June 30, 2014

Marilyn B. 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 Incentive Program (Vol. 79, No. 94), May 15, 2014

Dear Ms. Tavenner:

The Wisconsin Hospital Association is a statewide nonprofit association with a membership of more than 140 Wisconsin hospital and health systems that includes not only critical access hospitals providing crucial services to their rural communities, but also major academic medical centers providing world-class care, research, and training. On behalf of our members, we appreciate the opportunity to provide comments on the Centers for Medicare and Medicaid Services (CMS) proposed rule on the hospital inpatient prospective payment system (PPS).

1. NATIONWIDE RURAL FLOOR BUDGET NEUTRALITY ADJUSTMENT

WHA continues to oppose the continued application of a nationwide rural floor budget neutrality adjustment as described in the proposed rule. CMS is aware that this policy was instigated by the orchestrated conversion of a single facility in Massachusetts — Nantucket Cottage Hospital — from a critical access hospital to an inpatient prospective payment system hospital. Coupled with the application of nationwide budget neutrality through section 3141 of the Patient Protection and Affordable Care Act, the conversion initiated a policy that unfairly skews Medicare payments. Payments to thousands of hospitals across the nation are diverted to produce gains for hospitals predominately located in Massachusetts.

CMS recognizes the problems and inequities raised by this nationwide rural floor budget neutrality factor, which contradicts the agency’s stated wishes in applying wage indexes. In its CY 2012 OPPS final rule (CMS-1525-FC), CMS expressed concern that allowing a change in hospital status as occurred in Massachusetts through the ACA distorts wage indexes across the nation:
“…In recent years, we have become concerned that hospitals converting their status significantly inflate wage indices across a State…Hospitals in Massachusetts can expect an approximate \textbf{8.7 percent increase} in IPPS payments due to the conversion and the resulting increase of the rural floor. Our concern is that the \textbf{manipulation of the rural floor} is of sufficient magnitude that it requires all hospital wage indices to be reduced approximately 0.62 percent as a result of nationwide budget neutrality for the rural floor (or more than a 0.4 percent total payment reduction to all IPPS hospitals).” (emphasis added)

In its proposed rule, CMS publishes the projected state-specific effect of the nationwide rural floor budget neutrality standard in FY 2015. The agency notes that Massachusetts hospitals are estimated to receive approximately a 4.9 percent increase in IPPS payments due to the application of the proposed rural floor. The estimated amount of windfalls to Massachusetts from the manipulation of the wage index is $157.8 million for FY 2015. In addition to Massachusetts, California is now a large beneficiary of the manipulation and the agency estimates a windfall of more than $196 million.

WHA would like to thank CMS for its work to publish the state-specific impact table. \textit{WHA urges CMS to include in its final IPPS rule an updated detailed state-specific analysis of the effects of nationwide rural floor budget neutrality.} Also, we ask that CMS build on its earlier analytical work on this topic by publishing tables showing the cumulative state-specific and aggregate inpatient and outpatient payment distortions produced by nationwide rural floor benefit neutrality in recent years and also projecting the estimated 10-year state-specific effects of continuing the current policy.

The adverse consequences of nationwide rural floor budget neutrality have been recognized and commented upon by CMS, the Medicare Payment Advisory Commission and many others over the past several years. That the policy continues into a fourth year is disconcerting at best. Until this policy is corrected, the Medicare wage index system cannot possibly accomplish its objective of ensuring that payments for the wage component of labor accurately reflect actual wage costs.

