May 20, 2013

Patrick Conway, M.D.
Chief Medical Officer
Director, Center for Clinical Standards and Quality
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Impact of Hurricane Sandy on Hospital Quality Reporting Programs

Dear Dr. Conway:

We are writing on behalf of our member institutions in New York, New Jersey and Connecticut affected by Hurricane Sandy, which hit the east coast in late October 2012, to provide additional information about the nature, scope and timing of the impact of the storm and how that relates to specific Centers for Medicare & Medicaid Services (CMS) hospital quality reporting and payment programs.

First, we applaud CMS's waiver of data submission and validation requirements for the Inpatient Quality Reporting (IQR) and Outpatient Quality Reporting (OQR) programs in federally designated major disaster counties. This disaster waiver provides hospitals with greater flexibility to direct resources toward caring for patients who suffered during the hurricane, as well as toward internal disaster recovery efforts. They also will enable hospitals to continue delivering high-quality care to the patients and communities that depend on them.

However, the storm has impacted other CMS quality reporting and payment programs, including the Inpatient Psychiatric Facility Quality Reporting (IPFQR) program, the Hospital Readmission Reduction Program (HRRP), the Hospital Acquired Condition (HAC) Payment Reduction Program, and the Medicare Electronic Health Record (EHR) Incentive Program. Our members also have voiced significant concerns about the impact of the storm on their scores on the Hospital Consumer Assessment of Healthcare Systems and Providers (HCAHPS) survey, and their performance in the value-based purchasing (VBP) program. Without changes to take into account the impact of the storm, hospitals in affected areas face an undue burden of data reporting and collection, as well as the potential for their performance to be unfairly reported and penalized.

We urge CMS to consider additional relief for hospitals impacted by Hurricane Sandy in federally designated major disaster areas. We have outlined below a number of specific recommendations and the rational for each. **While these recommendations are specific to the impacts of Hurricane Sandy, we believe <u>all</u> federal quality reporting and payment programs should include fair, consistent waiver mechanisms to ensure hospitals do not suffer undue data reporting burden, or reputational and financial penalties due to natural disasters and other extraordinary circumstances beyond their control.** We are pleased that CMS proposes waiver processes for several programs in the FY 2014 Inpatient Prospective

Payment System/Long-Term Care Hospital Prospective Payment System (IPPS/LTCH PPS) proposed rule. We look forward to submitting formal comments on each proposal, and are eager to work with you to inform and expand upon the agency's quality reporting and payment waiver development efforts.

With respect to hospitals affected by Hurricane Sandy, we recommend the following:

- **CMS should waive the fiscal year (FY) 2014 data reporting requirements for the IPFQR program.** Instead, CMS should only require that those hospitals complete administrative set-up requirements, such as registering on QualityNet, and completing a Notice of Participation.

- **CMS should suppress the reporting of readmission rates for storm-affected hospitals on *Hospital Compare* for the first two quarters of FY 2013 (Oct. 1, 2012 – March 31, 2013).** Hospitals were focused on meeting pressing disaster response needs in the periods immediately before and after the storm, which occurred in October 2012. Moreover, post-discharge resources normally relied upon to help reduce readmissions were greatly compromised by the hurricane. For these reasons, measure performance in this period is likely aberrant, and should not be publicly reported. We also recommend that CMS annotate the data displays for affected hospitals on *Hospital Compare* to indicate the non-reporting is due to the impact of the storm.

- **For storm-affected hospitals, CMS should exclude discharges from the first two quarters of FY 2013 (Oct. 1, 2012 – March 31, 2013) from future calculations of payment reductions in the HRRP.**

- **Moreover, CMS should conduct an analysis of readmissions data to ensure that, after excluding data from the first two quarters of FY 2013, there is an adequate sample to fairly calculate penalties for storm-affected hospitals. If this assessment shows bias in the scores, then CMS should exempt storm-affected hospitals from the HRRP during fiscal years that include readmissions data from the first two quarters of FY 2013.** Given that performance for these hospitals during the time period may not be representative, it would be unfair to use data from the time of the storm and subsequent recovery efforts to calculate a payment penalty.

