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Via Electronic Submission (www.regulations.gov)

June 17, 2016

Mr. Andrew Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
ATTN: CMS–1655–P
7500 Security Blvd.
Baltimore, MD 21244-1850

Dear Mr. Slavitt:

Re: FY 2017 Inpatient Prospective Payment System Proposed Rule, File Code CMS–1655–P

Dear Acting Administrator Slavitt:

The Association of American Medical Colleges (AAMC) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS's or the Agency's) proposed rule entitled, *Acute Care Hospitals and Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2017 Rates,* 81 *Fed.Reg* 24946 (April 27, 2016).

The AAMC is a not-for-profit association whose members are comprised of all 145 accredited US medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs Medical Centers, and more than 80 academic societies. Through these institutions and organizations, the AAMC represents 148,000 faculty members, 83,000 medical students, and 115,000 resident physicians.

Summary of Major Issues on Which AAMC Provides Comments

Medicare Payment for Short Inpatient Hospital Stays (page 3)

In the past the AAMC questioned the CMS's contention that the 2 midnight rule would increase the number of inpatient admission and opposed the reductions to the inpatient hospital rate. Therefore, we strongly support the Agency's proposal to rescind the 0.2 percent reduction in the inpatient FY 2017 payment rate and restore the 0.2 percent reduction taken in FYs 2014 through 2016.

Documentation and Coding Adjustment (pages 3-4)

The AAMC believes that the -1.5 percent adjustment is too great of a reduction and is not based on original estimates made in FY 2014. The AAMC is also concerned that due to timing issues with implementation of the Medicare and CHIP Reauthorization Act of 2015 (MACRA) the additional 0.7 percent reduction will be permanently reflected in rates.

Medicare Disproportionate Share Hospital (DSH) Payments (pages 4-8)

While the AAMC supports the use of three cost reporting periods to calculate Factor 3 in FY 2017, the Association believes that Worksheet S-10 should not be used until the issues raised are resolved and the Worksheet data is verified through audit. Specifically, direct graduate medical education (DGME) costs should be included in both the numerator and denominator of the cost-to-charge ratio in the Worksheet S-10 and the Worksheet instructions should be changed to include shortfalls from Medicaid State Children's Health Insurance Program (SCHIP) and other state and local government indigent care programs.

Direct Graduate Medical Education (page 8)

During a meeting in December the AAMC discussed this issue with CMS staff and urged them to expand from 3 to 5 years the amount of time an urban hospital with a rural training track would have to build a cap. The AAMC is pleased that CMS incorporated this suggestion in the proposed rule and strongly supports it. Due to the way in which the legislation is drafted, CMS has limited this expansion to only urban hospitals with rural training tracks. Rural hospitals are not able to take advantage of this expansion. The AAMC asks CMS to clarify the terms under which rural hospitals can receive a cap increase.

Hospital Quality Programs (pages 10-24)

- Hospital Acquired Conditions Reduction Program (HAC or HACRP) (pages 16-18)
- Hospital Value-Based Purchasing (VBP) Program (pages 18-20)
- Inpatient Quality Reporting (IQR) Program (pages 20-24)
- Hospital Readmissions Reduction Program (HRRP) (page 24)

The AAMC continues to have serious concerns that the three hospital quality performance programs have a disproportionate negative impact on the nation's teaching hospitals. The Association recommends that CMS take immediate steps to address the numerous underlying issues with the quality measures to ensure that they do not disadvantage certain types of hospitals.

The AAMC also strongly recommends that CMS not finalize the modified PSI-90 composite, or the 15 month performance period for this measure, in FY 2018. The modified PSI-90 measure has been proposed for the HACRP, but has not yet been finalized for the IQR program. The Association strongly believes that all measures should be publicly reported for at least one year before being proposed for a performance program. In addition, the proposed 15 month

performance period greatly reduces the reliability of the measure and compounds the flaws that currently exist with the composite (described in detail in the quality section of the AAMC's comments, starting page 10). The Association urges CMS to remove the measure entirely from the performance programs in FY 2018 and to fully consider the appropriateness of including this measure in the performance programs moving forward.

Other comments will focus on:

- Implementation of the NOTICE Act requirements related to observation stays lasting more than 24 hours. (page 9)

MEDICARE PAYMENT FOR SHORT INPATIENT HOSPITAL STAYS

The AAMC Supports Rescinding the 0.2 Percent Reduction and Implementing a Temporary Increase of 0.6 Percent to Offset Cuts in the Previous Three Fiscal Years

In the FY 2014 final rule, CMS imposed a 0.2 percent reduction to IPPS payments to offset expected shifts in utilization between inpatient and outpatient settings due to implementation of the Two-Midnight rule. To justify this reduction, CMS stated that its actuaries projected an increase in IPPS expenditures resulting from the Two-Midnight rule. Specifically, CMS estimated $220 million in additional expenditures that would result from an expected net increase in hospital inpatient encounters. As a result, CMS applied a -0.2 percent adjustment to all rates in FY 2014 and subsequent years. The AAMC, along with other stakeholders, strongly opposed CMS's -0.2 percent payment adjustment as there was insufficient evidence to support the projected increase in inpatient stays.

In the FY 2017 proposed rule CMS is proposing to rescind the 0.2 payment reduction first taken in 2014 and continued into subsequent years. Based on concerns expressed by the AAMC and other stakeholders, and after conducting its own analysis as ordered by the court, the Agency concluded that the payment reductions should not have been taken as inpatient admissions did not increase due to the implementation of the 2 midnight rule. The Association applauds CMS for returning this money to the inpatient hospital rates by rescinding the 0.2 percent reduction for FY2017 and increasing rates by 0.6 percent in FY 2017 to offset cuts made in FYs 2014-2016.

THE MS-DRG DOCUMENTATION AND CODING ADJUSTMENT

The -1.5 percent Payment Adjustment Does Not Reflect Congressional Intent

The American Taxpayers Relief Act of 2012 (ATRA) requires the Secretary of the Department of Health and Human Services (HHS) to make a recoupment adjustment(s) totaling $11 billion, to recover overpayments from FY 2010 through FY 2012 attributed to changes in documentation and coding. ATRA requires that the adjustment be completed by FY 2017. ATRA further requires that once the necessary amount of overpayment is recovered, any adjustments made to reduce rates in one year eventually will be offset by a single, positive adjustment in FY 2018.

This ensures the recoupment adjustments to the rates do not have a permanent effect on the rates. CMS anticipated a single, positive adjustment in FY 2018 to offset the recoupment reductions. However, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires 0.5 percent positive adjustment in FYs 2018 through 2023 instead of a one-time positive adjustment.

To comply with ATRA, CMS anticipated that a cumulative -3.2 percent adjustment to the rates would achieve the $11 billion recoupment, and imposed a -0.8 percent payment adjustment in FY 2014, and imposed an additional -0.8 percent on top of previous cuts each subsequent year through FY 2016. However, in the FY 2017 proposed rule, CMS states that its original estimates were low so the Agency must make a -1.5 percent adjustment in FY 2017 to recover the remaining amount. This is an additional 0.7 percent above the initial estimate and would result in a cumulative -3.9 percent adjustment.

