

WISCONSIN HOSPITAL ASSOCIATION, INC.



June 13, 2017

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

Re: Comments on Proposed Rule CMS–1677–P: Medicare Program Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Long Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2018 Rates; etc.

Dear Administrator Verma:

On behalf of our more than 135 member hospitals and integrated health systems, the Wisconsin Hospital Association (WHA) appreciates the opportunity to provide comments on the Centers for Medicare & Medicaid Services' (CMS) proposed FY 2018 rule related to Medicare Program Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Long Term Care Hospital Prospective Payment System and Proposed Policy Changes.

WHA was established in 1920 and is a voluntary membership association. We are proud to say that we represent all of Wisconsin's hospitals. Our members include small, mid and large-sized hospitals, including many Critical Access Hospitals and several large academic medical centers. We have hospitals in every part of the state—from very rural locations to larger, urban centers like Milwaukee. In addition, we count close to two dozen psychiatric, long-term acute care, rehabilitation and veterans hospitals among our members.

The following comments relate to various provisions in the proposed rule as well as the Agency's request for comments on regulatory burdens.

Posting of Accrediting Organization Survey Findings

Hospitals are able to demonstrate compliance with the Medicare conditions of participation (CoPs) through deemed status with an approved accrediting organization (AO). Accrediting organizations post the accreditation status of their accredited hospitals, however they do not post the details of survey findings. WHA is concerned about the proposal that would require AOs to post statements of deficiencies and plans of correction.

WHA and our members are strong proponents of public transparency. We have been voluntarily reporting hospital quality results since 2004, which precedes even CMS Hospital Compare. The reporting of quality measures ensures the use of standardized definitions and true comparability.

The public may assume hospital surveys have that same level of standardization, which is not true.

CMS has been posting the CMS Form-2567 hospital complaint investigations since 2013 and the proposed rule implies the use of data in this format by journalists and the public is helpful, which is questionable. Flaws in a mandate to post raw, redacted, survey findings similar to the Form-2567 include:

- Survey findings, of both AO surveys and CMS surveys conducted by state surveyors, can be quite variable based on the training, experience and personal interests of the surveyor. Clear standards and survey guidance still have not removed the subjective nature of a survey, which creates variability the public will not be aware of or able to understand.
- Each AO incorporates the CoPs, but they also include a varying number of additional standards that strive for improvement above and beyond the basic CoP compliance requirements. If an AO is required to post all deficiencies it could create a disincentive for hospitals to strive for higher levels of quality and patient safety and for staff to openly discuss issues during a survey in the true interest of improving the quality of care they provide.
- The CoPs and AO standards are very technical and have varying impact on quality and patient safety. We are also concerned that one survey finding often results in multiple citations. Posting of raw findings without context and explanation of the seriousness and prevalence of the deficiency will be confusing and has the potential to be misleading to the public.
- Reports that reflect only the deficiencies and fail to include the areas a hospital is excelling at can be unnecessarily alarming.
- A survey finding represents a single point in time. Most survey findings are corrected within 30 to 60 days, which will not be understood by the public. The public may also not understand that surveys occur in different cycles. The presence or absence of findings may be more related to where a hospital is at in their accreditation cycle, not the quality of care they provide.
- Posting of raw, redacted, findings like those of the Form-2567 in a small community can be a violation of patient and staff confidentiality. While the names of people are not used there is enough information given about the patient and their clinical condition that creates the potential for them to be easily identified.

CMS should give careful consideration to the unintended consequences this proposal could have for both hospitals and the public. WHA opposes posting of findings in a format similar to the Form-2567. However, we are supportive of posting a summary of survey findings that are limited to standards reflected in the CoPs, provide a context for the seriousness of the citation,

protect the confidentiality of both patients and staff and clearly and promptly indicate when an appropriate plan of correction has been accepted.

Changes to PSI-90

CMS proposes to adopt a modified version of this measure, the Patient Safety and Adverse Event Composite measure that was previously adopted as part of the Inpatient Quality Reporting (IQR) Program and the Hospital Acquired Condition (HAC) Reduction program beginning with FY 2023 payment.

The modified PSI-90 measure, which was recently endorsed by the National Quality Forum, adds three indicators, modifies two and removes one. In addition, the measure was modified to incorporate harms associated with events into the weighting of the component indicators; this change links the PSI indicators with changes in clinical status rather than just sheer volume of events. The Wisconsin Hospital Association supports these modifications to the PSI-90 measure.