\textbf{2. TWO-MIDNIGHT POLICY}

CMS finalized its “two-midnight” policy in the FY 2014 inpatient PPS final rule. Under this policy, CMS will generally consider hospital admissions spanning two midnights as appropriate for payment under the inpatient PPS. \textit{Although we appreciate CMS’s attempt to clarify what is required for payment of inpatient hospital services under Medicare Part A, WHA still believes the two-midnight policy is an arbitrary time-based benchmark that undermines the role of physician judgment.} While it was purported to address some problems, its downstream impact has created additional problems. In order to address this confusion and the ongoing need to develop a short stay payment methodology, \textit{WHA supports the continuation of CMS’s current enforcement delay until improvements can be made.}
CAH Condition of Payment
With respect to Critical Access Hospitals (CAH) under this policy, WHA appreciates CMS’s proposal to allow for greater flexibility for physician certification of expected discharge or transfer within 96 hours of admission. However, we still believe the policy is misguided. The 96 hour certification combined with the two-midnight policy creates a situation for physicians where they must now predict whether or not a patient will surpass that two midnights rule but not surpass 96 hours. Instead, WHA strongly recommends that CMS pursue authority to align the payment side with the current Condition of Participation requirement of an annual average length of stay not to exceed 96 hours.

Payment Reduction
In the FY 2014 inpatient PPS final rule, CMS finalized a permanent prospective 0.2% reduction to the operating PPS standardized amount as a result of the agency’s belief that the two-midnight policy would increase inpatient PPS expenditures by $220 million. WHA does not believe a permanent prospective payment reduction is appropriate under any circumstance and urges CMS to reverse this decision.

3. RECOVERY AUDIT CONTRACTOR (RAC) PROGRAM REFORM

Hospitals across Wisconsin regularly complain about the complexity and redundancy of the RAC program as well as the arbitrariness of claim denials. Without reform, RACs will continue to second guess medical decisions made up to three years earlier, leading to inappropriate and excessive denials, and resulting in significant strain on hospitals and a clogged Medicare appeals process.

Among the reforms WHA supports are to: allow for rebilling Part B claims outside of the one-year timely filing requirement; improve RAC program oversight; ensure compliance with statutory timeframes for appeals (providing a default judgment to provider if appeal not heard); cease recoupment until the appeals process is completed; and impose financial penalties and/or other program requirements that will force the RACs to focus on high percentage targets rather than casting an arbitrarily broad net in their search for claims denials.

4. CHANGES TO GRADUATE MEDICAL EDUCATION (GME) PROGRAMS

Proposed Indirect Medical Education (IME) Medicare Part C Payments to Sole-community Hospitals (SCHs)
SCHs are paid their hospital-specific rate or the inpatient PPS federal rate, whichever is higher. Typically, hospitals providing services to Medicare Part C Medicare Advantage patients receive add-on IME payments to account for the additional costs incurred in treating these patients. As a result of the way payments to SCHs are structured, however, SCHs that are teaching hospitals and paid on their hospital-specific rate do not currently receive IME add-on payments for Medicare Part C patient discharges. CMS now proposes to provide all SCHs that are teaching hospitals with IME add-on payments for Medicare Part C patients, regardless of whether the SCH is paid on its hospital-specific rate or the federal rate. WHA supports these proposals.
In addition, CMS proposes that these add-on payments would not be included in the comparison of whether the SCH should receive the hospital-specific or the federal rate, but would be added after the higher of those two rates is determined. SCHs are only eligible for DSH and uncompensated care payments if they are paid under the federal rate; therefore this proposal would have the unintended effect of disqualifying a subset of SCHs that otherwise would have qualified for DSH and uncompensated care payments. Accordingly, WHA does not support this proposal and recommends that CMS allow the Medicare Part C payments to be included in determining whether an SCH will receive the hospital-specific or the federal rate.

