



June 6, 2017

Ms. Seema Verma
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: *Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2018 Rates; Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Electronic Health Record (EHR) Incentive Program Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Provider-Based Status of Indian Health Service and Tribal Facilities and Organizations; Costs Reporting and Provider Requirements; Agreement Termination Notices (CMS-1677-P)*

Dear Administrator Verma,

CHRISTUS Health ("CHRISTUS") appreciates the opportunity to submit the following comments and recommendations to the Centers for Medicare and Medicaid Services (CMS) in response to the *Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2018 Rates; Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Electronic Health Record (EHR) Incentive Program Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Provider-Based Status of Indian Health Service and Tribal Facilities and Organizations; Costs Reporting and Provider Requirements; Agreement Termination Notices ("Proposed Rule")* as published in the Federal Register on April 14, 2017. CHRISTUS is an integrated, not-for-profit international health system that includes nearly 350 services and facilities, including more than 50 hospitals in seven U.S. states. We share the Administration's strong commitment to promoting health and wellness solutions that improve the lives of the individuals and communities we serve.

We appreciate the ongoing efforts by CMS to administer and improve the payment systems for acute inpatient hospital services, especially considering the agency's many competing demands and limited resources. CHRISTUS offers the following comments on several aspects of the proposed rule.

I. FY 2018 Medicare-Severity Diagnosis-Related Group (MS-DRG) Documentation and Coding Adjustment

The proposed rule would make an adjustment to IPPS payment rates of +0.4588 percentage points as the first step in a six-year process of restoring prior year downward adjustments to IPPS

payment rates that were required by the American Taxpayer Relief Act of 2012 (ATRA). ATRA instructed CMS to recoup \$11 billion in payments to IPPS hospitals between FYs 2014 and 2017. CMS had estimated that \$11 billion in IPPS payments were made in FYs 2010, 2011 and 2012 due to documentation and coding changes that CMS believed did not reflect real changes in case-mix.

Beginning with the FY 2014 final rule, CMS had planned to adopt a policy to mitigate the impact of the ATRA payment cut on hospitals by reducing the otherwise applicable change to IPPS payment rates by 0.8 percentage points each year, FY 2014 through 2017, for a total over four years of 3.2 percentage points. With the \$11 billion recoupment then complete, CMS planned to restore the aggregate reduction by increasing the otherwise applicable change to IPPS rates by 3.2 percentage points for FY 2018.

However, Congress enacted the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 on April 16, 2016. Section 414 of MACRA replaced that one-time FY 2018 increase with increases of 0.5 percentage points over a six-year period (FYs 2018 through 2023). This would have resulted in a cumulative 3.0 percentage point increase to the otherwise applicable changes to IPPS rates, short of the total 3.2 percentage points that would have been restored under prior law. Shortly thereafter, CMS proposed and finalized for FY 2017 a final recoupment adjustment of -1.5 percentage points instead of the prior estimated adjustment of -0.8 percentage points for a total recoupment over four years of 3.9 percentage points, increasing the shortfall of the MACRA restoration to .9 percentage points.

Making matters even worse, the 21st Century Cures Act signed into law on December 13, 2016 reduced the first-year restoration adjustment in FY 2018 from 0.5 percentage points to 0.4588 percentage points. Thus, while 3.9 percentage points were removed from the IPPS rates as recoupment, only 2.9588 percentage points will be restored to the rates. As a result, hospitals will not lose the difference between the 3.2 percentage points that would have been restored to IPPS rates in FY 2018 and the cumulative amount actually restored to the rates between FY 2018 and FY 2023, but they will suffer a permanent reduction in IPPS rates going forward.

CHRISTUS recognizes that CMS' flexibility may be limited. Nevertheless, CHRISTUS believes that fairness and equity dictate that all recoupment adjustments be fully restored to IPPS rates. For this reason, **CHRISTUS urges CMS to make every effort to interpret and apply the statutory provisions related to documentation and coding to fully and permanently restore all recoupment adjustments to IPPS rates by FY 2023.**

II. Disproportionate Share Hospitals (DSH)

Since FY 2014, hospitals that qualify for Medicare DSH payments receive two separately calculated payments. The first payment equals 25 percent of the amount they would have received under the Medicare DSH formula required by statute prior to the Affordable Care Act (ACA). The second payment is based on the remaining 75 percent of the total Medicaid DSH payments that would have been paid under the old formula, adjusted by the change in the number

of uninsured individuals in the under 65-aged population since FY 2013. The amount received by a given hospital from this fund is based upon that hospital's share of national uncompensated care costs.

