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Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1677–P
P.O. Box 8011
Baltimore, MD 21244–1850

Re: CMS 1677-P: Comments to FY 2018 Medicare Hospital Inpatient Prospective Payment System Proposed Rule

Dear Administrator Verma:

The Health Law Section of the American Bar Association (the Section) respectfully submits the following comments on the proposed rule issued by the Centers for Medicare and Medicaid Services (CMS) entitled "Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2018 Rates; Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Electronic Health Record (EHR) Incentive Program Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Provider-Based Status of Indian Health Service and Tribal Facilities and Organizations; Costs Reporting and Provider Requirements; Agreement Termination Notices" and published in the April 28, 2017 Federal Register (CMS 1677-P; 82 Fed. Reg. 19796- 20231) (the Proposed Rule).

The views expressed herein are presented on behalf of the Section.[1] No government attorneys or government professional participated in the drafting of submission of these comments. Accordingly, the views expressed in these comments should not be construed as representing the policy or views of any government employee who is a member of the Section or its Council. These comments have not been approved by the House of Delegates or the Board of Governors of the American Bar Association and, accordingly should not be construed as representing the position of the American Bar Association.

I. Background of the American Bar Association

The American Bar Association (the ABA) is the largest voluntary professional association in the world. The Section, with nearly 9,000 attorney members, is the voice of the organized health care bar within the ABA. Its members represent clients

[1] These comments were prepared by a working group of the Health Law Section's Payment & Reimbursement Interest Group. The contributors to these comments are Allie Petrova and Ayeisha Cox. Although members of the Section who participated in the preparation of these comments represent clients who may be affected by the proposed rule, no such member has been engaged by a client to participate in the drafting or submission of these comments.

in all aspects of the health care industry, including physicians, institutional providers, teaching and research organizations, managed care organizations and other third-party payors, governmental health care programs and regulatory bodies, pharmaceutical companies, and device manufacturers. Accordingly, the Section believes that it brings a broad and unique perspective to the many issues raised by the Proposed Rule.

II. Summary of the Comments

The Section's comments focus on several key areas where we believe there is room for improvement in the Proposed Rule and respond to the comments specifically solicited by CMS. The areas that are addressed within this letter are: (a) the proposed methodology for adjusting hospitals' performance in the Hospital Readmissions Reduction Program; and (b) the methodology for distributing Medicare disproportionate share hospital (DSH) uncompensated care payments.

III. Proposed Methodology for Adjusting Hospitals' Performance in Hospital Readmissions Reduction Program

Historically, readmission rates used in the Hospital Readmissions Reduction Program (HRRP) have not accounted for the demographics of a hospital's patient population. On December 13, 2016, Congress passed the 21st Century Cures Act (the Act), which mandated that CMS begin using the HRRP to account for socioeconomic status (SES) factors or socio-demographic status (SDS) factors in its assessment of readmissions.

In the Proposed Rule, CMS has presented its proposed implementation of the Act, starting in FY 2019. CMS intends to divide hospitals into five peer groups according to their dual-eligible patient ratio. Within each peer group, a hospital's metrics will be compared to its peers' metrics based on each of the program's six critical conditions. Specifically, a hospital's excess readmission ratio for each condition will be compared to the peer group's median excess readmission ratio for that condition.

Hospitals have control over certain types of readmissions, such as avoidable, unplanned readmissions related to the initial admission. However, they have limited or no control over unplanned readmissions that are unrelated to the initial admission. Despite a hospital's efforts, certain clinical and other patient-specific factors may impact readmissions while being outside the hospital's control. CMS acknowledges in the Proposed Rule that SES and SDS social risk factors such as income, education, race and ethnicity, employment, disability, community resources, and social support play a major role in health. CMS has requested stakeholder feedback on how best to factor SES and SDS adjustment into the Value-Based Purchasing, Hospital-Acquired Condition, and Inpatient Quality Reporting programs.

A. Target avoidable, unplanned readmissions, but not unavoidable, unplanned readmissions.

The Section proposes that CMS target avoidable, unplanned readmissions, but not unavoidable, unplanned readmissions under the HRRP. In reducing readmissions without unfairly penalizing hospitals, the HRRP's hospital improvement efforts should target the reduction of only avoidable, unplanned readmissions related to the initial admission. The impact of these readmissions is properly included in the HRRP current penalty computation. A prime

example of an avoidable, unplanned readmission would be an infection or other complication resulting from a surgical procedure for which the patient was originally admitted.

However, certain readmissions may be both unplanned and unavoidable – for example, an unplanned readmission for a condition that is unrelated to the original admission, such as a bone fracture readmission after an original admission for coronary bypass grafting. The HRRP should not penalize hospitals for unplanned, unrelated admissions because they are unpredictable and not normally preventable. The occurrence of unplanned, unrelated readmissions does not reflect the quality of care or hospital performance associated with the original admission. Yet, these readmissions are currently included in the HRRP penalty calculation.

In finalizing the Proposed Rule, we recommend that CMS focus on only avoidable, unplanned readmissions related to the original admission. Hospitals can control reducing unplanned, avoidable readmissions by implementing certain strategies. For example, hospitals can: (i) educate patients about typical post-discharge conditions, developments, and medication, (ii) arrange follow-up consultations by telephone in the first several days following a discharge to answer questions and ensure progress is as expected, and (iii) arrange follow-up appointments and consultation in the weeks after discharge to confirm there is no deterioration in status.