Proposed Changes in the Effective Date of the Full-Time Equivalent (FTE) Resident Cap, Three-year Rolling Average, and Intern- and Resident-to-Bed (IRB) Ratio Cap for New Programs in Teaching Hospitals

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

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

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

CMS proposes to begin “synchronizing” the effective date of the FTE resident caps with the effective dates and application of the 3-year rolling average and the IRB ratio cap, such that all three would go into effect at the start of the hospital cost reporting period that precedes the start of the sixth program year after the start of the first program. This proposal would apply to any urban hospital that first began training residents in its first new residency training program on or after October 1, 2012 and would apply to any new program at a rural hospital that was started on or after October 1, 2012. While WHA acknowledges that this proposal would provide administrative simplicity, WHA recommends that CMS synchronize these three events effective as the start of the hospital cost reporting period that follows the start of the sixth program year to enable hospitals to fully benefit from the five-year cap building window.
Under current regulations governing new programs, CMS permits hospitals in their five-year cap building window to be reimbursed for “the actual number of residents participating in the new program” for each of the first five years, so long as that number does not exceed the number of accredited positions available to the hospital for that program year.\[1\] By setting the date the cap takes effect at the beginning of the cost reporting period that precedes the start of the sixth program year, CMS imposes the cap prior to the end of the cap-building window, effectively denying hospitals in certain circumstances the ability to be reimbursed for the actual number of residents participating in the new program in the fifth year.

Hospitals incur significant expense in establishing new training programs and should be permitted the benefit of the full five-year cap-building window to grow their caps and be paid for actual numbers of resident FTEs. Therefore, if CMS proceeds with its plan to synchronize the effective dates of the cap, three-year rolling average, and IRB ratio cap, WHA urges CMS to set the effective date as the start of the hospital cost reporting period that follows the start of the sixth program year after the start of the first program so that new teaching hospitals may retain the payments they are entitled to under the current regulations.

Changes to GME Policies as a Result of the New OMB Labor Market Delineations

Rural Teaching Hospitals. Under existing regulations, a new teaching hospital that starts training residents for the first time on or after Oct. 1, 2012 has five years from when it first begins training residents in its first new program to build its permanent FTE resident cap. If a teaching hospital is rural, it can continue to receive permanent cap increases for training residents in new programs after the initial five-year cap-building period ends. As a result of CMS’s proposal to use the new OMB labor market delineations, some rural teaching hospitals may be redesignated from a rural area to an urban area, thereby losing their ability to increase FTE resident caps for new programs started after the initial five-year cap building period ends. CMS proposes to allow hospitals in this situation to continue to grow that program for the remainder of the period and receive a permanent cap adjustment for the new program.

WHA supports these proposals.

Participation of Redesignated Hospital in Rural Training Track. Urban hospitals that establish separately accredited approved medical residency training programs (or tracks) in a rural area or have an accredited training program with an integrated rural track, may count the FTE residents in the rural track in addition to those FTE residents allowed under the cap up to a “rural track FTE limitation.” As a result of CMS’s proposal to use the new OMB labor market delineations, some rural teaching hospitals may be redesignated from a rural area to an urban area, which would impact this policy that requires the participation of a rural teaching hospital. Therefore, CMS proposes that in this situation, where the rural hospital is redesignated as urban, the urban hospital would continue to receive the rural track FTE limitation for new programs that started while the redesignated hospital was still rural and for the duration of the three-year period in which the rural track FTE limitation is calculated. Additionally, CMS proposes a two-year transition period during which the either of the following conditions must be met in order for the urban hospital to be able to count the residents under its rural FTE limitation when

\[1\] See 42 C.F.R. § 413.79(e)(1)(ii).
the two-year transition period ends – (1) the redesignated newly urban hospital must reclassify back to rural; or (2) the original urban hospital must find a new geographically rural site to participate for purposes of the rural track. WHA supports these proposals.

Changes to the Review and Awards Process for Resident Slots

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

Under CMS’s current application rules, teaching hospitals are permitted to apply for FTE slots for purposes of general cap relief. This option is the last ranking criterion, used only after all available positions have been distributed for other reasons. In this rule, CMS proposes to eliminate this option because there have been only a relatively small number of slots awarded specifically for cap relief and the application review process is administratively burdensome. While WHA appreciates the effort CMS has put into administering this program, we disagree with CMS’s proposal to eliminate the cap-relief option from the Section 5506 application process.