DSH and using S-10 data

WHA is very concerned about the accuracy and consistency of the Worksheet S-10 data and we urge CMS to take additional steps to ensure the accuracy, consistency, and completeness of the data prior to their use. This entails auditing the S-10 data, as well as adopting a broad definition of uncompensated care costs to include all unreimbursed and uncompensated care costs, such as Medicaid shortfalls and discounts for uninsured. In addition, once CMS ensures the accuracy and consistency of the Worksheet S-10 data, we like the concept of transitioning to its use through a phase-in approach. Given that the 2017 cost report year will be the first time that the S-10 worksheet will be subject to desk review, and that the 2018 Disproportionate Share Hospital (DSH) payments would be based on the 2014 cost report S-10 worksheet, we recommend delaying the implementation of any new DSH formula using S-10 data for three years.

Medicare and Medicaid EHR Incentive Programs

WHA supports CMS's proposal to shorten the EHR Incentive Program 2018 reporting period for hospitals and physicians from CY 2018 to any continuous 90-day period within CY 2018. This proposed change would create flexibility for hospitals (PPS hospitals and CAHs) and physicians seeking to attest to meaningful use and thereby avoid escalating Medicare reimbursement penalties. The proposal is consistent with recommendations that WHA has made to CMS in previous comment letters that CMS should establish a 90-day EHR reporting period for the first year of any new meaningful use "stage."

Instructions on Critical Access Hospital (CAH) 96-Hour Certification Requirement

CMS indicates that, based on feedback from stakeholders and to reduce regulatory burden, it is directing Quality Improvement Organizations (QIOs), Medicare Administrative Contractors (MACs), the Supplemental Medical Review Contractor (SMRC), and Recovery Audit Contractors (RACs) to make the CAH 96-hour certification requirement a low priority for

medical record reviews conducted on or after October 1, 2017. The Wisconsin Hospital Association has longed raised the need to statutorily fix and/or address through regulations the 96 hour certification requirement.

WHA appreciates that agency's understanding that this requirement places undue burden on rural, Critical Access Hospitals and runs counter to the requirements under the Medicare Conditions of Participation. WHA agrees with CMS that Medicare contractors should not review these situations and appreciates CMS specifically indicating it will not authorize any medical record reviews by the RACs related to this issue. WHA continues to advocate to Congress and the Administration that a legislative fix is needed to permanently remove the 96-hour physician certification requirement as a condition of payment for CAHs.

Administrative Burden

WHA appreciates the opportunity to provide comment to CMS on regulatory burdens. WHA highlights several regulations that create financial and human resource commitment for compliance, which may outweigh the benefits of the regulation to the general public, taxpayers and payers of health care services, including:

- Under the current audit landscape, hospitals are faced with any number of oversight programs and contractors at both the state and federal level for both Medicare and Medicaid, including the: Comprehensive Error Rate Testing (CERT) program, Office of Inspector General (OIG), Medicaid Integrity Contractors (MIC), Medicaid Integrity Program (MIP), Payment Error Rate Measurement Program (PERM), Medicare Administrative Contractor (MAC), Zone Program Integrity Contractors (ZPIC), and the Recovery Audit Program (RAC) to name a few. While WHA does not question there is a need for *appropriate* oversight and compliance related to government programs, we believe these programs are not coordinated, are redundant and burdensome. Unfortunately, this creates an unfunded burden on health care providers. One particular example that has been problematic for years is the RAC program. It was created under The Tax Relief and Healthcare Act of 2006 and implemented nationwide in 2010. RACs are paid on a contingency basis, have aggressively and inappropriately recouped millions of dollars from Wisconsin hospitals. WHA continues to believe this program must be further refined and aligned with other audit/compliance programs.
- The Centers for Medicare and Medicaid Services (CMS) has any number of burdensome and restrictive regulations that create financial and access to care hardships. One such provision is known as “shared space” or “mixed use” space. While there is no codified provision, CMS has nonetheless cobbled together a policy that is being interpreted differently within the agency. In the absence of clear but flexible guidance from CMS on this issue, hospitals are concerned that their mixed use areas – spaces where, say, a visiting specialist can see patients at the hospital – must have separate entry doors, waiting rooms or other structural/building requirements. Not only does this reduce access to care, particularly in rural areas, it increases the costs for hospitals if they can even afford to build out to these requirements. It is an unnecessarily burdensome regulation.

- CMS requires hospitals to collect and report 60 quality measures, many with complicated measure definitions. For example, the sepsis measure requires collection of 83 data elements, which takes on average one hour to collect per patient. The complexity of the measures requires highly skilled clinical staff, such as registered nurses. In addition to the staff resource need to collect the measure data, hospitals must have a contract with an approved data vendor for submitting and managing the data. An annual contract for a data vendor can range from \$50,000 to \$100,000 per year for a mid-size hospital.

These are only a few of the federal mandates and requirements that are placed on the nation's hospitals and health systems. Hospitals face thousands upon thousands of pages of federal regulatory changes every year which stem from federal laws or changes to governmental programs. The pace of these changes has rapidly increased in recent years and is putting substantial stresses on hospitals and health care staff.