The AAMC is concerned that with the implementation of MACRA in FY 2018, CMS will not have an opportunity to restore the additional 0.7 percent reduction taken in 2017, which means that this reduction would be built into the payment rates indefinitely, and the total recoupment will therefore exceed the $11 billion authorized by ATRA. Therefore, the Association urges CMS not to make the proposed -1.5 percent payment adjustment in FY 2017.

At the time that MACRA was enacted the expectation was that the cumulative reduction would be 3.2 percent. That estimate is specifically referenced in the statute. By replacing what would have been a 3.2 percent restoration to the rates in FY 2018 with a 6-year stream of increases of 0.5 percent the Congress made clear that it did not intend for the recoupment provision to result in a permanent 0.7 percentage point reduction to the IPPS rates.

MEDICARE DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS

The Affordable Care Act (ACA) reduced DSH payments based on the assumption that with expanding insurance coverage, the need for DSH payments would be less. The ACA DSH reduction, though, did not factor in the growth of high deductible health plans that result in underinsurance among individuals with insurance coverage and the impact on hospitals' uncompensated care costs. To implement the ACA DSH reductions, CMS established a 3 factor methodology to compute the uncompensated care pool amount. Factor 1 is equal to 75 percent of the amount that otherwise would have been paid as Medicare DSH payments. Factor 2 reduces that 75 percent to reflect changes in the percentage of individuals under age 65 who are insured because of ACA implementation (*i.e.*, a ratio of the percentage of people who are insured in the most recent period following ACA implementation to the percentage of the population who were insured in a base year prior to ACA implementation). Factor 3, expressed as a percentage, represents a hospital's uncompensated care amount for a given time period relative to the uncompensated care amount for that same time period for all hospitals that receive Medicare DSH payments in that fiscal year. In short, the product of Factors 1 and 2 determines the total pool available for uncompensated care payments. This product multiplied by Factor 3 determines the amount of uncompensated care payments each eligible hospital will receive.

The AAMC continues to be concerned about the lack of transparency regarding the data used to calculate Factor 1 and ask that the methodology be publicly shared. Without this information hospitals are not able to either confirm the accuracy of the calculation or challenge it.

In FY 2017 and subsequent years, CMS proposes a change to the methodology used to calculate Factor 3. For 2018 CMS proposes to begin using data from Worksheet S-10 which, over a 3-year period, will become the sole data source used to calculate Factor 3. The AAMC supports CMS's proposal to use data from three cost reporting periods to calculate Factor 3 of the uncompensated care payment in FY 2017. However, the Association believes that Worksheet S-10 should not be used until the issues raised are resolved and the Worksheet data is verified through audit. As described in more detail below, there are two issues with the use of S-10: (1) DGME costs are not included in the numerator of the cost-to-charge ratio and (2) instructions regarding reporting charity care costs should be revised before moving to Worksheet S-10. Finally, CMS must audit the data from S-10 to ensure its accuracy. If CMS does not extend the transition period, the Agency should cap hospital losses at 10 percent on any redistribution of UCP funds to provide some relief to those hospitals that care for the most vulnerable patients.

CMS Should Provide More Information on the Calculation of Factor 1

In the FY 2017 IPPS proposed rule, CMS explains that to calculate Factor 1, the Agency used the most recently available projections of Medicare DSH payments for the applicable fiscal year, as calculated by CMS's Office of the Actuary (OACT). The AAMC and the hospital community have repeatedly asked for more information to clarify how the projection for Factor 1 is determined, but stakeholders have yet to receive sufficient information to understand or replicate the methodology behind the relevant projections and estimates. As a result, a critical source of funding for teaching and safety net hospitals, those institutions that take all patients and regularly provide care to the sickest, most complex and vulnerable patients, is being reduced drastically based on estimates and projections that are not transparent or verifiable.

The Association continues to urge CMS to clarify how the OACT makes these projections, so that providers can verify these calculations and comment on any necessary corrections during the rulemaking process. This transparency is particularly critical given that the statute precludes judicial review, and the estimates will not be revised or updated after CMS publishes the final Medicare DSH payment amounts for FY 2017.

The lack of transparency regarding the data in the "other" column that is used to determine Factor 1 continues to be particularly troubling. The "other" column in the supplemental file is meant to show the increase in various factors that contribute to the Medicare DSH estimates. These factors include the difference between total inpatient hospital discharges and the IPPS discharges, various adjustments to the payment rates that have that have been included over the years but are not reflected in the other columns, and a factor for the Medicaid expansion due to the ACA. The AAMC urges CMS to explain the variability in this and other factors that directly impact the DSH pool so that providers will have an opportunity to understand and verify these projections. It is critical that hospitals have some ability to plan for the rate at which Medicare DSH cuts will be implemented.

The AAMC Supports CMS's Proposal to Calculate Factor 3 Using Three Cost Reporting Periods in FY 2017. However, FY 2018 Is Too Soon to Begin the Transition to Worksheet S-10.

FY 2017

For the Factor 3 calculation, CMS uses Medicaid inpatient days plus Medicare Supplemental Security Income (SSI) inpatient days from one cost reporting period as a proxy for low-income patients. CMS states in the proposed rule that the Agency received feedback from the hospital community that using only one cost reporting period caused wide swings and anomalies in uncompensated care payments from year to year. To address stakeholder concerns, CMS proposes to compute Factor 3 for FY 2017 using data derived from three cost reporting periods. The AAMC supports CMS's proposal and the Agency's efforts to reduce the fluctuation of data used to calculate uncompensated care payments.

FY 2018

In FY 2018, CMS proposes to calculate Factor 3 using Worksheet (WS) S-10 of the hospital cost report. In past comment letters the Association has expressed concerns with the use of data from the S-10. We urge CMS to modify the Worksheet S-10 instruction before using it as a data source for uncompensated care payments and also to audit the data to ensure its accuracy.

DGME Costs Should be Included in Both the Numerator and Denominator of the S-10 Cost-to-Charge Ratio

The AAMC believes DGME costs should be included in the numerator of the S-10 cost-to-charge ratio (CCR) in the same manner DGME costs are included in the denominator. The AAMC believes such a change is appropriate because Worksheet S-10 is used to report services by payers other than just Medicare. For example, in the Worksheet S-10, the net revenue for Medicaid includes DGME payments. Applying a CCR that does not include DGME costs would mean that the DGME Medicaid costs will be excluded from hospital Medicaid costs, artificially reducing Medicaid costs for teaching hospitals. This change also is consistent both with DGME being a Medicare allowable cost and Medicare's policy that allows if not encourages other payers (e.g. Medicaid) to pay their share of DGME. As the Association has previously stated, including DGME costs in the cost-to-charge ratio is the simplest way to achieve alignment and consistency.

