June 30, 2014

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

RE: CMS-1607-P, Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Fiscal Year 2015 Rates; Quality Reporting Requirements for Specific Providers; Reasonable Compensation Equivalents for Physician Services in Excluded Teaching Hospitals; Provider Administrative Appeals and Judicial Review; Enforcement Provisions for Organ Transplant Centers; and Electronic Health Record (EHR) Incentive Program; Proposed Rule (Vol. 79, No. 94), May 15, 2014

Dear Administrator Tavenner:

CHE Trinity Health is pleased to submit these comments on the Centers for Medicare & Medicaid Services’ (CMS) proposed rule entitled Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Fiscal Year 2015 Rates; Quality Reporting Requirements for Specific Providers; Reasonable Compensation Equivalents for Physician Services in Excluded Teaching Hospitals; Provider Administrative Appeals and Judicial Review; Enforcement Provisions for Organ Transplant Centers; and Electronic Health Record (EHR) Incentive Program; Proposed Rule (Vol. 79, No. 94), published on May 15, 2014

CHE Trinity Health is one of the largest multi-institutional Catholic health care delivery systems in the nation, serving people and communities in 20 states from coast to coast with 84 hospitals, 109 continuing care facilities, and home health and hospice programs that provide nearly 2.8 million visits annually. The organization formed in May 2013, when Trinity Health and Catholic Health East joined to strengthen our shared mission, increase excellence in care, and advance transformative efforts with our unified voice. With annual operating revenues of about $13.3 billion and assets of about $19.3 billion, the new organization returns almost $1 billion to its communities annually in the form of charity care and other community benefit programs. Combined, CHE Trinity Health employs more than 87,000 people, including 3,200 physicians.

We appreciate your staff’s ongoing efforts to administer and improve the payment systems for acute inpatient hospital services and long-term care hospital services, especially considering the agency’s many competing demands and limited resources. CHE Trinity Health has provided detailed comments that follow this cover letter. We appreciate the ability to respond to the proposed rule changes. If you have any questions, please feel free to contact Tonya Wells at wells.tk@trinity-health.org or 734-343-0824.

Sincerely,

Tonya K. Wells
Vice President, Public Policy & Federal Advocacy
CHE Trinity Health
CHANGES TO MS-DRG CLASSIFICATIONS AND RELATIVE WEIGHTS

MS-DRG Documentation and Coding Adjustment
The Centers for Medicare & Medicaid Services (CMS) proposes a cut of 0.8 percent in fiscal year (FY) 2015 that would fulfill part of the American Taxpayer Relief Act of 2012 (ATRA) requirement that CMS recoup what CMS claims is the effect of documentation and coding changes from FYs 2010, 2011 and 2012 that CMS says do not reflect real changes in case-mix. We agree with CMS that this proposal helps mitigate extreme annual fluctuations in payment rates. While we continue to believe these congressionally mandated adjustments are not warranted, the proposal has provided hospitals with additional time to manage these sizeable cuts.

We are troubled that CMS continues to compare hospitals’ documentation and coding practices in FY 2010 to their documentation and coding practices under an entirely different system in FY 2007. We also are concerned that necessitating larger adjustments in the future would be contrary to the agency’s stated goal of mitigating extreme annual fluctuations in payment rates. Section 7(b)(1) of the TMA, Abstinence Education and QI Programs Extension Act of 2007 (Public Law 110-90), as amended by the American Taxpayer Relief Act of 2012, only applies the documentation and coding adjustment to the standardized amounts. Nowhere does Congress authorize CMS to make a documentation or coding adjustment to the HSP. For these reasons, we urge CMS not to apply any portion of the 0.8 percent proposed recoupment on a prospective basis to the standardized amount or the hospital-specific payment rate.

In addition, we agree with the American Hospital Association's (AHA) previous assertion that CMS’ coding cuts are overstated is not limited to only the 0.8 percent cut related to FY 2010 – it also applies to cuts the agency made related to FYs 2008 and 2009. Specifically, CMS made one-time payment cuts of 5.8 percent to recoup what it states were overpayments made in FYs 2008 and 2009. Yet, the Medicare Payment Advisory Commission (MedPAC) found that CMS could have overstated these cuts by cumulatively as much as 0.36 percent in FY 2008 and 0.36 percent in FY 2009 – or by a total of 0.72 percent. Therefore, we urge the agency to correct this over-recoupment by implementing a one-time increase of 0.72 percent to inpatient payment rates.

DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENT CHANGES

DSH Payments / 75% Pool
The Patient Protection and Affordable Care Act of 2010 (ACA) requires that, beginning in FY 2014, hospitals initially receive 25 percent of the DSH funds they would have received under the current formula, with the remaining 75 percent flowing into a separate funding pool for DSH hospitals. This pool would be reduced as the percentage of uninsured individuals declines, and would be distributed based on the proportion of total uncompensated care each Medicare DSH hospital provides. We understand that changes to the DSH payment methodology are mandated by the ACA.

We are very concerned that hospitals will be negatively impacted in States that do not expand their Medicaid programs as the currently prescribed redistribution mechanism relies on Medicaid inpatient days and Medicare SSI inpatient days as a proxy for uncompensated care.

Per Section 3133 of the ACA, CMS has established an uncompensated care pool, funded with 75% of the otherwise calculated DSH amount (75% pool). While the 75% pool is statutorily mandated by the ACA, the allocation methodology is at the discretion of the Secretary. Although CMS considered adopting definitions of uncompensated care to include the cost of bad debt and charity care as provided on the Medicare cost report worksheet S-10, the proposed rule for FFY 2015 is not using the S-10 to allocate the 75% pool. We agree with the proposal not to use the worksheet S-10 data, but recommend that CMS continue to work with hospitals to help improve consistency of the data compiled and recorded in this worksheet, and develop a timeline to transition to using this worksheet. CMS recognized the concerns of the Provider community in the new format of the S-10 and confusion with the instructions impacting the accuracy and consistency of the data reported on the S-10. We acknowledge that CMS has made improvements to the
instructions to the S-10 over the last year, in response to comments in the FFY 2014 IPPS rule. We believe there still remain several issues to clarify with the S-10 prior to its use as an allocation source for the DSH 75% pool. We recognize and appreciate the changes to the S-10 instructions in the latest transmittal already made by CMS, however, we have included several clarifying comments for CMS’ consideration.

We have several recommendations to CMS to assist in further clarifying the CMS-2552-10 worksheet S-10 instructions and recommended timeline for implementation as the basis for the allocation of the uncompensated care pool:

- **Line 1**: Uses the cost-to-charge ratio from worksheet C of the cost report, which excludes intern/resident costs. The cost report calculations should include an adjustment to add that intern/resident cost back into the numerator for the calculation of the cost-to-charge used on S-10. Intern/resident cost is allowable cost, it is only backed off on the cost report flow due to the separate GME/IME reimbursement. As allowable cost, interns/Residents cost should still be included in cost-to-charge ratio used to calculate the cost of uncompensated care.

- **Line 20**: In the first sentence of the instructions, we recommend that CMS remove the phrase “(measured at full charges)”. This is confusing, as some preparers have read this to apply to all numbers on line 20, and entered full charges in column 2 for the insured patients, instead of just the deductible and coinsurance obligation. Further into the paragraph the instructions properly segregate column 1 input as “patient’s total charges” from column 2 input as “deductible and coinsurance payments required”.

- CMS should delay using the S-10 as the basis for allocating the DSH Uncompensated Care Pool until such time that the HCRIS database contains the cost reports filed with further clarified instructions. After incorporating S-10 instruction clarification comments submitted with this proposed rule, cost reporting periods beginning on or after 10/1/14 would have used the clarified instructions. That would run through the FYE 8/31/16 cost reports to get complete cost report year data using updated S-10. Therefore the earliest that S-10 data would be included in the Proposed Rule for the DSH Uncompensated Care Pool allocation is FFY 2018 (three years from now).

The Factor 1 (estimated 75% of DSH), the proposed rule did not provide enough detail of how the CMS Office of the Actuary calculated the estimated DSH payments, in such a way that it could be replicated by commenters inclined to verify the calculation. The Medicaid days being used in Factor 3 allocation reflect FFY 2011/2012 (i.e. FYE 6/30/12 & FYE 12/31/12) cost reports. Without further detail of the assumptions and calculations, hospitals cannot be assured that the CMS Office of the Actuary properly took into account reasonable estimates for Medicaid expansion under the Affordable Care Act, which would tend to increase DSH payments and help border-line hospitals to qualify for DSH, creating an even larger aggregate DSH payment total for FFY 2015 as the basis for the 75%/Uncompensated Care Pool.