B. Confidential hospital-specific reporting of stratified measure rates to providers.

CMS is also proposing the assessment of differences in outcomes for dual eligible and non-dual eligible patients by first providing hospitals with these results confidentially. CMS intends for these reports to show hospitals the outcomes stratified by patient dual eligibility within the hospital.

The Section supports CMS's approach to confidential reporting of stratified measure rates to providers before making this information public. We agree that these confidential results can be presented to hospitals through confidential preview reports containing stratified results. Confidentially reported disparities in outcomes can aid hospitals in understanding correlations between stratified outcomes and the quality of care. In turn, hospitals can target improving these stratified outcomes through quality improvement efforts. We agree that this would help to ensure the information is reliable, valid, and understandable before any future public display to consumers on Hospital Compare.

C. Statistical model using three additional factors.

Commenters have previously raised concerns about the small sample size associated with measure stratification by social risk factors, which would skew the reliability of stratified quality measures. The proposed statistical approach using a hospital-specific indicator (random coefficient) for dual eligibility would allow quantification of the difference in readmissions between dual and non-dual eligible patients within each hospital only if a hospital has a sufficient number of cases to produce a reliable estimate for both groups. In other words, this approach may not be effective for hospitals with a small sample size of cases, and results reported for such hospitals may be skewed and inaccurate. The Section suggests that CMS may wish to consider studying this issue further to determine the size of the patient pool for reliable

results and should consider not reporting results for hospitals with an insufficient number of cases.

D. Reduce lag in performance period measurement.

Further, the HRRP does not factor in a hospital's improvement in performance on a real-time basis, but penalizes hospitals based on trailing-period performance assessments. Because the three-year "performance period" begins over four years before the payment adjustment, a hospital may face an HRRP penalty despite more recent improvements in performance. This lag could be avoided if the performance period covers only a single year of performance that is not too far removed in time from the effective date of the penalty.

In finalizing the Proposed Rule, the Section recommends that, for defining dual eligibility, CMS use the most recent one-year period to capture the most recent population served by the hospital. Using the one-year period instead of the three-year period would enable a more accurate stratification to calibrate the impact of payment adjustments to the proportion of dual eligible patients that the hospital currently serves.

IV. Medicare Disproportionate Share Hospital Uncompensated Care Payments

CMS established a three-factor methodology for distributing Medicare DSH uncompensated care payments, which were reduced by the Affordable Care Act. Factor 1 is equal to 75 percent of estimated Medicare DSH payments that would have been paid under old statutory formula. Factor 2 reduces Factor 1 by a percentage that reflects the percent of uninsured individuals in FY 2013 and the most recent period for which data are available. Factor 3 reflects the uncompensated care amount for each hospital relative to DSH payments received by all hospitals.

For Factor 3, CMS proposes to begin a three-year transition using Worksheet S-10 data to determine the distribution of uncompensated care payments to hospitals. CMS states that MedPAC analyses provide that Worksheet S-10 data are a better proxy for predicting uncompensated care costs than Medicaid and Medicare SSI days. CMS also states that it has undertaken additional analysis by DaVanzo & Associates, LLC that shows Worksheet S-10 data is strongly correlated with data reported on IRS Form 990.

CMS also proposes to define uncompensated care as charity care and non-Medicare bad debt. The new definition excludes Medicaid shortfall. CMS states that the exclusion will allow uncompensated care payments to better target hospitals that have a disproportionate share of patients without insurance coverage.

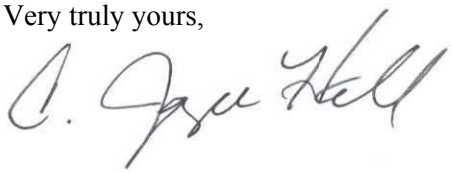
As in the past, concerns remain with the accuracy of Worksheet S-10 data. Although CMS states that hospitals have done a better job of reporting their data on Worksheet S-10, there is still lack of uniformity in data reporting that could negatively impact hospitals that have not reported data as accurately or diligently as others. The Section suggests that CMS delay or extend the transition to fully implement Worksheet S-10 data until the agency's auditing mechanisms have significantly improved and the agency can ensure that hospitals are reporting their data accurately. The Section further suggests that CMS also delay or extend transition to make certain the Worksheet S-10 reporting instructions are clear.

Furthermore, uncompensated care payments have provided additional support to hospitals that treat patients in vulnerable communities. CMS's new definition of uncompensated care does not account for the Medicaid shortfall. When the cost to treat Medicaid patients is significantly lower than Medicaid reimbursement rates, hospitals have a harder time treating the nation's most vulnerable. The Section encourages CMS to ensure that hospitals receiving uncompensated payments receive fair payments that reflect the vulnerable patients they treat, including Medicaid patients where Medicaid reimbursement does not cover a hospital's costs.

V. Conclusion

Thank you again for the opportunity to provide these comments. If you have any questions or would like any additional information, please contact Joyce Hall, Chair of the Health Law Section, at (601) 965-1982 (jhall@watkinseager.com) or Simeon Carson, Director of the Health Law Section, at (312) 988-5824 (simeon.carson@americanbar.org).

Very truly yours,



C. Joyce Hall
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