CMS states that it is not appropriate to modify the calculation of the CCR to include DGME costs because uncompensated care payments should not be used to provide additional payments to teaching hospitals that already are receiving DGME payments. The AAMC agrees that there should not be additional payments for teaching hospitals related to training residents but that is not the case here; rather, by including DGME only in the denominator and not in the numerator the costs for teaching hospitals are artificially reduced. Alternatively, if CMS continues to exclude DGME costs it should do so from both the numerator and the denominator. However, as

it is more difficult to exclude DGME costs from the denominator, CMS should include DGME costs in the numerator.

For accuracy of data, the AAMC recommends to limit the use of Worksheet B based cost-to-charge ratios to only teaching hospitals that report DGME FTE. Again, Worksheet S-10 is used for other payers, not Medicare, and it is appropriate to make changes to the cost-to-charge ratio here.

CMS provides a summary of its analysis on the effect on all hospitals' cost-to-charge ratio when GME costs are included in the numerator. Instead of using Worksheet S-10 to calculate cost-to-charge ratios, the Agency included DGME costs and recomputed cost-to-charge ratios using Worksheet B. CMS should provide an impact of this analysis on UCP payment.

Revisions Needed to S-10 Instructions

CMS must revise the definition of uncompensated care to include unreimbursed and uncompensated care costs for Medicaid, State Children's Health Insurance Program (SCHIP), and other state and local government indigent care programs. Additionally, CMS proposes that charity care will be reported based on date of write-off instead of date of service. The AAMC supports this change and asks that it be implemented before CMS moves to using Worksheet S-10. This will ensure consistency of data when calculating the uncompensated care payment. Before the S-10 can be used as a data source for the costs of treating the uninsured, hospitals need more explicit instructions and guidance regarding how to report on this form.

The Data in Worksheet S-10 Must Be Audited to Ensure Accuracy

The AAMC also strongly recommends that CMS conduct a separate Medicare Administrative Contractor (MAC) survey audit before the data is used. Only with the benefit of an audit will hospitals be able to trust that the data used for the UCP payments are accurate. As part of the S-10 audit protocols, CMS should establish a process for hospitals to appeal auditor decisions.

A Longer Transition Period is Needed

Lastly, the transition to Worksheet S-10 is likely to cause a large redistribution of uncompensated care payments. CMS should understand the impact of the redistribution and to the extent of its authority ensure that DSH money goes to hospitals with higher rates of caring for poor, complex patients. The AAMC recommends that CMS explore ways to mitigate the effect on hospitals by lengthening the transition to the Worksheet S-10 from the proposed 3 years. Should the Agency not adopt this change then it should cap the amount a hospital can lose at 10 percent on any redistribution of UCP funds.

Since 2014 the AAMC has requested that CMS modify Worksheet (WS) S-10 of the hospital cost report and develop guidance to ensure that the data is reported consistently. Many of the issues have not yet been addressed. CMS should ensure the data is accurate and consistent before starting the transition to Worksheet S-10. Finally, the AAMC encourages CMS to continue to

engage the provider community and to review the AAMC FY 2015 IPPS comments regarding necessary modifications to the WS S-10. The Association would welcome an opportunity to work with the Agency on any revisions.

DIRECT GRADUATE MEDICAL EDUCATION

AAMC Supports CMS's Proposal to Allow Urban Hospitals with Rural Training Tracks 5 Years to Establish FTE Limitation

The Medicare program limits payments to a teaching hospital to the number of resident full time equivalents (FTEs) the hospital reported during its most recent cost reporting period ending on or before December 31, 1996. Hospitals that were not training residents at that time are, however, permitted to establish FTE caps for direct graduate medical education (DGME) and IME payments by meeting certain requirements. In the FY 2013 final IPPS rule, CMS amended regulations to allow new teaching hospitals to grow their programs over a period of 5 years for the purpose of establishing FTE resident caps. However, at that time CMS inadvertently neglected to change the program growth window for urban hospitals with rural training tracks.

CMS acknowledges in the proposed rule that urban hospitals with rural training tracks have found 3 years to be an insufficient amount of time to establish FTE caps that accurately reflect the number of FTE residents the hospital will actually train when their programs are fully grown. CMS proposes to extend this window to a 5-year period for urban hospitals with rural training tracks. Additionally, CMS is proposing to extend the program growth an additional two years for urban hospitals that began training residents in urban training tracks on or after October 1, 2012.

The AAMC discussed this issue with CMS staff in December and urged them to expand the program growth from 3 to 5 years. The AAMC is pleased that CMS has incorporated its suggestions in the proposed rule and strongly encourages the Agency to finalize the proposal. The AAMC believes CMS has accurately characterized the challenges urban hospitals have faced under the 3-year window and appreciates CMS's willingness to extend the cap-building windows. This additional time will permit rural training tracks to meet accreditation timelines and grow programs responsibly in ways that begin to address the nation's looming physician shortage by encouraging the training of residents in rural areas.

The AAMC has reviewed the existing legislation pertaining to the expansion of rural training tracks. We ask CMS to clarify the circumstances under which rural hospitals can increase their resident caps.

HOSPITAL AND CAH NOTIFICATION PROCEDURES FOR OUTPATIENTS RECEIVING OBSERVATION SERVICES

CMS should delay enforcement of the NOTICE Act Provisions

The Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act) was enacted by Congress to ensure that individuals receiving observation services as outpatients for more than 24 hours at hospitals or CAHs are aware of their status and the financial implications of being an outpatient. The Act requires all hospital and CAHs to provide written notification and an oral explanation of such notification to individuals receiving observation services as outpatients for more than 24 hours. CMS is proposing that all hospitals and CAHs be required to use a standardized form, the Medicare Outpatient Observation Notice (MOON), which will fulfill all written requirements under the Act.

In the preamble to the proposed rule, CMS cites the Medicare Claims Processing Manual that says that hospital reporting for observation services "begins at the clock time documented in the patient's medical record, which coincides with the time that observation services are initiated in accordance with a physician's order." In teaching hospitals residents frequently write the admission order. CMS now requires that the order be confirmed by the attending physician prior to the discharge of the patient. As the intent of the NOTICE Act is that the clock should start at the time the order is written, CMS should be clear that the resident's order will start the clock regardless of any action on the part of the attending.

The AAMC supports transparency and believes that patients who receive observation services should be aware of the potential financial obligations they may incur if they do not become inpatients. The Association notes, however, that the NOTICE Act will go into effect on August 6--before the FY 2017 final rule is released. Hospitals are working now to comply with the Act to the extent they understand the requirements, but until the rule is final they will not have certainty about what they must do. Therefore, the AAMC asks that as long as hospitals make a reasonable effort to comply with the provisions of the Notice Act, CMS delay enforcement for at least 6 months or until the MOON is translated into the requisite number of foreign languages to meet anti-discrimination requirements for individuals with limited English proficiency. The Agency also should recognize that hospitals with state law observation services notice requirements will have to comply with both federal and state law requirements, which requires providing two notices to patients. This is an additional administrative burden and may potentially confuse patients if notices are required to be delivered at different times. The Association asks CMS to consider whether compliance with state requirements will be sufficient, or to find another way to reduce burden on providers and avoid potential confusion on the part of patients.