**WAGE INDEX**

**Core-Based Statistical Areas (CBSA)**

We support CMS’ proposal to adopt new urban/rural delineations consistent with the updated Office of Management and Budget Bulletin No. 13-01, and the transition plan that CMS is proposing for CAHs and hospitals negatively affected by these changes with respect to their wage index. However, we also urge CMS to provide similar transitions for hospitals with Sole Community Hospital and Medicare Dependent Hospital status. MDHs and SCHs also may face significant instability due to the implementation of the new delineations. Specifically, CHE Trinity Health recommends that CMS also provide for a two-year transition for SCHs and MDHs that are located in a rural area that would be reclassified as urban under the new delineations. This transition would allow a hospital with SCH or MDH status to maintain that status for the next two fiscal years (i.e., FY 2015 and 2016). After that transition period, the hospital would need to reclassify from an urban to a rural location, or would lose its SCH or MDH status. This transition would be consistent with CMS’ other proposed transitions intended to shield hospitals from short-term financial instability arising from dramatic changes in payment amounts.
**Imputed Rural Floor**

We agree with the CMS’ proposal to extend the imputed floor program for one year. CMS states in the proposed rule that this is a result of trying to continue to explore potential wage index reforms as well as their intention to further evaluate the need, applicability, and methodology for the imputed floor. We note that the AHA Medicare Area Wage Index Task Force has issued draft recommendations and have requested comments from hospitals prior to finalizing the report. The imputed rural floor program is included in the AHA report. We recommend that the industry consider all recommended changes to area wage index and have a chance to provide input to CMS prior to finalizing any decisions regarding the imputed rural floor.

We recommend that if CMS concludes the expiration of the imputed rural floor will occur in the final rule, that CMS afford those hospitals a multi-year phase-out, as their wage index is returned to their CBSA determined factor. To realize such a cut in revenue without the benefit of a phase-out may result in dramatic cost cutting through elimination of services vital to their community, in order to offset the lost revenue.

**New Timetable**

CMS is proposing Wage Index timetable changes across the board for the FFY 2017 cycle and targeted transitional changes for the FFY 2016 cycle. We agree with CMS proposed changes to the Wage Index timetable, as it affords all involved more time to ensure accuracy of the data, the hospitals, the MACs, and CMS.

**APPROPRIATE CLAIMS IN PROVIDER COST REPORTS; ADMINISTRATIVE APPEALS BY PROVIDERS AND JUDICIAL REVIEW**

The cost reporting rules are revised to generally require a provider to include in its cost report items which may be subject to appeal (either claimed on the cost report or included in the Protested Amount). These changes mark a transition from making a claim for an item a condition of jurisdiction to a condition of payment.

As a condition of payment, the proposed rule precludes payment if an item is not claimed on the cost report to its fullest extent. We believe that settlement data items should always be corrected by the Contractor, whether claimed or not, i.e. capital DSH if the SS% is mistakenly left off of the filed cost report by a Provider that does not qualify for operating DSH; Nursing and Allied Health Education Managed Care payment since it is an oddity on the settlement page that does not calculate on the cost report or come from the PS&R, but rather must be calculated using data from a prior year cost report and the result input on worksheet E Part A, in addition the cost report instructions do not include a description of how this amount should be calculated, only to include the amount, if applicable.

The CMS proposed rule is too focused on limiting the phenomenon of Providers changing their DSH Medicaid eligible days after filing the cost report and NPRs. We caution CMS that they may be painting with too broad a brush with this rule, there could be unintended consequences where other reimbursement issues would be adversely effected. There could be instances where the amount claimed on the cost report is incorrect, or an updated number is available later. For instance: intern/resident FTEs on a prior year cost report get changed on audit or reopening after the current year cost report is filed using the original prior year FTE count in the IME and GME calculations. This would impact the 3-year rolling average and the prior-year-resident to bed ratio. The way this proposed rule is written, if the Contractor does not correct the current year incorrect number on audit or reopening, the hospital has no recourse through the PRRB.

