American Hospital Association

800 10th Street, NW
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100 Phone
www.aha.org

December 18, 2014

The Honorable Kevin Brady
Chairman
U.S. House Committee on Ways and Means, Subcommittee on Health
1135 Longworth House Office Building
Washington, DC 20515

Re: Hospital Improvements for Payment Act of 2014 Discussion Draft

Dear Chairman Brady:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and 43,000 individual members, the American Hospital Association (AHA) is pleased to respond to your request for comments on your discussion draft of the "Hospital Improvements for Payment Act of 2014" (HIP). Thank you for seeking our input.

The proposals in this discussion draft are deserving of serious and thoughtful consideration and discussion. While we support some proposals in the discussion draft, others raise significant concerns or need clarification or modification. At the same time, we strongly object to any reduction in hospital payments to pay for any of the provisions in the discussion draft.

The AHA appreciates the Committee's attempt to offer a solution to the vexing issues related to patient status determinations, the two-midnight policy and the overwhelming number of claims trapped in the appeals process. We support several elements of the Committee's proposed short-stay payment solution: the repeal of the 0.2 percent payment reduction associated with the two-midnight policy; the continued enforcement delay of the two-midnight policy for an additional six months and the more limited enforcement delay until fiscal year (FY) 2020; and a transition period for developing a short-stay payment solution.

The Committee has responded positively to our members' concerns relating to extension of the moratorium on enforcement of the direct supervision requirements for outpatient therapeutic services furnished in critical access hospitals (CAHs) and small rural hospitals with fewer than 100 beds; the 96-hour condition of payment for CAHs; and the incorporation of an adjustment for sociodemographic factors in the Hospital Readmissions Reduction Program.

Notwithstanding our support of these provisions, the AHA is extremely concerned that the proposed short-stay payment solution is complex, confusing and administratively burdensome.

We do not understand completely how some of the elements of the payment solution fit together. Moreover, the proposed reforms of the Recovery Audit Contractor (RAC) program fall far short of what will be necessary to reduce excessive and inappropriate denials by RACs and alleviate the administrative and financial burden the RAC program imposes on hospitals and the administrative appeals process. We urge the Committee to consider additional fundamental RAC program reforms. In addition, we strongly oppose the proposal to weaken significantly the moratorium on physician-owned hospitals.

Our detailed comments on the discussion draft are attached. We look forward to continuing to work with the Committee as it refines and revises the discussion draft, which addresses issues of importance to both hospitals and the Medicare program.

If you have any questions, please feel free to contact me or Priya Bathija, senior associate director, policy, at (202) 626-2678 or pbathija@aha.org.

Sincerely,

/s/

Rick Pollack
Executive Vice President

TITLE I: HOSPITAL PAYMENT AND QUALITY PROVISIONS

Title I of the discussion draft addresses issues related to patient status determinations, the two-midnight policy, the Recovery Audit Contractor (RAC) program and the broken and overwhelmed appeals process. We appreciate the Committee's attempt to tackle this complicated set of related issues and support some of the proposed solutions. We note a number of inconsistencies in the bill language and the section-by-section description, which we will not comment on here. Below we outline our concerns with the discussion draft and describe alternatives that our members believe may offer a better solution.

Short-Stay Payment Methodology
The discussion draft includes three separate short-stay payment provisions. These include a new, site-neutral hospital prospective payment system (HPPS), initially applicable to both short-stay inpatient cases and overnight outpatient observation services, to be implemented by fiscal year (FY) 2020; an interim (transitional) payment provision for short-stay cases from FY 2016 through FY 2019; and a permanent short-stay per diem payment provision in the existing inpatient prospective payment system (IPPS) beginning in FY 2016.

The AHA is generally supportive of the concept of a carefully structured budget-neutral short-stay payment (SSP) policy. We appreciate the Committee's attempt to address this issue. **While the AHA supports some elements of the Committee's proposed short-stay payment solution, we oppose others and believe the Committee's solution is confusing, needs further clarification and detail, and would impose a significant regulatory burden on hospitals.**

<u>Hospital Prospective Payment System</u>
Sec. 101(b) creates the HPPS, a third and separate site-neutral prospective payment system that would apply to both short-stay inpatient cases and overnight outpatient observation services. The HPPS would begin on Oct. 1, 2019 (FY 2020). The Medicare Payment Advisory Commission (MedPAC) would be directed to report on extending the HPPS to additional inpatient and outpatient services.