HOSPITAL QUALITY PROGRAMS

Starting FY 2017, the nation's IPPS hospitals will have the maximum amount at risk for the three hospital quality performance programs as required under the Affordable Care Act. Eligible hospitals will have at least 6 percent of their base DRG payments at risk through the following programs:

- **Hospital Value-Based Purchasing (VBP) Program**, a pay-for-performance program that rewards or penalizes hospitals up to 2.0 percent based on performance for a variety of measures. This is the final year that the amount at risk for the VBP program will increase;

- **Hospital Readmissions Reduction Program (HRRP)**, a program that penalizes hospitals up to 3 percent for excess readmissions for selected conditions; and,

- **Hospital Acquired Condition Reduction Program (HAC or HACRP)**, a program that assesses hospitals with a 1 percent penalty for relatively poor performance on certain patient safety measures.

In addition, hospitals publicly report measures through the Inpatient Quality Reporting (IQR) Program. Because so much of the payments are at stake, CMS has the obligation to ensure that measurement and comparisons are as accurate as possible.

CMS proposes numerous changes to these programs in this IPPS rule; however, the AAMC is disappointed that CMS is not addressing some key overarching issues with these programs which are creating disparities with respect to the type of hospital being penalized. The following are the AAMC's top concerns with the existing hospital quality reporting and performance programs and policies.

Systematic Biases in the Hospital Quality Performance Programs Must be Addressed

The AAMC analysis below (Figure 1) displays the disparity in penalties in all three performance programs for large hospitals, major teaching institutions, and those with a higher DSH proportion compared to other hospitals. Hospitals most likely to receive no penalties are those that are fewer than 100 beds, or in the lowest DSH quartile. By contrast, in FY 2016:

- 30 percent of major teaching institutions, which disproportionately care for vulnerable and disadvantaged patient populations, will be penalized under all three performance programs. This is compared to 6 percent of non-teaching hospitals.
- 22 percent of large institutions (500 beds or higher) are also penalized in all three programs compared to only 3 percent of small institutions (bed size under 100).
- 16 percent of high DSH hospitals are penalized in all three programs compared to only 5 percent of low DSH hospitals.

This stark disparity in penalties between teaching and non-teaching, large and small, and high-DSH and low-DSH hospitals is due, at least in part, to deficiencies in the quality measures and the scoring methodologies. We urge CMS to revise the performance programs to ensure that penalties are fairly and appropriately assessed.

Figure 1: FY 2016 Hospital Penalties by Size and Type

Hospital Characteristics	Received No Penalties Across Programs	Received Penalties in All Three Programs
Teaching Status		
• Major Teaching (Resident to Bed Ratio >= 0 .25)	**6%**	**30%**
• Minor Teaching (0<Resident to Bed Ratio < 0 .25)	**10%**	**14%**
• Non-Teaching (Resident to Bed Ratio = 0)	**19%**	**6%**
Bed Count		
• Greater than or equal to 500 beds	**5%**	**22%**
• Between 100 and 499 beds	**10%**	**13%**
• Fewer than 100 beds	**27%**	**3%**
DSH Percent		
• Quartile 1 (High DSH Percent)	**10%**	**16%**
• Quartile 2	**10%**	**10%**
• Quartile 3	**13%**	**9%**
• Quartile 4 (Low DSH Percent)	**31%**	**5%**

*VBP Penalty = if hospital receives less than the withheld amount.
Source: AAMC Analysis of FY 2016 IPPS Final Rule Files

The AAMC believes that such systematic differences in penalties are the result of ***measurement limitations*** that affect performance scores. As previously noted by AAMC, these limitations include:

- **Lack of Sociodemographic (SDS) Adjustment for Outcome Measures.** Most outcome measures, particularly readmission measures, are associated with sociodemographic status. Hospitals that disproportionately care for vulnerable patient populations, who are at higher risk of readmissions, are disadvantaged when these factors are not considered in either the adjustment or the payment scoring methodology.[1]

- **Adjustments for Small Sample Size Differentially Affects Hospitals.** In an effort to add stability and reliability to some measures, CMS uses a statistical technique that skews small sample sizes towards the average. The result is that it is more difficult to notice

[1] *See*, Hu J, Gonsahn MD, Nerenz DR. Socioeconomic status and readmissions: evidence from an urban teaching hospital. *Health Aff (Millwood).* May 2014;33(5):778-785.

true variation for smaller hospitals as compared to larger ones."[2] This method favors smaller hospitals at the expense of larger ones.

- **Other Limitations in Risk Adjustment.** Claims measures have limited clinical information, and other data sources are either expensive to collect or may have missing data. Models that do not have all the relevant patient comorbidities or complexities will not have a sufficient risk adjustment.

The cumulative effect of these limitations is that CMS compares "apples to oranges" when the Agency should be comparing "apples to apples." Differences in comparison groups are then compounded when similar or related measures are used in multiple programs, bringing into question the fairness of the program.

The AAMC asks CMS to reevaluate the three hospital quality programs and consider strategies to mitigate any unintended biases and make the comparisons more equitable. The AAMC outlines a number of potential solutions below that will help achieve this goal:

- **Comprehensive Review of PSI-90 to Determine Appropriateness in the Hospital Pay-for-Performance Programs**
  The PSI-90 Patient Safety Composite has been previously finalized for both the HACRP and VBP programs. MedPAC and academic researchers have noted serious deficiencies with the measure, which include the following concerns regarding the components of PSI-90: susceptible to surveillance bias; may not be preventable through evidence based practices; lack appropriate and necessary exclusions, some of them associated primarily with larger and academic centers; and, are based on administrative claims data so cannot capture the full scope of patient-level risk factors.[3][4] In addition, since the PSI-90 components focus on surgical care, teaching hospitals are more likely to be disproportionately impacted by this measure because they tend to have a larger volume of surgical cases.[5] Finally, as a composite measure PSI90 is (by design) weighted more toward some events than others, so that bias can be further magnified beyond the intrinsic limitations of an individual PSI when it is weighted more significantly in the composite.

  CMS has proposed a modified version of the PSI-90 composite, described below, for the HACRP and IQR programs starting FY 2018 payment determination. The AAMC has concerns that the issues cited above may continue to apply. Therefore, the AAMC urges

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[2] *See*, Silber JH, Rosenbaum PR, Brachet TJ, et al. The Hospital Compare mortality model and the volume-outcome relationship. *Health Serv Res.* Oct 2010;45(5 Pt 1):1148-1167.
[3] "MedPAC Comments on FY 2014 IPPS Proposed Rule." June 25, 2013. Retrieved from: http://www.medpac.gov/documents/comment-letters/medpac's-comment-on-cms's-acute-and-long-term-care-hospitals-proposed-rule.pdf?sfvrsn=0
[4] Rajaram, Ravi et al. *Concerns About Using the Patient Safety Indicator-90 Composite in Pay-for-Performance Programs*. JAMA. Vol 313, No. 9. March 3, 2015. Retrieved from: http://jama.jamanetwork.com/article.aspx?articleid=2109967
[5] "Medicare's Hospital-Acquired Condition Reduction Program. Health Affairs: Health Policy Briefs. August 6, 2015. Retrieved from http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=142

CMS to immediately review this measure to determine the appropriateness of both the current and modified measures in the performance programs moving forward.

