts to create additional discharge status codes to track planned readmissions and include such information in future readmissions research.**

REFINEMENT OF RELATIVE WEIGHT CALCULATION

Since FY 2009, the relative weights have been cost-based rather than hospitals' billed charges. Due to concerns about "charge compression," the hospital practice of applying higher charge mark-ups to lower cost items and applying smaller charge mark-ups to higher cost items, CMS added a series of cost centers to the cost report including: Implantable Devices Charged to Patients, Computerized Tomography (CT), Magnetic Resonance Imaging (MRI), and Cardiac Catheterization. For FY 2013, costs were determined by calculating CCRs for 15 cost centers from hospital cost reports and using national CCRs to convert billed charges to costs. In FY 2014, CMS proses to create CCRs for each of the new cost centers bringing the total to 19.

According to CMS, using the December 2012 update of FY 2011 HCRIS, CMS can calculate a valid implantable device CCR for 2,285 IPPS hospitals, a valid MRI CCR for 1,402 IPPS hospitals, a valid CT scan CCR for 1,470 IPPS hospitals, and a valid cardiac catheterization CCR for 1,022 IPPS hospitals. We are concerned that CMS concluded that there are sufficient data in the FY 2011 cost reports to support a meaningful analysis of using distinct CCRs, but did not share how it arrived at that conclusion. We are unclear if, for instance, 1,022 hospitals reporting cardiac catheterization are representative since it is less than a third of the total hospitals. Perhaps given that not all hospital performs such procedures, this is all that are expected to report, but CMS does not provide such information. **CMS should report in the final rule**

how it determined that the level of reporting on these new cost centers was sufficient for use.

We used the Premier QualityAdvisor™ software product database to examine the cost to charge ratios of the new cost centers proposed for FY 2014. The Premier database currently contains data from more than 309 million patient encounters, or approximately one in every four discharges in the nation. The Premier database contains data from standard hospital discharge files, including a patient's demographic and disease state, and information on billed services, including medications, laboratory, diagnostics and therapeutic services in de-identified patient daily service records. In addition to the data elements available in most of the standard hospital discharge files, the Premier database also contains a day of service-stamped log of billed items, including procedures, medications, laboratory, and diagnostic and therapeutic services at the individual patient level. All procedures and diagnoses are captured for each patient, as well as all drugs and devices received. Drug utilization information is available by day of stay and includes quantity, dosing, strength used and cost.

Hospitals with Premier's QualityAdvisor software product have the option of submitting costs based on procedural accounting or the tool will back into costs using cost-to-charge ratios found on the most recent (final) Medicare cost report. Procedural accounting, also known as activity-based costing, is a more accurate way to determine costs. This method relates costs to activity drivers rather than just fixed and variable designations, and attempts to tie areas that are often considered overhead under traditional methods to their associated activities. Hospitals that do not use procedural costing often associate overhead to product costs through very general allocation methods such as by square footage. This method can also include very sophisticated methods where actual product costs are included in the estimates and resource intensity is accounted for based on relative value units. The idea is to identify all activities contributing to cost in order to understand where to eliminate activities that do not add value.

We focused our analysis on the relationship between charges and costs for procedures and supplies associated with the new CCRs: CT scans, MRI procedures, procedures associated with cardiac catheterization, and implantable devices. Given the two options for cost accounting, we were able to compare proxy, charge-weighted cost-to-charge ratios (total costs divided by total charges, limited to Medicare fee-for-service patient discharges from IPPS hospitals and trimmed in accordance to the CMS methodology) derived from procedural accounting data with ratio of cost to charge or "RCC" data. We assumed that differences in cost attribution would be apparent in the two methods. If the CCRs constructed from procedural based cost accounting hospital data were very different from the CMS published CCRs, it may indicate hospitals were not appropriately allocating costs associated with the procedures mapped to the new cost centers. Our results show close agreement between our calculated cost-to-charge ratios and what CMS published for the FY 2014 CT scan, MRI, implantable devices charged to patients, and cardiac catheterization, as shown in Table 1. Note that the RCC Based Cost Accounting hospitals approximately align with the previous cost center CCRs as those costs were initially derived from applying cost-to-charge ratios from the Medicare cost report under the old cost centers to the reported charges. Thus, these CCRs do not suggest that the new CCRs are flawed, but rather are a tautological result of the method used.

Table 1. CCRs for New Cost Centers – FY 2014 Proposed versus Premier Proxies

	CMS Proposed (Based on 19 CCRs)	CMS Final FY 2013 (Based on 15 CCRs)	All Premier Hospitals		Procedural Based Cost Accounting		RCC Based Cost Accounting	
New Cost Centers			N	CCR	N	CCR	N	CCR

CT Scans	0.045	0.136	463	0.076	302	0.066	161	0.10
MRI	0.091	0.136	463	0.119	302	0.108	161	0.14
Implantable Devices	0.361	0.335	456	0.342	298	0.345	158	0.33
Cardiac Catheterization	0.135	0.145	338	0.149	219	0.128	119	0.20

While the similarity between the CMS published CCRs and the proxy CCRs from our procedural based cost accounting hospitals gives us some comfort that the new cost centers are capturing costs as intended, we remain somewhat concerned that hospitals, whether in Premier data or Medicare data are not consistently reporting costs, particularly for CT scan and MRI. We urge CMS to further investigate the reasonableness of the reported costs, with particular attention to whether capital costs are being properly allocated as opposed to distributed based on square footage as noted in the RTI report as a possible problem. **We support CMS using data from the new implantable devices charged to patients and cardiac catheterization cost centers to formulate new CCRs for calculating DRG relative weights, but urge CMS to conduct additional validation analyses on CT scan and MRI before proceeding with their inclusion in the weight calculations.**

We also are concerned about the somewhat dramatic swings in certain DRG relative weights. As shown in Table 2, 10 DRGs drop by more than 5 percent and one by nearly 8 percent.

Table 2:

MS-DRG	Type	Title	Potential Relative Weight with 15 CCRs	Potential Relative Weight with 19 CCRs	% Char
090	MED	Concussion without CC/MCC	0.7614	0.7013	-7.9%
084	MED	Traumatic Stupor & Coma, Coma > 1 hour without CC/MCC	0.9137	0.8516	-6.8%
087	MED	Traumatic Stupor & Coma, Coma < 1 hour without CC/MCC	0.7899	0.7369	-6.7%
965	MED	Other Multiple Significant Trauma without CC/MCC	1.0450	0.980	-6.1%
185	MED	Major Chest Trauma without CC/MCC	0.7281	0.6845	-6.0%
089	MED	Concussion with CC	0.9959	0.9366	-6.0%
123	MED	Neurological Eye Disorder	0.7355	0.6920	-5.9%
343	SURG	Appendectomy without Complicated Principal Diagnosis without CC/MCC	0.9880	0.9517	-5.7%
053	MED	Spinal Disorders and Injuries without CC/MCC	0.9355	0.8825	-5.7%
066	MED	Intracranial Hemorrhage or Cerebral Infarction without CC/MCC	0.8034	0.7579	-5.7%

Table 3 shows the top 10 extremes in the other direction all gaining more than 5 percent. The single greatest gain is nearly 7 percent.

TABLE 3:

MS-DRG	TYPE	TITLE	Potential Relative Weight with 15 CCRs	Potential Relative Weight with 19 CCRs	% Chan
454	SURG	Combined Anterior/Posterior Spinal Fusion with CC	7.6399	8.0563	5.5%
455	SURG	Combined Anterior/Posterior Spinal Fusion without CC/MCC	5.9862	6.3133	5.5%

484	SURG	Major Joint and Limb Reattachment Procedure of Upper Extremity without CC/MCC	2.1211	2.2380	5.5%
225	SURG	Cardiac Defibrillator Implant with Cardiac Catheterization without AMI/HF/Shock without MCC	5.6298	5.9530	5.7%
223	SURG	Cardiac Defibrillator Implant with Cardiac Catheterization with AMI/HF/Shock without MCC	6.0956	6.4482	5.8%
458	SURG	Spinal Fusion Except Cervical with Spinal Curve/Malignant/Infection OR 9+ Fusion without CC/MCC	4.8794	5.1630	5.8%
245	SURG	AICD Generator Procedures	4.4627	4.7320	6.0%
849	MED	Radiotherapy	1.3423	1.4258	6.2%
946	MED	Rehabilitation without CC/MCC	1.1295	1.2024	6.5%
227	SURG	Cardiac Defibrillator Implant without Cardiac Catheterization without MCC	5.2193	5.5714	6.7%

While it is relatively few DRGs, we note that many of the negatively affected DRGs are trauma related, and many of the positively affected DRGs are cardiac and orthopedic related. Thus, specific types of hospitals have more to gain or lose under the policy based on their mix of services. Moreover, CMS should consider whether an immediate move to such a policy would unduly incent volume growth in procedures as most of the DRGs that will see a dramatic increase are surgical, while the DRGs that expect reductions are medical. **CMS should implement a dampening policy to give hospitals an opportunity to budget for such shifts and avoid unintended consequences.**

There are many examples in CMS' history where it has transitioned to policies to ensure no unintended consequences arise. When the cost-based weights and MS-DRGs were implemented it was in a staged fashion with a blend. Similarly, in the early years of the outpatient PPS CMS applied a dampening policy to smooth the shifts in Ambulatory Payment Classification weights. It is not yet clear, since the cost centers are relatively new

and not all hospitals are reporting them, whether the data will be stable over time. **To avoid unintended consequences, CMS should blend the old and new weights on a 70/30 basis in FY 2014 and then revisit the blend in FY 2015 once new cost report data is available. CMS should also consider the magnitude of the impact on Ambulatory Payment Classifications and a payment blend in the Outpatient PPS proposed rule this summer.**

DISPROPORTIONATE SHARE HOSPITAL

Section 1886(d)(5)(F) of the Act provides for additional Medicare payments to PPS hospitals that serve a significantly disproportionate number of low-income patients. The ACA revised the methodology for computing the Medicare DSH payment adjustment. Beginning with FY 2014 discharges, hospitals that qualify for Medicare DSH payments will receive two separately calculated payments. The first payment will equal 25 percent of the amount they previously would have received under the current statutory formula for Medicare DSH payments that will be called the "empirically justified" Medicare DSH payment. The remaining amount, equal to an estimate of 75 percent of what otherwise would have been paid as Medicare DSH payments, reduced to reflect changes in the percentage of individuals under age 65 who are uninsured, is used make additional payments to each hospital that qualifies for Medicare DSH payments and that provides uncompensated care. CMS refers to these additional payments as the "uncompensated care payments."

Empirically Justified

CMS proposes to maintain the established method for distributing the "empirically justified" DSH payments, or 25 percent of what otherwise would have been paid. This portion is retained by DSH hospitals as MedPAC studies concluded that this portion could be mathematically justified as accounting for the higher costs associated with treating low-income patients, whereas the

remaining 75 percent is generally considered a subsidy for uncompensated care. **We support CMS proposal to use the existing methodology to determine the empirically justified DSH payments and distribution processes.**

CMS should also make clear in the final rule that 340b eligibility will not be affected by the changes in the DSH calculation and payment. Given that the empirically justified payments will continue to be calculated under the old methodology without change, we believe it should be easy for CMS to continue establishing 340b eligibility on the DSH operating percentage as in the past.

Uncompensated Care Payments

The statute provides that the uncompensated care payment is to be determined as the product of three factors:

1) Factor 1 equals 75 percent of the aggregate DSH payments that would otherwise be made under section 1886(d)(5)(F) without application of the DSH changes made by the ACA;

2) Factor 2 is a ratio of the percent of the population who are insured in the most recent period following implementation of the ACA to the percent of the population who were insured in a base year prior to ACA implementation; and

3) Factor 3 is determined by 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.

Factor 1

Factor 1 is the difference between CMS' estimates of: (1) the amount that would have been paid in Medicare DSH payments for FY 2014 and subsequent years, in the absence of the ACA payment provision; and (2) the amount of empirically justified Medicare DSH payments that are made for FY 2014 and subsequent years,

which takes into account the requirement to reduce Medicare DSH payments by 75 percent. The statute gives CMS authority to estimate these amounts recognizing that under a prospective payment system, CMS would not know the precise aggregate Medicare DSH payment amount that would be paid for a Federal fiscal year until cost report settlement for all IPPS hospitals is completed, which occurs several years after the end of the Federal fiscal year. We note that CMS did not detail its assumptions around the expansion of Medicaid and it included a 2 percent documentation and coding adjustment, rather than the proposed 0.8 percent. **We support the methodology proposed by CMS to calculate Factor 1 of the uncompensated care payment equation, but urge CMS to recalculate it for the final rule with the corrected documentation and coding adjustment.**

Given potential errors or underestimations, CMS should annually recalculate the prior year's pool to ensure that CMS was not dramatically off in its estimates given that providers cannot appeal this calculation. If a major error is found, CMS could adjust the pool for the following year to account for the over or under estimate of the prior pool. **CMS should establish an annual review process to prospectively correct material misestimations of Factor 1.**

Factor 2

Factor 2 is based on the percent change, essentially since implementation of the ACA, in the percent of individuals under the age of 65 who are uninsured. CMS proposes that the amount available for uncompensated care payments for FY 2014 will be $8.217 billion (0.888 times its proposed Factor 1 estimate of $9.2535 billion), subject to changes in the final rule to reflect more recent Congressional Budget Office (CBO) estimates.

CMS' proposal reduces overall Medicare DSH payments by more than $1 billion based on the CBO assumption that there will be a two percent reduction in the number of uninsured Americans during FY 2014. However, we believe this projection is overly optimistic as enrollment does not begin until October 1, 2013 and

coverage does not begin until January 1, 2014. While we recognize that CMS is required to use the CBO estimate to measure the projected increase in the rate of people with health insurance, we believe CMS should recognize that the CBO estimate is based on a calendar year while Medicare DSH funding is addressed on a Federal fiscal year basis. The best way to adjust for this, we believe, is to normalize the CBO estimate by using a weighted average to blend the estimates for the parts of the two separate calendar years that are part of FY 2014.

In February 2013, CBO estimated that 80 percent of the non-elderly population will have insurance in *calendar year* 2013 and 84 percent of the non-elderly population will have insurance in *calendar year* 2014. To determine the *FY* 2014 rate of insurance coverage, we propose using one quarter of CBO's calendar year 2013 estimate and three quarters of CBO's calendar year 2014 estimate. The result is an FY 2014 rate of insurance coverage of 83 percent. This is the case because:

(80% *0.25) + (84% * 0.75) = 83%

Because CBO estimated coverage rates of 82 percent for both calendar years 2012 and 2013 in its March 2010 report, the FY 2013 coverage estimate would remain 82 percent.

This normalizing methodology would enable CMS to continue using the CBO estimates, as required by statute, but would account for a portion of the estimated insurance increases not occurring until after the fiscal year in which the cuts are made – a distinction with dramatic consequences.

Calculating Factor 2 according to the proposed rule:

> "Percent of individuals without insurance for 2013: 18 percent
> Percent of individuals without insurance for 2014: 16 percent
> 1 – |[(0.16 - 0.18)/0.18]| = 1 - 0.111 = 0.889 (88.9 percent)
> 0.889 (88.9 percent) - 0.001 (0.1 percentage points) = 0.888 (88.8 percent)
> 0.888 = Factor 2"

Calculating Factor 2 with the normalized estimates proposed above:

> Percent of individuals without insurance for 2013: 18 percent
> Percent of individuals without insurance for 2014: 17 percent
> 1 – |[(0.17 - 0.18)/0.18]| = 1 - 0.056 = 0.944 (94.4 percent)
> 0.944 (94.4 percent) - 0.001 (0.1 percentage points) = 0.943 (94.3 percent)
> 0.943 = Factor 2

This, in turn, would require adjusting the reduction of the uncompensated care pool from 88.8 percent of Factor 1 to 94.3 percent of that factor, or from the proposed $8.217 billion (at the 88.8 percent rate) to $8.726 billion (at the 94.3 percent rate). In this manner, CMS would avoid imposing more than $500 million in inappropriate Medicare DSH cuts on eligible hospitals in FY 2014 for insurance increases that will not occur until FY 2015. **We support the methodology proposed by CMS to calculate Factor 2 of the uncompensated care payment equation, but urge CMS to normalize the calendar year CBO estimates to reflect the payment fiscal year.**

Factor 3

Factor 3 is a hospital-specific value that represents the proportion of the estimated uncompensated care amount attributed to each PPS hospital with the potential to receive DSH payments relative to the estimated uncompensated care amount for all hospitals estimated to receive DSH payments in the fiscal year for which the uncompensated care payment is to be made. The product of Factors 1 and 2 determine the total pool available for uncompensated care payments. This product multiplied by Factor 3 determines the amount of the uncompensated care payment that each eligible hospital will receive.

The statutory requirements for this factor requires the Secretary to determine: (1) the definition of uncompensated care; (2) the data source(s) for the estimated uncompensated care amount; and (3) the timing and manner of computing the quotient for each hospital estimated to receive DSH payments.

Data Sources

The statute instructs the Secretary to estimate the amounts of uncompensated care for a period "based on appropriate data." In addition, it permits the Secretary to use alternative data if the Secretary determines that available alternative data is a better proxy for the costs of PPS hospitals for treating the uninsured.

CMS states that applying a definition of uncompensated care costs based upon information reported on the Worksheet S-10, the only national data source with a consistent definition of uncompensated care costs, would require using the 2010/2011 cost reports, which were submitted on or after May 1, 2010, when the revised Worksheet S-10 went into effect. These are the most recently available full year of cost reports and the first cost reports with detailed uncompensated care data on Worksheet S-10 that would be available for use in implementing the new methodology for uncompensated care payments for FY 2014.

Given stakeholders concern about the accuracy and consistency of the data through the S-10 reporting mechanism, CMS does not propose to use the Worksheet S-10 at this time. CMS estimates that 2,349 hospitals, or 68 percent of all applicable hospitals, would be eligible for DSH payments in FY 2014. The Premier healthcare alliance analyzed the FY 2010 and FY 2011 cost report data (hospital cost report form 2552-10) and found that about one-third of hospitals expected to qualify for DSH payments in FY 2014 did not have a cost report in HICRIS during that time period, and therefore are missing uncompensated care cost information at this time. A very small number of hospitals (0.5 percent) failed to fill in the uncompensated care cost amounts on their submitted cost report. With only two cost reporting fiscal years for the revised Worksheet S-10, CMS does not have the ability to look back at historical cost reports for the uncompensated care cost information.