To calculate the change in the number of uninsured since FY 2013, the statute initially requires CMS to use Congressional Budget Office (CBO) estimates of the uninsured. CMS used as its baseline the CBO's estimate that 18 percent of the under 65-aged population were uninsured in FY 2013. For each subsequent fiscal year, it determined the change in the number of uninsured by comparing that year's CBO estimate of the uninsured to 18 percent and decreased the 75 percent fund accordingly. In 2017, CBO estimated that 10 percent of the under 65 population was uninsured, and CMS decreased the projected 75 percent Medicaid DSH fund by 8 percent.

Beginning with FY 2018, the statute no longer requires that CMS use the FY 2013 CBO figure for the baseline estimate of the uninsured in the under aged-65 population. CMS is proposing to use estimates from its own National Health Expenditure Accounts (NHEA) to estimate the percent of uninsured individuals in the under 65-aged population in FY 2013 and since that time. Using the NHEA figures, CMS estimates that the under aged-65 population that was uninsured has declined from 14 percent in FY 2013 to just over 8 percent for FY 2017 and FY 2018, or a decline closer to 6 percent rather than the 8 percent that was used to determine FY 2017 uncompensated care payments. As a result, the amount available to distribute for hospital's uncompensated care costs is about \$1 billion higher from using the NHEA figures in place of the CBO figures. **CHRISTUS supports CMS' proposal to determine uncompensated care payments using the NHEA estimates of changes in the uninsured beginning in FY 2018.**

From FY 2014 through FY 2017, CMS has distributed uncompensated care payments to hospitals based on each hospital's share of national uncompensated costs using low income patient days—Medicare inpatient days when the patient was eligible for Supplemental Security Income (SSI), and Medicaid inpatient days where the patient was not also eligible for Medicare—as proxy data for uncompensated care. For FY 2018, CMS proposes to begin a three-year transition period to use of Worksheet S-10 of the Medicare Hospital Cost Report in place of low income patient days to distribute Medicare uncompensated care payments. Under this proposed transition, CMS would use two years of low income patient days (FY 2012 and FY 2013) and one year of Worksheet S-10 data (FY 2014) to distribute FY 2018 uncompensated care payments. For FY 2019, CMS would use one year of low income patient days (FY 2013) and two years of Worksheet S-10 data (FY 2014 and FY 2015) to distribute uncompensated care payments. For FY 2020, CMS would use three years of Worksheet S-10 data (FY 2014, FY 2015 and FY 2016) to distribute uncompensated care payments.

CHRISTUS is generally supportive of CMS' proposal to transition to the use of uncompensated care costs, as derived from the Worksheet S-10 cost report, to replace the current use of Medicare SSI days and Medicaid days as a proxy for uncompensated care. We strongly urge, however, that CMS develop a longer phase-in for incorporating the data from the S-10 cost reports and include Medicaid shortfalls and other types of uncompensated care in the definition.

We note that CMS is not proposing to do any audits of the first three years of Worksheet S-10 data that it will use to distribute uncompensated care payments. In the proposed rule, CMS indicates that cost reports beginning in FY 2017 will be the first cost reports for which the Worksheet S-10 data will be subject to a desk review. The FY 2017 Worksheet S-10 will not be used to distribute uncompensated care payments until FY 2021.