The AHA strongly believes that hospitals must be appropriately and adequately reimbursed for the care they provide to beneficiaries and we have explored the design of a SSP policy to supplement the existing two-midnight policy. A carefully structured SSP policy could alleviate some problems regarding beneficiary cost-sharing. Recently, the AHA membership crafted eight guiding principles to be used as a framework for evaluating proposed SSP policies. We use these principles to evaluate the proposal in the discussion draft:

1. The SSP policy should provide more appropriate and adequate reimbursement for medically necessary inpatient services that span less than two midnights – payment should be higher than the outpatient PPS rate for the service, but should not exceed the applicable full inpatient diagnosis-related group (DRG) payment;

2. The SSP policy should not apply to those procedures on the "inpatient-only" list, regardless of the length of stay;

3. The SSP policy should be budget neutral;

4. The SSP policy could be designed similarly to the Centers for Medicare & Medicaid Services'(CMS) longstanding transfer policy, which reimburses hospitals at a graduated per-diem rate, instead of a full DRG payment rate, to approximate the reduced costs of transfer cases; (Note: further AHA analysis of how a "transfer-like" policy might work for payment of short-stay cases has shown it has several weaknesses and is no longer a viable option.)

5. Under the SSP policy, hospitals should be eligible for all add-on payments they would otherwise receive (e.g., Medicare indirect medical education (IME) payments and disproportionate share hospital payments (DSH)) on a pro-rata basis;

6. Beneficiaries requiring short inpatient hospital stays reimbursed under the SSP policy should be considered inpatients and cost-sharing obligations should be calculated under Medicare Part A;

7. The SSP should be developed in a way that would not increase administrative burden for hospitals, physicians or other medical providers; and

8. CMS should provide clear and consistent guidance and allow adequate time for hospitals to implement the SSP policy prior to its effective date.

The AHA questions the need to establish a third, separate and entirely new payment system for short-stay inpatient cases and overnight observation services. Operational complexity and reporting burdens abound. The draft requires hospitals to submit two separate claims (both inpatient and outpatient) for each short-stay case during FY 2016 so that blended rates can be calculated for the new system. We note the technical difficulty of combining two very different and already complex payment systems. For example, the outpatient PPS rates include capital and operating costs while payments under the IPPS include only operating costs. It is unclear from the draft how the blended rates will be calculated. How IME and DSH payments will be accounted for in creating the blended rates is not clear given that the bill eliminates separate payment for them under the HPPS, but they are not affected by the interim payment methodology for FY 2016 through FY 2019.

The AHA commends the Committee for several aspects of its proposal. We agree that clarifying the inpatient status of beneficiaries who receive services is sorely needed. Under the HPPS, short-term hospital stays, including overnight outpatient observation stays, would be treated as inpatient hospital services for purposes of payment and calculating beneficiary deductibles and cost-sharing. The AHA also appreciates a four-year transition period to a different way of paying for short-stay cases. We learned from the implementation of the two-midnight policy that CMS

needs to provide clear and consistent guidance to the hospital field prior to the effective date of such a significant change in payment policy. Doing so would allow the agency to avoid many of the problems and pitfalls it faced with implementation of the two-midnight policy.

We believe the HPPS is far more complicated than other alternatives. For example, MedPAC has modeled a short-stay policy that does not add new structures to the current system. Another alternative is the concept of DRG refinement. Under this method, using CMS's current methodology, two separate sets of DRG weights could be created – one for short stay cases, or cases having a stay of strictly less than two days, and one for non-short-stay cases.

The discussion draft includes a complex, three-part definition for short-term hospital stays that combines inpatient and outpatient services – thereby establishing a "site-neutral" payment system. Specifically, the discussion draft defines a short-term hospital stay as an inpatient short-term hospital discharge or overnight hospital outpatient services (outpatient services with an observation stay of more than 24 hours). Inpatient short-term hospital discharge is then defined as the following: (1) having an actual length of stay less than three days; (2) classified to a Medicare Severity Diagnosis-Related Group (MS-DRG) that has a national average length of stay that is less than three days; and (3) classified to a MS-DRG that is among the most highly ranked discharges that have been denied for reasons of medical necessity by RACs. The Secretary also has the ability to raise the three-day threshold (for an individual and national average length of stay), if justified.