Premier also analyzed the S-10 data to assess its accuracy. We see wide variation in reported uncompensated care costs, both for charity care and non-Medicare bad debt costs, even within groups

of similar types of hospitals (i.e., by size, urban or rural status, teaching status, and control type). The range for all hospitals that submitted Worksheet S-10 data on the 2010 Medicare cost report form in FY 2011 or FY 2010 was -$1.14 million to $320.3 million. Charity care costs were reported on line 23, column 3 and non-Medicare bad debt costs were reported on line 29 of Worksheet S-10. We understand CMS must use a standardized measure that is available for all hospitals eligible for DSH payments for FY 2014. **Thus, we support CMS' proposal to forgo using the Worksheet S-10 to calculated Factor 3 at this time due to concerns about its completeness and accuracy.**

We believe that the instructions for Worksheet S-10 still require clarification to ensure standardized and consistent reporting by hospitals. For example, there is a separate line for out of network care; however, this should be either charity care or bad debt. If the service is not covered because it is out of network, then the case should be considered against charity rules to determine such eligibility. If not, then the patient should be expected to pay reduced charges, which would in turn become bad debt if the patient did not fulfill this expectation. Confusion over this line is resulting in hospitals reporting costs in ways that are not comparable. Another example is the non-Medicare bad debt calculation. If a hospital fails to record total bad debt for the entire hospital complex (Line 26), but does record a Medicare bad debt amount (Line 27), non-Medicare and non-reimbursable bad debt expense will be a negative value (Line 28 is defined as Line 26 minus Line 27). We note that some hospitals record negative values for the entire hospital complex as well. **CMS must ensure that the instructions associated with the Worksheet S-10 are as clear as possible. Furthermore, CMS should issue FAQs and provide educational events to ensure that the cost reports are filled out properly and comparably to ensure an apples to apples comparison in Factor 3.**

In addition, we point out that the initial instructions on the Worksheet S-10 refer to the statutory requirement for hospitals to report costs "incurred by the hospital for providing inpatient and

outpatient hospital services." However, the instructions for line 20 direct the hospital to report gross charges for charity care for the "entire facility," which is generally understood to include portions of the facility on the cost report that are not paid under inpatient PPS/outpatient PPS such as inpatient rehabilitation/psychiatric facilities and skilled nursing facilities. This is problematic as charity care is reduced to cost on line 21 using the hospital cost to charge ratio on line 1. Given that the CCR for the hospital and the subparts are in many instances very different, this will lead to an inappropriate reporting of charity care costs. A similar problem occurs on line 26 for bad debt reporting. **CMS needs to clarify its instructions as to whether providers should report only charity care charges and bad debt expense related to inpatient and outpatient services on line 20 and 26. If CMS intends for providers to report subpart charity care charges, this should be done with separate lines and have corresponding separate lines for CCRs to accurately adjust charges for each provider type to cost.**

We thought that CMS contractors had begun to audit the Worksheet S-10 due to its use in the EHR incentive program, but we note that HCRIS is not showing an audit flag for any facilities in its latest release. We support auditing this information because the accuracy of all payments are in question when certain hospitals misreport information due to the relativity of the calculation. However, we also note that there are no published charity care audit instructions for Medicare contractors to follow when reviewing charity care and non-Medicare bad debt. CMS should develop such guidelines and they should be similar to those for allowable Medicare bad debt. **CMS should institute a fatal edit in cost report audit process for negative or zero uncompensated care costs, and undertake wider spread auditing of the Worksheet S-10 in preparation for its use in calculating uncompensated care payments in the future.**

Furthermore, as we understand it, the S-10 is not subject to appeal as it currently has no settlement impact. As we understand it, in order to appeal an auditor adjustment to the PRRB there must be

an impact of at least $10,000. If CMS plans to use the S-10 for DSH purposes and the future and directs its contractors to begin auditing the worksheet, hospitals should be able to appeal a disallowance made by an auditor. At this point, hospitals would not be able to demonstrate a financial impact as its use has not been finalized and the impact would be years in the future. **CMS should consider how to allow providers to appeal disallowances based on auditor reviews of the S-10.**

For FY 2014, CMS instead proposes to determine Factor 3 using insured low-income patient days from the 2010/2011 cost reports (including the FY 2011 or FY 2010 SSI ratios, whichever represents the most recently available inputs prior to October 1, 2013) as an alternative data proxy for the treatment costs of uninsured patients. It further proposes to define insured low-income patient days as inpatient days of Medicaid patients plus inpatient days of Medicare SSI patients as defined in 42 CFR 412.106(b)(4) and 412.106(b)(2)(i), respectively. One advantage to this proxy is that CMS could use older cost reports to fill missing values in the current cost reports as these data are well-established.

We tested the validity of using the ratio of low income days as a proxy for the ratio of uncompensated care costs as reported on the Worksheet S-10. These two measures are strongly correlated overall ($r = 0.75$ Spearman correlation coefficient, $r = 0.64$ Pearson correlation coefficient), but less so when certain hospital characteristics are factored into the analysis. The two measures are highly correlated for large, urban, teaching hospitals but somewhat less so for non-teaching, rural, and smaller hospital providers (see Table 4). Although the variation in reported uncompensated care costs on the S-10 is quite high, the variation observed in low income days is also quite high (see Figures 1 and 2). The coefficient of variation for low income days for all hospitals that submitted an FY 2010/2011 cost report using the new form was 1.38 while the coefficient of variation in the uncompensated care cost data from this same set of hospitals was 1.62. After log transformation to control for the long-tail distribution of both low income days and uncompensated care costs, the standard

deviations are comparable (0.134 compared to 0.136 respectively). **The Premier healthcare alliance supports the use of Medicaid and Medicare SSI days as the best available proxy for uncompensated care in FY 2014.**

Table 4. Correlation Analysis of Low Income Days and Uncompensated Care Costs

	N	Pearson R-Value	Spearman R-Value
All Hospitals	**1,666**	**0.64183**	**0.74852**
Large	365	0.5123	0.48199
Medium	802	0.40995	0.38491
Small	499	0.37276	0.51509
Teaching	545	0.58425	0.66949
Non-Teaching	1,121	0.49371	0.68546
Urban	1,265	0.63418	0.68245
Rural	401	0.30118	0.66811

Figure 1. Distribution of Uncompensated Care Costs and Low Income Days

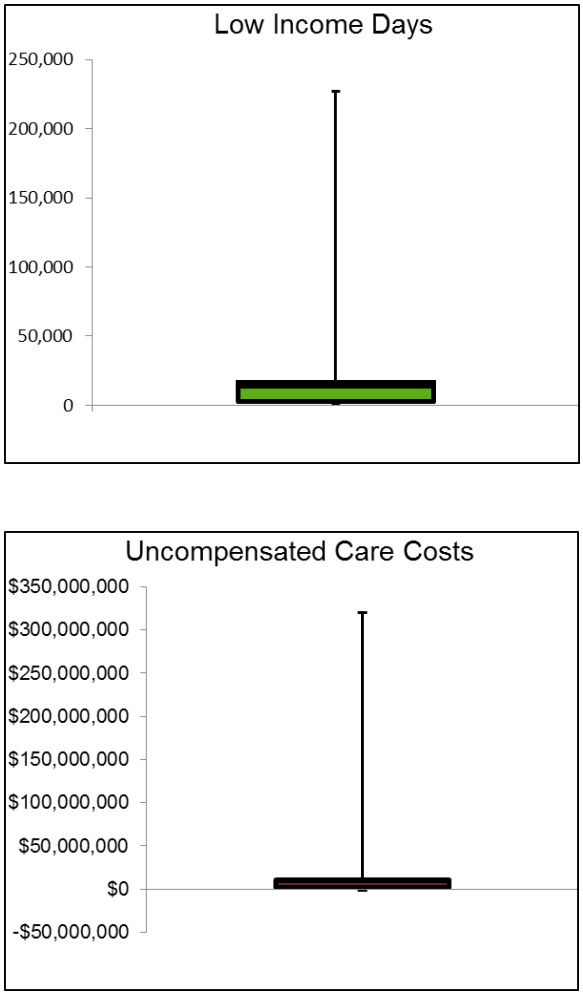
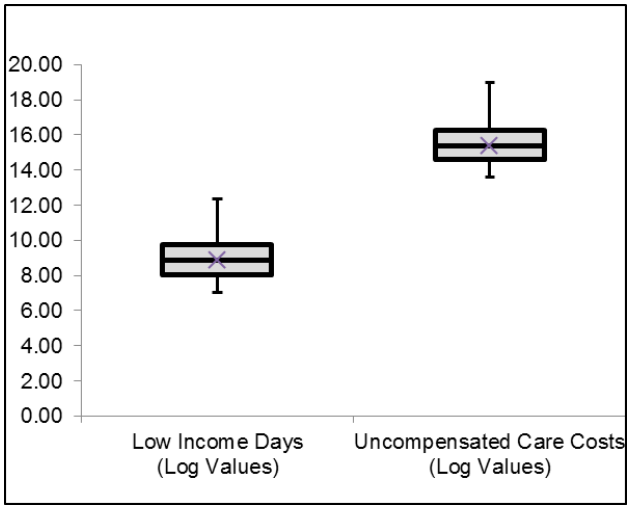


Figure 2. Distribution of Uncompensated Care Costs and Low Income Days, Log Values



As we note above, charity care costs for uninsured patients derive from all inpatient and outpatient services, but are a higher-than-average share of inpatient psychiatric costs. Therefore, to improve the insured low-income days proxy for uninsured costs, it is recommended that CMS include exempt unit days in the proxy. The impact of this change would be a modest increase in the uncompensated care redistribution, but it is warranted.

CMS did not specify how Medicaid expansion would be accounted for in the methodology for calculating Factor 3 in future years. We are concerned that the relationship between low income utilization days and uncompensated care costs will degrade over time, potentially disproportionately for some hospital types and geographic areas, with the expansion of Medicaid. In states where Medicaid is expanding, it will be inversely related with uncompensated care. **Given our concerns about the long-term reliability of the proposed proxy days and its ability to outperform the S-10 data, Premier believes that CMS should only temporarily rely on the proxy.**

CMS indicates that it "may propose" to use data on the Worksheet S-10 to determine uncompensated care costs in the future, once hospitals are submitting accurate and consistent data through this reporting mechanism. CMS should definitively state its intention to use the S-10 data for calculating uncompensated care payment and

put forth an expected timeline to provide hospitals incentive to more accurately report. CMS should consider a blended Factor 3 that would use S-10 cost data and low income days at varying ratios over time, to eventually be fully based on the S-10 data. This will ensure a smooth transition without wide swings in payment. **In the final rule, CMS should clearly delineate a plan for the future adoption of the S-10 worksheet on the Hospital cost report in future years and consider a transitional blend of the two methodologies as part of that plan.**

Timing and Manner

CMS proposes to make these interim uncompensated care payments on a periodic basis and not on a per discharge basis, which affects multiple other calculations. For example, it affects the outlier payments as DSH is included in the calculation of costs to surpass the fixed-loss threshold. In addition, it affects the interim rates on which Medicare Advantage (MA) plans often base their payments. We are concerned that this will dramatically reduce payments to safety net hospitals in particular, but will affect a broad array of hospitals. If this policy was scheduled to begin in a few years, the facilities would be able to consider this in their contract negotiations, but there is not enough time and likely opportunity in the next four months. This unintended and unexpected decline in revenue is very concerning. Preserving uncompensated care payments for MA admissions is especially essential for hospitals in states participating in the Fully Integrated Duals Advantage (FIDA) demonstration, because MA penetration rates will increase significantly in that program. If CMS finalizes this policy, it should at least alter the PRICER similarly to how it deals with IME where there is an additional line to net it out. For DSH, it could have an additional line with a factor to gross up the payments. **CMS should either pay uncompensated care on a per-discharge basis, or if not, alter the PRICER to include the estimated uncompensated care payments to ensure interim rates are more accurate.**

CMS further proposes that cost report settlement would not include reconciliation of the values of Factors 1, 2, and 3 that were

established in the final rule. Reconciliation only would include adjustments for changes in whether the hospital actually was eligible to receive empirically justified DSH payments. We believe it makes most sense for CMS to continue paying DSH on a per-discharge basis. However, it could finalize the target uncompensated care amount in advance and only reconcile actual payments against this target amount. We recognize that reconciling all of the factors for each hospital as new data comes in would be an unwieldy iterative process.

CMS should build in a process, regardless of the payment method, for hospitals to review the uncompensated care CMS will use in its final calculations for Factor 3. As we have seen from the wage index process and readmissions adjustment, errors occur despite best efforts and transparency will help to bring these to light. We are not suggesting that CMS open up an avenue to provide additional information subsequent to cost report filing, but rather a data mishandling issue that is strictly a technical correction. **CMS should develop a process for hospital review of its Factor 3 numerator and allow a period for the correction of errors due to data mishandling.**

CMS also needs to consider what it will do for organizations that do not have data, whether it is under a policy with the proxy days or possibly in the future with the S-10, that is reasonable and equitable. For instance, new facilities will not have a cost report to rely upon for this calculation. **CMS should include a plan for how to handle hospitals with no cost report data in an interim-final rule and accept comments.**

MARKET BASKET REBASING AND REVISING

CMS rebases and revises the hospital market basket every four years. In this year's rule, CMS would establish FY 2010 as the base period for determining expenditures by spending category. The "all other" (residual) category derived from the cost report data represents about 31.9 percent of total costs. CMS proposes to

again use the 2002 Benchmark Input-Output (I-O) Tables created by the Bureau of Economic Analysis (BEA), U.S. Department of Commerce to disaggregate the "all other" cost category into more detailed hospital expenditure category shares, which allows for use of more appropriate price proxies. However, new BEA data based on 2007 are due to be released in the summer of 2013. CMS proposes to use the 2007 BEA data if they are available with sufficient time to incorporate the data into the final rule. **We support CMS' proposal to move to a 2010 based market basket. We further support the use of 2002 BEA data if it is not possible to move to 2007 data in the final rule.**

LABOR-RELATED SHARE

The Secretary periodically estimates the proportion of payments that are labor-related and subject to adjustment by the hospital wage index for those hospitals with an area wage index above 1.0. For those below 1.0, the labor-related share is fixed at 62 percent by law. Based on the updated weights for the cost categories by moving to a 2010 based market basket, the proposed rule would increase the labor related-share from 68.8 percent to 69.6 percent. **The Premier alliance supports the increase in the labor-related share for hospitals with area wage indices above 1.0.**

ADMISSION AND MEDICAL REVIEW CRITERIA

In the rule, CMS makes a series of proposals out of concern related to the growing length of stay for hospital observation services.

Admission Guidelines

CMS proposes to establish the following guidelines for when physicians should order an inpatient admission. It would create presumptions used in the medical necessity reviews of inpatient admissions based on how long the beneficiary spent, or was expected to spend, in the hospital as an inpatient. Medicare review contractors would be instructed to:

1. presume that the inpatient admission is reasonable and necessary for a beneficiary who requires
    a. more than one Medicare utilization day (meaning an encounter that crosses two "midnights") in the hospital receiving medically necessary services; or
    b. a procedure specified as inpatient only under 42 CFR 419.22; and
2. presume generally that services spanning less than two "midnights" should have been provided on an outpatient basis, absent clear physician documentation in the medical record specifying the relevant factors that support the physician's order and expectation that the beneficiary required an inpatient level of care.

We appreciate CMS' genuine effort to bring clarity to this area that has resulted in significant hospital resources being diverted to RAC appeals. However, we remain concerned because CMS uses terminology such as "presumed" reasonable. If providers remain vulnerable to RAC audits, even after the two-midnight-stay guideline is met, the policy will fall short of its goal. **Premier does not support the proposed admission guideline, but if CMS finalizes the policy, it should clearly state that cases that meet the guidelines will not be available for medical necessity review unless there is evidence of fraud and abuse.**

CMS proposes that the starting point for its time-based instruction is when the beneficiary is moved from any outpatient area to a bed in the hospital in which additional hospital services will be provided. We question this approach to beginning the "clock" for the two-midnight rule. When and if a patient is moved to an inpatient bed is not something that is commonly marked in the medical record or an EHR. Often times, the care of both groups of patients occurs in the same patient *setting*. All patients, whether inpatient or under observation, are cared for in an acute care hospital setting and receive the same level of care and complete scope of services required under the acute care hospital license. Though some patients have discreet limited clinical conditions that lend themselves to a directed assessment and management plan, others have complex medical conditions that require significant nursing evaluation and management, and intensely coordinated

care between multidisciplinary teams and ancillary services. The time at which a physician orders admission is, however, something that is commonly collected and documented. **If CMS finalizes the policy, it should revise the time-based instructions to begin when a physician orders inpatient admission.**

CMS also proposes to focus medical review efforts on inpatient admissions with lengths of stay less than or equal to one "midnight," which would not benefit from the presumption of medical necessity. We concur that it is fair to subject these cases to medical review if the reviewers adequately assess the medical record to ensure complex medical factors are considered. **CMS should ensure that its contractors appropriately review short stay cases to allow Part A payment when the documentation supports an admission rather than issuing de facto denials.**

We further urge CMS to consider the comments submitted by Premier and others in May on rebilling Part A services under Part B. If CMS will be reviewing essentially all cases of less than two midnights, the assumption is that many of those will fail to meet medical necessity criteria, making the rebilling rules all that more pertinent. **CMS should alter its timely filing requirements to ensure that services provided to patients as inpatients, but which must be rebilled as outpatient services, are extended.**

If CMS does not believe it can alter the time-based criteria to satisfy stakeholders, it could consider certifying medical necessity vendors. There are a few products relied on by the bulk of hospitals nationally. We would not want CMS to limit hospital choice, but to certify any qualifying vendors. Hospitals could rely on the results of these programs to justify appropriateness given the factors available at admission. However, physician decision making would still be relied upon in cases where it differed from the program's advice provided that the physician's decision is documented and approved by CMS contractors after review. **As an alternative, CMS could create a medical necessity software certification program so that hospitals could rely on these programs in admission decisions.**

In response to the CY 2013 proposed outpatient PPS rule, Premier suggested an alternative time-based rule, but from the reverse perspective of CMS' two-midnight rule. We urged CMS to consider an option that would create some certainty for hospitals and protect beneficiaries. Specifically, CMS could establish a payment policy whereby a patient would be deemed an inpatient, even though a physician order is not on file, after 72 hours of observation services. CMS would then pay hospitals a diagnosis related group (DRG) payment for these "deemed-admitted" patients and the inpatient deductible would apply to the patients. This is consistent with the existing policy whereby payments to hospitals for outpatient services provided within 72 hours of an admission are bundled into the DRG payment. As noted above, these patients are treated in the same setting and at the same level of care, so deeming the patients to be inpatients after the fact should not raise any concerns that certain patients are being treated differently. In fact, this *retrospective* time-based method should give us more confidence that the payment level matches the services received. Moreover, through separate rulemaking, CMS could modify its requirement for skilled nursing facility coverage so that the period of observation care is counted toward meeting the three-day requirement for patients who are subsequently admitted to the hospital, including these "deemed-admitted" patients. **CMS should consider a policy that automatically deems patients receiving more than 72 hours of observation services as inpatients and pays the hospitals accordingly.**

Another option CMS could consider is creating an "inlier" policy whereby short stay cases are subject to a reduced payment policy. This is similar to the concept of the home health low utilization payment adjustment or LUPA. Under the inpatient PPS, this might be consistent with the transfer policies whereby the payment is converted to a per diem with the first day paid two times the per diem and the per diem thereafter. Careful analysis and thought would have to be given to such a policy with significant stakeholder input, but could provide some certainty to providers when it is unclear if a patient should remain as an observation

patient or be admitted for a short stay. **CMS should also consider developing a short-stay payment policy.**

Budget Neutrality Adjustment

CMS proposes a rare exercise of its general authority to provide for exceptions and adjustments to IPPS payments under section 1886(d)(5)(I)(i) of the Act to offset the estimated additional costs of the proposed new admissions policies ($220 million) in FY 2014. CMS proposes to reduce the national standardized amount, the Puerto Rico-specific standardized amount, and the hospital-specific rates by 0.2 percent.

There is no statutory requirement that CMS make budget neutrality adjustments for changes in coverage decisions or service volume and it is long-standing inpatient PPS policy not to make such adjustments. Applying budget neutrality to volume changes or coverage decisions would violate the fundamental structure and policy that have governed the inpatient PPS since its inception in 1983. Inpatient PPS payments adjust automatically to both the level and reason (i.e., as reflected in service mix) of hospital admissions, which vary from year to year based on many factors, and these changes are incorporated into the base for determining budget neutrality in future years. The Secretary has never made budget neutrality adjustments for these changes.