- **Implementation of an SDS Adjustment for HRRP and Other Outcome Measures.** The NQF is currently undertaking a trial period to review the impact of SDS on certain quality measures. The trial period is not scheduled to end until 2017, and there is no clear mechanism for CMS to formally adopt NQF's findings. In the meantime, teaching hospitals, which disproportionately care for disadvantaged and vulnerable patient populations, are disproportionately penalized by performance programs that do not include such an adjustment. Until this trial period trial concludes, AAMC requests that the Agency take steps to account for the impact of SDS through a stratification approach or through other means. The literature on the impact of SDS factors on hospital performance is overwhelming.[6][7]

- **Use Peer Cohorts or Matching Algorithms to Create Better Benchmarks** In order to create a fairer system for assessing hospitals, CMS could utilize peer cohorts of hospitals of similar characteristic. Alternatively, CMS could employ advanced matching algorithms to ensure that performance measurement is compared across similar organizations, instead of comparing hospitals that treat different types of patients and provide a different mix of services.

CMS Should Justify Deviations from Recommendations made by the Measure Applications Partnership (MAP)

The Measure Applications Partnership (MAP) is a multi-stakeholder group created under the Affordable Care Act (ACA) that provides input to CMS regarding quality measures used in all CMS quality reporting and payment programs. This is the fifth year that the MAP has provided feedback to the Agency. In the FY 2017 rule, CMS proposed a significant number of new measures for the VBP and IQR programs that were explicitly not recommended by the MAP. The proposed measures are listed in Figure 2 below. Measures highlighted were either not supported by the MAP or were supported with conditions that have not yet been met:

[6] Michael Barnett, MD, et al. Patient Characteristics and Differences in Hospital Readmission Rates. JAMA, 2015
[7] Jianhui Hu, et al. Socioeconomic status and readmissions: evidence from an urban teaching hospital. Health Affairs, 2014

Figure 2: Measures Proposed By CMS that were not supported by the MAP, or were supported with conditions

Measure	Program	MAP Recommendation
Hospital-Level Risk-Standardized Payment Associated with the 30-Day Episode-of-Care for AMI	VBP	Did not support
Hospital-Level Risk-Standardized Payment Associated with the 30-Day Episode-of-Care for HF	VBP	Did not support
Modified pneumonia mortality measure	VBP	Support on the condition that the measure be NQF-endorsed. Condition has not been met
All Cause Mortality Following CABG	VBP	Supports
Modified pneumonia payment measure	IQR	Support on the conditions that the measure be reviewed under the SDS trial period and NQF endorsed. Conditions have not been met.
Modified PSI-90 patient safety composite	IQR	Supports
Aortic Aneurysm Procedure 30 day payments	IQR	Did not support
Cholecystectomy and Common duct exploration 30 day payments	IQR	Did not support
Spinal fusion 30 day payments	IQR	Did not support
Excess days in acute care after hospitalization for pneumonia	IQR	Support on the conditions that the measure be reviewed under the SDS trial period and NQF endorsed. Conditions have not been met.

Adopting quality measures that were not approved by the MAP's consensus-based approach, without providing a convincing explanation, undermines the purpose of this important stakeholder body. The AAMC supports the MAP process and suggests that in general CMS follow the MAP recommendations. When CMS decides not to adopt a MAP recommendation the Agency should provide a clear explanation to support its decision.

CMS Must Take Additional Steps to Reduce Measure Burden for Hospitals

By FY 2019, hospitals will be responsible for monitoring and responding to over 50 measures as a requirement of the Medicare hospital performance and reporting programs. This number does not include measures proposed for removal from the IQR program, the nearly 30 measures required under the Outpatient Quality Reporting (OQR) program, or other measures mandated by the Joint Commission, states, and private insurers. Reporting, monitoring, and transmitting these quality measures requires intensive staff training, labor, and resources. The AAMC recognizes the importance of quality measurement as one way to ensure that hospitals and physicians are

providing high quality care. The Association was a founding member of the Hospital Quality Alliance, which pushed hospitals to publicly report core process measures and later worked closely with CMS on the creation and development of the Hospital Compare website, where all federal inpatient and outpatient measures are reported. The AAMC, however, has serious concerns that the increase in quality measurement has become unmanageable for providers and must be addressed by CMS.

The AAMC urges the Agency to consider the recommendations included in the Institute of Medicine (IOM)'s April 2015 Vital Signs report on Core Metrics for Health and Health Care Progress.[8] The IOM noted that the "sheer number [of measures], as well as their lack of focus, consistency, and organization, limits their overall effectiveness in improving performance of the health system." In addition, the organization cited the "significant burden" on providers to collect and examine this data. A committee convened by the IOM proposed 15 core measure areas, along with 39 additional priority measures, in which to provide benchmarks and improve overall health system performance. CMS should take steps to reduce overall measure burden across all programs by creating a streamlined measure set that provides the most value for patients and providers.

Summary of Key AAMC Recommendations on Changes to Quality Programs in the FY 2017 IPPS Proposed Rule

- **Do not Finalize the Modified Version of the PSI-90 Composite or the Measure's Proposed Performance Period for the HACRP in FY 2018**

  CMS has proposed to include a modified version of the PSI-90 composite measure in the HACRP and IQR program starting with the FY 2018 payment determination. The AAMC strongly believes that all measures should be reported first in the IQR program for one year before the performance period in a payment program begins. This has not occurred with the modified version of PSI-90. Therefore the modified version of the PSI-90 measure should not be included in the HACRP at this time.

  In addition, due to challenges with ICD-10 claims data, the proposed performance period for PSI-90 in the HACRP and VBP programs is 15 months for FY 2018. This is a significant reduction in the previously finalized performance periods of 24 months. The AAMC appreciates the problems surrounding the ICD-10 conversion but urges CMS to instead remove the PSI-90 measure altogether for FY 2018 instead of making a flawed measure even worse by utilizing a shortened performance period.

[8] Vital Signs: Core Metrics for Health and Health Care Progress. April 2015. Retrieved from: http://iom.nationalacademies.org/~/media/Files/Report%20Files/2015/Vital_Signs/VitalSigns_RB.pdf

- **Do Not Finalize the Efficiency Measures Proposed for the VBP Program in FY 2021**
  The AAMC urges CMS not to finalize the HF and AMI episode of care payment measures for the VBP efficiency domains, since they have not been adjusted for SDS. In addition, the Association strongly recommends that MSPB, the only measure finalized for the VBP efficiency domain, be adjusted to account for SDS variables.