CMS should not finalize this rule including the proposed preclusion from payment requirement if an issue is not fully claimed. The rule uses Medicaid eligible days for DSH as an example, however I offer an example tied to Medicare settlement data. For the Provider who files the cost report using the PS&R paid claims data at the time of filing, is not fully claiming all of the Medicare settlement data due to outstanding
unprocessed claims. One may argue that the claims were made subsequent to the cost report through submission of patient bills, later processed and reflected on the PS&R. The reimbursement impact of these claims typically nets to zero change on the NPR, with the addition of the claim amount and the interim payment. That may be true for claims payments, however, the cost report contains a claim for GME reimbursement, which is in part based on the Medicare days to total days ratio. As those later Medicare claims are processed, no additional GME claims or payments are made, as GME is paid on an interim basis as bi-weekly PIP payments. Therefore, by using the PS&R data as of the time cost report filing, the Provider is not making the full claim for the Medicare share of GME reimbursement (based on the ratio of Medicare days to total days). Following this proposed rule literally would preclude the Provider from receiving the additional GME payment related to the increased Medicare share calculated on the NPR as a result of the additional Medicare days.

The proposed rule uses an example to describe the multi-layer process of filing a complete claim, with Medicaid eligible days for DSH being claimed on the cost report, and additional days included through an amended cost report, Contractor audit adjustments, and a reopening by the Contractor. The problem with each step after the initial cost report filing is the unfettered Contractor discretion to not act on the Provider’s request to correct the days. There should be a process to have such discretion reviewed for reasonableness by CMS Regional or CMS Central. Safeguards need to be in place if Contractor discretion is to be the determining factor.

The proposed rule is reliant on a claim or protest of a self-disallowance being made. CMS refers to the Contractor proactively reviewing the protested items for an “… opportunity to correct any misconceptions…” of the Provider in the protested items, to alert the Provider of allowable items. “In such cases, the contractor’s deep expertise and experience and its resources can be brought to bear in reviewing self-disallowed items, making any necessary corrections, and finally allowing payment for corrected items in the NPR.” From my experience with multiple Contractors, their audit program instructs them to eliminate the filed protested item with an audit adjustment (thereby preserving the Provider’s appeal rights). This is typically the limit of the Contractor’s review of the protested amount, until an appeal is filed, and then only to challenge the appealed issue as not being included in the filed protested amount. In order to ensure that CMS’ expressed vision of the Contractor’s review of the self-disallowed items is realized consistently, we recommend CMS make a change to the audit program to include steps to review the protested amounts and to consult with the Provider prior to issuance of the NPR, reflective of the process described in this proposed rule, which “… comports with section 1874A(a)(4) of the Act and §413.20(b) of the regulations, which require the contractors to furnish provider with consultative services, education, training, information and instructions, and technical assistance regarding the interpretation and application of payment principles and other program policies.”

We recommend that CMS should not remove or limit the Provider Reimbursement Review Board’s (Board’s) statutory authority and ability to grant jurisdiction. This proposed rule will result in limiting access to the Provider’s right of Board review provided by section 1878(a)(1)(A) of the Act, when “dissatisfied”. There are instances in cost report preparation where the Provider could not reasonably be expected to know the facts needed to either make a claim or protest, particularly given the level of specificity required, such as CMS’ own calculation inaccuracies and misinformation as shown in recent court cases, i.e. *Baystate, Cape Cod, and Allina*. There is a need to maintain access to the Board through *Bethesda*-type cases for CMS changes and clarifications, like the Labor & Delivery days change in the FFY 2010 IPPS Final Rule, for when cost reports are filed in compliance with the rules prior to the change or clarification. There is also a need for access to appeal directly from the Federal Register final rules, without waiting to voice dissatisfaction until the filed cost report. Payment should be allowed, and not precluded as proposed, when the reviewing entity has ruled in favor of the Provider, as the appeals/review process is part of the entirety of the “claims” process.
GME NEW PROGRAM

CMS is proposing to simplify and streamline the timing of the intern/resident FTE cap, 3-year rolling average, and IRB ratio cap, so that all will be effective at the same time, the cost reporting period that precedes the start of the sixth program year of the first new program started. We appreciate and support CMS simplifying and coordinating these various aspects of intern/resident reimbursement for new programs.