CMS' proposal essentially is a coverage decision, or a clarification of policy, that the agency believes would lead to an increase in volume. Specifically, hospital services would be covered under Part A if the physician expects that the beneficiary's length of stay will exceed a two-midnight threshold or if the beneficiary requires a procedure specified as inpatient-only. The agency estimates that this coverage decision would lead to a net increase of 40,000 in inpatient hospital admissions. We emphasize that the proposal would *not* increase payment rates for inpatient cases, which are made budget neutral as part of the annual rate adjustment process,

but would only cause an increase in the volume of inpatient cases, which is not subject to budget neutrality.

In addition, we question CMS' projection that changes in inpatient volume will lead to a net increase in payments. The proposed rule merely asserts this conclusion and does not provide the assumptions and data behind it, thus denying our ability to review this critical element of the proposed policy. Moreover, inquiries made of CMS were not successful in obtaining additional information. We note that many hospitals which have simulated the impact of the proposed policy are projecting that their payments will decrease if the policy is finalized. They believe that the net effect of the changes will be a net decrease in Medicare payments for inpatient and outpatient services. **Premier requests that CMS not use its general exceptions authority to reduce inpatient PPS payment rates by 0.2 percent.**

OUTLIERS

CMS proposes that cases will qualify for outlier payments in FY 2014 if their costs exceed the inpatient PPS rate for the MS-DRG, including IME, DSH and new technology payments, plus a fixed-loss threshold of $24,140 up from $21,821 in FY 2013. For FY 2013, CMS estimates that it will pay out 5.17 percent of inpatient PPS payments for outlier cases, or 0.1 percent more than the 5.1 percent of payments withheld for outlier cases. In FY 2012, CMS estimates it overspent the set aside for outliers by 0.37 percent. However, we are concerned that CMS may not have actually calculated FY 2012 outlier payments, but rather continues to report an estimate. Furthermore, given the proposed change to remove 75 percent of DSH payments and pay them through periodic interim payment that would not be considered within the calculation of whether a case has surpassed the fixed-loss threshold, we urge particular caution in calculating the threshold accurately given that CMS does not go back and make adjustments. **CMS should rerun the 2012 actual spending, use more recent data to calculate the 2013 spending, and scrutinize its methodology for dealing with the DSH interaction based on its final policy.**

The proposed rule includes changes to improve the accuracy of its methodology for setting the outlier fixed-loss cost threshold consistent with the 5.1 percent target. First, CMS will determine the charge inflation factor using a one-year period of the most recent charge data instead of comparing periods using only the most recent 6 months of charge data. Specifically, it proposes to compare the second quarter of FY 2011 through the first quarter of FY 2012 (January 1, 2011, through December 31, 2011) to the second quarter of FY 2012 through the first quarter of FY 2013 (January 1, 2012, through December 31, 2012).

Second, it proposes to adjust the CCRs from the December 2012 update of the Provider of Services File (PSF) by comparing the percentage change in the national average case-weighted operating CCR and capital CCR from the December 2011 update of the PSF to the national average case-weighted operating CCR and capital CCR from the December 2012 update of the PSF. **Premier supports CMS' proposed alternations to the methodology to calculate the fixed-loss cost threshold to improve the simplicity and accuracy of the calculations.**

NEW TECHNOLOGY

Section 503 of the Medicare Modernization Act (MMA) of 2003 provided new funding for add-on payments for new medical services and technologies and relaxed the approval criteria under the inpatient PPS. This important provision was enacted to ensure that the inpatient PPS would better account for expensive new drugs, devices and services. We are pleased to see that CMS is proposing seven new technologies for FY 2014. However, Premier is disappointed that CMS has not increased the marginal payment rate. **CMS should pay 80 percent, rather than 50 percent, of the cost of the technology consistent with the outlier payment methodology, as we have previously requested.**

LOW-VOLUME ADJUSTMENT

The Affordable Care Act (ACA) of 2010 revised the criteria for the low-volume payment adjustment. While ATRA extended these criteria, the provision expires at the end of FY 2013. CMS proposes, for discharges occurring during FY 2014, to revert to the criteria in effect prior to FY 2011: the road mileage qualifying criterion reverts to 25 road miles from the nearest subsection (d) hospital, and the discharge qualifying criterion reverts to no more than 200 total (Medicare and non-Medicare) discharges. However, we note that CMS still has the authority under the original legislation to provide an adjustment for hospitals up to 800 discharges. **We urge CMS to mitigate the impact of the expiration of the enhanced low-volume adjustment by using its authority to adjust payments for hospitals with up to 800 rather than 200 discharges.**

GRADUATE MEDICAL EDUCATION

Labor & Delivery Days

In the FY 2013 inpatient PPS/LTCH PPS final rule, CMS included labor and delivery (L&D) patient days in the disproportionate patient percentage of the Disproportionate Share Hospital (DSH) payment adjustment for purposes of IME and DSH payment adjustments. CMS notes that some commenters observed that if these days are considered inpatient days, they should also be counted as patient days in allocating direct Graduate Medical Education (GME) payments. CMS proposes that patient days associated with maternity patients admitted as inpatients who receive ancillary labor and delivery services when the inpatient routine census is taken shall be included in the Medicare utilization calculation. This applies regardless of whether the patient actually occupied a routine bed prior to occupying an ancillary labor and delivery bed and regardless of whether the patient occupies a maternity suite (i.e., where labor, delivery, recovery, and postpartum care all occur in the same room).

Thus for cost reporting periods beginning on or after October 1, 2013, CMS would include Medicare L&D inpatient days in the numerator and all labor and delivery inpatient days in the denominator of the Medicare utilization ratio. CMS notes this proposal would also impact other Medicare policies where the number of patient days or a ratio of Medicare inpatient days to total inpatient days is used to determine eligibility or payment; however, it does not impact reasonable cost payments for routine inpatient services. CMS further acknowledges that this would reduce direct GME payments and estimates the proposal would save $15 million for FY 2014.

While we understand CMS' efforts to apply the policy consistently, we continue to disagree with the inclusion of L&D days for IME and DSH purposes. We believe this is inconsistent with longstanding CMS policy regarding services that typically are not covered by the Medicare program. More specifically, CMS' proposal is in direct conflict with the agency's policy on healthy newborn nursery beds, which are included in the *patient day* count but excluded in the *bed day* count. In the August 1, 2003, *Federal Register*, CMS explained the agency's rationale for treating healthy newborn beds differently in each context:

> The costs, days, and beds associated with a healthy newborn nursery are excluded from inpatient calculations for Medicare purposes. Meanwhile, for the purpose of computing the Medicaid patient share computation of the DSH patient percentages, these days are included both as Medicaid patient days and as total patient days. **Newborn nursery costs, days, and beds are treated this way because the costs are not directly included in calculating Medicare hospital inpatient care costs because Medicare does not generally cover services for infants. However, Medicaid does offer extensive coverage to infants, and nursery costs would be directly included in calculating Medicaid hospital inpatient care costs.** Therefore,

> these costs, days, and beds are excluded for Medicare purposes, but included for determining the Medicaid DSH percentage. (This policy was previously communicated through a memorandum to CMS regional offices on February 27, 1997.)

68 *Fed. Reg.* 45346, 45417 (August 1, 2003) (emphasis added).

Just as with healthy newborn nursery beds, L&D beds are used frequently for services to Medicaid patients (given that state Medicaid programs offer "extensive coverage" to large numbers of child-bearing women) but are not generally used for services provided to Medicare patients (given that very few Medicare recipients are even of child-bearing age). For the same reasons, then, CMS should exclude L&D bed days from the denominator of the IRB ratio and for DSH bed-counting purposes, while also continuing to include L&D patient days for purposes of calculating the DPP. **Excluding L&D days would maintain consistency between similarly situated labor and delivery and healthy newborn nursery services that are not typically covered Medicare services.**

In changing the agency's policy in FY 2010 to count L&D patient days in the calculation of the DPP, CMS stated in the *Federal Register* that the policy "would not affect existing policies related to the allocation of costs for Medicare cost reporting purposes or for determining the number of available beds under § 412.105(b)(4) or § 412.106(a)(1)(i). In other words, our hospital instructions in the PRM-I for those purposes remain unchanged and unaffected by the proposed policy." CMS presumably had a logical rationale for continuing to treat these patient days and bed days differently in FY 2010, and Premier urges CMS to continue the distinction rather than inappropriately "aligning" the two definitions.

Excluding L&D beds from the facility bed count is also consistent with the CMS' longstanding definition of beds in the hospital cost report. The definition in CMS' instructions for cost report 2552-96, Worksheet S-3, Part I, states that

> Beds in labor room, birthing room, postanesthesia, postoperative recovery rooms, outpatient areas, emergency rooms, ancillary departments, nurses' and other staff residencies, and other such areas which are regularly maintained and utilized for only a portion of the stay of patients (primarily for special procedures or not for inpatient lodging) are not termed a bed for these purposes.

Clearly, L&D beds that are not also used for recovery and post-partum care are used "for only a portion of the stay" of any patient. **To remain consistent with this definition, CMS should exclude these beds from the bed count.**

CMS should rescind its change last year to include L&D days in the disproportionate patient percentage of the DSH payment adjustment and interns and residents to beds ratio for IME payment purposes. Furthermore, CMS should not include L&D patient days in allocating direct Graduate Medical Education (GME) payments.

MEDICARE DEPENDENT HOSPITALS

The Medicare Dependent Hospital (MDH) program will, under current law, expire on September 30, 2013. We very much appreciate that CMS is again seeking to provide a seamless transition for an MDH hospital applying for SCH classification effective October 1, 2013. CMS proposes that the MDH hospital would have to apply by September 1, 2013, and specifically request an effective date for the SCH classification concurrent with the expiration of the MDH program. If approved, CMS proposes an effective date of October 1, 2013, for the SCH classification. **We support CMS' special process to seamlessly covert MDHs under the expiring program to SCH status.**

INPATIENT QUALITY REPORTING PROGRAM

We appreciate that CMS is continuing to take a multi-year approach to proposing measures for the hospital Inpatient Quality Reporting (IQR) program, a strategy suggested in the past by the Premier healthcare alliance. In identifying new measures for the hospital IQR program, we continue to believe CMS should consider an assessment of the feasibility of constructing the measure from data contained in the typical hospital EHR, the degree to which the measure adds information not captured in other measures and the degree to which the measure captures an outcome as opposed to information on a "micro process" which might be subject to modifications based on evolving medical evidence. Choosing a manageable number of measures each year that meet these objectives is an appropriate way to steadily grow the program. Furthermore, all new measures for the Hospital IQR program should have a direct line of sight to the aligned objectives of the National Priorities Partnership, Health and Human Services (HHS) Strategic Plan and the National Strategy for Quality Improvement in Healthcare. Thus we appreciate CMS' effort to incorporate many of these steps in their review process and propose measures that meet these criteria.

ICD-10 codes

The ICD-10-CM/PCS is currently scheduled to begin October 1, 2014, yet we have seen no proposed re-specified quality measures based on ICD-10 for comment. CMS should release the measure specifications for all measures comment expeditiously as it may result in material differences in whether a measure remains appropriate for not only the Hospital IQR program, but also Value-Based Purchasing. **CMS should release re-specified existing Hospital IQR measures for comment and ensure that new measures developed for payment determination in FY 2017**

(measurement period CY 2015) and beyond are developed using the new code sets.

In addition, CMS should clarify how it will treat measures where the measurement period overlaps across ICD-9 and ICD-10 based payment periods. For instance, the mortality measures within the Hospital IQR program and publicly displayed on *Hospital Compare* uses a 'rolling' three year performance period from July 1, 2012-June 30, 2015 for FY 2017 measurement period. Thus, both ICD-9 (July 1, 2012- September 30, 2014) and ICD-10 (Oct 1, 2014 – June 30, 2015) based claims will feed this time period unless CMS establishes a crosswalk for the measure. Moreover, it is unclear how VBP baselines and performance periods that split ICD-9 and ICD-10 implementation years or when a baseline is in one period and the performance period in another will be handled within the VBP program. For instance, CMS is seeking comments on using a rolling two-year VBP performance period (24 months of data) for claims-based measures. Using the mortality measures as an example, CMS plans to use the FY 2017 performance period of July 1, 2013, through June 30, 2015, for payment determinations in FY 2018.Thus, a single performance period will be calculate based on claims spanning the transition between the code sets. **CMS should provide detail in the final rule about its plans to alter the quality measures within the Hospital IQR program based on ICD-10 and implement conforming changes within the VBP and accept comments on the proposals.**

Measures for FY 2016 payment determination

Public Display of Quality Measures

CMS proposes to continue its policy of publicly reporting data from the Hospital IQR Program as soon as it is feasible on the *Hospital Compare* or *Medicare.gov* websites. However, CMS specifically discusses public reporting regarding the AHRQ public safety indicators, in particular PSI-90, which is a composite measure of eight individual indicators. Based on feedback from consumer advocates and large purchasers, CMS proposes to make publicly available hospital level data for the individual indicators

as well as the composite. While the composite rate may be more useful for beneficiaries, the individual rates are critical to providers to determine areas of opportunity for quality improvement. **We support the posting of both the individual rates and composite on *Hospital Compare*.**

In general, CMS should post hospital-level data for all measures where the level of performance is used to calculate payment. This information is not only used by beneficiaries, but also by providers in assisting their quality improvement and budgeting efforts. This would include measures in the Value-Based Purchasing (VBP) program and the Hospital Readmission Reduction Program (HRRP), and the Hospital-Acquired Condition Reduction Program. In addition to CMS posting measure results specifically for beneficiaries in an easy to understand fashion (e.g., higher than expected, as expected, or lower than expected type displays), CMS should also consider provider and researcher needs and release raw rates in an Excel File format. This information is key to modeling the impact of CMS policy, determining provider opportunity, and monitoring trends in performance over time (including the appropriateness of measures). The detailed data can be released on the Medicare.gov site if there is concern that beneficiaries may stumble upon what might be a confusing display of information. **CMS should post the hospital-level data for any measures that are in are used in calculating payments in a timely and routine fashion.**

Furthermore, CMS is considering a "graphic display" of *Hospital Compare* data such as a star rating system. We encourage CMS to test different methods of clearly and easily communicating the information for beneficiaries using state of the art techniques. However, again, we stress that the actual raw rates should be available to individual providers as well as public use files of the measure results. **CMS should develop and test graphic depiction of measure results to improve beneficiary use of the *Hospital Compare* website.**

Measure Suspension

CMS proposes to continue the suspension of data collection on four measures unless there is evidence that performance on the measures is in danger of declining. These are:

- AMI-1: Aspirin at arrival (NQF #0132);
- AMI-3: ACEI/ARB for left ventricular systolic dysfunction (NQF #0137);
- AMI-5: Beta-blocker prescribed at discharge (NQF #0160); and
- SCIP INF-6: Appropriate hair removal (NQF# 0301).

The Premier healthcare alliance continues to support the suspension of AMI-1, AMI-3 AMI-5 and SCIP-Inf-6.

Measure Removal

CMS proposes to remove eight measures from the Hospital IQR Program for the FY 2016 payment determination and subsequent years including:

- IMM-1, Immunization for pneumonia (NQF #1653);
- PN-3b, Blood cultures performed in the emergency department prior to initial antibiotic received in hospital (NQF #0148);
- HF-1, discharge planning (NQF #0136);
- Participation in stroke registry;
- AMI-2: Aspirin prescribed at discharge (NQF #0142);
- AMI-10: Statin prescribed at discharge (NQF #0639);
- HF-3: ACEI or ARB for LVSD (NQF #0162; and
- SCIP-Inf–10: Surgery patients with perioperative temperature (NQF #0452).

CMS proposes removal of these measures because they are either "topped out" or no longer NQF endorsed/MAP approved. The exceptions are Participation in Stroke Registry, which is proposed for removal in favor of the chart-abstracted outcome measures of Stroke, and IMM-1, which CMS states it cannot feasibly alter to incorporate new Advisory Committee on Immunization Practices

guidelines. Premier has commented in the past that these reasons are appropriate grounds for removal from the IQR program. **The Premier alliance supports the removal of IMM-1, AMI-2, AMI-10, PN-3b, HF-1, HF-3, SCIP-Inf-10, and Participation in a Stroke registry from the Hospital IQR program.**

Measure Refinements

CMS proposes to make refinements to several IQR program measures. In all but one case the refinements are the result of the NQF measure maintenance process. The proposed measures to be refined are:

- 30-day readmission measures (for AMI, HF, PN, THA/TKA, and Hospital-Wide Readmission);
- CLABSI and CAUTI measures;
- SCIP Inf 4: Controlled 6AM Glucose for Cardiac Surgery Patients; and
- Medicare spending per beneficiary (MSPB).

Readmissions

CMS proposes to modify the various 30-day readmission measures (for AMI, HF, PN, THA/TKA, and Hospital-Wide Readmission) to incorporate an algorithm identifying planned readmissions beginning in 2013. The algorithm was endorsed by NQF during its review of the readmission measures. We appreciate CMS taking Premier's previous comments into consideration and making an effort to remove additional planned readmissions. However, in the readmissions section of this letter we provide additional suggested refinements to the measures to meet the statutory requirements under the Hospital Readmissions Reduction Program (HRRP). We also provide suggested refinements in the discussion of the new COPD and Stroke readmissions measures. **In the meantime, Premier supports the adoption of the refined readmission measures in the Hospital IQR program, but urges CMS to continue researching additional exclusions for planned readmissions.**

CLABSI and CAUTI

CMS proposes to expand the CLABSI and CAUTI measures to select non-ICU locations beginning with infections occurring on or after January 1, 2014. The locations are medical wards, surgical wards, and medical/surgical wards. CMS believes this expansion is consistent with the NQF update of these measures allowing for their application beyond ICUs.

Premier supported the adoption of the CLABSI and CAUTI measures in the Hospital IQR program specifically for ICUs within acute care settings. Collection beyond this setting will be very burdensome and labor intensive as it requires the manual collection of *all* device days for the denominator. For instance, CAUTI requires the collection of data on all patients with catheters, which are widespread across the hospital. Our members report that despite a significant move toward EHRs, the technologies' ability to identify device days is still somewhat variable and not yet precise enough on which to rely. For instance, an EHR might miss that while a Foley catheter was removed, it was replaced with a condom catheter before the patient was actually catheter free. In addition, a knowledge gap remains in the epidemiology of CAUTI, including the accuracy of surveillance definitions in select populations, (e.g., elderly patients) as identified in the National Action Plan to Prevent HAIs. Also, the CAUTI surveillance definitions are under review by the CDC and expected to change to increase sensitivity and specificity, and the NQF endorsed measure from 2009 is currently under annual review. **CMS should focus on ICU only because that is where patients are at most risk until more accurate surveillance definitions and validated ways to more simply collect the data are available.**

Premier partnered in a research project with the CDC and Rush Medical Center in Chicago to test the automation of blood stream infection detection through algorithms applied to clinically enhanced databases (i.e., pharmacy and laboratory data). We hope that the product of such research, along with other efforts, will lead to publicly available automated algorithms for both CAUTI and CLABSI that will further reduce the burden on hospitals in complying with such requirements. However, we question the rush to broaden the measure before there is availability of less burdensome paths, such as direct submission through electronic surveillance systems and electronic health records (EHRs), as well as automated data collection processes. If CMS adopts an expansion, the accuracy of the reporting may be greatly diminished, which is particularly concerning as CMS proposes to use these two measures as part of VBP *and* the new HAC program.