- **For storm-affected hospitals, CMS should consider excluding discharges from the first two quarters of FY 2013 from future calculations of HAC rates, as well as any payment penalties in the HAC Payment Reduction Program mandated by the *Patient Protection and Affordable Care Act* (ACA).** While measures have not yet been finalized for future fiscal years, we are concerned that the storm may have caused substantial deviations in performance and limited staff's ability to appropriately note what was present on admission.

- **CMS should suppress the reporting of HCAHPS scores for the first two quarters of FY 2013 (Oct. 1, 2012 – March 31, 2013) on *Hospital Compare* for any storm-**

affected hospitals that have submitted HCAHPS data. While HCAHPS reporting in this time period was waived, those storm-affected hospitals that chose to resume reporting as quickly as they could have observed aberrantly lower scores. Hospitals should not be exposed to reputational damage for coping with a disaster.

- **For storm-affected hospitals, CMS should conduct an assessment of VBP scores for FYs 2014 and 2015 to determine whether they are lower than expected, and consider adjustments to scores, if necessary.** Both fiscal years have performance periods that coincide with the onset and subsequent recovery period from the storm. We believe this analysis will prevent hospitals from being unfairly penalized for factors beyond their control.

- **We urge CMS not to withhold Medicare EHR Incentive Program payments to storm-affected hospitals for the reporting periods that include Oct. 1, 2012 through March 31, 2013.**

INPATIENT PSYCHIATRIC FACILITY QUALITY REPORTING PROGRAM

IPFQR-participating hospitals are required to collect data from and report on discharges from Oct. 1, 2012 through March 31, 2013, to qualify for a full marketbasket update in FY 2014. This reporting period is concurrent with the onset of the storm and with subsequent disaster recovery efforts. **Thus, we propose that CMS require hurricane-affected hospitals to complete only the initial administrative requirements of the program, including registering on QualityNet, and completing a notice of participation to qualify for the FY 2014 payment update.** In addition to alleviating an undue burden to hospitals that are working tirelessly to fully restore services, there are several other justifications for a disaster waiver.

CMS has the regulatory authority to grant disaster waivers to hospitals participating in the IPFQR program. The FY 2013 IPPS final rule enables CMS to grant extensions or complete waivers of IPFQR program reporting requirements to hospitals that request them due to extraordinary circumstances, such as natural disasters. The final rule also authorizes CMS to grant waivers or extensions to hospitals participating in the IPFQR "… that have not requested them when [CMS] determine[s] that an extraordinary circumstance … affects an entire region or locale."[1] CMS already has recognized the geographic extent of Hurricane's Sandy's impact by granting the IQR and OQR reporting waivers under similar authority. Thus, we believe a waiver for the IPFQR is consistent with actions that CMS already has taken to assist hospitals in the affected area.

Moreover, the IPFQR program began on Oct. 1, 2012, providing little time for storm-affected hospitals to ready their resources to meet new requirements. The FY 2013 IPPS proposed rule, issued in May 2012, was the first formal communication from CMS that the

[1] Published in the August 31, 2012 *Federal Register* (Information for the Inpatient Psychiatric Facility Quality Reporting Program begins on page 53644), available at: http://www.gpo.gov/fdsys/pkg/FR-2012-08-31/pdf/FR-2012-08-31.pdf.

IPFQR program would begin with Oct. 1, 2012, discharges. Initiating any new quality reporting program, particularly one using measures requiring chart abstraction, requires a significant commitment of time and resources from participating hospitals. **The data collection period for the IPFQR measures began only weeks before the hurricane struck.** Hospitals in the disaster area must carefully balance their available resources between recovery and continuing operations. A reporting waiver would relieve an undue reporting burden.

Finally, the storm had a far-reaching impact on the psychiatric care provided by hospitals, and their ability to collect accurate data. In New York City, for example, the storm caused several psychiatric facilities to close or stop accepting new patients. Patients sent to shelters often lost access to psychiatric medications crucial to managing symptoms. Patients also presented to hospitals without their medical records, making it much more difficult for hospitals to use a patient history to guide treatment decisions. Outpatient services, and other community resources, such as caseworkers, were also severely impacted by the storm, taking away vital resources normally available to psychiatric patients with their care. Finally, this disruption of services compromised the ability of facilities to collect accurate data from that time period. Given all of the issues outlined above, we believe a waiver of data submission requirements for the IPFQR program is appropriate.