Under CMS' proposal, FY 2014-FY 2016 Worksheet S-10s used in the distribution of uncompensated care payments will not be subject to any desk review or audits. Further, CMS indicates that it does not anticipate making any further modifications to the Worksheet S-10 instructions at this time. CHRISTUS disagrees with CMS' proposal not to use desk-reviewed Worksheet S-10 data to distribute uncompensated payments. **CHRISTUS urges CMS to use audited Worksheet S-10 data in the distribution of uncompensated care payments and to continue working with hospitals to make improvements to the Worksheet S-10 instructions.**

CHRISTUS believes that a longer phase-in period would allow CMS to continue to fine-tune the accuracy, consistency and completeness of the S-10 data before relying solely on that data, and would give hospitals more time to ensure accurate reporting based on any revised instructions CMS may issue with respect to the timing of reporting charity care and other revisions. A longer phase-in with desk review audits would also allow for improvements in reporting of data as CMS and hospitals have more experience with these data. **CHRISTUS recommends a longer phase-in of the use of S-10 cost report data than the three-year transition period proposed by CMS and would instead suggest a five-year transition period to mitigate wide swings in hospital payments from year-to-year.** CHA strongly urges that CMS adopt a longer phase-in period to allow for improvements to the data over the phase-in period.

CHRISTUS supports CMS' proposal to annualize data if a hospital's cost report does not equal 12 months. CMS further requests comment on whether it is necessary to continue using three years of cost reports if it finalizes its proposal to annualize short or long period cost reports for the distribution of Medicare uncompensated care payments. **CHRISTUS believes CMS should continue to use three years of cost reports in the distribution of uncompensated care payments to mitigate year-to-year fluctuations in payments and also to assist with the transition from low income patient days to Worksheet S-10.**

CMS reiterates its proposed definition of uncompensated care from prior years. Under this definition, CMS would recognize non-Medicare bad debt and charity care. However, CMS would not recognize payment shortfalls from public health programs like Medicaid, the Children's Health Insurance Program (CHIP) and state and local indigent care programs. **CHRISTUS believes that uncompensated care should also include the unreimbursed costs of public health care programs, including Medicaid, CHIP and state and local indigent care programs.** This approach would be a fairer way to allocate uncompensated care dollars to hospitals, especially given that analyses we have reviewed suggest that hospitals located in states that opted out of Medicaid expansion do significantly better under the CMS proposed approach than hospitals located in states that have expanded Medicaid. Broadening the definition to

include Medicaid shortfalls and other forms of unreimbursed costs of other public health care programs would help make the allocation more equitable.

III. Critical Access Hospitals (CAHs)

In the proposed rule, CMS indicates that the Medicare statute requires a physician to certify that the individual may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the CAH for inpatient CAH services to be paid under Medicare Part A. Since October 1, 2014, CMS has required that all physician certification requirements must be completed, signed, and documented in the medical record no later than 1 day before the date on which the claim for payment for the inpatient CAH service is submitted. While CMS indicates that it does not have discretion to modify the physician certification requirement through regulation, CMS does propose to make enforcement of the CAH 96-hour certification requirement a low priority for medical record reviews conducted on or after October 1, 2017. **CHRISTUS supports CMS' proposal to make the 96-hour certification requirement a low priority for enforcement.**

IV. Accounting for Social Risk Factors in the Hospital Quality Reporting and Pay-for Performance Programs

The proposed rule seeks comment on accounting for social risk factors in the various hospital quality programs: the Hospital Readmission Reduction Program (HRRP); the Hospital Value-Based Purchasing (VBP) Program; the Hospital-Acquired Conditions (HAC) Reduction Program; and the Hospital Inpatient Quality Reporting (IQR) Program. We are responding to each of those requests.

CHRISTUS agrees that all hospitals should be held to high standards of quality for all patients. The links between social risk factors and poor outcomes are well known, however, and providers serving a high percentage of disadvantaged patients can be subject to unnecessary payment reductions if appropriate adjustments for social risk factors are not made in performance-based payment incentive programs. The data now available are limited to demographic information such as area of residency, gender, ethnicity, etc., which is only a portion of the information needed for robust risk adjustment. We feel that other factors such as support systems, services available and financial resources available to the patient are equally important to capture. However, there appears to be no clear and objective means to capture this information for each patient admitted to or discharged from the hospital or long-term care hospital (LTCH) setting. **For this reason, CHRISTUS believes that quality outcome measures should be risk-adjusted for sociodemographic factors such as income, education, race, homelessness and language proficiency, which have been shown to have a significant relationship to health outcomes.**