We recognize that small hospitals without ICUs will continue to conduct CAUTI surveillance in non-ICU settings; however, this should not be a requirement for all hospitals units until gaps in epidemiology are addressed. One additional concern is the calculation of rates. As we move to hospital-wide reporting, the hospitals that are doing their best to reduce the use of catheters

will look comparatively worse. For example, in calculating rates, as their device days are reduced from efforts to reduce catheter use, a stable number of infections or even a decrease in CAUTIs may look like an increase in CAUTI rates. When combining ICU rates with the rest of the hospitals, this would be exacerbated. Therefore, we are concerned about combining the ICU in with the rest of the hospital, rather than keeping the two areas separate. **CMS should retain the existing specifications and confine the data collection for CLABSI and CAUTI to ICUs within acute care hospitals, and should instead focus on developing an electronically specified hospital-wide measure that relies on ICD-10.**

CMS also notes in the rule that CDC was planning to submit a revised version of the CLABSI measure for NQF endorsement that would involve a reliability adjustment. While we very much support the concept of a reliability-adjusted measure that would better account for differences in patient case-mix, exposures to medical devices or procedures and unmeasured factors that cause variation in outcomes among hospitals, the measure changes are not yet NQF endorsed. Waiting to implement this measure until after it is NQF endorsed is also consistent with the recommendation of the MAP. **Thus, we support CMS' proposal to continue using the current CLABSI measure for FY 2016.**

SCIP Inf 4

CMS proposes revisions to the specifications for the measure SCIP Inf 4: Controlled 6AM Glucose for Cardiac Surgery Patients to incorporate recent NQF endorsement maintenance decisions, beginning with January 1, 2014, discharges. The NQF changed the measure from controlled glucose at 6AM to a more comprehensive measure of controlled glucose 18-24 hours post-cardiac surgery, and requires that corrective action be documented if post-operative glucose if over 180mg/dl. We await the full specifications this summer, but urge CMS to replace "corrective action plan," which calls to mind compliance infractions, and replace it with "improvement plan." **We support the adoption of the measure specification changes, assuming specifications are released, which will result in a more clinically meaningful measure.**

Medicare spending per beneficiary

CMS proposes to revise the Medicare spending per beneficiary (MSPB) measure to include Railroad Retirement Board beneficiaries for the FY 2016 payment determinations. **We have no reservations about adding the Railroad Retirement Board beneficiaries who are served under Medicare in the MSPB measure.**

However, we continue to have major reservations with the concept and construct of the MSPB measure that we outline below, and with the proposed application to Maryland facilities.

Appropriateness — There is no variation in hospital spending per DRG other than appropriate differences due to wage adjustments and add-on payments. The variation in hospital spending per episode is in readmissions, which are already captured by other measures and the HRRP. Thus, the major variation that this measure identifies, that is not otherwise accounted for in the IQR and VBP, is Part B spending and particularly the level and frequency of post-acute care use as can be seen in the slide below from a presentation by Deputy Administrator Jonathan Blum.

PREMIER

SLIDE REDACTED

We urge CMS to first develop measures of hospital efficiency that are limited to factors within the hospital's control and sufficiently risk adjusted, such as inpatient care-only measures, that can be implemented within the VBP program. CMS should also continue developing measures of efficiency across silos of care and payment, but such measures should be applied within the Medicare Shared Savings program and the Bundled Payment for Care Improvement initiative rather than hospital IQR and VBP programs as the right underlying financial incentives must be present to successfully implement such a measure within a payment system. Or, at minimum, should be applied within other programs such as the physician Value-Based Modifier at the same time. **Episode payment measures are not appropriate at this point unless they are part of an accountable care or bundled payment frameworks, or if comparably applied across all of the relevant settings.**

Adequacy — We would like to reiterate our concerns with the fact that the MSPB measure is not NQF endorsed. Furthermore, we remain very concerned that this measure has a poor predictive power. While the measure was voted out of the NQF committee, there were no votes for high reliability. This is particularly concerning given that the measure is included in not only the IQR, but in VBP. **CMS should make major refinements to improve the reliability of the measure expediently if it plans to continue its use in the IQR and VBP.**

Equity — Premier has additional concerns that the measure does not adjust for sex and race, because NQF discourages adjusting measures based on these factors. Premier strongly believes that the adjustment methodology for all measures should consider demographic factors such as age, sex, race and severity of illness, as well as the type of services being provided along with other factors such as socio-economic status.

Clearly, hospitals should not be encouraged to vary the standard of care by sex or race, and there is literature demonstrating that among Medicare beneficiaries, women and minorities meeting clinical criteria are less likely to receive certain procedures. However, Premier is concerned that by not adjusting the proposed measure for these factors, CMS would ignore underlying clinical differences. There is clear evidence that variations in socioeconomic factors and beneficiary characteristics affect healthcare expenditures. There is also precedent for such adjustments as the Medicare Advantage program adjusts payment for not only prior health conditions and age, but also beneficiary characteristics, including sex and status as working aged, Medicare disabled, and Medicaid enrollee. **CMS should stratify the measure based on dual-eligible status as a proxy for socio-economic status to ensure that safety net hospitals are not unduly penalized for factors outside their control.**

Coordination — CMS engaged several contractors to develop an episode of care grouper for use in Medicare payment, including the hospital stay. The episode grouper project was designed to implement two provisions of the ACA: the Improvements to the Physician Feedback Program; and the Value-based Payment Modifier under the Physician Fee Schedule. As part of its implementation of these provisions, CMS awarded contracts to four entities to design and build competing prototypes of a Medicare episode of care grouper system and accompanying software, and selected one to continue refining its methodology. In addition, the Innovation Center is in the process of rolling out its Bundled Payment for Care Improvement (BPCI) initiative in which

Premier is a facilitator convener. In BPCI, CMS has constructed episode definitions with some customization by the participants (e.g., length of episode).

It is not clear how or if these efforts will coalesce in the future. However, Premier believes that the techniques and learnings from the episode grouper project and BPCI could be helpful to the development of an appropriate measure of Medicare spending per beneficiary for the IQR and VBP programs. **CMS should consider how the episode grouper methodology and BPCI could be useful in developing more robust, consistent and appropriate measure of Medicare spending for the hospital IQR and VBP programs that recognizes factors within the control of hospitals.**

Maryland — CMS proposes to include Maryland hospitals in the MSPB measure and calculate rates for them. The proposed rule offers two methodologies for determining a base operating DRG payment amount for Maryland hospitals. However, neither methodology effectively recognizes that payments for disproportionate share and indirect medical education are not discretely identifiable in Maryland payments as they are in the national system.

Using Maryland's case payments would compare Maryland hospitals' costs, including all price differences, to national costs with nearly all price differences removed. This approach would intermingle Maryland hospitals' utilization and price differences and would result in hospitals with justifiably higher costs appearing to perform worse in managing utilization, and conversely for hospitals with inherently lower costs to appear to be better performers.

The other method CMS proposes is to adjust Maryland hospital payments for estimates of the amount of disproportionate share and indirect medical education in each hospital's rates. This approach is also not appropriate. In the year 2000, the Maryland Health Services Cost Review Commission developed a rate setting tool to

evaluate a hospital's efficiency, and later in the decade the tool was used to adjust hospitals' annual payment rate updates. The analysis compared the reasonableness of a hospital's inpatient charge per case to the charges of similar hospitals. It adjusted each hospital's charges for certain costs such as the labor market in which the hospital operated, uncompensated care, disproportionate share, indirect medical education. The disproportionate share and indirect medical education adjustors were developed by regression, and represent estimates that would explain a portion of the differences in rates among hospitals. These estimates were never discrete payment amounts and were never intended, nor viewed, as precise measures of the amounts added to hospital rates for these costs. The Maryland Health Services Cost Review Commission began phasing out the tool in 2010 as it implemented global budget payment systems for rural hospitals. Hospitals on a global budget system would be disadvantaged under the Reasonableness of Charge methodology as they reduced unnecessary utilization. The tool was discontinued completely in 2011.

We would propose two options for determining a base operating DRG payment amount for Maryland hospitals:

- Option 1: Use the same methodology as in the rest of the country; or
- Option 2: Establish an Average Statewide Charge by DRG-SOI, which would require that relative case weights generated by the Maryland Health Services Cost Review Commission be multiplied by the average Charge per Case Target at a case-mix index of 1, which would generate statewide average charges for each DRG-SOI.

We recommend that CMS calculate the MSPB measure for Maryland hospitals in the same way it calculates the measures for all other hospitals.

New Measures

CMS proposes to add five new measures to the Hospital IQR Program measure set for the FY 2016 payment determination and subsequent years including two readmissions, two mortality, and one spending measure. Combined with the proposed removal of

eight measures, the proposed measure set consists of 57 total measures.

Readmissions

CMS proposes to add two new readmission measures to the Hospital IQR Program:

- Hospital 30-day All-Cause Risk Standardized Readmission Rate following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization (NQF #1891); and
- Hospital 30-day All-Cause Risk Standardized Rate of Readmission Following Acute Ischemic Stroke.

While we agree that reducing the number of unnecessary, preventable or avoidable readmissions is a laudable goal, and while we further agree that hospitals can play an important role in accomplishing this, we believe it is premature to incorporate these measures into the Hospital IQR program.

Stroke — The Stroke readmission measure is neither NQF-endorsed nor MAP supported, and was withdrawn for consideration by the measure steward. Given the reservations we have about the use of even the endorsed readmission measures, we cannot support one that is not endorsed. Premier, among many other organizations, have commented extensively about the importance of NQF endorsement and MAP support. If at all possible, CMS should only adopt measures that have successfully been through the consensus building process where providers can have some confidence that the measure has been sufficiently tested and is methodologically sound. Even if the measure were NQF-endorsed we would still have reservations about this measure due to its construction and lacking risk-adjustment methodology as noted in the COPD section below, which is constructed using the same basic methodologies. In particular, we have concerns that indicators of stroke severity (e.g., the value of the NIH Stroke Scale) and socio-economic status are not included in the risk-adjustment models, or at least institutional level stratification. **CMS should not adopt the Hospital 30-day All-Cause Risk Standardized Rate of Readmission Following Acute Ischemic**

Stroke and should instead focus on developing an e-specified measure based on ICD-10 for future adoption.

COPD — The proposed readmission measure for COPD is NQF-endorsed and supported for addition to the IQR program by the MAP. In discussing the readmission measures, CMS notes the high incidence of COPD, which has been identified by AHRQ as an ambulatory-care-sensitive condition for which hospitalization can potentially be prevented. We agree that COPD is an important area on which to focus efforts to reduce readmissions. However, we remain concerned about the measure construction and ability to truly differentiate performance between hospitals for both public reporting purposes and use in payment policies. Moreover, we are concerned about the potential impact on hospitals that serve a disproportionately high population with low socio-economic status.

Readmissions to a hospital facility within 30 days occur for many reasons. Not all readmissions are avoidable nor are all inappropriate. While reducing the number of unnecessary readmissions is clearly providing more efficient care, reducing the number of appropriate readmissions is not consistent with patient-centered care, nor is it necessarily consistent with providing safe care. The potential unintended consequences are many and potentially serious. The incidence of unintended consequences is not know at this time; moreover, no mechanism has been provided to measure and monitor these unintended consequences. All clinical trials proposing interventions for which there is a potential for the occurrence of unintended consequences are ethically bound to establish a mechanism for monitoring such occurrences and for stopping the trial if patient safety requires it. This proposed intervention – to reduce the number of readmissions within 30 days – should be no different.

Specifically, we are concerned about the following:

- Impact on use of ED and observation stays

Premier is concerned that if the financial pressure to reduce all-cause readmission is severe, patients may be forced to make repeated trips to the ED or will be compelled to endure multiple observation stays during the 30-day period. Providing care through repeated observation stays may be the most efficient way to deliver care in some instances, but from the patient's point of view, this may be entirely suboptimal and certainly not patient-centered. Use of this measure should be accompanied by balancing measures such as number of ED visits seen within 30 days and number of multiple observation stays within 30 days. Not only will this allow a monitoring of potentially unintended consequences, it will allow CMS and the public to interpret the readmission data in true context.

- Potential impact on clinical outcomes
  Adoption of numerous readmission measures is designed with the aim of reducing utilization of the hospital. While it is true that the aim is the reduction of unnecessary utilization, the measure itself is coarse, and the state of the art insufficient to separate cleanly unnecessary utilization from appropriate variation. For any intervention designed to withhold treatment, no matter how well-intentioned, there must be a mechanism to monitor impact on clinical outcomes and to intervene quickly and decisively to terminate the intervention should an adverse impact be detected. CMS proposes no mechanism to monitor clinical outcomes or to intervene when necessary to protect patient health.

- Impact on the safety net
  Strong evidence exists that dual eligible beneficiaries have higher readmission rates. These realities may have nothing to do with quality of care, but more to do with the multifactorial nature of the problem. In reviewing the all-condition readmission measure last year, which is based on essentially the same methodology, the NQF Measures Steering Committee felt that incorporating into the model

SES proxies like Medicaid share or DSH status was needed to compare hospitals on an even playing field as the unintended consequences of shifting economic resources away from hospitals serving at-risk populations was a very real and potentially devastating possibility.

Premier is concerned that publicly reporting numerous hospital readmission rates without a mechanism to report and monitor potentially adverse unintended consequences could result in care that is suboptimal and not patient-centered.

Premier is concerned that if additional readmission measures ultimately become the basis of financial penalty to hospitals with higher than average rates, resources may be withheld to hospitals that need them most, namely those that serve populations of at-risk patients. Ample evidence exists to demonstrate that the dual eligible population accounts for more 30-day readmissions than the population as a whole, and certainly not all of this variation can be attributed to variation in hospital quality. CMS should establish a mechanism to report and monitor the disparities observed between hospitals that serve a disproportionate share of low income individuals and those that do not. Not because we should expect or tolerate such disparities; to the contrary. It is because we should endeavor to understand the drivers behind these disparities and act in such a way that we rectify these drivers and not simply financially penalize already vulnerable institutions serving an even more vulnerable population. **Premier is concerned that the proposed reporting mechanism, may result in an unintended adverse consequence of diverting resources away from hospitals that need them most, based solely on long-standing societal factors that are beyond the control of the provider institutions.**

Given these major reservations with the COPD readmission measure, the Premier healthcare alliance does not support its adoption into the IQR. CMS should continue to make major refinements to the measure, as well as create electronic

specifications based on ICD-10, prior to adoption in IQR or a payment penalty program.

Mortality

- Hospital 30-day All-Cause Risk Standardized Mortality Rate following COPD Hospitalization risk (NQF #1893)
- Hospital 30-day All-Cause Risk Standardized Rate of Mortality Following an Admission for Acute Ischemic Stroke

Stroke — The Stroke mortality measure is neither NQF-endorsed nor MAP supported as it was withdrawn from consideration by the measure steward. Given the reservations we have about the use of even the endorsed mortality measures, we cannot support one that is not endorsed. Premier, among many other organizations, have commented extensively about the importance of NQF endorsement and MAP support. If at all possible, CMS should only adopt measures that have successfully been through the consensus building process where providers can have some confidence that the measure has been sufficiently tested and is methodologically sound. We note that we continue to have concerns that indicators of stroke severity (e.g., the value of the NIH Stroke Scale) and socio-economic status are not included in the risk-adjustment model, or at least institutional level stratification. **CMS should not adopt the Hospital 30-day All-Cause Risk Standardized Mortality Rate Following an Admission for Acute Ischemic Stroke and should instead focus on developing an e-specified measure based on ICD-10 for future adoption.**

COPD — The COPD mortality measure is NQF-endorsed and supported by the MAP for inclusion in the IQR program. CMS believes that data on variation in hospital mortality rates for COPD patients suggests opportunities for improving care, and Premier believes mortality is an important measure for beneficiary transparency. However, many of our concerns noted above in the readmissions measure section hold here as well. We are uneasy about the adequacy of the measure, which is shown as higher than expected, as expected, or lower than expected with the vast

majority of hospitals as performing as expected because it is not able to further differentiate performance on a statistically significant basis. In most cases, this does not provide much assistance to beneficiaries who are trying to distinguish between their hospital options. We are also greatly concerned that the measure does not include socio-economic status in its risk-adjustment methodology. **Given these major reservations with the COPD mortality measure, the Premier healthcare alliance does not support its adoption into the IQR program. CMS should continue to make major refinements to the measure, as well as create electronic specifications based on ICD-10, prior to adoption in IQR or a payment penalty program.**

Spending

- Hospital Risk-Standardized Payment Associated with a 30-Day Episode of Care for Acute Myocardial Infarction (AMI)

CMS proposes to add a new condition-specific spending measure in the Hospital IQR program. The proposed measure of risk-adjusted payment per episode of care for AMI patients is not NQF endorsed, and MAP support was made contingent on NQF endorsement. CMS, however, believes that this measure would provide valuable information on the substantial variation in the cost of care for AMI patients and would be paired with the current 30-day AMI mortality and readmission measures. We agree with the concept of providing beneficiaries families of condition-specific measures. We further believe that some key condition-specific measures of spending could help providers identify areas of opportunity to reduce spending. However, we are concerned that the measure is not yet NQF endorsed, and that holding a hospital accountable for 30-day spending absent alternative payment structures is unrealistic and unfair. In addition, we have reservations about the construction of the measure, including its reliability and lack of adjustment for socio-economic status. We are also unclear of how this measure, which relies on methodologies similar to the readmissions and mortality measures, is related to the other episodes of care being developed by other areas of the agency as discussed in the Medicare Spending Per

Beneficiary portion of this letter. The specifications are actually similar to the related quality measures for AMI rather than the other spending measure. Yet, CMS does not discuss how the measures relate. For example, if a hospital has low spending for AMI, but high readmissions and mortality for AMI should the low cost still be considered positive performance? Moreover, such a measure would be duplicative of the all-condition spending measure if it were to be adopted into the value-based purchasing program. **At this time, Premier does not support the addition of the 30-day episode of care measure for AMI.**

Medicare Beneficiary ID numbers

For FY 2016 payment determinations and subsequent years CMS is proposing to require hospitals to report the Medicare Beneficiary ID numbers (MBID) to NHSN for all events reported for Medicare beneficiaries. NHSN currently supports the voluntary submission of this information, but CMS is proposing to make it mandatory for patients with HIC numbers. CMS does not provide any analysis of how often NHSN users currently are capturing this identifier. Without this, it is unclear how feasible the capture of this number or the timing of it would be. **CMS should explore the feasibility of capturing this number and its incorporation into the work of infection perfectionists and healthcare epidemiologists who conduct and report to NHSN before proceeding.**

Voluntary Electronic Submission of IQR Measures in CY 2014

In order to incentivize participation in the voluntary electronic reporting program, CMS proposes to use the electronically reported IQR Program data to determine whether a hospital has satisfied the Medicare EHR Incentive Program clinical quality measure reporting requirement. Although, CMS notes that a hospital must also satisfy all the other requirements of that program.

To electronically report data for the third quarter of CY 2014 under the IQR Program would need to submit that data by November 30,

2014, rather than the February 15, 2015, deadline that generally applies for chart-abstracted data in the IQR Program. **Premier supports the earlier deadline to coincide with the EHR Incentive program for electronically submitted measures to meet the IQR reporting requirements.**

In addition, CMS notes that it will not accept Quality Reporting Document Architecture (QRDA) category III, aggregate data, but rather will require QRDA category I, patient level data. We are unclear why CMS cannot accept QDRP 3 since it is our understanding that it plans to do so for the Comprehensive Primary Care Initiative. Our members are reporting that the major EHR vendors were prepared to submit QDRP 3 and are still in the testing phase for QDRP 1. Moreover, since CMS is not validating the data at this point, we are unclear why it believes it needs patient level data. If CMS does not allow the submission of aggregate data, CMS may find a significant number of hospitals continuing to rely on the attestation process, which is counter to its efforts to conduct large-scale testing of electronic submission of measures. **CMS should move to accept QDRP 3 data for electronic submission of IQR data.**

CMS proposes that data submitted through the voluntary electronic submission in CY 2014 will not be publicly reported. We concur with CMS that there may be abnormalities in the data or submission process during the first year of reporting. Furthermore, we do not believe that CMS should not post the electronically specified measures next to the same traditionally specified measures on *Hospital Compare* as they are not truly comparable. **We support CMS' decision to suspend the electronically submitted measures from *Hospital Compare*.**

CMS seeks comment on how to acknowledge hospitals electing voluntary electronic submission, such as through a "Pioneer" designation on the *Hospital Compare* website. While we agree some form of recognition is appropriate, we do not recommend "Pioneer" as it is used elsewhere in the Medicare program. **CMS should develop a recognizable icon and name through focus**

group testing to recognize hospitals that are submitting quality measure information electronically.