The draft's HPPS proposal fails to provide add-on payments, such as IME and DSH, to hospitals that incur the associated costs on a pro-rata basis. The discussion draft indicates IME and DSH payments for the HPPS would be built into the base rate payment for the HPPS, but hospitals would not receive separate payment adjustments for IME and DSH. We believe those payments should be linked proportionately to those hospitals incurring the indirect costs associated with operating graduate medical education programs and caring for low-income patients. It also is unclear how IME and DSH payments are treated in calculating the blended rate. **The AHA strongly opposes a payment mechanism that does not distribute IME and DSH payments – or other add-on payments – to the hospitals that currently receive them under the IPPS.**

The discussion draft requires the creation of a new and separate area wage adjustment that would go into effect in FY 2020 with the implementation of the HPPS. This new area wage index (AWI) would be calculated based on the surveys of pay localities for the Employer Cost Index (wages and salaries, private industry workers) published quarterly by the Bureau of Labor Statistics (BLS data). The Secretary is strictly prohibited from creating wage floors or reclassifying hospitals into another pay locality for purposes of the HPPS.

The AHA has significant concerns with the creation of a new AWI for the HPPS. Another wage index simply adds to the complexity of the payment system. Over the years, hospitals have expressed concerns that the AWI in the existing IPPS is greatly flawed in many respects. We believe the Committee's proposal to create a separate HPPS AWI, with no wage floors or reclassifications, would result in a second, equally flawed AWI.

In July 2011, the AHA Board of Trustees created the Medicare AWI Task Force to lead an in-depth examination of the AWI from the hospital field's perspective. After lengthy consideration, the Task Force ultimately decided against recommending the use of BLS data. While several members found the use of BLS data promising, others were very concerned about the use of BLS data. They felt that hospital employers differ from the universe of all employers in terms of the wage levels necessary to recruit and retain qualified health care employees, the percentage of compensation paid in benefits, the likelihood of unionization and other factors that might affect compensation rates for some types of employees. They also were troubled by the fact that the BLS survey is voluntary and a sample of employers, not a census of all employers, and that the data was not fully transparent.

The AHA strongly opposes the dual submission of claims, which imposes a substantial burden on hospitals. To build the new HPPS, which would include inpatient cases and overnight outpatient observation services (as currently defined), the discussion draft requires hospitals to submit two separate claims for each short-term hospital stay during FY 2016. This would drastically increase administrative burden for hospitals. Currently, two distinct and vastly different code sets exist for hospital procedure coding: ICD-9-CM volume 3 for inpatient services (scheduled to be replaced by ICD-10-PCS starting FY 2016) and CPT/HCPCS for hospital outpatient services. Coding the same short-term hospital stay with both ICD-10-PCS and CPT/HCPCS is not an easy or automated process and requires double the procedure coding work that hospital coders already do. Our members tell us that even with the assistance of automated tools such as encoders, coders would need to review individual operative reports for different concepts and terminology that may impact code selection in one code set, but not the other.

In addition, the AHA opposes RAC audits to determine whether a hospital has complied with the dual-submission requirement. The committee proposes awarding RACs a fee of 10 percent of the hospital payment for claims in which they determine the hospital did not meet the requirement. This contingency fee – which would be, in some cases, greater than the percentage current RACs receive for a claim denial based on a full complex medical review – would allow RACs to capitalize on the complexity of dual coding while reducing hospital payments for medically necessary services.

We question whether an accurate viable crosswalk, as mandated in the discussion draft, can be developed. The creation of a crosswalk will be difficult and result in "approximate" maps with many concepts existing in one code set but not in other code sets. CPT and ICD-10-PCS codes are significantly different in terms of structure, terminology and foundational principles. For example, while current procedural terminology (CPT) may have different codes to distinguish differences in physician work; ICD-10-PCS codes focus on differences in the objectives of a procedure. Additionally, we are concerned that these crosswalks will be used to bolster future ill-advised site-neutral payment proposals in Congress. The AHA does not support such proposals because they do not recognize the costs that hospitals incur to support their requirements to provide services to their patients and communities.

The AHA also notes clarifications are needed on a number of issues:

- There is no language in the discussion draft that ensures the payments for the short-term hospital stays under the HPPS will exceed those payments currently available under the outpatient PPS for those services. The Committee should include explicit language in the discussion draft ensuring that the new blended rate must exceed the outpatient payment rate.