- **Continue Analysis of Proposed HACRP Scoring Methodology**
  The AAMC requests that CMS perform additional analysis on the proposed HACRP scoring methodology to determine whether certain types of hospitals are disproportionately disadvantaged under the new approach and if so, why.

HOSPITAL-ACQUIRED CONDITIONS (HAC) REDUCTION PROGRAM

CMS Should Take Additional Steps to Reduce the Disproportionate Penalties in the HACRP

As CMS transitions into the third year of the HACRP, the AAMC remains extremely concerned that this program continues to overwhelmingly and disproportionately have a negative impact on the nation's major teaching hospitals. This is due to factors that do not reflect true differences in the quality of care, such as limitations in the scoring methodology, data collection, risk adjustment, and the size of teaching facilities compared to other hospitals. By CMS's own estimate, approximately 56 percent of major teaching institutions will be penalized by the program in FY 2017, which is twice the national average and three times higher than non-teaching hospitals. Unlike VBP and HRRP, the HACRP also includes penalties for add-on policy payments, such as IME, DSH, and UC, which disproportionately affect teaching hospitals.

CMS has highlighted potential deficiencies in the quality measures used in this program, noting that MedPAC and other stakeholders have raised concerns that the claims-based measure used are not "as reliable or actionable" as the CDC NHSN measures. Additionally, hospitals that have instituted a rigorous program to identify (and treat) infections are placed at a disadvantage when they are compared to those with less comprehensive quality programs as hospitals that more aggressively search for infections are more likely to find them. Because this program is mandated by Congress to penalize 25 percent of all hospitals, it is especially important that CMS ensure that the measures used are as fair and accurate as possible and do not create a systematic bias that disadvantages any particular type of hospital.

CMS Should Withdraw the Proposal for the Modified PSI-90 Composite and the Measure's 15 month Performance Period in FY 2018

In the rule, CMS proposes to include a modified version of the PSI-90 composite measure in the HACRP and IQR program simultaneously starting FY 2018 payment determination. The AAMC strongly believes that all measures should be reported first in the IQR program for one year before the performance period in a payment program begins. Publicly reporting measures in the

IQR program provides transparency, allows stakeholders to gain experience submitting the measures, and allows time to identify errors, unintended consequences, or other concerns with the measure methodology.

Furthermore, CMS proposes to modify its policy to use a 2-year performance period for measures in the HACRP and VBP program. Specifically, CMS proposes a 15-month performance period [July 2014 – September 2015] for the PSI-90 patient safety composite starting FY 2018. In making this proposal, CMS cites concerns that a 24-month performance period would require combining ICD-9 and ICD-10 claims data, something that AHRQ has recommended against doing at this time. The start date for ICD-10 implementation was October 1, 2015.

The AAMC appreciates AHRQ's concerns regarding combining claims data for ICD-9 and ICD-10 and supports the Agency's decision not to do so at this time. However, reducing the performance period to 15 months in FY 2018 will undermine the reliability of the results. According to an independent analysis conducted by Mathematica Policy Research, a CMS contractor, only 81 percent of hospitals achieve median reliability with 12 months of data, and 86 percent achieve median reliability with an 18 month reporting period.[9]

Considering the concerns with the current and modified versions of the PSI-90 measure, which would be compounded by a significantly reduced performance period, the AAMC strongly recommends that CMS remove the PSI-90 composite from the HACRP and VBP program for FY 2018.

AAMC Requests Clarification on the FY 2019 Performance Period for the PSI-90 Measure in the HACRP

For the PSI-90 measure, CMS proposes a reduced performance period of 21 months for FY 2019 payment determination. However, the dates listed in the rule – October 1, 2015 through September 30, 2017 – are a total of 24 months. The AAMC requests that CMS provide clarification as to which years/months will be used to determine performance for FY 2019.

AAMC Requests that CMS to Continue Analysis of the Proposed HACRP Scoring Methodology and Requests Additional Modifications

CMS has proposed a new scoring methodology starting FY 2018 that would replace the current decile-based system with a winsorized z-score method. A technical expert panel (TEP), convened by CMS in late 2015 recommended the use of z-scores - which represent the number of standard deviations from the national mean – in order to reduce the number of "ties" at the 75th percentile. CMS estimates that approximately 200 hospitals would have been affected by the new scoring methodology in FY 2016, with a decrease in the number of large hospitals (greater

[9] http://cms.hhs.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/hospital-value-based-purchasing/Downloads/HVBP_Measure_Reliability-.pdf

than 500 beds) penalized and an increase in the penalization rate of moderately high DSH hospitals.

Before finalizing the new scoring methodology, the AAMC requests that CMS take additional time to evaluate the impact of the proposal to sufficiently understand whether any particular category of hospital is disproportionately impacted by the change. While additional analysis is warranted, we believe that a winsorization step is valid and appropriate for the HACRP in limiting extreme values. The winsorization step may not be appropriate in other programs, such as the Hospital Compare Star Ratings, when it is used to manipulate the hospital star distribution. For the overall star rating composite, CMS planned to institute a winsorization approach, without public comment, for the sole purpose of artificially creating more one star and five star hospitals, which may exaggerate small differences in actual performance and mislead-consumers. CMS should allow sufficient stakeholder review and should consider the effect on the distribution of scores before implementing winsorization in performance rating systems.

While the AAMC appreciates that CMS is open to addressing ongoing challenges with the HACRP, the Association believes that more must be done to ameliorate deficiencies in the program. As a start, the TEP should reconvene as soon as possible to discuss critical concerns, including the two issues described below:

- **Comprehensive Review of PSI-90 Composite Measure.** The AAMC urges CMS to review the concerns with the PSI-90 measure (described earlier in this letter) and examine whether the current or revised composite measure is appropriate for continued inclusion in the HACRP.

- **Use of Hospital Peer Cohorts to Determine Overall Performance.** The AAMC recommends that CMS explore measure performance within specific hospital peer cohorts so that hospitals with similar characteristics and risk profiles are compared to each other. The use of peer cohorts may help mitigate limitations in comparing hospitals with different types of service mix and patient complexity.

Finally, the AAMC requests that all information concerning TEP nominations, meetings, and comment periods be widely distributed to stakeholders with sufficient opportunity for response. TEP announcements are often not relayed to the public through CMS's multiple communications channels.

HOSPITAL VALUE-BASED PURCHASING PROGRAM

Summary of Changes

Starting in FY 2019, CMS proposes to adopt a 15 month performance period for the PSI-90 patient safety composite, shorten the name of the "Care Coordination and Patient and Caregiver Centered Experience of Care" domain to "Person and Community Engagement," and expand data collection for the CLABSI and CAUTI measures to include adult and pediatric medical,

surgical, and medical/surgical wards. CMS also proposed two new measures and one refined measure starting FY 2021, and one new measure starting FY 2022. CMS also sought feedback on a future composite score reflective of value in the VBP program.