READMISSIONS: REPORTING OF RATES AND USE OF DATA IN THE HOSPITAL READMISSION REDUCTION PROGRAM

Readmission rates are calculated and reported at the hospital level for the IQR and HRRP. However, performance on readmissions is influenced by a variety of factors that span the care continuum, including in-hospital discharge planning and care coordination, post-acute facility care, outpatient physician management, and the availability of community-based resources like home health agencies and pharmacies. Medicare reimbursement for FY 2013 is not affected by readmissions occurring prior to and after the storm. However, future public reporting in the IQR, and payment penalties assessed through the HRRP, are likely to include those time periods.

We recommend that CMS suppress the reporting of rates for patients admitted or readmitted during the first two quarters of FY 2013 (Oct. 1, 2012 – March 31, 2013) on *Hospital Compare*, providing an annotation on the website indicating the reason rates were not reported. We also strongly urge CMS not to use data from that same time period in calculating any future readmissions penalties for storm-affected hospitals.

We also are concerned that the exclusion of data from the first two quarters of FY 2013 may result in biased scores for storm-affected hospitals since they would have a smaller data sample than other hospitals. **Given the financial impact of the HRRP, we recommend that CMS conduct an analysis of readmissions data to ensure that, after excluding data from the first two quarters of FY 2013, there is an adequate sample to fairly calculate penalties. If this assessment shows bias in the scores, then CMS should exempt storm-affected hospitals from the HRRP during fiscal years that include readmissions data from the first two quarters of FY 2013.**

Readmission rates for storm-affected hospitals reported immediately before and after the storm, as well as during subsequent recovery efforts, are unlikely to represent the normal quality of care, and would not fully reflect the circumstances under which care was provided. **Storm-affected hospitals have reported extraordinary but necessary deviations from normal in-hospital care processes so that they could meet disaster response needs.** Consistent with Office of Assistant Secretary for Preparedness and Response (ASPR) guidance on hospital emergency preparedness, hospitals activated disaster response plans that, in part, prepared them to receive a surge of patients with storm-related injuries.[2] Such hospital plans often call for patients to be discharged as early as it is safe to do so in order to free up inpatient bed capacity. Many storm-affected hospitals reported that they needed to discharge patients earlier than they normally would. While this was appropriate under the extraordinary circumstances, these early discharges increased the risk of readmission for many patients.

In spite of the steps taken to free up capacity, hospitals faced incredible challenges in managing patient volumes during and following the storm. Patients were often moved into acute care hospitals from other acute hospitals and post-acute care facilities whose infrastructure and staffing was no longer functioning. The volume pressures of one New York hospital, which normally has an inpatient census of 330 patients, and a nursing home census of 570 patients, vividly illustrates this point. On Oct. 28, it accepted 57 hospital patients and 35 nursing home patients from closed facilities. By Nov. 3, the hospital's census swelled to 546 inpatients, and 600 nursing home patients, well over licensed capacity and normal census. The capacity issues persisted for weeks after the storm, and by Nov. 11, the hospital census peaked at 560 inpatients, and 620 nursing home patients. A Connecticut hospital reported similar issues when it accepted the 60 hospice patients, their families and providers into its facility from an inpatient hospice facility closed due to the storm. While stretching resources to care for these extra patients, storm-affected hospitals had to curtail some functions such as expanded discharge planning and post-discharge outreach to patients.

Further, the care and resources normally available to patients that reduce the likelihood of readmissions were severely compromised by the storm. For example, visits to primary care physicians, as well as in-home visits from home health agencies often help patients manage any post-discharge issues without a return to the hospital. But in several areas, electricity was out for weeks after the storm. Transportation also was severely disrupted, with many roads blocked and public transportation unavailable, as well as severe shortages of gasoline. This made it difficult for recently discharged patients to get to scheduled physician appointments, and for home health agencies to reach patients for needed care.