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

CMS also proposes to change Ranking Criteria One and Three, which give preferences for Section 5506 slots to hospitals that assume an entire program or part of a program from the closed hospital. CMS currently requires hospitals applying under these ranking criteria to show that they are “seamlessly” replacing displaced FTE residents with new FTE residents once the displaced residents graduate. The Agency now proposes to eliminate the “seamless” requirement, effective for application rounds announced after October 1, 2014. CMS indicates that hospitals applying for Section 5506 slots under Ranking Criteria One and Three “would continue to be required to submit a supporting document when applying…that indicates that they have made a commitment to take over the closed hospital’s program or that they have made the commitment to permanently expand their own residency training program resulting from taking over part of a closed hospital’s program.” WHA supports this proposal, but requests that CMS provide clear and consistent guidance explaining what type of supporting documentation would meet this new requirement.
Finally, CMS proposes to permit hospitals that were members of an emergency Medicare GME affiliation agreement with the closed hospital prior to its closure to be considered under Ranking Criterion Two. The current application expressly permits only the application of Ranking Criterion Two to hospitals that received slots from the closed hospital through a Medicare GME affiliation agreement. **WHA supports this proposal.**

5. **HOSPITAL PRICE TRANSPARENCY**

Wisconsin hospitals have a long history of providing charge transparency through the voluntary PricePoint website. This online tool provides users with hospital specific average charge information for all inpatient DRGs and for most outpatient surgeries and procedures. Therefore, we think it is important to provide flexibility on how transparency initiatives are conducted to promote innovative approaches like PricePoint.

As proposed, WHA supports the flexibility for hospitals in determining how to make a list of standard charges available to the public. Specifically, WHA supports the flexibility of allowing a hospital to meet the ACA requirement by providing a “policy for allowing the public to view a list of those charges in response to an inquiry.”

As stated in the proposed rule, hospitals “are in the best position to determine the exact manner and method by which to make those charges available to the public.” Often times, it takes education and additional communication with patients to understand charges. Due to this, WHA supports the two-prong approach of either making public a list of their standard charges or their policies for allowing the public to view a list of those charges in response to an inquiry.

6. **MEDICARE DISPROPORTIONATE SHARE PAYMENTS**

The Medicare DSH payment mechanisms and calculations significantly changed in FFY 2014. CMS continues proposing changes for FFY 2015. Decisions on future distribution methods for DSH funds are very important, which includes the data source that will be used for the allocation method. WHA agrees that the S-10 uncompensated care data are not appropriate for use in FY 2015. However, we note that, if reported in an accurate and consistent manner, these data have the potential to serve as a more exact measure of the treatment costs of uninsured patients.

We urge the agency to take action to revise and improve both the Worksheet S-10 and the instructions, and once stakeholders have had an opportunity to weigh in on the proposed changes, educate both the field and CMS’s contractors about the Worksheet S-10 so that these data could potentially be used. CMS should also consider taking additional steps to verify the accuracy of these data given the concerns about their current validity and completeness.

7 **MEDICARE SEVERITY DIAGNOSIS-RELATED GROUP (MS-DRG) DOCUMENTATION AND CODING ADJUSTMENT**

CMS proposes a cut of 0.8 percentage point in fiscal year (FY) 2015 to fulfill part of the American Taxpayer Relief Act of 2012 (ATRA) requirement that CMS recoup what the agency 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. This is in addition to the cut of 0.8 percentage points that was finalized by CMS for FY 2014. While we continue to believe these congressionally mandated adjustments are not warranted, we appreciate the agency’s proposal to help mitigate extreme annual fluctuations in payment rates and provide hospitals with additional time to manage these sizeable cuts. However, WHA continues to be troubled by CMS ongoing policy proposals that compare hospitals’ documentation and coding practices in FY 2010 to their documentation and coding practices under an entirely different system in FY 2007. We urge CMS not to propose any documentation and coding cuts, beyond those required by ATRA, in future rulemaking.