OUTLIER THRESHOLD INCREASE

CMS is proposing to increase the outlier fixed-loss threshold from $21,748 to $25,799, an increase of 18.6%. We believe this increase is overstated. In the discussion of their rationale, CMS stated that the increase was related to the charge inflation factor by the hospitals. However most hospitals would not be increasing charges by greater than 5% on average, due to restrictions in their multi-year managed care contracts which require downward rate adjustments if the hospital increases charges over a certain percentage, typically 3 – 5%. In addition, with the existence of the outlier reconciliation requirement for changes in the cost-to-charge ratio of over 10 percentage points, hospitals would not be inflating their charges by over 18% (the amount the fixed-loss threshold is proposed to change). We would recommend that CMS verify the accuracy of the data and calculations being used and share that data and calculations with the AHA, HANYS, or other hospital representatives for review, input and concurrence.

Per section 1886(d)(5)(A)(iv) of the Act, outlier payments for any year are projected to be not less than 5 percent nor more than 6 percent of total operating DRG payments (which does not include IME and DSH payments) plus outlier payments. We do not believe it is reasonable for CMS to expect to hit the 5.1% target with an increase in the fixed-loss threshold of over $4,000, 18.6%. The actual FFY 2013 outliers, per the FFY 2015 proposed rule, were 4.81% of MS-DRG payments, below the statutory 5%. For FFY 2014, CMS is using FFY 2013 claims data to estimate at 5.79%, which while greater than the target of 5.1% is still within the statutory range of 5% to 6%. Given that trend, we believe a $4,000 increase in the fixed-loss threshold is excessive and will result in outlier payments below the 5% statutory target floor.

PRICING TRANSPARENCY

CHE Trinity Health supports the transparency of data that will provide more access to information that will serve to advance the triple aim of better care, better health, and lower costs. Transparency is a critical element of health care transformation. However, we believe that the posting of charges, which are often different than the actual amount paid, creates additional patient confusion in an already complex reimbursement system and may not provide the most meaningful picture of a patient’s out-of-pocket costs.

We, however, join with the Catholic Health Association (CHA) and American Hospital Association (AHA) in applauding CMS for not establishing regulatory requirements concerning what hospitals must do to satisfy the Affordable Care Act requirements around transparency of hospital charges. The proposed rule would allow hospitals to determine how to comply, including what to report and the format of the report. We believe that giving hospitals flexibility in meeting the statutory requirement will allow beneficiaries and the public to receive the necessary information without creating unnecessary burden beyond what is created by the requirement itself to release the data.

SHORT INPATIENT STAY

CHE Trinity Health appreciates the opportunity to provide our comments on the possibility of establishing an alternative payment methodology for short inpatient hospital stays. We believe strongly that hospitals need to be appropriately and adequately reimbursed for the care that they provide, and the two-midnight policy adopted in the FY 2014 IPPS final rule does not address the inherent problems of short hospital stays.
Problems with and Recommended Changes to the Two-Midnight Policy

While we understand that the proposed rule is only requesting suggestions to supplement, not replace, the two-midnight policy, we fundamentally disagree with this policy where payment is hinged on the physician documentation of his or her expectations that the patient will stay two midnights, rather than whether the patient actually stays two midnights. CHE Trinity Health believes that hospitals should get reimbursed for the care that is provided, not a physician's expectation. Therefore, we do not believe that a short stay payment policy in isolation will address the issues adversely affecting providers, physicians, and beneficiaries. Problems created by the two-midnight policy can only be addressed by eliminating the presumption that stays of less than two midnights should be denied on grounds that the care could have been provided on an outpatient basis. Until CMS removes the ambiguity and uncertainty affecting contractor treatment of short inpatient stays, hospitals are likely to continue to provide care on an outpatient basis, including observation care.

The aggressive contractor activity by MACs and RACs, which is due in large part to these ambiguous and conflicting Medicare rules concerning the appropriateness of a hospital admission, are burdensome and costly to hospitals and have also harmed beneficiaries by imposing additional out-of-pocket costs. CHE Trinity Health urges CMS to refocus the RAC program activity on appropriate medical review not on time-based denials.