- The discussion draft does not specifically identify how services and procedures on the "inpatient-only" list would be treated after development of the HPPS. The AHA recommends, consistent with current policy, that these procedures be excluded from the definition of a "short-term hospital stay," and continue to be paid under the IPPS.

- The discussion draft and conversations with Committee staff have provided mixed messages regarding budget neutrality for all of the policies it has proposed. The Committee should include explicit language to clarify that the new HPPS would be budget neutral to both the IPPS and outpatient PPS.

- Committee staff has implied that the discussion draft intends to eliminate the two-midnight policy upon establishment of the HPPS in FY 2020. If that is the case, the Committee proposal should include explicit legislative language ending the two-midnight policy starting in FY 2020 and for subsequent years.

- Sec. 101 does not apply to critical access hospitals (CAHs), which also are required to comply with the two-midnight policy, but not paid under the IPPS or outpatient PPS. We ask the Committee to exempt CAHs from compliance with the two-midnight policy.

<u>Transitional Payment Structure</u>
Beginning Oct. 1, 2015, Sec. 101(c) establishes a transitional payment structure for short-stay inpatient cases. The transitional payment structure will be in place until the HPPS is established in FY 2020.

The discussion draft requires the Secretary to establish an inpatient short-term payment pool to fund payment of these short-stay inpatient cases in FY 2016 through FY 2019. The specific amount in the pool is not set in the discussion draft, but for any given year, is described as an amount equal to not less than "X" percent and not greater than "Y" percent of the payments made under subsection (d) in the fiscal year which is two years prior to the year of application. The percentage will then be set to achieve a reduction in payments equivalent to "Z" percent. To calculate the payment rate for short stay cases during the transition, the Secretary is required to determine an inpatient short-term adjustment factor to the base operating DRG payment amount for each year. This factor will be computed so that total payments for short-stay inpatient cases under the transitional payment structure will be equal to the inpatient short-term payment pool. The Secretary is directed to adjust the amount in the inpatient short-term payment pool for any

year if the aggregate amount of payments made for inpatient short-term hospital discharges in the preceding fiscal year exceeded or fell short of the amount in the short-term payment pool for that year.

These details are not sufficient for the AHA to analyze fully and provide comment on the transitional payment structure. The Committee appears to create a pool for short-stay cases that is similar to the outlier mechanism in the existing hospital IPPS. However, we do have the following concerns:

- The levels of X, Y and Z factors are not specified in the draft bill. We are concerned that the level of Z could be set at a level that improperly reduces payments to hospitals.

- There is confusing language in the discussion draft relating to how IME and DSH payments will be made in the transitional payment structure. The draft indicates that the transitional payment structure will not interfere with aggregate payment adjustments made for IME and DSH payments. The AHA seeks clarity on this issue. The AHA strongly believes it is essential that these add-on payments continue to be linked proportionately to those hospitals incurring the indirect costs associated with graduate medical education programs and caring for low-income patients.

- **The AHA vigorously opposes any attempt to create a short-stay policy that reduces overall payments to hospitals for any purposes.** Committee staff has indicated that during the transitional period, the funding removed from the IPPS for short-term hospital stays will be utilized to fund payments for short-term hospital stays *and* the provisions set forth in Title II of the discussion draft.

<u>Per Diem Payment Structure</u>
Sec. 102 adds a new paragraph (14) to Section 1886(d) as a permanent feature of the current IPPS beginning Oct. 1, 2015. This new paragraph (14) would establish a per diem payment for unusually short-stay inpatient cases other than those that are included in the definition of inpatient short-stays for purposes of the HPPS or the transitional FY 2016 through FY 2019 payment methodology. This per diem rate would be defined as 80 percent of each base operating DRG and would be reimbursed in a way that ensures payment for the first two days of any discharge is at a higher rate than other days within the discharge.

