Submitted Electronically

June 16, 2015

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Room 445-G, Hubert H. Humphrey Bldg.
200 Independence Avenue, SW
Washington, DC 20201

Re: File Code CMS-1632-P

Dear Mr. Slavitt:

The Florida Hospital Association (FHA), on behalf of its more than 200 member hospitals and health systems, welcomes the opportunity to comment on the Medicare proposed rule entitled "Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System Policy Changes and Fiscal Year 2016 Rates; Revisions to Quality Reporting Requirements for Specific Providers, including Changes Related to the Electronic Health Record Incentive Program" published in the *Federal Register* on April 30, 2015. The rule revises the hospital inpatient prospective payment system (IPPS), the long-term care hospital (LTCH) payment system, and quality reporting requirements for specific providers. In this letter, we are submitting comments on the following issues:

- Uncompensated care payments
- Readmission reduction program
- PSI-90
- Quality reporting and ICD-10
- ICD-10 coverage determination policies

Uncompensated care payments
In the proposed rule for FY2016, as in prior years, CMS has indicated its desire to eventually determine the uncompensated care (UCC) payment factor (Factor 3) under the Medicare disproportionate share program using UCC data from Worksheet S-10 of the Medicare cost report. CMS has been using a low-income patient days proxy for Factor 3 in FYs 2014 and 2015 and is proposing to do so again for FY2016 due to concerns regarding data variability and lack of reporting experience with this relatively new cost report worksheet. We urge CMS to revise and improve the Worksheet S-10 and then to transition toward using the S-10 to estimate UCC costs as the S-10 more closely tracks hospitals' relative costs of caring for the uninsured. A three-year transition will prevent financial shocks to hospitals and will create an incentive for hospitals to more accurately report UCC on the S-10.

Readmissions reduction program
CMS is not proposing to add any additional readmissions measures to the program; however, it is proposing a significant refinement to the Pneumonia measure for FY2017 and future years that would expand the number of patients evaluated by the measure. Currently, the Pneumonia measure evaluates hospital readmissions for patients with a principal diagnosis of viral or bacterial pneumonia only. The refined measure would include patients with a principal diagnosis of sepsis or respiratory failure who also have a secondary diagnosis of Pneumonia. Under the Readmissions Reduction program (RRP), the refinement would have an effect on hospital readmission rates, national readmission rates, excess readmission ratios, and total revenue for the condition and will likely increase impacts under the program. CMS believes the change will better reflect the full population of Pneumonia patients and would reduce variation between hospitals that results from differences in coding practices. CMS estimates the refinement would result in a 65 percent increase in patients evaluated under the measure. As we move from ICD-9 to ICD-10, however, it is possible that the use of the expanded codes and the associated clarity of the new code set will negate the proposed refined Pneumonia measure. CMS should not make any changes to the current Pneumonia measure until they can evaluate the impact of ICD-10.

A potential issue with the proposed expansion of the pneumonia readmission measure is the double counting of cases in two different readmission measures – pneumonia and chronic obstructive pulmonary disease (COPD) – as both the revised pneumonia measure and COPD measure can include the same cases if respiratory failure is the primary diagnosis and both COPD and pneumonia are listed as secondary diagnoses. The same double counting issue is also a potential problem for the AMI and Coronary Artery Bypass Graft (CABG) readmission measures, as patients who are admitted for AMI and then undergo a cardiac bypass operation during their stay may be counted in both measures.

The readmission penalty formula is problematic. Aggregate penalties remain constant even if national readmission rates decline. More importantly, the condition-specific penalty per excess readmission is higher for conditions with low readmission rates than conditions with high readmission rates. This issue became more important in 2015 when elective total hip and total knee arthoplasty – both low readmission rate conditions – were added to the readmission policy. Now, the penalty for a hip or knee admission is roughly $200,000 per excess discharge, an amount that is dramatically higher than the revenue from an admission.

Hospitals' readmission rates and penalties are positively correlated with their low-income patient share. This puts hospitals that treat a large share of low-income patients at a financial disadvantage under the current program.

PSI-90
In October 2014, CMS began using Patient Safety for Selected Conditions (PSI-90) as a core metric in both the Hospital-Acquired Condition (HAC) Reduction program and the hospital Value-Based Purchasing (VBP) program. PSI-90 is a composite measure consisting of eight weighted component PSI measures. In the HAC Reduction program, PSI-90 is responsible for 35 percent of the overall score, and the poorest-performing hospital quartile will have their Medicare payments reduced by up to one percent. In the hospital VBP program, CMS reallocates 1.5 percent (FY2015) of the base Medicare payments to hospitals according to their overall score, 30 percent of which is composed of PSI-90 and four other outcome measures.

We do not believe the PSI-90 measure is reliable and urge CMS to phase PSI-90 out of both programs altogether. The PSI-90 composite measure includes components such as postoperative venous thromboembolism (VTE) for which measurement is easily flawed due to surveillance bias. In addition, many of the component measures under PSI-90 are counted multiple times in the VBP and HAC programs. Other criticisms of PSI-90 include its failure to adequately measure clinically relevant complications and adequacy of the risk adjustment.

Quality reporting and ICD-10

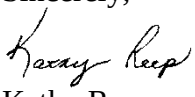
The FHA is concerned that CMS has yet to articulate a plan for calculating VBP scores affected by the transition from ICD-9 to ICD-10. Hospitals are required to use ICD-10 for diagnosis and inpatient procedure reporting beginning October 1, 2015. We are concerned that CMS has both finalized and proposed VBP baseline and performance periods that mix performance data collected using both ICD-9 and ICD-10 codes. CMS should engage stakeholders quickly in order to develop a plan to address the potential unintended consequences of combining measure data collected under the two code sets.

ICD-10 coverage determination policies

With the October 2015 adoption of ICD-10, it is imperative that CMS complete the translation and posting of all policies and edits related to systems referencing diagnosis and procedure codes, such as Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs). Providers need this information promptly in order to update their systems, allow for testing, training, financial analysis and financial planning.

The FHA appreciates the opportunity to provide these comments for consideration in finalizing the IPPS rule for FY2016. If there are questions, please do not hesitate to contact me at kathyr@fha.org.

Sincerely,



Kathy Reep
Vice President/Financial Services