Long Term Care Hospitals (LTCH) and 25 Percent Rule

With respect to the LTCH proposed rule, WHA supports suspending of the implementation of the 25% Rule, which reduces LTCH payment amounts to the inpatient PPS amount for LTCHs that admit more than 25% of Medicare cases from an onsite or neighboring inpatient acute care hospital. Under the proposed rule, the 25% threshold policy would not be implemented until October 1, 2018. WHA supports CMS's commitment to using this time period to examine the impact of LTCH site-neutral payments to and to determine whether the 25% rule is still necessary. WHA is hopeful CMS will permanently remove the 25% policy. The combination of the 25% Rule and site-neutral payments is unwarranted, excessive, and would bring major access challenges for the severely ill patients treated in LTCHs.

WHA continues to be very concerned about, and is opposed to, the continued application of duplicative budget-neutral adjustments for site-neutral cases, as the redundant adjustment represents a systematic and sizeable underpayment. CMS proposes to continue applying a 5.1% budget neutrality adjustment to the site-neutral payment amount because it believes that this is necessary to avoid increasing aggregate FY 2018 LTCH PPS payments. However, since the inpatient PPS rates used to pay site-neutral cases have already been reduced by 5.1% to ensure budget neutrality for inpatient PPS outlier payments, this additional 5.1% budget neutrality adjustment applied within the LTCH framework is unwarranted.

Proposed Short-Stay Outlier Payment Adjustments

CMS's current methodology for Medicare payment of short-stay outlier (SSO) cases pays an SSO case the lower of several payment options. The proposed rule would change this methodology to pay these cases a single, graduated per diem adjustment, in order to eliminate any incentive to delay a patient's discharge for financial reasons. WHA supports this proposed change. However, we oppose the application of CMS's proposed one-time permanent budget

neutrality factor to the LTCH PPS standard federal payment rate in FY 2018. CMS calculated this budget neutrality factor based on a series of assumptions about LTCH behavior that would result in a 10% reduction in non-SSO cases in an increase of 10% in SSO cases. We consider these assumptions arbitrary, as demonstrated in an alternative analysis by the American Hospital Association. Therefore, we urge CMS not to apply this one-time budget neutrality factor.

Reduced Regulation for Certain Co-Located LTCHs

WHA supports the proposed removal of the separateness and control requirements for LTCHs and other IPPS-exempt hospitals that are co-located on the campus of another IPPS-exempt hospital. CMS's concerns that a de facto LTCH unit would allow the hosting general acute-care hospital to receive higher payments by transferring the case to the LTCH have been addressed through other regulatory protections, such as establishment of rigorous clinical criteria for an LTCH PPS standard rate.

Maintaining Access and Payments for High-Resource Site Neutral Cases

WHA urges CMS to examine access to care for certain site-neutral cases that require specialized high-resource LTCH services, such as severe wound cases. Some of these cases should be examined to determine if they are being underpaid, since some of these site-neutral cases remain relatively costlier and have longer average length of stays than their inpatient PPS counterparts.

Proposed LTCH Quality Report Program

The WHA is concerned by several new data elements included in the proposed rule. The first is to remove the "Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay)" and replace it with a modified version of that measure, "Changes in Skin Integrity Post Acute Care (PAC): Pressure Ulcer/Injury." WHA is concerned this measure will be difficult for providers to capture, as there is no universally accepted definition of injuries like deep tissue injuries and providers will be asked to report on a wholly different data element. We urge CMS to provide guidance on the correct collection and calculation of the measure results.

The second measure proposed for removal is the "All-cause Unplanned Readmission Measure for 30 Days Post-Discharge from Long-Term Care Hospitals." WHA supports removal of that measure. CMS is also proposing the adoption of three new measures for FFY 2020 and subsequent years:

- Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury
- Compliance with Spontaneous Breathing Trial (SBT) by Day 2 of the LTCH Stay
- Ventilator Liberation Rate

LTCHs would only be required to submit data on these proposed measures for the last three quarters of calendar year 2018. Starting in calendar year 2019, LTCHs would be required to submit data for the entire year beginning with the FFY 2021 LTCH QRP. WHA is concerned

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that the expanded patient assessment data reporting requirements would impose a significant burden on providers.

In addition, CMS would also require LTCHs to collect certain standardized patient assessment data beginning with LTCH admissions on or after April 1, 2018 to meet requirements of the IMPACT Act. Specifically, the agency would require LTCHs to collect data on functional status, cognitive function, and several types of special treatments and services. WHA is concerned that these expanded patient assessment data reporting requirements would impose a significant burden on LTCHs, and have not yet been adequately tested to ensure they collect accurate and useful data in this setting.

WHA appreciates the opportunity to provide CMS with our comments.

Sincerely,

A handwritten signature in black ink that reads "Eric Borgerding". The signature is written in a cursive style with a prominent initial "E" and a stylized "B".

Eric Borgerding
President & CEO