In its 2014 report, the National Quality Forum (NQF) Risk Adjustment Expert Panel recommended that performance accountability programs should include risk adjustment for those sociodemographic factors for which there is a conceptual relationship with outcomes or

processes of care and empirical evidence of such an effect, for reasons unrelated to quality of care. This would apply to all the measures used in the HRRP and the mortality and efficiency measure in the VBP Program. As noted by the Department of Health and Human Services (HHS) Assistant Secretary for Planning and Evaluation (ASPE) in a December 2016 report, social risk factors and patient safety events are related, and social risk factors may be a proxy for medical complexity that is not accounted for in performance measures.¹

In addition, more could be done to use performance measurement systems to identify and eliminate health disparities. Enhanced data collection on social risk factors, along with improved statistical techniques as recommended by the ASPE, would allow better measurement of performance and outcomes with respect to individuals with social risk factors.

Regardless of future steps taken toward stratification and social risk factor adjustment, CMS should continue to monitor the effect of the hospital quality programs on vulnerable and disadvantaged populations and the providers that serve them to ensure they are not being harmed. This should be undertaken with consideration of program interactions. The ASPE has recommended that the cumulative penalties on providers that serve beneficiaries with social risk factors across the three hospital pay-for-performance programs (HRRP, HAC Reduction Program, VBP Program) should be tracked. In addition, we agree with the ASPE that CMS should undertake prospective monitoring of the effects of possible changes in quality programs on hospitals serving beneficiaries with social risk factors, so that program changes are made with these concerns in mind.

V. Hospital Readmissions Reduction Program

The stratification of hospitals into peer groups by percentage of dual eligibles, as required under the 21st Century Cures Act and proposed in this rule for implementation in 2019, is a reasonable step in the direction of recognizing that social risk factors contribute to high readmission rates in some hospitals. As discussed above, CHRISTUS believes that the HRRP readmission measures should be risk adjusted for social risk factors that are associated with higher readmission rates. The percentage of dual eligibles is a proxy for identifying hospitals with a patient mix that could experience higher readmission rates due to the prevalence of social risk factors. Moving forward, CMS should undertake analysis that would directly measure those factors and make appropriate risk adjustments as part of the measure calculation.

VI. Hospital Value-Based Purchasing Program

CHRISTUS has been concerned about the Agency for Healthcare Research and Quality (AHRQ) PSI 90 patient safety composite measure, and for that reason we are pleased that it will be removed from the VBP Program beginning in FY 2019. However, we believe that the proposal

¹Department of Health and Human Services. APSE. Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs. December 2016. <https://aspe.hhs.gov/pdf-report/report-congress-social-risk-factors-and-performance-under-medicares-value-based-purchasing-programs>.

to add the modified PSI 90 Patient Safety and Adverse Events Composite measure beginning in FY 2023 is premature. While we appreciate that this measure has been endorsed by the NQF, **CHRISTUS believes the proposal to include the Patient Safety and Adverse Events Composite measure in the VBP Program should be postponed until stakeholders in the field can comment on its possible use in the program based on experience with this measure.** For both the IQR Program and the HAC Reduction Program the first performance periods for the modified PSI 90 Patient Safety and Adverse Events Composite measure that involve use of ICD-10-CM data will not end until June 30, 2017, and hospitals will see initial performance scores once CMS performs those measure calculations for FY 2019.

In addition, CHRISTUS does not agree with the proposed weighting of the measures in the efficiency domain. While the Medicare Spending per Beneficiary (MSPB) measure has been in the VBP Program the longest, that is not sufficient reason to weigh it at 50 percent of the domain score as is proposed. The MSPB measure is so broad that it is difficult for hospitals to interpret, and it is not a true reflection of appropriateness, quality of care, or patient outcome. By contrast, the condition-specific spending measures at least allow hospitals to develop internal analyses that might lead to targeted actions and improved performance.

CMS also proposes to add to the efficiency domain the risk-stratified measure of payment for a 30-day episode of care for pneumonia. The Measure Applications Partnership (MAP) did not support the addition of this measure when it was reviewed in December 2015. **CHRISTUS believes that if CMS finalizes its proposal to add this measure to the VBP program, the existing measure of total MSPB should be adjusted for this and the other two condition-specific payment episode measures (for heart failure and AMI) to ensure that there is no overlap and double-counting of these costs in the efficiency domain.**

VII. Inpatient Quality Reporting Program

CHRISTUS supported the previously finalized removal of the three-question Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey Pain Management dimension from the hospital VBP Program. That removal resulted from confusion about the intent of these questions and the public health concern about the ongoing prescription opioid overdose epidemic.