Request for Feedback on Value of Care Scoring Methodology

In the rule, CMS notes that the Agency is considering a future scoring methodology in the VBP program that would assess quality and efficiency measures together in order to produce a composite score reflective of value. CMS is seeking feedback from stakeholders on possible approaches to achieve this goal. Specific proposals highlighted in the rule include developing new "measures of value," directly comparing existing quality and cost measures, or directly comparing quality and efficiency domains scores.

The AAMC thanks CMS for requesting stakeholder input on this important topic. The Association plans to work closely with member institutions to gather feedback on how best to incorporate value in the VBP program and will share these responses with CMS at a later date.

Individual Measure Recommendations

Measures Proposed to Be Added in FY 2021

Starting FY 2021, CMS proposes to add two new measures to the Efficiency and Cost Reduction domain:

- Hospital-Level Risk-Standardized Payment Associated with the 30-Day Episode-of-Care for AMI
- Hospital-Level Risk-Standardized Payment Associated with the 30-Day Episode-of-Care for HF

These two measures calculate risk-standardized payments for patients admitted with either AMI or HF over a 30-day episode-of-care using claims data. The measures are NQF endorsed but have not been recommended for inclusion by the MAP.

The AAMC does not support the inclusion of these two payment measures in the VBP program at this time. The Association echoes concerns cited by the MAP that inclusion of condition-specific payment measures may double count and overlap with services already captured by the Medicare Spending Per Beneficiary (MSPB) measure, potentially penalizing hospitals twice for the same episode. If CMS intends to transition to condition-specific or treatment-specific payment measures, the Agency should strongly consider removing the MSPB measure from the Efficacy Domain in future rulemaking. The AAMC also strongly recommends that the two payment measures be adjusted for SDS before inclusion in the VBP program.

In FY 2021, CMS also proposes to include a modified measure in the clinical care domain:

- Hospital 30-Day All-Cause Risk-Standardized Mortality Rate Following Pneumonia Hospitalization

CMS intends to include the expanded pneumonia mortality measure for the VBP program starting FY 2021. As finalized for the IQR program in the FY 2016 IPPS rule, the mortality measure cohort would be expanded beyond patients with a principle discharge diagnosis of pneumonia to now include patients with a principal discharge diagnosis of aspiration pneumonia **and** patients with a principal discharge diagnosis of sepsis with a secondary diagnosis of pneumonia coded as present on admission.

CMS's reason for this expansion is to make this measure more comprehensive for pneumonia and to account for potential discrepancies in how the measures are coded. The AAMC remains concerned that this change could make hospitals that care for the most complex patients look worse than other hospitals because it does not appropriately adjust for differences in the patient population. Since this measure has significantly changed, the AAMC strongly recommends that it not be finalize until it goes through a formal NQF appeal by experts in the field.

Measures Proposed to Be Added in FY 2022

Starting FY 2022, CMS proposes to add one new measure to the clinical care domain:

- Hospital 30-Day, All Cause, Risk Standardized Mortality Rating following CABG.

This measure would assess hospitals' 30-day all-cause risk standardized rate of mortality for patients who receive a qualifying CABG procedure. This measure has been NQF-endorsed and was supported for inclusion by the MAP. The AAMC supports the inclusion of this measure into the VBP program; however, the Association strongly urges CMS to include adequate risk-adjustment modifications to the measure that address both SDS and clinical factors.

INPATIENT QUALITY REPORTING PROGRAM

Because IQR measures are publicly reported on the Hospital Compare website and are eligible for the VBP program, the AAMC believes these measures should meet a certain standard. In particular, the AAMC considers whether measures proposed for this program have been reviewed by the NQF and follow the recommendations (including any conditions) issued by the MAP. Specific measure recommendations are below.

Concerns with the Electronic Clinical Quality Measures (eCQMs)

In the FY 2016 rule, CMS finalized a requirement that hospitals select and electronically submit 4 out a possible 28 eCQMs for 1 quarter (either Q3 or Q4) of CY 2016. CMS now proposes to increase the number of required eCQMs from 4 to 15 and would mandate hospitals to report a

full year of data for FY 2018 payment determination. CMS also proposes to remove 13 eCQMs from the IQR program, which if finalized would lower the total number of eligible inpatient eCQMs to 15.

The AAMC appreciates CMS's desire to transition towards greater electronic reporting of clinical data and to increase alignment between the EHR Incentive and IQR programs; the Association asks CMS to continue to address concerns regarding the feasibility and validity of electronically-submitted measures. The Association believes that hospitals and vendors may not be sufficiently prepared to fully implement this change. The AAMC has heard from members about numerous problems implementing e-measures, including the resource burden required to map the necessary data elements from the EHR to the appropriate Quality Reporting Data Architecture (QRDA) format, some vendors are not properly equipped to collect and transmit such data through the CMS portal, and hospitals can face additional fees to extract the EHR data from the system. Additionally, mandatory eCQM reporting depends on hospitals using the correct version of specifications, which is generally in the control of the EHR vendors, not the hospitals. The AAMC urges CMS to continue outreach to EHR vendors, hospital quality staff, and other affected stakeholders to identify underlying structural problems and barriers to successful reporting of these measures.

Individual Measure Recommendations

The AAMC supports Measures Proposed for Removal in FY 2019

CMS proposes to remove 15 ECQM, chart abstracted, and structural measures from the IQR program starting in FY 2019. The measures proposed for removal are as follows:

- AMI-2:Aspirin Prescribed at Discharge (eCQM)
- AMI-7a:Fibrinolytic Therapy Received within 30 Minutes of Hospital Arrival (eCQM)
- AMI-10: Statin Prescribed at Discharge (eCQM)
- HTN: Healthy Term Newborn (eCQM)
- PN-6:Initial Antibiotic Selection for CAP in Immunocompetent Patients (eCQM)
- SCIP-Inf-1:Prophylactic antibiotic received within one hour prior to surgery (eCQM)
- SCIP INF-2 Prophylactic antibiotic selection for surgical patients (eCQM)
- SCIP INF-9 Urinary catheter removed on POD1 or POD2 (eCQM)
- STK-4 Thrombolytic therapy (eCQM and Chart Abstracted)
- VTE-3 Venous thromboembolism patients with anticoagulation overlap therapy (eCQM)
- VTE-4 Patients receiving un-fractionated Heparin with doses/labs monitored by protocol (eCQM)
- VTE-5 VTE discharge instructions (eCQM and chart abstracted)
- VTE-6 Incidence of potentially preventable VTE (eCQM. Chart Abstracted Measure Retained)
- Participation in a Systematic Database for Cardiac Surgery (structural)
- Participation in a Systematic Clinical Database Registry for General Surgery (structural)

The 13 electronic measures have also been proposed for removal from the EHR Incentive Program. CMS notes that they are proposing removal of the eCQMs since they are topped-out, higher performance does not lead to improved outcomes, or because they are not feasible to implement. The chart abstracted measures proposed for removal are topped-out and the structural measures do not provide information on patient outcomes. The AAMC supports removal of these measures.