The AHA fails to understand the rationale for a permanent per diem payment mechanism and how it integrates with the transitional payment methodology and the HPPS. The language in the discussion draft needs clarification. However, we suspect the purpose of this payment is to create an "inlier" payment for unusually short-stay cases. A basic principle of the IPPS, based on the DRG classification system, is to account for variation in length of stay and patients' resource use, so that on average hospitals experience losses on caring for some patients and gains on others. If the purpose of an inlier payment is to improve payment equity, then the inlier payment must be budget neutral (not 80 percent of the DRG) to the payment system. It appears that the

sole reason for including this per diem payment structure in the discussion draft is to reduce payments to hospitals arbitrarily. **The AHA does not support any short-stay payment methodology that would reduce payments to hospitals improperly. Accordingly, we believe that Sec. 201 should be eliminated from the discussion draft.**

Two-Midnight Enforcement Delay

The AHA supports the continued enforcement delay of the two-midnight policy for an additional six months and the more limited enforcement delay until FY 2020, as set forth in the discussion draft.

Repeal of the Two-Midnights Payment Reduction

The AHA supports the repeal of the 0.2 percent reduction to the standardized amount that CMS implemented in its FY 2014 final rule as a result of the agency's belief that the two-midnight policy would increase IPPS expenditures by $220 million. In fact, data from more than 500 hospitals for two fiscal quarters show that, post-two-midnight implementation, short inpatient stays have decreased while outpatient observation stays have increased – the opposite impact estimated by CMS's actuary. **We continue to believe that the permanent prospective payment reduction is inappropriate and unwarranted.**

Proposed Changes to the Recovery Audit Contractor (RAC) program

Sections 104 and 105 outline proposed changes to the RAC program. Specifically, the discussion draft would:

- Limit the RACs' look-back period for auditing claims to three years;
- Require RACs to wait at least 30 days after a claim denial to turn the claim over to a Medicare Administrative Contractor (MAC) for collection and require RACs to acknowledge a hospital's request for discussion within three days;
- Require CMS to set hospital audit limits that vary by payment system and to adjust those limits based on its error rate, so that a hospital with a higher error rate has a higher audit limit and a hospital with a lower audit rate has a lower audit limit;
- Require all Medicare contractors that conduct pre- and post-payment audits to report claims audited to an existing central database to reduce duplicative audits; and
- Require CMS to create a "RAC Compare Website," which the agency would use to publicly report data on the RAC program.

We commend the Committee in attempting to address problems with the RAC program. While we support the proposal to increase transparency in reporting on the RAC program through a RAC Compare website, the remaining proposed changes fall far short of the significant RAC reform necessary to reduce the heavy administrative and financial burden that the RAC program has imposed on hospitals.

The proposals outlined in the discussion draft incorporate marginal changes that CMS has either already implemented or has stated that it plans to implement as part of the next round of RAC contracts. For example, while statute provides RACs a four-year look back period, CMS limited the RACs to a three-year look back period in the first round of permanent RAC contracts. Further, CMS has given public assurances that the next round of contracts, which the agency is in the process of awarding, will incorporate the requirements regarding provider discussion periods and variation of audit limits based on hospital error rates.

The RACs' contingency fee structure incentivizes inappropriate denials – under the last round of contracts, RACs received 9-12.5 percent of each provider payment they denied. Hospitals must pursue the lengthy Medicare appeals process to receive payment for the medically necessary services they have provided to Medicare beneficiaries. According to the HHS Office of the Inspector General, hospitals have been successful at winning appealed inpatient claims at the administrative law judge level more than 70 percent of the time. We urge the Committee to consider additional fundamental RAC program reforms and support the following changes to the RAC program:

- Impose a financial penalty on RACs when a denial is overturned on appeal. A penalty assessed in such instances would curb overzealous RACs and create a level playing field for both RACs and providers in addressing incorrect payments.

- Require RACs to consider only the medical documentation available at the time the admission decision was made in determining whether an inpatient stay was medically necessary. Currently, RACs utilize information that may not have been available to the physician at the time of the admission decision in order to deny claims. This requirement would restrain RACs' current practice of second-guessing physicians' judgment based on the outcome rather than the facts the physician had at the time.
- Eliminate application of the one-year timely filing limit to rebilled Part B claims. When a Part A claim for a hospital inpatient admission is re-opened and denied by a Medicare review contractor because the inpatient admission was determined not reasonable and necessary, the hospital could submit a subsequent Part B claim for services provided within 180 days of a revised or final determination. This would allow hospitals to either rebill immediately after the claim is denied or pursue their appeals rights and receive a final determination on the Part A claim before rebilling under Part B.
- Limit RAC auditing of approved issues to a defined time period, instead of approving them indefinitely, as is now the practice. After the issue's audit time period has expired, RACs should be prohibited from auditing that issue. CMS should then analyze the audit results and offer education to providers in that jurisdiction if warranted. A RAC would need to seek new approval from CMS to audit for that same issue again, but must wait a certain defined time period to allow providers to incorporate education before requesting new approval. Additionally, a senior CMS official should be held accountable for approval of audit issues.