8. QUALITY MEASURE PROGRAMS FOR HOSPITALS

The National Quality Forum has been selected to assist CMS in the development of quality measures to be used in hospital quality reporting programs. WHA supports the use of measures that have received NQF approval prior to their use in the hospital value-based purchasing (VBP), hospital acquired condition (HAC) reduction and hospital inpatient quality report (IQR) programs. We are disappointed that CMS is proposing the use of measures not yet endorsed by NQF.

Hospital Value Based Purchasing Program

The IPPS proposed rule for FY 2015 proposes policies related to implementation of the hospital VBP Program. WHA supports the goals of the hospital VBP program to reward high quality hospitals and to incentivize performance improvement. Overall, we support emphasizing outcome measures and increasing the weighting of efficiency measures. We also support the Centers for Medicare & Medicaid Services (CMS) in its efforts to align the hospital VBP program with existing hospital and physician quality reporting initiatives, as well as the physician value-based payment modifier. We remain concerned that the incentives and penalties under the hospital VBP program are too insignificant to drive real change in hospital quality and cost containment efforts, but understand that the applicable percentages are capped by statute. Below are our specific comments, suggestions, and recommendations regarding the FY 2015 IPPS proposed rule.

Hospital VBP Incentive Funding Pool

The FY 2015 proposed rule implements the incremental increase in the amount of payment withheld from all participating hospitals to fund incentive payments. Current law sets a ceiling of 2% on the amount of Medicare hospital payments subject to withholding and value-based distribution beginning FY 2017. In a study previously appearing in Health Affairs\(^1\), the researchers suggest the current hospital VBP program, as currently structured, is unlikely to cause meaningful reform as incentive payment differentiations were miniscule among 2/3 of hospitals in the program. Although we understand the 2% cap is statutory and cannot be modified through rulemaking, 2% is not sufficient to drive significant value-based change in the system.

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\(^1\) Werner, R.M. & Dudley, R.A. (2012). Medicare’s new hospital value-based purchasing program is likely to have only a small impact on hospital payments. Health Affairs, 31(9), 1932-1940. doi:10.1377/hlthaff.2011.0990
Hospital VBP Performance Scoring

Currently, the Hospital VBP program assesses both performance improvement and achievement, and allows hospitals to do well in the program by either attaining benchmarks or improving on their own performance. Recognizing improvement at the outset of the program is very important to encouraging historically poor-performing hospitals to invest in improvement. However, WHA believes that these incentives should be phased out over time such that hospitals are compared and paid on their achievements and not merely for improving on subpar performance. As such, we ask CMS to consider developing and disseminating a plan to incrementally phase out improvement scoring in the hospital VBP program for measures that have been included in the program for three years.

Hospital VBP Program Quality Measures – Removal of “Topped Out” Measures

WHA supports an increased emphasis on outcome-based measures, and removal of measures “topped out,” and/or losing NQF endorsement. WHA believes it is important to align measures across the domains and with the physician value-based payment modifier program to the extent practical. Overall, WHA supports the strategic goals of the National Quality Strategy and CMS in transitioning the program towards emphasizing outcome-based measures. Thus, we continue to support the removal of process measures deemed “topped out” where little difference in performance exists among high and low performers. This approach ensures that hospitals are not adversely affected by an insignificant difference in actual performance. Additionally, WHA believes that all measures in IQR, HAC, and the VBP programs should be endorsed by the National Quality Forum (NQF) before being used. Therefore, we support the removal of measures losing endorsement by the National Quality Forum (NQF), an important panel of quality experts.

New Measures of Quality

For FY 2017 program year, CMS proposes to add one process and two outcome quality measures. The process measure is Elective delivery prior to 39 weeks gestation. The new outcome measures proposed are Clostridium difficile infection and Methicillin-Resistant Staphylococcus aureas Bacteremia. WHA does not support the addition of the two infection measures. These measures are also part of the HAC program. The overlap in measured between the HAC and the hospital VBP programs creates the potential for unfair double payment penalties. In general, to streamline programs, we recommend not having penalties in two separate programs for the same measures.