CMS notes that data submitted electronically for the FY 2016 IQR Program would not be validated. CMS intends to develop and propose a validation strategy for electronically reported quality measure data in next year's rulemaking, and seeks comments on potential validation methodologies.

Electronic Clinical Quality Measures

CMS proposes that hospitals may voluntarily report 16 of the FY 2016 IQR program measures electronically during CY 2014. The 16 selected measures are the complete measure sets for stroke (eight measures), venous thromboembolism (six measures), and perinatal care (one measure) plus one of the two emergency department measures. We supported these measure sets as part of the IQR program and believe they are suitable for electronic submission.

As we have stated in the past, we believe that moving forward, the IQR program measures should align with the criteria for meaningful use of EHRs. Therefore, we support CMS' focus on measures that can be specified for automated collection from EHRs and efforts to remove duplicative reporting requirements under the IQR and EHR Incentive programs. This will diminish the manual data abstraction from patient medical records and/or non-electronic reporting of quality measures. Among other things, we believe that duplicate reporting (once using certified EHR technology and once involving manual data extraction) will lead to confusion, especially if measure specifications for both reporting methods are not identical. Further, even with identical measure specifications, the results produced by two different methodologies might not agree. **Thus, the Premier healthcare alliance supports the four measure sets hospitals could report electronically to satisfy a portion of the IQR and EHR Incentive program requirements.**

CMS strongly urges participation in this voluntary reporting program, as it intends to propose a requirement for electronic reporting for some measures beginning in CY 2015. CMS is proposing voluntary electronic reporting for CY 2014 rather than a requirement for electronic reporting based on comments it received in a previous Request for Information. Those comments led to concerns that hospitals and vendors might not be able to comply with a requirement in CY 2014. Again, we support CMS' efforts to move to electronic submission of measures for the IQR program. However, we continue to believe that not all hospitals will be able to meet such a requirement in FY 2015. **The preponderance of hospitals should be meaningful users under the EHR Incentive program prior to making electronic submission of quality measures mandatory.**

Possible Future Quality Measures and Topics

CMS emphasizes its interest in moving to electronic reporting for all chart-abstracted and HAI measures in the IQR program, and indicates its intention to propose five measures that would be collected via EHRs for addition to the IQR program in future rulemaking. CMS notes that these measures were considered by the MAP. The measures and CMS' indication of MAP support are:

- Severe Sepsis and Septic Shock Management Bundle NQF #0500 (MAP supported)
- PC-02 Cesarean Section NQF #0471 (MAP supported)
- PC-05 Exclusive Breast Milk Feeding NQF #0480 (MAP supported)
- Healthy Term Newborn NQF #0716 (MAP supported the direction of this measure)
- Hearing Screening Prior to Hospital Discharge NQF #1354 (MAP supported).

We support CMS' efforts to move to electronically specified measures for the IQR program and appreciate CMS considering measures into the future. However, we believe we need to see how

the experience with the first measure sets goes before weighing in on these measures.

Modifications to Validation Process

CMS proposes several changes to the validation process for chart-abstracted measures in the IQR Program, and proposes new procedures for validation of the CDC HAI measures.

Timing and Number of Quarters Included in Validation

For the FY 2015 payment determination and future years, CMS proposes to modify the data validation time period so that the determination of whether a hospital has met the requirements of the IQR Program and therefore will be included in the VBP Program for a fiscal year can be made by July 1 prior to the start of the fiscal year. The proposed rule includes a chart illustrating the proposed time frames. For example, for the FY 2015 determination, the validation period would include the fourth quarter of CY 2012 through the second quarter of CY 2013 (October 1, 2012, through June 30, 2013). For FY 2016 and later, the validation period would include the third and fourth quarters of the year two years prior to the payment determination and the first and second quarters of the subsequent year (e.g., for FY 2016 the dates would be July 1, 2013 – June 30, 2014). However, for FY 2016, data validation for the CDC HAI measures could not begin until the fourth quarter of CY 2013 because CMS would not have the infrastructure ready in time. **Premier supports the proposed time frames for validation to provide hospitals with their IQR and VBP determinations.**

Selection of Measures

For FY 2015, the previously finalized data validation process includes 21 chart-abstracted clinical process of care measures and three CDC HAI measures. In this rule, CMS proposes to continue validation of 12 clinical process of care measures, and add validation of the two new HAI measures (MRSA and C. diff.). Validation would be suspended for nine process of care measures:

seven that CMS proposes to remove from the IQR Program measure set, and the two ED measures, for which CMS states it does not have the ability to validate electronically reported versions. CMS believes that it would be inequitable to continue validation for the ED measures only when they are submitted by chart abstraction. **Premier agrees that it would be inequitable to validate chart abstracted measures that can be electronically submitted. However, we encourage CMS to develop the methodology for validating the electronic data.**

Sampling of Charts for Process of Care Measures

The validation sample would continue to include three records each sampled from the heart attack, heart failure, pneumonia, and surgical infection measure sets. For the immunization measures, three records will be sampled from among principal diagnoses and procedures not already included in the four topic areas separately sampled, and the other 12 charts selected for the four identified measure sets will be sampled for immunizations as well. **Premier agrees with the proposed validation sample process.**

Validation Templates for CLABSI and CAUTI

Changes are proposed with respect to the validation templates developed for the CLABSI and CAUTI measures to align with NHSN definitions and remain up-to-date. In the future, CMS proposes to notify hospitals of changes in definitions of HAI events though HAI validation guidance posted annually on QualityNet. It believes that very detailed specifications are better handled through subregulatory process than through rulemaking. In addition, CMS proposes to require that hospitals submit data to the Validation Template posted on QualityNet without modifying the formatting. **Premier supports the proposal to provide detailed specifications for the validation templates and restrict the ability to modify the template.**

Exclusion of Long-Stay Cases

CMS proposes to exclude from HAI validation all patient episodes of care with lengths of stay of more than 120 days. These cases are relatively rare and the policy would align the length of stay

maximum with the IQR Program specifications. It would also reduce the burden of validation when medical records may be tens of thousands of pages. **Premier supports the exclusion of cases with lengths of stay greater than 120 days from validation.**

Validation MRSA and C. diff (CDI)

For validation of the new HAI measures, CMS proposes to use processes similar to those developed for the CLABSI and CAUTI measures. Sampled hospitals would be required to provide a list of final blood cultures positive for MRSA and a second list of all final stool specimens toxin positive for CDI. Both hospital and community-onset cases would be reported. Only hospital-onset infections are publicly reported, but community-onset cases are used by NHSN in risk adjustment. **Premier supports the proposal to use similar processes to validate MRSA and CDI as hospitals are already familiar with the process.**

Selection of Hospitals for HAI Measures

To limit the burden associated with validation of HAI measures, CMS proposes half the hospital validation sample would be assigned to submit templates for CLABSI and CAUTI validation and half for MRSA and CDI validation. (Validation of the SSI measure would continue for all sampled hospitals.) While we are supportive, CMS should monitor that one group is not consistently failing at a higher rate than the other, in which case, CMS should consider a different pairing or alternative strategy. **Premier appreciates CMS recognition of the additional burden to validate the new HAIs. Premier supports pairing the CLABSI and CAUTI measures, and MRSA and CDI measures for validation; and assignment of 300 hospitals for one set and 300 hospitals for the other set.**

Stratification of Sampling by HAI

For the FY 2016 payment determination and subsequent years, CMS proposes to target separate sampling strata for each type of HAI, and these are displayed in a table published in the proposed rule. For FY 2016, for hospitals submitting the CLABSI and CAUTI templates, the proposed quarterly sample sizes are two for

SSI, five for CLABSI and five for CAUTI. Similarly, for hospitals submitting the MRSA and CDI templates, the proposed quarterly sample sizes are two for SSI, five for MRSA and five for CDI. Cases would be randomly selected from among patient episodes of care with at least one candidate event. If there are insufficient cases in any stratum, these would be reallocated to any stratum that have enough cases to meet sample size targets. Because for FY 2017 and later, there will be validation data drawn from four quarters instead of three, CMS proposes to reduce the total quarterly sample size from 12 to nine, with a configuration of three, three, and one for CLABSI, CAUTI and SSI or MRSA, CDI and SSI, and two additional cases randomly drawn. **Premier supports the stratification proposal.**

Scoring of CLABSI, CAUTI and SSI

For FY 2016 and later, CMS proposes to score each case sampled for the infection for which it was sampled. For CLABSI, CAUTI and SSI, cases will be scored with a 1 if the medical record matches the hospital reporting and 0 if there is a mismatch. **Premier supports the change to score each infection case separately.**

Scoring of MRSA and CDI (C. diff infection)

For MRSA and CDI, CMS proposes to score two components, with a 1 for a match and a 0 for a mismatch. First, whether an event should have been reported to NHSN and was reported, and second whether the correct dates of admission and event were reported so that NHSN correctly classified the infection as hospital or community onset. No more than four events could be validated for an episode of care. Hospitals would not be credited or penalized with respect to certain events that are automatically excluded by NHSN. **Premier supports this proposal and encourages CMS to evaluate the process the two component process after the first year of MRSA and CDI validation is completed.**

Combining Scores

CMS proposes no changes to the calculation of the total score, which weights the clinical process of care and HAI validation scores by the number of measures in each group. For FY 2016, this would be 12/17 for clinical process of care measures and 5/17 for the HAI measures. The determination of whether a hospital passes validation would not change. As has been CMS' practice, specific formulas would be posted on QualityNet at least one year prior to computation.

Premier supports the proposal for combining scores.

Targeting of Hospitals for Validation

CMS proposes to continue drawing a random validation sample of 400 hospitals annually, with up to 200 hospitals selected for more targeted validation. CMS proposes to add one additional criterion for targeting, which is that any hospital which failed to report to NHSN at least half of actual HAI events detected as determined during the previous year's validation efforts. CMS is concerned that the VBP Program might give hospitals an unintended incentive to underreport HAI events.

Premier has in the past recommended that CMS adopt targeting criteria for hospital validation selection. **Premier supports the addition of this new criterion.**

Procedures for Submitting Records for Data Validation

CMS proposes that for validation of the MRSA and CDI measures for FY 2016 and later, hospitals would be required to submit only those parts of the medical record needed to validate those measures, namely all final positive blood culture and toxin positive CDI specimens and documentation of dates of admission, transfer and discharge. CMS also proposed that a hospital selected for validation would meet the current requirement for submission of patient charts either through paper charts (the only option currently available) or, beginning with the FY 2016 payment determination, through secure transmission of electronic medical information. The specific guidelines for electronic transmission will be posted on QualityNet. Hospitals, which are reimbursed 12 cents per page plus shipping for paper medical records, would be reimbursed for

the labor and supply costs of electronic transmission, although CMS does not indicate what the reimbursement would be. **Premier supports the proposal for secure transmission of electronic medical information as it will increase efficiencies to submit the requested records.**

PPS EXEMPT CANCER HOSPITAL QUALITY REPORTING (PCHQR) PROGRAM

FY 2015 Measures

CMS also proposes to add the CDC NHSN SSI measure. This measure is reported in several other Federal programs, is NQF-endorsed and supported by the MAP. However, we also urge CMS to exercise care in publicly reporting the measure in the future. Reporting the measure for cancer patients presents different challenges than reporting the measure for general acute care hospital patients. For example, many cancer patients are immune-compromised because of their disease, making them more susceptible to infections. This may, in turn, lead to higher than expected infection rates. We also encourage CMS to engage with cancer centers to determine whether stratifying SSI reporting by type of cancer may allow for a more meaningful comparison of rates. Currently, SSI reporting is done on a surgical procedural. **Premier supports the addition of the SSI measure to the PCHQR program.**

FY 2016 Measures

SCIP

CMS proposes to add six SCIP measures that are already included in the hospital IQR program. The measures are:

- SCIP – Inf 1 (NQF #0527),
- SCIP – Inf 2 (NQF #0528),

- SCIP – Inf 3 (NQF #0529),
- SCIP – Inf 9 (NQF #0453),
- SCIP-Card-2 (NQF #0284) and
- SCIP – VTE 2 (NQF #0218).

Premier supports the addition of the six SCIP measures for PCHQR program as this would align the quality reporting programs, and are recommended by MAP.

Clinical Process

We are concerned about the burden of reporting the clinical and oncology process measures CMS has proposed for FY 2016. All of these measures must be reported on an entire patient population because there is no allowance made for sampling. Moreover, in some cases, superior measures that more meaningfully capture cancer quality of care may be preferable to the measures CMS has proposed. Three of the measures – oncology: radiation dose limits to normal tissues, prostate cancer: adjuvant hormonal therapy for high-risk patients, and prostate cancer: avoidance of overuse of bone scan for staging low-risk patients – are NQF-endorsed and MAP-recommended or supported. We could support these three measures for inclusion in a future program, but only if CMS develops an appropriate sampling methodology. Where appropriate, it also must seek NQF review of the methodology. **We recommend that CMS not finalize any of these proposed processes for the FY 2016 program.**

INPATIENT PSYCHIATRIC FACILITIES QUALITY REPORTING (IPFQR) PROGRAM

New Measures

CMS proposes to add three new chart-abstracted measures for the IPFQR Program:

- SUB-1: Alcohol Use
- SUB-4: Alcohol & Drug Use

- Follow-Up After Hospitalization for Mental Illness (FUH) (NQF #0576).

The Joint Commission Substance Abuse core measure set consists of four measures to be applied to all hospitalized inpatients regardless of their diagnosis/procedures. **Premier does not support adding the Substance Abuse measures to only IPFQR as the measures were specified for all hospitalized inpatients and should be used as a complete set to identify and improve care processes. Additionally, CMS should consider the burden of additional data collection and not add any new chart abstracted measures during the transition to electronic measurement.**

The Follow-up After Hospitalization for Mental Illness would be challenging for the psychiatric hospitals to collect as they may not have access to the necessary data to determine follow-up, whether chart or administrative data sources. The measure assesses the percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental health disorders, and who subsequently had an outpatient visit or an intensive outpatient encounter with a mental health practitioner, or received partial hospitalization services. From review of the measure specifications it appears the measure was developed for health plan use not inpatient hospitals. The inpatient hospitals would not be able to identify outpatient and practitioner follow-up occurring outside of their system. Thus the reporting would not be accurate. **Premier does not support adding this measure due to the data collection challenges for the hospitals to identify all follow-up activity.**

HOSPITAL-ACQUIRED CONDITIONS

Since October 1, 2008, select hospital-acquired conditions (HACs) that are not present on admission (POA) cannot qualify an inpatient hospital discharge for a higher paying MSDRG. For FY 2014 CMS does not propose any changes to this existing HAC

policy. The ACA, however, requires CMS to implement a new program in FY 2015 that uses some of these conditions to identify and penalize the highest quartile, or worst performing hospitals.

Existing HAC policy

As we have commented previously, the existing HAC policy should be limited to truly preventable conditions that do not lend themselves well to rate-based measurement. Of the existing HACs, these are foreign objects retained after surgery, air embolisms, blood incompatibility, and manifestations of poor glycemic control. While claims-based measures may be sufficient for such events, chart-abstracted measures that compare a provider's actual hospital-acquired condition to a reasonable rate of such event given the provider's patient population are more appropriate for the remaining conditions in the existing HAC policy including catheter-associated urinary tract infections, pressure ulcers, surgical site infections, vascular catheter-associated infections, hospital-acquired falls leading to injuries, and DVT/PE. Such measures will assist providers in performance improvement and beneficiaries in assessing a provider's quality of care and are better suited for the VBP program. **CMS should maintain foreign objects retained after surgery, air embolisms, blood incompatibility, and manifestations of poor glycemic control within the existing HAC payment policy.**

HAC Reduction Policy

The ACA requires the Secretary to reduce payment to the top quartile, or worst performing, hospital by 1 percent or what would otherwise apply. The Secretary is also required to provide these hospitals with confidential reports and an ability to review and correct this information before it is made public on the *Hospital Compare* website.

Data and Analyses

The statute provides that there may be no administrative or judicial review with respect to what qualifies as an applicable hospital, the specifications of a HAC, the determination of an applicable period, and what information is reported to hospitals and the public. Thus, we would have hoped that CMS would have provided additional data, information and analysis of their proposal to inform commenters in preparing feedback for CMS. In particular, CMS should have released sufficient data to replicate CMS' proposal so that specific alternatives could be modeled and recommended to CMS. At minimum, CMS should have provided information on the distribution of scores under its alternatives as well as the differential impact of particular types of hospitals. Without such information, commenters can only provide general guidance as the practical impact of specific recommendations is unknown. **In an interim-final rule, CMS should release additional data and information publicly so that commenters can replicate CMS' methodology, test alternatives, and suggest refinements based on data rather than supposition.**

Measures

CMS proposes to adopt eight measures for the FY 2015 HAC Payment Reduction Program grouped into two domains as shown in Table 5 and 6 below. Proposed Domain 1 includes six Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicator (PSI) measures, which are claims-based measures calculated by AHRQ. Proposed Domain 2 includes two Centers for Disease Control and Prevention (CDC) healthcare-associated infection (HAI) measures. Hospitals report on these measures through CDC's National Healthcare Safety Network (NHSN).

Additional CDC HAI measures are proposed for inclusion in the measure sets for FY 2016 and FY 2017, as noted in the tables below. While CMS believes that its proposed approach would be simpler to interpret, it seeks comment on an alternative Domain 1 in which instead of the proposed six AHRQ Patient Safety Indicators, the AHRQ measure PSI 90 (NQF #531) would be used. AHRQ PSI 90 is a composite of eight component AHRQ PSI

indicators. The eight components overlap partly but not completely with the proposed six measures.

Domain 1

Table 5 details the specific measures CMS proposes in Domain 1 along with the alternative proposal.

Table 5

Domain 1: AHRQ Patient Safety Indicators	
Proposed Approach: 6 individual measures (FY 2015 and onward)	Alternative Approach: One composite of 8 measures (PSI-90) (FY 2015 and onward)
PSI-3 Pressure Ulcer Rate	PSI-3 Pressure Ulcer Rate
PSI-5 Foreign Object Left in Body	PSI-6 Iatrogenic Pneumothorax Rate
PSI-6 Iatrogenic Pneumothorax Rate	PSI-7 Central Venous Catheter-Related Blo Stream Infection Rate
PSI-10 Postoperative physiologic and metabolic derangement rate	PSI-8 Postoperative Hip Fracture Rate
PSI-12 Postoperative PE/DVT rate	PSI-12 Postoperative PE/DVT rate
PSI-15 Accidental puncture and laceration rate	PSI-13 Postoperative Sepsis Rate
	PSI-14 Wound Dehiscence Rate
	PSI-15 Accidental puncture and laceration rate

Including in the HAC Reduction program the Agency for Healthcare Research and Quality (AHRQ) PSI composite composed of measures that do not have substantial evidence to support their ability to identify true differences in hospital performance is a concern. The Premier healthcare alliance over the years has urged CMS not to include PSI 90 in the IQR program or as part of the VBP program. Some AHRQ indicators have very

high false positive rates, meaning that they indicated potential problems, but further investigation by the hospital showed the care was adequate and no event occurred. CMS is using claims data to calculate these measures, which limits CMS' ability to validate an actual occurrence. The result is that CMS may score a hospital using unsubstantiated measure results including false positives.