Proposals to Address Problems in the Medicare Appeals System

Sections 106-108 propose solutions to problems in the Medicare appeals system that have resulted in an overwhelming backlog of Medicare appeals, with the result that at present providers must wait years after filing an appeal before their claims will be heard by an administrative law judge (ALJ). We note some inconsistencies between the legislative language and the section-by-section description. As best we understand, to address the problems with the appeals backlog, the discussion draft would require CMS to offer hospitals two new ways to resolve pending appeals for certain claims that were denied by Medicare contractors as not reasonable and necessary and for which appeals are pending at the ALJ level. The structure of this offer would allow hospitals to choose settlement on a claim-by-claim basis as opposed to the "all-or-nothing" approach offered by CMS earlier this year.

- Medical DRGs: CMS would be required to establish a voluntary settlement offer and process similar to the one announced by the agency on Aug. 29, 2014. The offer would apply to claims for medical DRGs with dates of service between July 1, 2007 and Sept. 30, 2013. CMS would be required to use rulemaking to set a settlement rate through an analysis of empirical data and other factors, such as interest on denied claims for an average time period of claims pending with ALJs. Hospitals with qualifying claims could choose to settle the claims for that rate.
- Surgical DRGs: CMS would be required to allow hospitals to rebill under Part B denied claims for surgical DRGs with dates of service between July 1, 2007 and Sept. 30, 2013. The one-year timely filing period, which requires hospitals to rebill within one year of the date of service, would not apply for those claims.

The AHA agrees that the problems identified by the Committee are real and significant, and we commend this attempt to address the overwhelming backlog of Medicare appeals. However, we do not understand the rationale behind the Committee's proposal and do not believe that the changes suggested by the Committee will solve the underlying issues that caused this overwhelming backlog. The AHA continues to believe fundamental reform of the RAC process is at the heart of an effective and permanent solution to the appeal backlog problem and will enable hospitals to get timely administrative review that clearly is required by the Medicare statute.

With respect to the committee's specific proposals, it is not clear whether they would be sufficient to attract hospitals that chose not to settle appeals as part of the original CMS settlement. We also question whether the process could be implemented under the timeframe included in the discussion draft. In addition, current CMS policy already allows hospitals to rebill medical and surgical claims that would be subject to this provision under its Administrator's Ruling announced March 17, 2013, in conjunction with the FY 2014 IPPS rule that included CMS's final rebilling policy.

The AHA supports the proposal in Sec. 108 to increase transparency in reporting accurate appeals information. This section would require HHS to implement an electronic system to manage Medicare appeals. Further, the agency would be required to post on its website certain appeals information, disaggregated by each level of appeal.

Hospital Assessment Data

The AHA urges the committee to reconsider the inclusion of the requirement to collect and report certain patient assessment data beginning with FY 2019 payments. Sec. 109 would require general acute-care, PPS-exempt cancer and CAHs to collect and report "standardized patient assessment data" on a range of patient factors, including clinical status, functional status, home living situation and any other data the Secretary deems necessary.

We appreciate the potential value of standardizing data collected by hospitals and exchanged with other providers at the times of transitions in care. However, we believe a mandate to report such data is premature. The field as a whole is still learning which particular assessment data are most valuable for improving care, and in what format and manner the data should be collected and transmitted. The lack of consensus about which assessment data are most helpful during care transitions is particularly salient as providers are drowning in data requests while implementing meaningful use and ICD-10, and answering to a plethora of program auditors. Indeed, the meaningful use program already includes a requirement to share a care summary after discharge. It is not clear to what extent the proposed reporting requirements in Sec. 109 would overlap or conflict with the meaningful use requirements.