Measures of Efficiency/Cost

WHA supports the Medicare Spending per Beneficiary measure for inclusion in the FY 2015 Hospital VBP program as finalized in prior rulemaking. WHA also supports development and implementation of additional measures of efficiency in the program. We are encouraged by the guiding principles for selecting efficiency measures outlined in the proposed rule, which include exploring services linked closely to hospital services, representing a significant share of Medicare payment for hospital care, and having significant performance variation.

While WHA is encouraged by CMS’ efforts to expand the efficiency domain to include a more robust measure set, and its consideration of six new episode-based standardized payment measures, we are
concerned about the special medical episodes identified (kidney/urinary tract infection, cellulitis and gastrointestinal bleed). These for new efficiency measures are not aligned to any other CMS related quality initiatives. Further, the specific Medical Episodes have no counter-balancing quality measure. Value is both quality and cost. Without the quality measure, if cost is driven down so low that quality suffers, there would be no way to identify the poor quality. In FFY 2017, CMS will be reporting Cost per Episode for pneumonia and heart failure through the hospital inpatient quality reporting program (HIQRP). It’s unclear why CMS is using different medical episodes here.

**Hospital Acquired Condition (HAC) Reduction Program**
Wisconsin’s hospitals are deeply committed to reducing preventable patient harm, and support quality measurement and pay-for-performance programs that effectively promote improvements in patient safety. However, WHA remains very concerned that the HAC program is poorly designed. We acknowledge that the HAC reduction program’s statutory requirements prevent CMS from addressing some of the program’s most important shortcomings. For example, even though it is arbitrary to do so, CMS must assess HAC penalties on 25 percent of hospitals each year, regardless of any significant improvements in a hospital’s performance, whether there is a significant difference between its performance and that of the rest of the field, or the overall progress the field has made in improving performance measures.

Further, as noted above, in practice the overlap of measures between the HAC and the hospital VBP programs creates the potential for unfair double payment penalties. We urge CMS to eliminate the overlap in measures between the HAC and VBP programs.

Finally, the PSI 90 measure does not have a level of reliability or validity acceptable for measures in accounting applications. We also are deeply concern that the current measures in the program disproportionately penalize teaching and large hospitals (more than 400 beds). We also urge CMS to identify and implement alternative measures to PSI 90 so that it can be phased out of the program as soon as possible, and replace it with a more reliable and valid measure or small set of measures.

**Inpatient Quality Reporting (IQR) Program**
WHA strongly supports the long-term goal of using electronic health records (EHR) to streamline and reduce the burden of quality reporting while increasing access to real-time information to improve care. Nevertheless, we are concerned that some of the proposed methods to encourage participation in the voluntary electronic reporting option and to align clinical quality measure reporting in the IQR program and EHR incentive program undermine the goals of the IQR program for continuous hospital improvement.

*Mandatory Reporting of eCQM*
WHA believes it is premature to consider implementing mandatory reporting of eMeasures for meaningful use by FY 2018 for IQR reporting requirements. There have been no validity and reliability studies to demonstrate the capture of equivalent data between chart-abstracted measures and electronically captured measures.
The electronic medical records were not developed with the purpose of capturing data to be used for measurement or comparison of data. When electronic measures were initially presented for potential future use of measures in lieu of chart-abstracted measures, CMS said there would be intensive comparison studies between the two programs to ensure the validity and reliability of these measures. WHA is not aware that this work has been scheduled or planned in the future. We believe this is a critical step in the transition to eMeasures.

WHA is aware of the proposed pilot for as many as 100 volunteer hospitals to participate in submitting data to a secure website. Because this initial pilot has not started, we believe it is very premature to establish a time line that is only three years away.