AHRQ defines coding sensitivity as "the proportion of patients who suffered an adverse event, based on detailed chart review or prospective data collection, for whom that event was coded on a discharge abstract or Medicare claim." It also defines predictive value as "the proportion of patients with a coded adverse event who were confirmed as having suffered that event, based on detailed chart review or prospective data collection." Based on a review of the AHRQ PSI guide, we note that measures PSI-06, PSI-14 and PSI-15 that are part of the composite lack coding sensitivity as defined by AHRQ:

- PSI 6-Iatrogenic pneumothorax, adult – no evidence,
- PSI 14-Postoperative wound dehiscence – no evidence, and
- PSI 15-Accidental puncture or laceration – conflicting evidence.

Four of the PSI measures that are included in the composite have validity concerns identified by the AHRQ panel review:

- PSI 6-Iatrogenic pneumothorax, adult – Denominator unspecific,
- PSI 12-Post Operative PE or DVT – Underreporting of event and Procedure Stratification suggested,
- PSI 14-Postoperative wound dehiscence – Case mix bias, and
- PSI 15-Accidental puncture or laceration – Underreporting of event and unclear preventability.

However, we recognize that CMS has statutory constraints with which it must abide. Despite being based on claims data, the PSIs are at least risk-adjusted and satisfy the legal requirement that this policy base its core set of measures on the existing HAC policy. However, AHRQ and CMS should invest funds in either refining

or replacing these measures with ones that have better predictive ability with more robust risk adjustment. Furthermore, we remain very concerned with the overlap with the VBP program. If CMS includes the same measures in both programs, then a single case of an infection will trigger a penalty under two separate payment penalty programs, which we discuss below. **Thus, the Premier alliance supports CMS' inclusion of the AHRQ PSI measures in the HAC reduction program in FY 2015 despite our misgivings about their performance.**

PSI-7 and 13 — The two proposed measure sets are somewhat duplicative. If both are retained, whether in two domains or one, they should be mutually exclusive. Both PSI-7 Central Venous Catheter-Related Blood Stream Infection and PSI-13 Postoperative Sepsis Rate are somewhat duplicative to the NHSN CLABSI measure. **CMS should remove PSI- 7 and PSI-13 from the composite or individual list of PSIs as it overlaps with the NHSN CLABSI measure.**

Composite — It is impossible to tell whether CMS should use the individual measures, the proposed composite, or an alternative composite given that CMS has not released sufficient data for stakeholders to model CMS' proposals. What little CMS released, including a November 18, 2011, Mathematica Policy Research report, suggests that the median reliability of the composite (as constructed by CMS) is higher than the individual measures. Premier undertook a series of its own analyses with what data were available during the comment period in an attempt to provide more informed comments to CMS. Using the HAC measure rate data available on *Hospital Compare*, we created a proxy for the CMS proposed methodology and a series of alternatives for the Domain 1 score. Where AHQR measure rate data were not available, unadjusted raw rates from claims data using the existing HAC policy methodology were used as proxy measures[1]. Since the PSI

1 We were able to use measure rates for AHRQ PSI-6, PSI-12, PSI-14, and PSI-15 from the Hospital Compare database. All other PSI measures were modeled using proxies from the CMS POA raw rates compiled from administrative claims.

composite was not available, we looked at those individual measures together, but this lacks the sophisticated risk adjustment of the AHRQ specifications.

As we note below in the scoring section, the measures you include change the group of hospitals penalized. Based on what we can tell with limited data, we believe CMS should err on including more measures than less to be more confident that the program is truly identifying the poor performers. During its deliberations in preparation of the final rule, we urge CMS to consider whether the predictive ability of a composite, using the AHRQ risk-adjustment methodology, is stronger than the individual measures (components of the composite). The composite may reduce concerns about the low-volume of these events and the possibility that outliers will skew results. CMS should further consider different combinations of measures within the composite than just NQF #531. Specifically, CMS should test all of the NQF endorsed measures that do not overlap with the NHSN measures (do not include PSI 7 or 13 as noted above). CMS should undertake testing for consistency between individual components and the composite scores, based on standard factor analysis, releasing the results and including Cronbach's alpha scores for the contribution of the individual components to alternative composites, as well as item-to-total Spearman rank correlations. **Based on limited data, we believe a composite measure with all of the NQF endorsed PSIs, but not including PSI 7 or 13, would be preferable to individual measures.**

Domain 2

Table 6

Domain 2: CDC HAI Measures	
FY 2015 and onward	Central Line-associated Blood Stream Infection (CLABSI)
FY 2015 and onward	Catheter-associated Urinary Tract Infection (CAUTI)

FY 2016 and onward	Surgical Site Infection (SSI) following Colon Surgery or following Abdomi Hysterectomy
FY 2017 and onward	Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia
FY 2017 and onward	*Clostridium difficile*

Generally speaking, the Premier healthcare alliance has always been very supportive of CDC's NHSN measures. These chart-based outcome measures are considered reasonably robust and actionable by our members. CMS' proposed staggered integration of the measures allows them to be publicly reported on *Hospital Compare* before they enter this program, which we believe should be the case for each of the payment penalty programs. This will allow hospitals to gain practice as collecting and submitting the requisite data before their payment is affected. However, we remain concerned about the overlap of this program and VBP as we note in the VBP section of this letter. **The Premier healthcare alliance supports the inclusion of the NHSN measures in the HAC reduction program on a staggered basis as proposed by CMS.**

Domain Weighting

If CMS maintains both the AHRQ and NHSN measure sets, which we encourage, we do not believe two domains are necessary. While the measure data sources, construction and other factors are very different, the scoring can be constructed where it is consistent across both types of measures. In fact, the PSI-90 composite and CLABSI are in the same outcomes domain in VBP in FY 2015. What is material is the weight given to each measure or composite. While we have more confidence in the NHSN measures, only two are currently proposed and these measures only apply to organizations with ICUs. Thus, we think it is reasonable to weight the PSI measure (whether composite or individual measures) at 50 percent. But CMS should test how the weighting affects the organizations penalized and how the weights should possible shift

as more NSHN measures get introduced and release these results publicly. **CMS should remove the two domain structure that unnecessarily complicates the program, but equally weight the infection measures and a PSI composite.**

Scoring

PSI-5

CMS proposes to have a special scoring system for PSI-5 Foreign Object Left in Body whereby a single occurrence will result in an automatic top score of "10" rather than a sliding score based on rank order. While we cannot fully replicate CMS' proposal due to a lack of data, we believe the automatic "10" will disproportionately drive the scores for the top quartile of hospitals despite the fact that it is a rare event. In our replication of CMS's proposed methodology, PSI-5 represented 22 percent of the weight of the total Domain 1 score. Many of the other conditions are considered "never events," yet CMS singles out this particular event for special scoring without any data to suggest that its signal value of this incredibly rare event is higher than other measures. **CMS should score PSI 5 the same as it does the other PSIs.**

Other Measures

In our analysis, we found a number of issues with the proposed CMS scoring process. CMS has chosen an arbitrary scoring method that may not appropriately capture poor performance across all measures. The proposed scoring method would assign a score of zero to a hospital with all measure rates at the 74th percentile, while hospitals above the 75th would get a penalty score. However, without applying a confidence interval in constructing the adjusted rates, there is no reason to believe the 75th percentile value is statistically different from the 74th percentile value. Moreover, under the proposed CMS scoring methodology, a hospital with measure rates reaching the 75th percentile in only one of the domain measures and close to a rate of zero in all other measures would be assigned a score and thus be at risk for the penalty, whereas a hospital reaching the 74th percentile in all

measures in that domain would receive a score of zero and not be at risk for the penalty.

While the law requires CMS to identify the worst performing quartile overall, it does not require that it be done on each individual measure basis. An alternative approach would be to assign points based on the decile breakdown of the *entire range* of the measure rate, as opposed to just the range above the 75th percentile value. We believe this would be a more equitable approach, so we modeled it using the CMS preferred Domain 1 measures (or proxies). As a result of this change in methodology alone, 70 percent of the same hospitals were penalized as in our replication of the proposed CMS scoring methodology. Thus, 30 percent of the "bottom performers" changed.

While improved, we believe this method still lacks specificity in the scoring of Domain 1 and 2 measures. The proposed scoring method risks penalizing too great a number of hospitals, meaning more than 25 percent of all eligible IPPS hospitals. If a large number of hospitals end up with the same number of points, the 75th percentile value may not be capable of capturing exactly 25 percent of the hospitals at risk for the penalty. Moreover, it may be that fewer than 25 percent of hospitals actually have an event or greater than expected events. **CMS should not assign points to hospitals with no events or those with less than expected events simply to meet the 25 percent threshold.**

An alternative that would deal with both the sensitivity and specificity issues is to use an average index with continual scoring to rank-order hospitals instead of a point scoring method. Premier currently uses this methodology in our QUEST®: High Performing Hospitals collaborative. The index score is a variation on a z-score calculation, calculated by subtracting the median (expected value) of a measure rate from a hospital's individual measure rate and then dividing by the standard deviation. Instead of the median, an average could be used as the expected value, but an average could be skewed by outliers. The index method gives each measure equal weight, adjusting for both central tendency and variance-centered

coefficient of variation. This method not only accounts for the expected rate of a HAC or HAI, but it allows for comparisons across measurement types.

Using the same measures but applying an index rank-ordering approach, we captured two-thirds of the same hospitals penalized under the CMS proposed scoring methodology. We believe an index will more accurately capture poor performance. An index value would also capture the specificity necessary for the 75th percentile point estimate for determining the penalty threshold. Furthermore, adding up individual decile scores (1 for first, 2 for second, and so on) treats ordinal values as if they were cardinal, which is like adding apples and oranges. Using a z-score to construct a total, as described above and in Premier's harm composite, is appropriate, especially with highly skewed data. **CMS should use an index approach with continual scoring, rather than a rank order approach for only the top quartile of hospitals at the measure level.**

Next, we modeled several scenarios keeping the scoring methodology constant but changing the measure mix. Varying the mix of Patient Safety Indicators (PSIs) selected for Domain 1 changes the group of hospitals reaching the 75th percentile penalty threshold. As seen in Table 5, we are concerned that only two thirds of the hospitals consistently fall in the bottom quartile using both our scoring alternative as well as CMS' proposal based on simply changing the measures included.

Table 5 Alternative Scoring Scenarios (percent of hospitals penalized under the CMS proposed scoring methodology)

	Proposed Scoring	Rank from Index Instead of Points
Less Measures	66%	63%
Same Measures	100%	66%
More Measures	69%	62%

While we cannot run sophisticated modeling without complete data, we believe that CMS should err on the side of adding additional measures to be more confident that it is accurately

capturing the worst performing quartile of hospitals. However, it should conduct research to determine why changing the measures changes a third of the hospitals included in the penalty box. How do we determine which measures are best and that we are not indiscriminately applying a 1 percent penalty to a third of the hospitals in the program? If only a few percent of hospitals were changing each time, we would have more faith that the core measures CMS recommended were sufficient. We believe a more comprehensive set of measures gives more face validity to that the worst performers will be identified. **CMS should conduct testing on a PSI composite that includes all of the NQF endorsed individual measures except PSI 7 and 13 and release the results in an interim-final rule with an associated comment period. It should then seek NQF endorsement for a revision to NQF#531 and seek to harmonize the measure with the Joint Commission.**

When looking across all of the scenarios we tested changing the PSI measure mix and/or the scoring methodology, almost half (46 percent) of all IPPS hospitals with HAC data fell into the worst performing quartile under one or more scenarios, and 19 percent of IPPS hospitals fell into more than half of the scenarios. Only 5 percent of all IPPS hospitals fell into the worst performing quartile under every single scenario, which represents 22 percent of the hospitals identified as the worst performers under the CMS proposed methodology. **CMS should conduct a sensitivity analysis of the various measure selection and scoring methodologies to avoid unintended consequences and release the results in an interim-final rule with an associated comment period.**

Future HACs

We further encourage CMS to continue developing safety measures. We know from our research developing Potential Inpatient Complications (PICs), that the CMS HACs and AHRQ PSI's only scratch the surface. In fact, in our analyses, the CMS HACs represent only 0.2 percent of patients, while the PICs identified 16 percent. We have identified 138 PICs in total, of which 86 are considered to be clinically significant based on a

number of factors including their impact on other outcomes such as mortality, length or stay and costs as well as the judgment of a panel of clinicians. **CMS should further research the development of additional measures of HACs that will improve the ability of CMS to identify the truly poor performers as part of the payment reduction program.**

Applicable Time Period

The definition of "applicable time period" is proposed to be, with respect to a fiscal year, the two-year period specified by the Secretary from which data are collected in order to calculate a Total HAC Score for purposes of the HAC Reduction Program. We are concerned that this is inconsistent with the VBP and IQR programs. If CMS duplicates the measures in VBP and the HAC program, it should use the time frames already finalized there: one year for the NSHN measures, and two years for AHRQ measures. Given that CMS uses two different time periods in that program, we do not consider that a problem for the HAC program. If CMS removes the measures from VBP as we recommend, we would still recommend keeping the same time periods as are included in the IQR for simplicity sake and to allow providers to track their performance. We note that the AHRQ measures, due to low-volume of events, need a two-year
performance period to improve the predictive ability of the measure. Thus, if CMS believes consistency is required, we agree that it should be two years and not one for both measure sets. **CMS should align the duration of the performance periods for the IQR, VBP and the HAC Reduction Program with two years of data for the AHRQ PSIs and one year of data for the NHSN HAI measures.**

Payment Adjustment

IME and DSH

The statute says that the HAC payment penalty should be "equal to 99 percent of the amount of payment that would otherwise apply to such discharges under this section or section 1814(b)(3)

(determined after the application of subsections (o) and (q) and section).” Thus a 1 percent reduction will be made to the worst performing quartile of hospitals after the application of the l VBP Program and HRRP adjustments. While CMS does not state it in the rule, we expect that this includes IME and DSH payments. However, we believe the Secretary should exercise her special exceptions and adjustment authority to apply this reduction to base operating payments as defined under the HRRP and VBP programs. We believe that these programs are essentially three legs of the same stool and should be consistent.

Moreover, we are not clear why this policy in particular should apply to IME and DSH payments that are unrelated to the underlying quality policy the provision enforces. Applying the penalty to IME and DSH payments will inherently disproportionately negatively affect teaching and safety net hospitals. Our model of the CMS HAC reduction program penalty showed that teaching hospitals are disproportionately found in the bottom quartile. The CMS impact analysis for this program included in the FY 2014 proposed rule did not support this finding, but the number of teaching hospitals overall is inconsistent with the number of teaching hospitals identified in the other impact tables. CMS identifies a total of 270 teaching hospitals in the HAC impact tables and 1,026 in the overall impact table for FY 2014 policy changes. We are concerned about the impact on these mission-driven organizations that will also be disproportionately impacted by VBP and the HRRP due to many factors outside their control as well as insufficient risk adjustment. **CMS should exercise its authority to apply the HAC Reduction penalty to base operating payments as defined for the purposes of the HRRP and VBP program.**

VALUE-BASED PURCHASING

FY 2014 is the second year of payment adjustments under the hospital Value-based Purchasing (VBP) program established by the ACA. For FY 2014, the available funding pool equals 1.25 percent

of the base-operating DRG payments to all participating hospitals, or $1.1 billion.

FY 2015 Measures

Existing Measures

While CMS does not solicit comments on the 2015 measures, we believe CMS should make changes in an interim-final rule as detailed below.

Infection Measures

The Premier healthcare alliance is very concerned about the overlap in the VBP program and the HAC Reduction Program starting in FY 2015. As CMS' proposal stands, a single event could trigger lower reimbursement for the case, a penalty under VBP and a HAC reduction penalty. We believe CMS should work to reduce the duplication of the three HAC policies, and simplify the information that will be shared with beneficiaries. For instance, CMS proposes a one-year performance period for the infection measures in VPB, but a two-year period in the HAC Reduction program. If both rates are posted on *Hospital Compare*, beneficiaries will be unsure why more than one measure with the same name is posted with different, and possibly conflicting, results.

While the Premier alliance believes that combining the Hospital Readmissions and HAC Reduction Programs under VBP would be ideal, we recognize that CMS does not currently have the authority to do this. An alternative to CMS' current proposal that we believe CMS has the authority to implement and is simpler for both CMS to administer and providers to follow is to remove all of the safety outcomes measures from VBP. The HAC Reduction Program would essentially be the "Safety Domain" of CMS' comprehensive quality policy consistent with the National Quality Strategy. Similarly, the HRRP would be considered its Care Coordination Domain. The SCIP infection process measures would, however, remain in VBP in the Process domain, or perhaps Clinical Care Domain should CMS move that direction in FY 2017. Although

HF-1 is proposed for removal, other similar process measures around readmissions could also be included in the Process or Clinical Care Domain.

Moving the safety outcomes measures into the HAC Reduction program protects against duplication while ensuring that the more actionable and robust NHSN measures are included in the payment penalty program with the AHRQ PSIs that we have less confidence in due to their low volume and other construction issues discussed below. It also makes clinical sense to keep these measures together where hospitals can monitor movement together as strategies to reduce one of these events often helps prevent other types of events. **We believe CMS should remove the NSHN and AHRQ PSI-90 composite measures from VBP in FY 2015 and instead include the measures in the HAC Reduction program. At minimum, CMS should not increase the weight of the outcome domain.**

We believe that CMS has the legal authority to remove the safety outcomes measures from VBP. While the statute mandates the use of five specifically articulated areas of measurement, including infections, listed under section 1886(o)(2)(B)(i) in subclauses (I) through (V), it only requires their use in VBP payment for discharges occurring *in* FY 2013. After that, the Secretary has the authority to replace measures with others as laid out in 1886(o)(2)(D). We also note that the rule for the addition of efficiency measures, under section 1886(o)(2)(B)(ii), specifies discharges for FY 2014 *and succeeding fiscal years*. Congress made a distinction in its rules by mandating the first measure areas under clause (i) only for FY 2013, and mandating the efficiency measures under clause (ii) for FY 2014 and later. By failing to provide for the same "and succeeding fiscal years" language in clause (i), the legal requirement on CMS to include any or all of those listed measures applies only for those discharges occurring in FY 2013. **CMS has the legal authority to remove the safety outcomes measures from VBP and instead include them in the HAC Reduction Program.**

Efficiency

For discharges occurring during FY 2014 *or a subsequent fiscal year*, the law requires that the VBP program include efficiency measures, including measures of Medicare spending per beneficiary. We supported CMS' decision to suppress the efficiency measure for FY 2014, and urged CMS to continue suppressing it in FY 2015. Unfortunately, CMS implemented the measure against the field's consensus position and without NQF endorsement. **We again urge CMS to suppress the measure in FY 2016 as our concerns about the measure remain as detailed in the IQR section of this letter.**

Under the existing measure, hospital A and hospital B could have the same inpatient and outpatient per beneficiary spending, but the physicians at hospital A could rely far more frequently on skilled nursing and rehabilitation while hospital B's physicians could rely more on home healthcare. This will make hospital A look far more costly than B even though the source of the spending is outside of the control of the hospital. As another example, factors outside the hospital and related to the beneficiaries themselves and their communities can dramatically influence spending. CMS should not hold the hospital solely accountable through the Inpatient VPB for variation outside their control.