Measures Proposed to Be Modified in FY 2018

Starting FY 2018, CMS proposes to modify an existing measure in the IQR program:

- Hospital Risk-Standardized 30-Day Episode-of-Care Payment Measure for Pneumonia

Similar to the previously finalized pneumonia readmissions and mortality measures, CMS intends to expand the cohort for the pneumonia episode-of-care payment measure beyond patients with a principle discharge diagnosis of pneumonia to now include: patients with a principal discharge diagnosis of aspiration pneumonia **and** patients with a principal discharge diagnosis of sepsis with a secondary diagnosis of pneumonia coded as present on admission.

CMS is including this expanded measure to make this measure more comprehensive for pneumonia and to account for potential discrepancies in how the measures are coded. The AAMC however, is concerned that this change could make hospitals who care for the most complex patients look worse for not appropriately adjusting for differences in the patient population. Since this measure has significantly changed, the AAMC strongly recommends that this measure go through NQF review for a formal review with experts in the field and should not be finalized at this time.

In FY 2018, CMS also proposes to modify one additional measure:

- Patient Safety and Adverse Events Composite – referred to as "modified PSI-90" composite measure

As noted earlier in our comments, the AAMC strongly believes that all measures should be reported in the IQR program for one year before the performance period in a payment program begins. Publicly reporting measures in the IQR program provides transparency, allows stakeholders to gain experience submitting the measures, and allows time to identify errors, unintended consequences, or other concerns with the measure methodology. The modified PSI-90 composite has been simultaneously proposed for the HACRP and IQR programs in FY 2018. At a minimum, the modified PSI-90 measure should be finalized for the IQR program and publicly reported before it is considered for a performance program.

The AAMC has additional concerns that the modified measure may does not sufficiently address the Association's concerns that PSI-90 is:

- Susceptible to surveillance bias;

- lack appropriate and necessary exclusions, some of them associated primarily with larger and academic centers;
- is based on administrative claims data so cannot capture the full scope of patient-level risk factors; and,
- may not be preventable through evidence based practices.

In fact, the measure developer noted that the name of the measure was changed to the Patient Safety and Adverse Events Composite "in response to comments that raised concerns over the preventability of some of the coded adverse events included in the measure." The developer noted that the name better reflects the fact that some of the component indicators capture adverse events occurring during hospital care, and there is room for discussion and disagreement about the exact percentage of those events that are preventable given current knowledge.[10] The AAMC urges CMS to perform a comprehensive review of the current and modified PSI-90 composite measure to determine their appropriateness for inclusion in the hospital performance programs.

Measures Proposed to Be Added in FY 2019

Starting in the FY 2019 payment year, CMS proposes to add three episode based payment measures to the IQR program:

- Aortic Aneurysm Procedure 30 Day Payments
- Cholecystectomy and Common Duct Exploration 30 Day Payments
- Spinal Fusion 30 Day Payments

These episode-based measures assess all payments (Parts A and B) for these conditions/services and use logic similar to the Medicare Spending Per Beneficiary (MSPB) measure, such as utilizing a 3-days prior to 30-days post-discharge methodology. The MAP did not support the inclusion of these measures in the IQR program due to the lack of NQF endorsement. NQF stakeholders must have the opportunity to appropriately evaluate these measures to ensure that it is scientifically valid, reliable, and feasible, and determine whether the measures are appropriate for review in the NQF SDS trial period. Until such a discussion occurs, relevant stakeholders do not have the necessary information to make a critical assessment as to whether a measure is appropriate for public reporting or performance programs.

The AAMC does not believe that these measures should be included in the IQR program at this time. However, even if the measures are not finalized for IQR, the AAMC recognizes that providers may benefit from seeing this claims data. We ask that CMS consider the approach finalized by the Agency in the FY 2016 IPPS rule and share confidential cost reports with hospitals for these measures, before they are adopted for the IQR program. While the measures are being reviewed by NQF, providers may want to analyze the information to understand the drivers of high cost payment episodes and possibly identify appropriate interventions that can

[10] NQF Memo to Patient Safety Standing Committee Regarding Voting Draft Report: MQF Endorsed Measures for Patient Safety. 21 October, 2015. Retrieved from: https://www.qualityforum.org/Projects/n-r/Patient_Safety_Measures_2015/Voting_Memo.aspx

lead to improved processes of care. Confidential reporting will allow providers time to better understand this data while the merits of the measure are discussed by the relevant NQF committee.

Starting FY 2019, CMS also proposes to add one additional measure to the IQR program:

- Excess Days in Acute Care After Hospitalization for Pneumonia

The excess days measure assess all-cause acute care utilization for post-discharge PN patients and includes readmissions, observation stays, and ED visits. The measure is a ratio of a patient's actual acute care utilization compared to expected utilization based on the patient's degree of illness. CMS did not provide measure specifications, and it has not been NQF endorsed or risk-adjusted for SDS factors.

The AAMC believes that this measure should be NQF endorsed before being proposed for the IQR program. The AAMC has concerns as to whether documenting the excess days provides a clear signal of quality. In particular, patients with higher complexity or with difficult personal circumstances may require more days in an acute setting. Until this measure is reviewed by the NQF, excess days does not represent an actionable or meaningful measure for the provider.

HOSPITAL READMISSIONS REDUCTION PROGRAM

CMS did not propose new conditions or make substantial changes to the readmissions program in this rule. The AAMC appreciates this period of stability for the HRRP and requests that in future rulemaking CMS review whether performance on certain conditions has significantly changed. If hospital performance on reducing readmissions for a condition has improved to a point where readmission rates are low and there is little variation among hospitals and little change from year-to-year, then that may be an indication that further improvements in aggregate readmission rates may not be achievable.

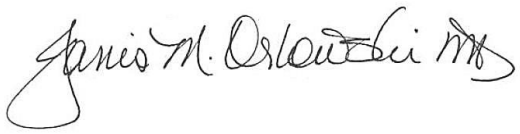
CMS Should Adjust Readmissions Measures for SDS Factors

The AAMC remains extremely concerned that CMS has continued the Agency's policy of not adjusting the readmissions measures to account for SDS factors. The AAMC appreciates that the NQF has started a trial period to review whether there are conceptual and empirical relationships between certain accountability measures and SDS factors. However, this trial period is not slated to end until 2017. In the meantime, CMS continues to use quality measures in the HRRP that are influenced by community-level factors without an appropriate adjustment. Until the NQF trial period concludes and a formal recommendation is released, the AAMC urges CMS to make adjustments, in a transparent fashion, to account for safety net hospitals that disproportionately treat low-income and more vulnerable patient populations.

CONCLUSION

Thank you for the opportunity to present our views. We would be happy to work with CMS on any of the issues discussed above or other topics that involve the academic medical center community. If you have questions regarding hospital payment issues please feel free to contact Ivy Baer at 202-828-0499 or at ibaer@aamc.org. For questions regarding the quality provisions please contact Scott Wetzel at 202-828-0495 or at swetzel@aamc.org.

Sincerely,



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