CHE Trinity Health also remains concerned about the adverse consequences this policy is having on patients, including confusion as to whether they are an inpatient or outpatient and higher costs if the inpatient stay is denied and they are billed as an outpatient. This is especially a problem with self-administered drugs where the beneficiary would be responsible for these non-covered services because their inpatient stay is not covered under Part A. Hospitals should have the option to waive these beneficiary financial liabilities resulting from a change in inpatient to outpatient status.

We agree with the Catholic Health Association (CHA) that any hospital stay ordered by an authorized clinician in compliance with Medicare rules should be considered to be an inpatient stay if the treating clinician determined that the patient required inpatient care and provided supporting documentation. CMS and its contractors should not overrule the judgment and decision of the treating clinician based on an after-the-fact review of the medical record performed by a medical adviser who did not examine the patient and who has the benefit of information not available when the admission decision was made.

Short-Stay Payment Policy Recommendations

Overall, CHE Trinity Health agrees with the Catholic Health Association (CHA) and does not recommend a different payment for short hospital stays. That said, we would support the proposal articulated by both the CHA and the American Hospital Association (AHA) which would base short-stay policy on post-acute care transfer policy, which reimburses hospitals a graduated per-diem rate rather than a full DRG payment rate. We believe this promotes administrative simplicity by removing the requirements for hourly observation status documentation. CMS should develop a payment amount that is empirically based on actual charges in short-stay cases compared to actual charges for all cases in the MS-DRGs to which the policy would apply. An empirically based formula would ensure that the payment is adequate to cover the cost of the services provided. CHE Trinity Health also supports AHA's recommendation that hospitals should be eligible for all add-on payments they would otherwise receive (disproportionate share, indirect medical education, etc) on a pro-rated basis under any short-stay policy. With both the two-midnight policy and a short-stay policy in place, physicians would determine whether patients should be admitted to the hospital as inpatients, in accordance with their medical judgment, as they would have prior to the two-midnight policy. If the beneficiary is expected to or actually does stay at least two midnights, the hospital would receive full payment under Medicare Part A. If the beneficiary is not expected to or does not stay at least two midnights, under the short-stay policy, the hospital would receive a reduced inpatient PPS rate.
RECOVERY AUDIT CONTRACTOR (RAC) PROGRAM REFORM

Finally, we agree with the American Hospital Association (AHA) that even upon implementation of an SSP policy, the two-midnight policy will continue to fail if it is not combined with comprehensive reform of the RAC program. Such reform must address the systemic issues that have led to avoidable claim denials and appeals. Without such reform, RACs will continue to second guess the medical judgment of the treating physicians, leading to inappropriate and excessive denials, and resulting in significant strain on hospitals and the appeals process.

We agree with the AHA’s urging for CMS to impose a financial penalty on RACs when a denial is overturned on appeal – not just to recoup their contingency fee – to provide some check on the strong financial incentive RACs have to improperly deny claims. CMS also should eliminate application of the one-year timely filing limit to rebilled Part B claims. The agency also should codify in regulation its assertion in the preamble of the FY 2014 inpatient PPS final rule that RACs are limited to using the medical documentation available at the time the admission decision was made when determining whether an inpatient stay was medically necessary.

We, too, believe that CMS also must improve oversight of the RAC program to ensure, among other things, that hospitals have an opportunity to avoid appeals by having an adequate and effective discussion period; problems with submitting documentation to RACs in response to additional documentation request are resolved; and claims for procedures on the “inpatient-only list” are no longer wrongly denied by RACs.

PHYSICIAN CERTIFICATION OF CAH INPATIENT SERVICES

Medicare statute requires as a condition for payment for inpatient services provided in a CAH that a physician certify “that the individual may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the critical access hospital.” CMS proposes to change when such physician certification must be received. Specifically, under CMS’ proposal, the certification “is required no later than 1 day before the date on which the claim for payment for the inpatient CAH service is submitted.” Currently, CMS requires that the certification be complete prior to discharge. CHE Trinity Health supports this change and encourages CMS to finalize it as proposed.