Adequate access to medication also is an essential component of post-discharge care that reduces the likelihood of readmissions. However, many pharmacies were closed due to lack of power or staff available to operate them. Hospitals did what they could to mitigate these effects. One New Jersey hospital, for example, deployed a mobile satellite emergency department that helped

[2] "The capability to handle a "Medical Surge" is one of several required capabilities for hospitals receiving federal emergency preparedness funds. For additional information, see *Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness*, January 2012. The document can be accessed at: http://www.phe.gov/Preparedness/planning/hpp/reports/Documents/capabilities.pdf.

many patients secure needed medications. Many other patients in the region had no other choice but to go to hospitals to treat conditions normally managed by medications. For example, a New York hospital treated a diabetic patient who did not have medication normally available to him.

Post-acute care at nursing homes and long-term care hospitals also can reduce hospital readmissions. However, the capacity of these facilities was severely strained by infrastructure damage, as well as overcrowding. One Long Island nursing home was so crowded that it had to house 50 patients in a cafeteria. Additionally, the State of New York issued a statewide moratorium on hospitals discharging patients to long-term care facilities from Oct. 29 – Nov. 2. This temporary ban meant that even an acute hospital physically connected to a post-acute facility could not discharge patients to that facility.

Taken together, the factors outlined above make readmission rates calculated for storm-affected hospitals inappropriate to use in quality reporting and payment programs. CMS already has exercised waiver authority for the IQR and OQR programs. **We also believe that the ACA provides enough flexibility for CMS to adjust the time periods used for reporting and penalty calculations in the HRRP.** Indeed, section 3025 of the ACA states that the "the term 'applicable period' means, with respect to a fiscal year, *such period as the Secretary shall specify*."[3] We believe the Secretary is thus empowered to identify the applicable period for the Sandy affected hospitals, and this period should not include readmissions during the storm and its aftermath.

HOSPITAL ACQUIRED CONDITION PAYMENT REDUCTION PROGRAM

For storm-affected hospitals, CMS should consider excluding discharges from the first two quarters of FY 2013 from future calculations of HAC rates, as well as any payment penalties in the HAC Payment Reduction Program mandated by the ACA. Section 3008 of ACA also instituted the HAC payment reduction program, which reduces Medicare payments to hospitals scoring in the top quartile of HAC measures by 1 percent beginning in FY 2015. CMS has not finalized the measures or the reporting periods it will use in the program, but we anticipate that discharges immediately before and following the storm will be included. Similar to the HRRP, we are concerned that storm response and recovery efforts may lead to aberrant performance. Using data from the first two quarters of FY 2013 may result in unfair penalties being assessed on storm-affected hospitals.

Similar to the HRRP, we also believe that the ACA provides enough flexibility for CMS to adjust the time periods used for reporting and penalty calculations in the HAC program. Indeed, section 3008 of the ACA states that the "the term 'applicable period' means, with respect to a fiscal year, *such period as the Secretary shall specify*."[4]

[3] Emphasis added. See Affordable Care Act text at: http://www.gpo.gov/fdsys/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf.
[4] Emphasis added. See Affordable Care Act text at: http://www.gpo.gov/fdsys/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf.

THE IMPACT OF THE STORM ON HCAHPS SURVEY SCORES

Storm-affected hospitals made many efforts to create as comfortable and welcoming an environment during and after the hurricane as the circumstances permitted.

The emergency circumstances made it difficult for hospitals to control and address all of the factors contributing to a positive patient experience. Patient care areas were likely noisier than normal due to high patient censuses. Hospitals that were over capacity had less time to communicate information about care. Health care providers also were dealing with the devastating impact of the storm to their own homes, neighborhoods and loved ones. Thus, HCAHPS scores from the periods during and after the storm are likely to be aberrant.

Therefore, we recommend that CMS suppress the reporting of HCAHPS scores for storm-affected hospitals on *Hospital Compare* for the first two quarters of FY 2013 (Oct. 1, 2012 – March 31, 2013). CMS also should include an explanation on *Hospital Compare* noting that the data are not being reported due to the effects of the storm. Storm-affected hospitals received a reporting waiver, but many of our members have continued to submit data. Those hospitals should not be exposed to undue reputational damage from public reporting.