We urge CMS to first develop measures of hospital efficiency that are limited to factors within the hospital's control and sufficiently risk-adjusted, such as inpatient care-only measures, that can be implemented within the VBP program. CMS should also continue developing measures of efficiency across silos of care and payment, but such measures should be applied within the Medicare Shared Savings program and the Bundled Payment for Care Improvement initiative rather than hospital IQR and VBP programs. The right underlying financial incentives must be present to successfully implement such a measure within a payment system. Moreover, it will take time for hospitals to take on the responsibility for efficiency beyond their walls, especially because CMS is not yet able to provide comprehensive data to hospitals on utilization across the continuum on a routine basis. Furthermore, CMS did not release a public use file that allows outside organizations to verify CMS calculations, determine if unintended consequences may result from the inclusion in VBP, or help hospitals identify opportunities for hospitals to reduce spending. **CMS should not include the MSPB measures in VBP at this time, and should weight the efficiency domain at zero until appropriate hospital measures are developed.**

FY 2016 Measures

Previously, CMS adopted all of the FY 2015 measures for FY 2016, except for CLABSI. In this rule, three measures are proposed for removal, the CLABSI measure is proposed for continuation and three new measures are proposed for addition. Thus, a total of 19 measures are proposed for the FY 2016 VBP program.

Measure Removals

In the FY 2013 rule, CMS adopted all of the FY 2015 measures for FY 2016, except for CLABSI. In this rule, CMS proposes to modify the VBP measure set for the FY 2016 payment determination by removing three measures, adopting CLABSI, and adding three new measures for a total of 19 measures.

CMS proposes to remove:

- AMI-8, Primary PCI received within 90 minutes of hospital arrival;
- PN-3b, Blood cultures performed in the emergency department prior to initial antibiotic received in hospital; and
- HF-1, discharge planning.

CMS proposes removal of AMI-8, because it meets the criteria for being "topped out." CMS proposes to remove PN-3b because this measure is no longer endorsed by the National Quality Forum (NQF). In review of this measure, an NQF work group concluded that there is insufficient evidence that performing blood cultures prior to initiating antibiotics leads to better outcomes, and significant issues with documentation of this measure were cited. Similarly, HF-1 is no longer NQF endorsed as its review of the measure found insufficient evidence linking it to patient outcomes. **The Premier alliance supports the removal of AMI-8, PN-3b and HF-1.**

Measure Additions

CMS proposes to add:

- Central-Line Blood Stream Infection (CLABSI);
- IMM-2, Influenza Immunization;
- Catheter Associated Urinary Tract Infection (CAUTI); and
- Surgical Site Infection (SSI), limited to colon and abdominal hysterectomy procedures.

CLABSI

The CLABSI measure, which is part of the FY 2015 VBP program measure set, is proposed for continuation in FY 2016. CMS did not automatically propose continuation of this measure last year because CDC was planning to submit a revised version of the measure for NQF endorsement that would involve a reliability adjustment. NQF has not yet endorsed a reliability-adjusted version of CLABSI, and CMS therefore proposes to continue the current CLABSI measure for FY 2016. Premier previously supported the addition of this measure in VBP and it is MAP supported. **Thus, we support the continued inclusion of the existing risk-adjusted, rate-based ICU-only NHSN CLABSI measure in VBP for FY 2016 payment determinations.**

Influenza Immunization

IMM-2 measures whether patients ages six-months and older are screened for influenza immunization status and vaccinated prior to discharge if indicated. Hospitals began reporting this NQF endorsed process of care measure under the IQR program with January 1, 2012, discharges. This measure is MAP supported for use in VBP. **The Premier alliance supports the addition of IMM-2 in VBP for FY 2016 payment determinations.**

CAUTI

CMS proposes to add CAUTI as an outcomes measure. Data collection on this measure, which occurs through the CDC National Healthcare Safety Network (NHSN), began for the IQR program with January 1, 2012, discharges. Premier continues to be supportive of the CAUTI measure that is ICU-only and not reliability adjusted as those modifications are still pending NQF

approval. **The Premier healthcare alliance supports the addition of the existing risk-adjusted, rate-based CAUTI measure in the VBP program for payment determinations in FY 2016.**

SSI

CMS proposes to add the SSI measure reported through the NHSN that began with January 1, 2012, discharges. Data collection and public reporting on this measure are currently stratified by surgery site: colon and abdominal hysterectomy procedures. To have a score, the hospital would have to meet the threshold for public display of performance data on this measure, which is that the hospital has at least one predicted infection during the reporting period. The performance standards for this measure would be calculated by equally weighting the measure's strata. **Premier supports the addition of the risk-adjusted rate based SSI measure in the ICU only as part of the VBP program for payment determinations in FY 2016. We further support the stratification of the SSI measure for both reporting and scoring purposes.**

Future Measures

CMS announces, and seeks comment on, its intention to propose adding two measures to the FY 2017 VBP program in next year's rulemaking. These are the Lab-identified NHSN measures of Methicillin-resistant *Staphylococcus aureus* (MRSA) Bacteremia and the *Clostridium difficile* (C diff) standardized infection ratio that were added to the IQR program measure set for reporting events beginning January 1, 2013. These measures are NQF endorsed and MAP supported for inclusion in VBP. We note that these lab-based measures are not robustly risk-adjusted, but are rather comparisons to a national norm. **Although we urge the CDC to improve its risk-adjustment of these measures, the Premier healthcare alliance supports the addition of the MRSA and C diff measures in the VBP program for payment determinations in FY 2017.**

CMS also seeks comment on the possible addition in future rulemaking of two measures to the VBP program efficiency domain:

- Rate and/or dollar amount of billing hospital inpatient services to Medicare Part B subsequent to the denial of a Part A inpatient hospital claim; and
- Medicare spending measures specific to physician services that occur during a hospital stay, such as radiology, anesthesiology and pathology services. CMS is interested in comments on how measures of inpatient physician services could be constructed.

We want to ensure that CMS raising the issue of these new measures in the VBP section of the rule is not to suggest that these measures would not first go through the IQR program as is the preference per the statute and the field.

A/B Rebilling

CMS describes the A/B rebilling measure as assessing the appropriateness of hospital inpatient services, and notes its recent proposal (78 FR 16632) to pay hospitals for what would have been allowable Part B services in cases where a claim for inpatient hospital services is denied after discharge because the stay was not reasonable or necessary. This measure also relates to CMS' admission and medical review proposal in this rule. We do not believe that this is an efficiency measure and that it is best left to payment auditors. Moreover, this measure will not help beneficiaries choose providers or hospitals improve performance. CMS would essentially be measuring the confusion over CMS' inpatient admission and outpatient observation policies, as further complicated by the Recovery Audit Contractors, along with a provider's inability to predict the future. When physicians choose to admit patients, it is based on the information available at the time and their best medical judgment about often complex care. Whether or when to admit is a gray and subjective area where bright-line judgments cannot be made. Tracking the prevalence of rebilling is to suggest that providers should not make such adjustments or that the admissions were somehow an error on the

hospital's and admitting physician's part. We wholly disagree with either of these premises. Everyone would be better served by CMS focusing their development efforts on condition-specific, risk-adjusted, rate-based measures of admission. **CMS should not pursue an A/B rebilling measure for IQR or VBP.**

Physician Spending

The other measures CMS notes it is considering are Medicare spending measures specific to physician services that occur during a hospital stay, such as radiology, anesthesiology and pathology services. While we agree that specialty specific measures of spending are needed, we disagree with the idea that hospitals should be measured on this spending as part of VBP. Such measures would be much better suited as part of the Value-based Modifier (VBM) program within the Physician Fee Schedule as ultimately, the physicians are the ones ordering the care whether in the hospital or in follow-up. Moreover, it seems that these measures would be duplicative of the total spending measure CMS has already implemented in VBP that we discuss earlier in this section. In addition, we are concerned that the optimum level of such services is still unknown. We have similar reservations to those expressed regarding the outpatient imaging measures. It is not clear if the lowest use of imaging is actually best, which makes it confusing for beneficiaries and providers alike to interpret. Moreover, such measures could result in unintended negative consequences if appropriate benchmarks are unknown. **CMS should develop measures of physician spending for the VBM program, not the VBP program.**

Baseline and performance periods in FY 2016

CLABSI and CAUTI

CMS failed to publish baseline and performance periods for both the proposed CLABSI and CAUTI measures. **CMS should quickly publish a correction notice with these time frames and extend the comment period for these particular issues.**

SCIP Inf 4

CMS has not provided any detail on its process for adjusting benchmarks and thresholds if measure specifications materially change. Earlier in the letter we gave an example of measures re-specified from ICD-9 to ICD-10, but this concern also applies to SCIP Inf 4. In this rule, CMS proposes material revisions to the specifications for the measure SCIP Inf 4: Controlled 6AM Glucose for Cardiac Surgery Patients to incorporate recent NQF endorsement maintenance decisions, beginning with January 1, 2014, discharges. While we support the measure specification changes as it will result in a more clinically meaningful measure, we are unclear how CMS will treat the measure as part of VBP. CMS needs to develop a process to reflect changes in the standard of care that would affect the ability of hospitals to meet the benchmarks and thresholds. **CMS should propose a process for accounting for such changes to ensure fair treatment of all hospitals. In the case of SCIP Inf 4, we urge CMS to suppress the old measure for FY 2014, and propose a new benchmark and threshold once enough data has been collected with the new specifications and the baseline and performance periods draw from data reported under consistent specifications.**

Mortality

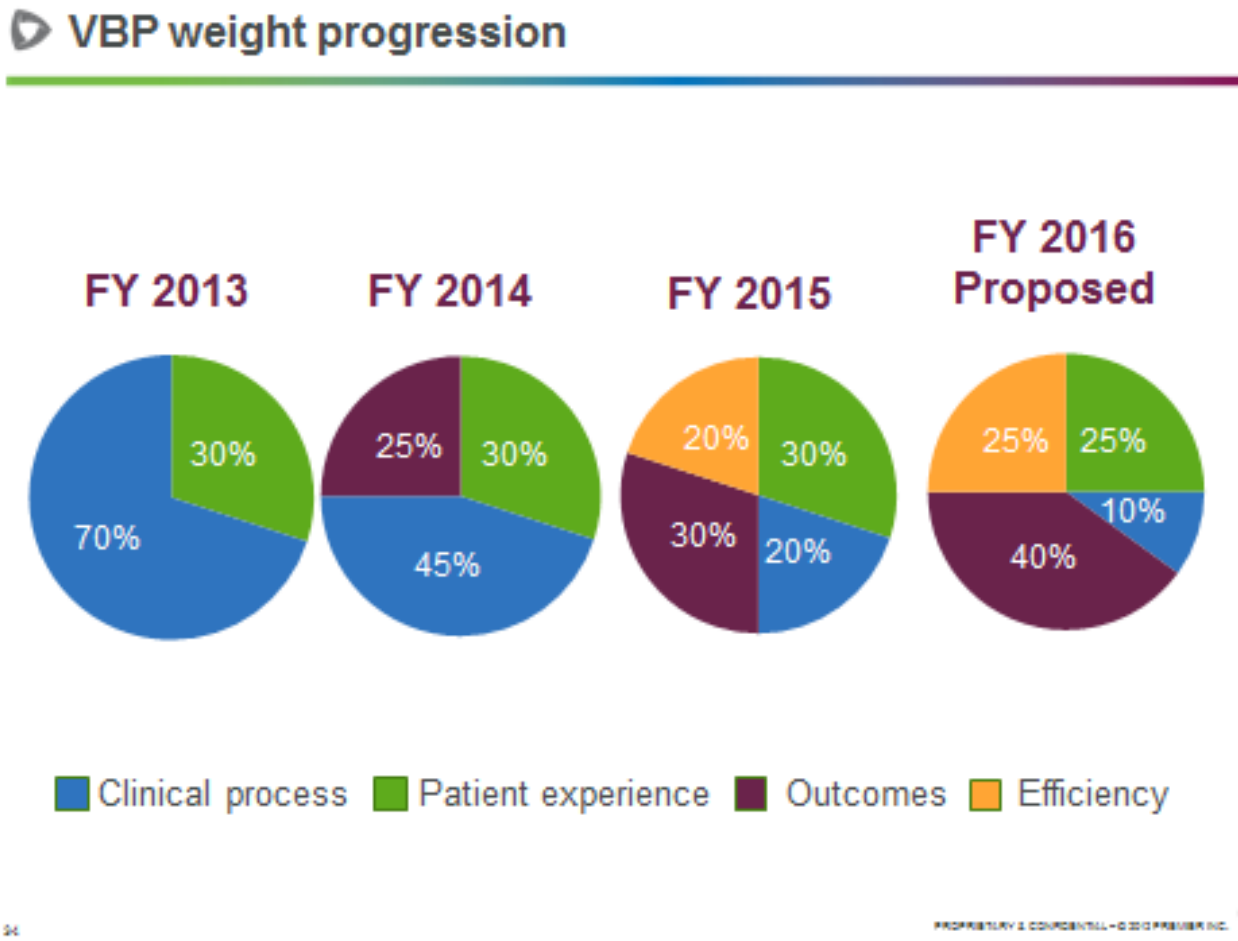
While we are concerned about the continued overlap of the performance periods in different payment determination periods, we appreciate the effort to lengthen the performance periods. **We believe that this will result in more stable and predictive measurement on which to base payment. Premier supports two-year performance periods for FYs 17, 18 and 19.**

AHRQ

While we are concerned about the continued overlap of the performance periods in different payment determination periods, we appreciate the effort to lengthen the performance periods. **We believe that this will result in more stable and predictive measurement on which to base payment. The Premier alliance supports the two-year performance periods proposed for FYs 17, 18 and 19.**

Domain weights in FY 2016

CMS proposes the following domain weights for FY 2016 as compared to 2013, 2014 and 2015.



Outcome

CMS proposes to increase the Outcomes Domain weight to 40 percent in FY 2016. The Premier healthcare alliance agrees that the outcome domain should eventually be given the highest weight among all the domains, but its weight in the initial few years should be lower and then phased in. Particularly, as CMS is still transitioning to sufficient baseline and performance periods for the AHRQ and mortality measures, and the ability of these measures to adequately distinguish performance between hospitals in questionable. CMS has added an NHSN measure and plans to add additional ones, which gives us more confidence in this domain as

compared to last year. However, as we note earlier in this section, we urge CMS to remove the safety measures from the VBP program and instead include them in the HAC Reduction program. **The outcome domain within VBP should not exceed 20 percent of the total weight in FY 2016 if the safety measures are included, or 15 percent if they are not.**

Patient Experience

Premier believes that the proposed 25 percent weight for the HCAHPS domain is too high given that the HCAHPS composite lacks sufficient risk-adjustment. Research, as detailed in our FY 2013 letter, shows that high-acuity patients score their patient experience at a lower level systematically disadvantaging hospitals that take on complex and sicker patients. Furthermore, the new consistency scoreing system CMS implemented was not thoroughly tested and we believe is not functioning as envisioned and should be revised or removed. Based on our analysis of CY 2009 and CY 2010 HCAHPS data, hospitals with consistently low scores were assigned a greater than average consistency score. This will have an impact on the total performance score and consequently how the hospital is rewarded under the program. **Thus, we reiterate that patient experience of care domain within VBP should not exceed 20 percent and that CMS should conduct further research to improve the population adjustment methodology of the survey.**

Medicare Spending Per Beneficiary

We would like to reiterate our concerns with the fact that the MSPB measure is not NQF endorsed. We also remain very concerned that this measure has a poor predictive power and highlights variation outside the hospital as expressed in the IQR section of this letter. Moreover, hospitals do not know what levels of spending to work toward, as is required by law, because CMS will not publish the benchmark and threshold until *after* the performance period is over. Lastly, even if CMS does publish the benchmark and threshold, CMS has not provided the necessary detailed data for hospitals to truly know where to focus on change. CMS has only provided very basic reports to individual hospitals

and has not released public use files. Nor has it heretofore been willing to release the full physician claims that would be necessary to nationally replicate the calculations. **The Premier alliance urges CMS to remove the efficiency domain until appropriate measures are developed. If CMS retains the domain, then it should be weighted no higher than 10 percent.**

Clinical Process

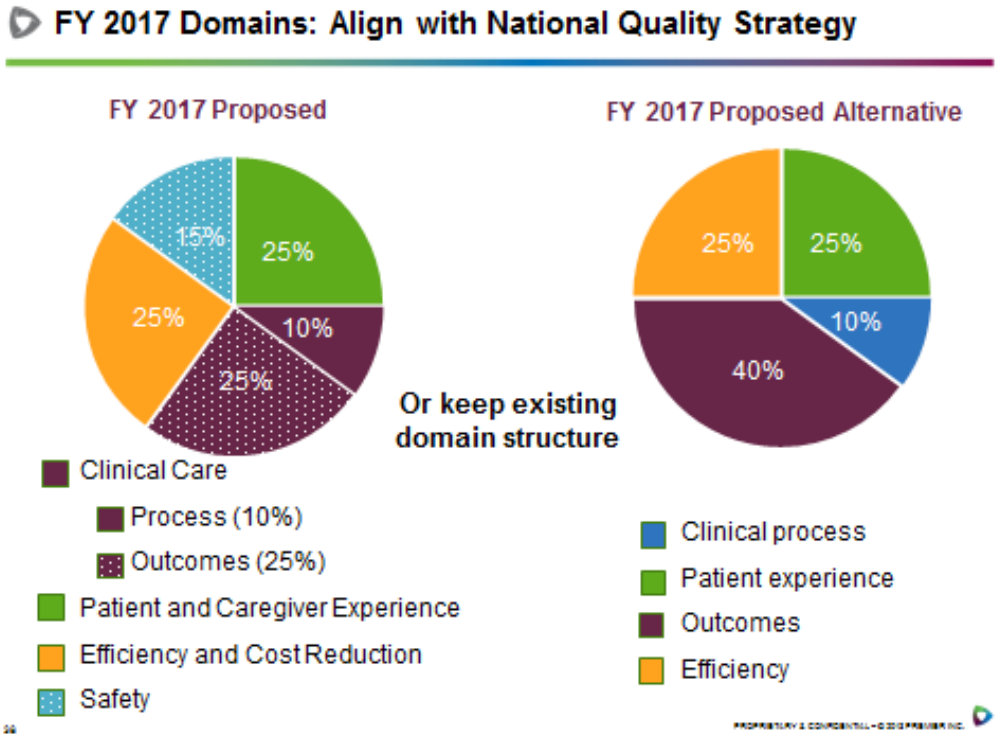
The clinical process measures are the longest standing measurers in the IQR and VBP programs. These measures have gone through extensive testing, were developed thorough a consensus building process, and are in wide use. These measures are not only helpful to beneficiaries in choosing a facility at which to seek treatment, they are also helpful to providers in identifying gaps in care that should be improved upon. We agree that the weight of these measures should decline in favor of outcome measures; however, we do not believe that the clinical process domain should go from 70 to 10 percent in four short years. **CMS should maintain a weight of at least 50 percent for the clinical process of care domain in the VPB program in FY 2016.**

The Premier alliance proposes the following alternative weighting scheme for calculation of the total performance score for FY 2016: clinical process of care weight of 55 percent, HCAHPS weight of 20 percent, outcome weight of 15 percent, and efficiency weight of 10 percent.