However, CHE Trinity Health also encourages CMS to continue to work on this policy, which because of recent actions by CMS, has proven very difficult for CAHs to navigate. CAHs typically maintain an annual average length of stay of 96 hours per patient, but on some occasions the length of stay will be greater than 96 hours. In some cases, the physician may expect the length of stay to be 96 hours or less, and while the stay may turn out to be longer, the physician can nonetheless credibly certify as to his/her expectation that the stay will be within 96-hour window. However, in some instances, the physician may expect the length of stay to exceed 96 hours at the outset of the admission. In these cases, the physician will be unable to certify that the beneficiary’s stay will be less than 96 hours, and the CAH will not satisfy
the condition of payment. Occasionally admitting a patient who is expected to stay longer than 96 hours is permissible, and should be paid.

So long as this requirement is enforced, CAHs may not be eligible for Medicare payment, a situation which is bad for both CAHs and the patients they serve. As such, CHE Trinity Health urges CMS to exercise its discretion and make clear that it will not enforce this requirement.

**HOSPITAL READMISSIONS REDUCTION PROGRAM (HRRP)**

CHE Trinity Health agrees with the refinement to the algorithm.

We would echo the comments we made in support of the National Quality Forum’s Draft Report on Risk Adjustment for Socioeconomic status or other Sociodemographic Factors and encourage adopting these recommendations as soon as possible. We take a holistic view to caring for each patient, i.e., not only understanding the disease process but understanding the role that each patient’s environment may play in it and the unique requirements to each patient’s recovery process.

CHE Trinity Health agrees with the Expert Panel’s conclusion that current policy is unintentionally weakening the network of providers that serve disadvantaged populations, which could end up worsening disparities. The failure to adjust measures can mask important factors that contribute to worse outcomes. Risk adjustment allows a more just assessment by leveling out the factors that are not under the control of the provider yet at the same time holding providers accountable for high quality care. In the absence of sociodemographic risk adjustment, the measures reflect the underlying disparities of the populations served instead of the relative quality of the services delivered.

CHE Trinity Health does not support that socioeconomic adjustment would reduce the standard of care for providers treating less privileged populations. On the contrary, we believe risk adjustment would create meaningful improvements, including increased accountability and stratification for identifying disparities and as well as providing a more accurate reflection of performance.

We agree that without further refinement of our measurements, that appropriately include sociodemographic adjustments, health disparities could become embedded in our delivery system. Evidence shows that hospitals that treat the poorest patients are disproportionately more likely to incur penalties under the program. As noted in the comments provided by the American Hospital Association (AHA) data from the fiscal year 2014 inpatient prospective payment system final rule show that 77% of hospitals in the top decile of disproportionate share hospital (DSH) payments incur a readmissions penalty, while only 36% of the hospitals in the lowest DSH decile will receive a penalty. CHE Trinity Health has had similar experience to these national averages.

**HOSPITAL-ACQUIRED CONDITION (HAC) REDUCTION PROGRAM**

CHE Trinity Health would continue to encourage that CMS reconsider those selected measures that inappropriately overlap with both the value-based purchasing and inpatient quality reporting programs, creating potential for "double dipping" or double payment penalties. We would echo AHA’s comments that this could send conflicting signals about the true state of hospital performance and to urge CMS to eliminate the overlap of measures between programs.

We would agree with CMS’ proposal related to using a standardized electronic composite measure; however, we would be interested in a timeline, in particular, if there is an expectation from CMS that this align with the proposal on having quality reporting go electronic effective with CY2016 data. We would also encourage that vendors be intimately involved in this discussion as given the work effort around meaningful use, this may not be a viable timeframe for all to meet. Lastly, we would encourage CMS to consider a similar methodology related to a composite measure that is currently in place for the AHRQ PSI-90 measure.
As noted in our prior comments related to the Quality Rating System scoring measures and methodology, CHE Trinity Health would encourage harmonization across all reporting programs inclusive of those outlined in this proposed rule as well as the Physician Quality Reporting System (PQRS). This overlap promotes consistency in quality measurement across a number of payers, will be particularly important for the Medicaid and exchange populations who may churn between these types of coverage, and should help ease the overall burden that measure collection places on providers. Data collection by health plans can be arduous, time consuming and inefficient for the providers who are conducting patient visits and who are responsible for the clinical interventions that optimize patient outcomes and increase overall plan performance.