Preliminary data from several institutions bears out the concern about abnormal HCAHPS performance scores. For example, a New Jersey health care system reported that its overall satisfaction score of 74.8 percent in July – September 2012 dipped to 65.1 percent in October-December 2012. One hospital in the system was especially impacted as it is located in an area where many trees were downed, and the hospital was on emergency generator power for an extended period of time. That hospital went from an overall satisfaction score of 63.6 percent one month pre-Sandy to 53.2 percent for the month post-Sandy. A unit at another hospital whose overall satisfaction scores had been in the 99th percentile of its comparison group for the eight consecutive quarters before Hurricane Sandy dipped to the 89th percentile in the 4th quarter of 2012.

THE IMPACT OF THE STORM ON VBP SCORES

For storm-affected hospitals, CMS should conduct an assessment of VBP scores for FYs 2014 and 2015 to determine whether they are lower than expected, and consider adjustments to scores, if necessary. We believe this will prevent hospitals from being unfairly penalized for factors beyond their control. Hospitals have at least one quarter of data in the performance periods for each fiscal year that may be influenced by the effects of the storm—discharges in July – December 2012 for FY 2014 VBP scores, and January – March 2013 for FY 2015 VBP scores.

We noted above our concerns about HCAHPS scores, which comprise 30 percent of a hospital's Total Performance Score in FYs 2014 and 2015. We continue to assess the impact of the storm to other key quality measures, and believe that many of them also may be affected by the storm and its aftermath.

Under the existing IQR reporting waiver, storm-affected hospitals do not need to report quality measure scores from the 3rd and 4th quarters of 2012. If hospitals choose not to submit data, then those quarters are effectively excluded from the calculation of a VBP score. However, this also means fewer overall cases will be used in CMS's calculations, which may result in biased or lower than expected scores.

With the benefit of all of the performance period data, CMS will be able to fully assess the impact of the storm on VBP scores, and take steps to mitigate the burden of any financial penalties.

THE IMPACT OF THE STORM ON THE MEDICARE EHR INCENTIVE PROGRAM

We urge CMS not to withhold Medicare EHR Incentive Program payments to storm-affected hospitals for the reporting periods that include Oct. 1, 2012 through March 31, 2013. The wide-reaching impacts of the storm severely compromised the ability for hospitals to fully comply with program requirements. We are concerned that hospitals that would have otherwise qualified for incentive payments may lose them because of factors beyond their control.

The Medicare EHR Incentive Program ties hospital incentive payments to meeting specific objectives of Meaningful Use of EHRs. Each program objective has an associated measure used to determine whether a hospital has met the objective and, therefore, the requirements of the program. For example, hospitals must report on quality measures generated by EHRs. They also must record medication allergy information on at least 80 percent of all admitted patients as structured data. Generally, hospitals are required to meet the program objective measures during the entire reporting period.

However, storm-affected hospitals faced significant challenges in continuously meeting program requirements during and after the storm. As demonstrated in the preceding discussion, the physical infrastructure and systems of storm-affected hospitals were severely compromised by the storm, requiring considerable time and resources to fully restore. EHRs rely on that infrastructure, and in many cases, their operation was disrupted.

Moreover, even if EHRs were able to operate during and after the storm, the emergency circumstances of the storm still made it difficult to meet the targets of all program measures. Hospitals faced incredible volume pressures during and after the storm, making it significantly more difficult to collect complete patient data. Hospitals were challenged, for example, to meet the program objectives for recording smoking status and patient demographic data in EHRs. With such high patient volumes, and so many systems being stretched to their limits, hospitals could not place the same priority on meeting program objectives as they normally would.

CONCLUSION

As the prevalence of quality reporting and payment programs continues to increase, the hospital field is learning about the impact of natural disasters on those programs. We look forward to

working with CMS to further develop fair and consistent quality reporting waiver mechanisms in all relevant federal programs. This will ensure that hospitals have the flexibility to direct resources toward caring for patients who suffered during disasters, as well as toward internal disaster recovery efforts.

Thank you for considering this request. Please contact Akin Demehin, AHA senior associate director of policy, at ademehin@aha.org or (202) 626-2365 if you have any additional questions.

Sincerely,

/s/

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/s/

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/s/

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