WHA suggests that CMS propose a systematic process to evaluate the validity and reliability of the electronic data. We believe it is critical this occur before any mandatory reporting of data that affects hospital reimbursement significantly through the quality reporting programs and value-based purchasing. WHA believes moving ahead with a program that is untested may unjustly penalize hospitals.

WHA highly supports the transition to the EHR measures and believes it will improve communication and documentation, as well as decrease resources currently needed for chart-abstracted core measures. However, we are very concerned about the aggressive time line CMS is proposing for the adoption of eMeasures for the IQR program.

WHA is concerned there is no proposed validation process for the eMeasures. We believe the use of electronic data that has not been validated and proven to be reliable should not be used for public reporting.

Voluntary Electronic Reporting and Removal of Topped Out Measures

Using its criteria for topped out measures, CMS proposes to remove 15 chart-abstracted measures from the IQR program. However, it proposes to retain the eCQM versions of 10 of those measures for use in the voluntary electronic reporting option. CMS also proposes to remove a structural measure – Participation in a Systematic Database for Cardiac Surgery – from the program on the recommendation of the MAP. Finally, CMS proposes to remove four previously suspended measures from the program.

WHA supports CMS’s proposed removal of the 15 chart-abstracted measures, the cardiac surgery participation measure, and the four previously suspended measures from the IQR. However, we do not support its proposal to retain the electronic versions of 10 of them to support the voluntary electronic reporting option.

WHA appreciates CMS’s recognition of the quality reporting burden placed on hospitals and the effort associated with developing a reporting option within the Hospital IQR Program that attempts to minimize duplicate submissions of clinical quality measure reports by hospitals. In the FY 2014 IPPS final rule, with a stated purpose of fostering greater alignment between the Medicare EHR Incentive Program and the IQR, CMS created an option to voluntarily report electronic clinical quality measure (eCQM) versions of IQR measures, thereby receiving credit in both programs.
The proposal to retain topped out measures as eCQMs in the IQR and add four additional measures that are available only as eCQMs is a concerning development. The proposed modification in the voluntary electronic reporting program holds the form of the data collected for quality measurement to a higher scientific significance than the data collected as a metric to assess the delivery of care. WHA disagrees with this proposal as it would neither lead to improved hospital quality nor offer CMS insight on how to improve eCQMs. We recommend that CMS work with Office of the National Coordinator and AHRQ to study the feasibility, reliability and validity of eCQMs to effectively calculate and report clinical quality measures that are at least as accurate as chart-abstracted measures.

To date, eCQMs have required hospitals to expend considerable effort to modify how data are captured, and generally do not lead to comparable results across measurement methodologies. WHA remains concerned that a premature requirement for electronic reporting of quality measures places at risk the longitudinal trend analysis central to quality reporting and ultimately value-based purchasing. Accepting data generated from CEHRT that have not been validated as comparable to chart-abstracted data to satisfy the IQR impairs the continued success of the IQR program and creates a significant impediment to moving any of measures deemed appropriate into the VBP program over the next few years. The proposal to simply not display data for eCQMs on Hospital Compare for any hospital that chooses to participate in the voluntary electronic reporting option also would fail to provide the public with reliable data for quality measures of importance such as stroke and VTE. WHA recommends that CMS work with other federal agencies and private sector experts to develop the protocols and testing environments needed to begin validation of eCQMs.

Finally, we note that the availability and use of certified EHRs should inform the timeline for requiring the use of eCQMs in other CMS programs. The proposed rule states that CMS intends to propose mandatory electronic reporting to meet IQR requirements beginning in CY 2016. WHA recommends that CMS not specify a date for mandatory electronic reporting until significant levels of CEHRT adoption are achieved, and a validation process for eCQMs is operational and yielding successful evidence of measure reliability.

Thank you for the opportunity to comment on the proposed rule and on these critical issues affecting Wisconsin hospitals. If you have any questions, please contact Brian Potter, Senior Vice President, at 608-274-1820, or bpotter@wha.org.

Sincerely,

/s/

Stephen F. Brenton
President