**HOSPITAL VALUE-BASED PURCHASING (VBP) PROGRAM**

CHE Trinity Health encourages CMS remove redundancy when selecting measures across programs and evolve all quality reporting programs to focus more on outcome rather than process measures. We support the proposed changes/ removal of topped out measures and incorporating the HCAHPS Care Transition Measure into the HCAHPS domain.

CHE Trinity Health agrees with CMS’s statement re: the concern “that the transition to a new coding system [ICD10] might have unintended consequences on quality measure data denominators, statistical adjustment coefficients, and measure rates.” This most definitely could have an impact not only on VBP but every other quality reporting program that is dependent on coded data. We would strongly encourage that CMS review performance once ICD10 is implemented given the potential decrease in rates. Dependent on the results, we would encourage some kind of adjustment be made as necessary.

CHE Trinity Health does not support changing definitions of performance standards in the middle of a reporting cycle.

**HOSPITAL INPATIENT QUALITY REPORTING (IQR) PROGRAM**

CHE Trinity Health agrees with removing topped out measures from the program and with those measures specifically targeted for removal for FY17 reporting period as well as the decrease in number of charts required for validation. We support the long-term goal of aligning with the Medicare EHR Incentive Program to reduce the burden of chart abstraction; however, would note that the timeline is very aggressive. We do not believe that as an industry we will be in position for mandatory reporting effective with CY16 data for FY18 payment determination. While it will decrease administration variation, there is competition with ICD10 readiness as well as significant workflow changes that are predicated on vendor solutions which may not yet exist. Related to e-measures validation, CHE Trinity Health would respectfully request further details as to what controls will be put in place to allow CDAC to remotely view records in real-time. Finally, we echo the AHA’s concern that CMS proposes several other measures for the IQR that are not NQF-endorsed and that are not appropriate for public reporting.

**ELECTRONIC MEASURES FOR FFY 2018 PAYMENT DETERMINATION**

CHE Trinity Health would echo AHA’s support of the long-term goal of using EHRs to streamline and reduce the burden of quality reporting while increasing access to real-time information to improve care. We concur that CMS leverage data from the EHR Incentive Program for insight and development of a report on lessons learned to date from hospitals’ experience with certified electronic health records (CEHRT), and their use for eCQMs. As AHA noted, hospitals have expended considerable effort to modify how data are captured, and this generally has not lead to comparable results across measurement methodologies.

Given that HIQR and VBP programs have historically been based on validated data, CHE Trinity Health would strongly encourage that CMS delay identifying a date for mandatory electronic reporting of quality measures until, as AHA noted, there is significant levels of CEHRT adoption and a validation process for
eCQMs is operational and yielding successful evidence of measure reliability. We do, however, agree with the incremental shift of aligning measure reporting/submission across reporting programs.

IX.D.4 Electronically Specified Clinical Quality measures Reporting for 2015
To transition a hospital into a truly meaningful user requires technology, work flow/process changes and culture changes. Technology is not yet truly interoperable, so that within a hospital, multiple technologies provide assistance to the care giver in an independent manner and the vendors do not provide interoperability from system to system. Therefore, we believe that the time table proposed here is too aggressive given constraints beyond the control of hospitals.

IX.D.5. Clarification regarding Zero Denominators
The specification for the eMeasure Meaningful Use reports, related to RXNORM codes for pharmacological treatment, rarely match with the actual dose, unit dosage, and route as prescribed by our physicians. Therefore, the reports that include medications in the measure do not provide an accurate picture of the care provided to our patients because the specs do not match how clinicians prescribe medications. We would recommend revising this to match physician prescribing process and workflow.

ELECTRONIC HEALTH RECORDS (EHR) AND MEANINGFUL USE

CHE Trinity Health agrees with the concerns identified by the American Hospital Association (AHA) regarding the need for policies that describe how the agency will identify and notify the appropriate hospitals that they are subject to the significant payment penalties for failure to meet meaningful use. Given the magnitude of the penalties, and the newness of the program, we too believe it is crucial for the agency to be transparent and fair in its process for applying the penalties, as it has done for the quality reporting programs. CHE Trinity Health also agrees with the recommendations provided by AHA to improve the regulatory guidance for this matter.