Because they focus on effective communication about pain during the hospital stay, CHRISTUS believes the proposed replacement questions represent an improvement over the existing questions, which remain part of the survey and for which hospital performance is reported on *Hospital Compare*. However, CHRISTUS urges CMS to seek NQF endorsement for the revisions and to continue to work with the Measure Applications Partnership to address concerns about the reliability and validity of the new questions before they are finalized.

CHRISTUS supports the proposed modification to the stroke mortality measure that would include the National Institutes of Health Stroke Scale in the measure risk adjustment. Before implementing this measure in the IQR Program, however, we urge

CMS to respond to concerns of the NQF and test the validity of the NIH Stroke Scale using ICD-10-CM codes. We support the proposal to engage in a trial of the modified measure and provide hospitals with confidential feedback prior to implementation of the measure. If the measure is finalized, CMS should remain open to delay of implementation as necessary depending on the results of the trial.

With respect to the proposed voluntary reporting of the NQF-endorsed Hybrid Hospital-wide Readmission Measure, CHRISTUS appreciates the benefits of testing the use of information drawn from the electronic health record (EHR) in calculating risk adjustments for claims-based measures. Refining risk adjustment using information from patient records has potential to improve the value of the measure in distinguishing hospital performance with respect to readmissions. While we continue to have concerns with the hospital-wide readmission measure itself, we agree that voluntary testing of the hybrid approach for risk adjustment is a reasonable activity to undertake because if successful the use of EHR-based patient information could potentially be applied to other claims-based measures. However, before CMS elects to propose this or any measure using the hybrid approach as a mandatory IQR Program measure, there would need to be sufficient experience and analysis to determine the benefits of the additional reporting effort.

VIII. Reporting of Electronic Clinical Quality Measures (eCQMs)

CMS proposes to revise the previously adopted eCQM reporting requirements for 2017 (2019 payment) and 2018 (2020 payment). These requirements apply to both the IQR Program and the Medicare Incentive Payment Program “meaningful use” requirements. Under the proposal, instead of reporting 8 eCQMs for a full year for 2019 payment, hospitals would report six self-selected eCQMs for two self-selected calendar quarters in 2017. Then, for 2020 payment, six eCQMs would be reported for the first three quarters of 2018. **While the proposed changes are a step in the right direction, CHRISTUS continues to be concerned about ongoing challenges hospitals encounter in meeting eCQM reporting requirements considering the time needed for hospitals, vendors and CMS’ own systems to adapt to electronic reporting of quality measures.**

IX. Extraordinary Circumstances Exceptions in Hospital Quality Programs

CHRISTUS supports the proposals in the rule that would modify extraordinary circumstances exceptions (ECE) policies in the HRRP, the HAC Reduction Program and the IQR Program in order to align these policies across CMS quality reporting and value-based purchasing programs.

X. Collection of Standardized Patient Assessment Data under the LTCH QRP

LTCHs offer hospital-based, long-term acute care services to arguably a very acutely ill patient population that is quite different than other post-acute care providers. Without a very robust risk-adjustment it is extremely difficult to confidently draw conclusions as related to quality of



care and patient outcome given the data that is currently collected. **CHRISTUS believes a robust risk-adjustment should be performed before drawing conclusions based upon data collected and submitted via the Long-Term Care Hospital Continuity Assessment Record and Evaluation Data Set (LTCH CARE Data Set) and the National Healthcare Safety Network (NHSN).**

On behalf of CHRISTUS Health, thank you again for the opportunity to provide feedback on this NPRM. We are hopeful that our constructive comments on improvements to the proposed rule are helpful, and we welcome any questions you may have.

Sincerely,

A handwritten signature in cursive script that reads "Gabriela M. Saenz".

Gabriela Saenz
Vice President Advocacy & Public Policy
CHRISTUS Health