Domain weights in FY 2017

CMS proposes to revise the domain structure for the VBP program beginning in FY 2017 and lays out where each existing measure would map under the new domains. In place of the current four domains (Clinical Process of Care, Patient Experience of Care, Outcomes and Efficiency), CMS proposes to more closely align with the six National Quality Strategy (NQS) priorities: Clinical Care; Person- and Caregiver-Centered Experience and Outcomes; Safety; Efficiency and Cost Reduction; Care Coordination; and Community/ Population Health. Below we show the specific

domains CMS proposes along with their weights, as well as an alternative proposal that CMS lays out, which aligns with the 2016 proposed domains and weights.



As we noted last year, we support the NQS and support the long-term goal of aligning the CMS quality programs with it. However, our concerns about domain weights expressed above still stand and we need CMS to provide some additional information. **Premier supports aligning the domain names with the National Quality Strategy.**

Given comments from the FY 2013 rulemaking cycle from Premier and others, CMS does not propose to include stand-alone Community/Population Health or Care Coordination domains as there are no measures in the IQR program to include in them. However, CMS does propose to add Care Coordination to the Patient and Caregiver Experience Domain. With no current, related measures that aren't part of the HCAHPS survey, we question why CMS would do this. We furthermore believe that CMS should take

a comprehensive view of its quality policy programs in the context of the NQS and consider the HRRP program as its Care Coordination Domain. If other process or outcome measures of care coordination are developed beyond readmissions, CMS could consider alterations in the domain structure at that time. In the meantime, we see no need to simply tack on Care Coordination to the Patient and Caregiver Experience name with no measures to back it up. **We agree that stand-alone Community/Population Health or Care Coordination domains would be premature to include in the VBP program, and further urge CMS to remove its proposal to add Care Coordination to the Patient and Caregiver Experience Domain.**

Again, we agree that the reliance on process measures will wane and outcome measures will wax, thus we support combining those measures in FY 2017. However, we are not clear if CMS is actually planning to calculate the domain score with all of the measures together or separately. Given that a weight compared to the total is provided, we would assume separately. If CMS scores them separately, it is unclear what weighting will be given to each and if the assumption by omission is 50/50. Given that the process and mortality measures are constructed very differently, it may make sense to maintain separate scoring for each and then roll these up to a domain score. **CMS should clarify in the final rule how the mortality and process of care measures will be scored within the revised clinical care domain. The outcomes portion of the domain should not exceed more than 25 percent of the total program score, and process should represent at least 45 percent on the total score.**

CMS also proposes to pull the safety measures out into its own domain. Premier has had a "harm" domain in its QUEST: High Performing Hospitals collaborative since its inception in 2008. We should note that we are in the process of developing our third three-year cycle within that collaborative and are also making efforts to align our domains with the NQS. We believe that safety is an important area of focus and agree that it warrants its own domain. However, we have concerns about the overlapping HAC,

VBP and HAC Reduction programs as detailed in the HAC section of the letter. **The Premier alliance urges CMS to remove the safety outcomes measures from VBP and consider the HAC Reduction Program as its Safety Domain. If CMS insists on keeping these measures in VBP, we urge CMS to devote a domain to safety and weight it no more than 5 percent on the total score.**

In addition, we urge CMS to be more transparent about how it anticipates these changes in the domain structure affecting hospitals. We are unclear if, for instance, by pulling out safety on its own and potentially mortality on its own (depending on how CMS scores the clinical care domain) how the case minimums would affect program participation and scores. This information would have been helpful to stakeholders in weighing the options at hand. **CMS should release any analyses and data it used to arrive at the proposed domain weights and scoring rules.**

Our comments above on the domain weights in FY 2016 for Patient and Caregiver Experience of Care and Medicare Spending Per Beneficiary continue to apply to the proposed and alternative

FY 2017 weights. **The Patient and Caregiver Experience of Care domain should not exceed more than 20 percent of the total score, while the Medicare Spending Per Beneficiary domain should not exceed 10 percent unless revisions are made to the measures prior to FY 2017.**

Disaster/Extraordinary Circumstances Waivers

CMS proposes a process by which a hospital may apply for a waiver from the VBP program due to a significant natural disaster or other extraordinary circumstances. Under existing IQR program policies, a hospital may request a waiver of one or more data submission deadlines in the event of extraordinary circumstances outside the hospital's control. However, we agree with CMS that this process is not sufficient with respect to the VBP program because there may be circumstances under which a hospital might continue to report data on VBP quality measures but the performance on the measures is negatively affected by the disaster and therefore the VBP payment adjustment is reduced.

We support CMS' proposal to add an extraordinary circumstance waiver to the VBP program. However, we are concerned that 30 days may not be enough time to determine if a waiver is necessary. In disaster situations that possibly warrant a waiver, hospitals are likely spending the first 30 days worrying about physical access to the facility, structural integrity, electrical power and other fundamental concerns rather than quality reporting. We think that allowing 90 days to make this decision is more appropriate as it will give the sites time to see if they can get their operations back up and running and then make a determination as to whether they can get their submission process back in place. For instance, sites may have a backlog of data to manually enter after being unable to access electronic medical records during power outages, or having to use paper forms with temporary staff. Otherwise, we fear that the automatic result will be the facilities default to removal from the program, which we do not believe is the ultimate goal of CMS or the facilities. **CMS should extend the time period hospitals have to initiate the VBP program extraordinary circumstance waiver process from 30 to 90 days after an extraordinary circumstance to allow sufficient time for a hospital to evaluate their need for such a waiver.**

CONDITIONS OF PARTICIPATION

Administration of Pneumococcal Vaccines

The Medicare hospital condition of participation (COP) includes a policy related to the preparation and administration of influenza and pneumococcal polysaccharide vaccines. CMS had intended to establish a policy under which hospitals had the flexibility to administer these vaccines without prior practitioner order and only after assessing patients for contraindications to the vaccine administration. While it did not intend to exclude other pneumococcal vaccines, its use of "polysaccharide" in regulatory text inhibited the use of a new, FDA-approved vaccination. CMS thus proposes to remove "polysaccharide" and clarify its policy that a hospital may include *any* type of pneumococcal vaccine in its physician-approved policy for administration by nurses without prior practitioner order, if the vaccine has been FDA-approved for the patient population involved. We concur that this will improve patient access to pneumococcal vaccines, particularly in possible shortage situations. **The Premier healthcare alliance supports the expansion of the COP related to the administration of the pneumococcal vaccines.**

READMISSIONS

The law requires FY 2013 payments for hospitals subject to the inpatient PPS to be reduced to account for excess readmissions for three conditions. Risk-adjusted actual and expected readmissions must be determined consistent with measures of readmissions that have been endorsed by the entity with a contract under section 1890(a) (currently, the NQF). Measures must have appropriate exclusions for certain readmissions such as a planned readmission, readmissions unrelated to the original admission, or a transfer to another hospital. CMS previously finalized the following three measures for payment in FY 2013, but proposes changes for FY 2014:

- Acute Myocardial Infarction 30-day Risk Standardized Readmission Measure (NQF#0505);
- Heart Failure 30-day Risk Standardized Readmission Measure (NQF#0330); and
- Pneumonia 30-day Risk Standardized Readmission Measure (NQF#0506).

The law stipulates that CMS grow the policy to a total of seven conditions in FY 2015 based on a Medicare Payment Advisory Commission report if feasible including:

- COPD;
- Coronary Artery Bypass Graft (CABG);
- Percutaneous Coronary Intervention (PCI), and
- Other vascular conditions (OVC).

However, CMS does not believe it is appropriate to include PCI and OVC as they are largely moving to the outpatient setting. Moreover, it does not believe that CABG is feasible at this time, but plans to investigate its future inclusion.

What the rule proposes is to add one condition from the MedPAC list and two additional conditions in the policy in FY 2015:

- Hospital 30-day All-Cause Risk Standardized Readmission Rate following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization (NQF #1891); and
- Hip/Knee Readmission: Hospital-Level 30-Day All-Cause Risk-Standardized Readmission Rate (RSRR) Following Elective Total Hip Arthoplasty (THA) and Total Knee Arthoplasty (TKA) (NQF #1551).

CMS further proposes to refine the methodology to calculate the aggregate payments for excess readmissions to conform to the measure exclusions.

In addition to providing comments on these proposals, Premier would like to reiterate continuing concerns we have about the

policy. Specifically, the proposed adjustment will result in excessive payment reductions that are not consistent with congressional intent. We also believe CMS has not met its statutory requirement that the measures "have exclusions for readmissions that are unrelated to the prior discharge" despite the proposed refinements. Furthermore, we remain concerned that the payment adjustment will disproportionately impact certain providers of medically complex and disadvantaged patients.

Technical correction

As specified by CMS in the past, the readmissions provision will cause excessive payment reductions to hospitals. Adopting a literal and rigid interpretation of the statutory language, as CMS proposes, can result in a single excess readmission causing a hospital to face a payment reduction that is more than four times greater than Medicare's payment amount for that one admission. MedPAC is considering this issue, among other aspects of the HRRP, as part of their deliberations this year and commissioners by and large have agreed that this is concerning. Particularly because it can have the perverse incentive of discouraging lower performers from making any efforts to improve performance because getting "out of the penalty box" can be so difficult. We believe that this is a problem that CMS could address with its rulemaking authority.

The readmissions provision states that for each relevant clinical condition (such as heart failure), the payment formula determines the "excess readmission ratio," which is defined as the ratio of risk-adjusted readmissions based on *actual readmissions* compared to risk-adjusted *expected readmissions* for the clinical condition. Next, the formula calculates the amount of aggregate payments due to excess readmissions for each condition by multiplying the *total number of admissions* for the condition times the average base DRG payment for the condition times the excess readmission ratio for the condition minus one.

The formula, however, should have specified that the calculation is based on the number of *expected readmissions* in each condition not the *total number of admissions*. The formula is inconsistent and combines quantities that are not comparable in that the denominator (or base) used to calculate the ratio of excess readmissions is the number of expected readmissions, but then this result is applied to the total number of admissions. The discrepancy is magnified when the effect is combined for all multiple conditions. Only a small excess admissions ratio of 1 percent leads to a highly disproportionate impact on hospitals.

The budget impact of the discrepancy is that the statutory language, read literally, would generate aggregate savings that are much greater than what the CBO scored when the ACA was passed by Congress. Congressional intent is indicated by the CBO score and also by the heading of 1886(q)(4)(A), which reads "AGGREGATE PAYMENTS FOR EXCESS READMISSIONS." As shown in the examples, the technical error causes the amount which is calculated using the statutory formula to greatly exceed the amount of *actual excess* payments caused by readmissions. For these reasons, the most literal reading of the readmissions provision does not reflect congressional intent and will reduce hospital payments excessively unless the provision is interpreted properly in consideration of congressional intent.

Premier strongly urges CMS to rectify this problem whereby the readmissions penalty can recoup more than four times the case cost of an excess readmission through rulemaking using its discretionary authority. This is particularly important if CMS is considering moving to the all-condition readmission measure in the Hospital IQR program in the future.

We believe that at least two approaches are available to CMS. Under the first approach, CMS would implement the readmission reduction by applying the corrected formula in the final regulation. CMS would state that it is using its discretionary authority to implement the policy as Congress intended. CMS regulatory action could be confirmed by Congress with a technical amendment.

Alternatively, CMS could determine the magnitude of the readmission reduction using the 25th percentile of hospital performance on the readmission measures rather than assuming average hospital performance, which is the assumption of the current methodology used to determine the number of expected readmissions. As proposed by CMS, the regulation would reduce payments to hospitals that do not achieve an average level of performance, which we believe is an unreasonable expectation, especially in the readmission reduction program's initial years. We also note that, as MedPAC observed in its 2012 report, the excessive penalty caused by the drafting error becomes a greater problem as the maximum reduction increases from the 1 percent, which applied in FY 2013, to the 2 percent maximum in FY 2014.

Readmission Measures

Exclusions

CMS currently excludes some cases from their existing measures such as for transfers to other acute care facilities and patients discharged against medical advice. While CMS considers these as meeting the statutory requirement that certain "unrelated" readmissions are excluded, we note that these exclusions represent only a small portion of unrelated readmissions for which hospitals should not be held accountable.

CMS proposes to further exclude a series of readmissions that are assumed to be planned such as maternity cases and rehabilitation. The measures, with these additional exclusions, have been through the National Quality Forum (NQF) consensus process including a stakeholder comment period. We appreciate CMS taking Premier's previous comments into consideration and making an effort to remove additional planned readmissions. **Premier supports the additional exclusions and CMS' related proposal to further track such readmissions through new discharge status codes.**

However, we remain concerned that CMS has not adequately accounted for conditions that may result in readmissions that are not "preventable" or are preventable to varying degrees depending

on the population served including: trauma, psychoses, substance use, and end-stage renal disease. CMS should be careful to ensure that certain hospitals are not disproportionately negatively affected for such readmissions that are often out of the control of hospital providers. For instance, a hospital treating a pneumonia patient who also has a substance use problem should not be penalized for a return to the hospital because of illicit drug use. **CMS should consider altering the measure specifications to exclude additional cases for which the hospital should not be penalized under this policy.**

Risk Adjustment

Premier remains concerned that CMS fails to recognize that patient characteristics beyond those of medical diagnosis, age and gender greatly affect health status. As we note in the Hospital IQR section, the readmissions measures as constructed are not sufficiently adjusted and may lead to unintended consequences for providers and patients if used as part of the payment policy. In particular, our research in developing our own risk-adjusted readmissions measure shows that SES is an important predictor of readmissions rates. **We continue to urge the agency to incorporate additional characteristics, such as SES, into its patient-adjustment methodology, both to comply with the law and to avoid penalizing the very providers who are trying to eliminate disparities in healthcare.**

MedPAC conditions

CMS declines to include all of the MedPAC recommended conditions for various reasons. For instance, it does not have an NQF-endorsed CABG measure. It does note, however that CMS is considering developing a measure in this area. We agree that CABG is a high-volume, high-value services where an readmission is more likely a result of treatment failure than many other conditions. **Premier supports CMS investigating the development of a CABG readmission measure for the IQR and HRRP programs.**

CMS does not propose pursuing OVC and PCI as these services are ever increasingly performed on an outpatient basis. We concur that the standard of care has shifted in these areas since the MedPAC report. **Premier supports CMS in choosing to pursue other conditions than OVC and PCI for the HRRP program.**

Hip/Knee

CMS proposes to add the Hospital-Level 30-Day All-Cause Risk-Standardized Readmission Rate (RSRR) Following Elective Total Hip Arthoplasty (THA) and Total Knee Arthoplasty (TKA) (NQF #1551) measure for payment in 2015. This measure was not included in the MedPAC report list referenced in the ACA, but it is a high-volume, high-value service for Medicare. Furthermore, we agree that readmissions associated with these procedures are more likely to be treatment failures than for the existing conditions. **The Premier alliance supports the addition of the THA/TKA readmissions measure in the HRRP program rather than the MedPAC recommended conditions, but urges CMS to continue refining the measure.**

COPD

CMS proposes to add the Hospital 30-day All-Cause Risk Standardized Readmission Rate following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization (NQF #1891) measure for payment in 2015. COPD is on the MedPAC report list referenced in the ACA, and is a high-volume, high-value service for Medicare.

We have reservations about adding COPD to the readmissions penalty. COPD is a condition that is sensitive to environmental factors (e.g., weather patterns, pollen counts, pollution, etc.) that are very clearly outside the control of the providers and differ geographically. In particular, exacerbations of the condition can be related to the patients' socio-economic status (e.g., availability of air conditioning, exposure to cigarette smoke, ability to purchase hypoallergenic bedding, etc.). While we understand CMS' rationale

for recommending COPD, and believe it is an important area of focus, we think this further underscores the need to calculate payments based on a blend of rates with dual eligibles and rates without dual eligibles as discussed below. This does not mask disparities in the delivery of care, it masks the disparities deeply engrained in American society that hospitals on their own cannot overcome (e.g., literacy rates, access to adequate nutrition, etc.) to isolate the difference in performance of the care providers. **The Premier alliance does not support the addition of COPD in the HRRP at this time and urges CMS to refine the calculation to account for socio-economic status.**

Furthermore, we are concerned that this particular condition may also be susceptible to unintended consequences. If hospitals focus on keeping patients with COPD out of the hospital, some patients may only return in such grave condition that they are even costlier and mortality rates may actually increase. The readmissions policy, as currently constructed, has no balancing measures. That is, measures that provide counter pressure with different incentives to ensure that the pendulum for an individual measure does not swing so far in the other direction that it causes harm. Premier believes that the readmissions measures should be included in the Value-Based Purchasing program where mortality, among others, is also measured. An organization that has high readmissions combined with low mortality would not be unfairly penalized, and incentives would be more rationally balanced. We need these counter pressures as we do not yet know the optimal readmissions levels, but do know they cannot be zero due to natural disease progressions and should err on the side of sending patients home early (e.g., immune compromised patients).

The focus of the readmissions penalty should be to set a reasonable, but high performance target for which all hospitals would aspire to achieve. If all hospitals are able to surpass the expected performance, then penalties should not be assessed. The goal should not be to save money at the expense of patient care; the goal should be to improve the value of care paid for by Medicare. This, similar to VBP, would establish a program where

hospitals will be encouraged to work together and raise all boats. **By including readmissions in the VBP program, or establishing similar scoring, CMS would alleviate the perverse incentives inherent to the current HRRP design. We will work with Congress to provide CMS the authority to make such changes.**

Payment reductions

CMS proposes a series of changes to the calculation of the aggregate payments for excess readmissions, most of which conform the calculation exclusions to the measure exclusions. For instance, index admissions that are not considered readmissions for the purpose of the readmissions measures, and are excluded from the calculation of the excess readmission ratio, would also be excluded from the admissions that determine a hospital's aggregate payments for excess readmissions. While CMS reports that the impact will be minimal overall, we believe it is important for there to be consistency across the elements of the calculation. **Premier supports the modified exclusions as part of the calculation of the aggregate payments for excess readmissions.**

Alternative Approaches for Adjustment

Despite errors in the chart CMS published in last year's proposed rule with the impact of HRRP by DSH patient percentage (DPP) by decile, CMS did not include such an analysis in the final rule or this year's proposed rule. **Premier remains concerned that the HRRP program will have a particularly negative impact on safety net hospitals, and urges CMS to transparently report on this issue each year.**

The Measure Application Partnership (MAP), including a Premier representative, has continued to examine the issue of the lack of socio-economic status (SES) adjustments as part of the readmission measures. There has been, however, widespread agreement that SES factors affect readmissions, and the measure developer found a similar correlation using Medicaid data. The committee recommended stratification by SES, which is consistent with NQF measure criteria.

Since last year, MedPAC has begun discussing this issue. Staff recommended that CMS use a stratification approach similar to what we recommended last year and consistent with the MAP recommendation. We believe the approach would not require a material change to the measures, and thus would be within CMS' current legal authority.

The stratification model, a patient-level approach, is based on Medicare/Medicaid dual-eligible status, which is a good proxy for socio-economic status. The "blended" model would be comprised of CMS calculating a hospital's readmission rate first based only on the dual population and then on the non-dual population. The results are added together and multiplied by the national readmission rate for an individual hospital's readmission rate. This adjustment allows each hospitals rate to be based on their percentage of dual-eligible patients and creates a level playing field when comparing hospitals that treat different patient populations. This provides hospitals the incentive to improve their readmission rates while maintaining access for vulnerable populations. **Premier recommends CMS implement a stratification approach based on dual-eligible status for HRRP in an interim final rule with comments.**

CONCLUSION

In closing, the Premier healthcare alliance appreciates the opportunity to submit these comments on the FY 2014 inpatient PPS proposed rule. Please do not hesitate to contact Danielle Lloyd, vice president for policy development and analysis, at 202.879.8002 or danielle_lloyd@premierinc.com if you would like to discuss further.

Sincerely,

Blair Childs
Senior vice president, Public Affairs