Furthermore, any future mandate to collect and report data should have a more clearly defined purpose and greater flexibility than is provided in Sec. 109. For example, reporting of the assessment data would be made a requirement of the hospital inpatient quality reporting (IQR) program and hospitals that do not report the data will be subject to payment penalties (i.e., subsection (d) hospitals would face a penalty that is one-quarter of the annual market basket, PPS-exempt cancer hospitals would receive a two percentage point reduction to their annual applicable increase, and CAHs and cancer hospitals would be subject to a 2 percent reduction in payments.) But the uses and purposes of the data are not articulated in the legislation. At a minimum, we would urge that any legislation articulate safeguards that prevent the data collected from being used to determine placement of patients transitioning from one setting to another. We also believe the Secretary should be permitted to revise or replace data collection domains that do not add value to clinical practice. Similar language is used in statute for the IQR to sunset measures no longer of value, and to address new measurement topics.

Cost Information on Hospital Payments

Sec. 110 requires hospitals to submit certain data on the actual amounts collected by the hospital from uninsured and insured patients. These data will then be posted on a publicly accessible and searchable website in a form that would allow patients to make meaningful comparisons of hospital collections and related policies. Each hospital would be required to include a link to these data on the hospital's website. **While the AHA generally supports price transparency,**

we do not understand the underlying purpose of Sec. 110 and the added value these data provide to patients.

Hospitals already are required to make charge information available to patients. For example, the Affordable Care Act (ACA) requires hospitals to report annually and make public a list of hospital charges for items and services. In addition, 42 states already report information on charges or payment rates and make that information available to the public. CMS also posts on its website the average hospital specific charges per patient and average Medicare payment for the most common DRGs as well as 30 ambulatory procedures.

Hospitals also make available information regarding their collection and financial assistance policies. The ACA requires that each non-profit hospital have a written financial assistance policy that includes eligibility criteria, the basis for calculating charges and the method for applying for financial assistance. These hospitals also are required to widely publicize (e.g., post on the premises and on the website and/or distribute directly to patients) these policies and share them with appropriate community health and human services agencies and other organizations that assist people in need. Tax-exempt hospitals also are required report significant amounts of information about their policies and the amount of financial assistance provided on the on the Internal Revenue Service (IRS) Schedule H, which is publicly available.

This section would require MedPAC to include information on charity care as a percentage of the total care furnished by hospitals and critical access hospitals in its annual report to Congress. **The AHA does not understand the purpose of this additional reporting.** In the case of tax-exempt hospitals, this information is already available on Schedule H of the IRS Form 990. We recommend that information on uncompensated care (i.e., the sum of charity care and bad debt) is more meaningful, since it is often difficult to distinguish charity care from bad debt.

TITLE II: HOSPITAL PRIORITIES OF THE COMMITTEE ON WAYS AND MEANS FOR THE 113TH CONGRESS

Title II of the discussion draft includes hospital priorities of the Members of the Committee. Our thoughts related to these Member priorities are included below.

Repeal of Moratorium on Physician-owned Hospitals

The AHA strongly opposes the committee's proposal to weaken significantly the prohibition on physician self-referral to new physician-owned hospitals and loosen restrictions on the growth of grandfathered hospitals that were set forth in the ACA. Sec. 201 would expand the ACA grandfather provision to allow hospitals that were under construction on Dec. 31, 2010 to bill Medicare for services provided to Medicare beneficiaries. In addition, this section would eliminate most of the conditions a physician-owned hospital must meet in order to receive approval for expansion, making it much easier for such hospitals to expand. **We urge the committee to maintain current law, which would preserve the ban on**

physician self-referrals to new physician-owned hospitals and retain restrictions on the growth of existing physician-owned hospitals.

Expanding the Availability of Medicare Data Act (Sec. 203)
Sec. 203 would enhance the availability of the Medicare data provision in the ACA, which allows qualified entities access to Medicare data. Beginning July 1, 2015, qualified entities would be able to use Medicare and other claims data to conduct non-public analysis and provide or sell such analyses to authorized users for non-public use, including for the purposes of assisting providers of services and suppliers to develop and participate in quality and patient care improvement activities, including developing new models of care.

It is difficult to offer comment on this issue without further information. The AHA seeks clarity on Sec. 203, including more information on the type of data that would be made available, the type of analyses that would be conducted, how these analyses would be used to support quality improvement and patient safety and its impact on clinical data registries. In general, however, the AHA cautions against the release of data for commercial purposes, as those data are susceptible to misuse or mischaracterization and could have unnecessary and harmful ramifications for payers, providers, and patients. While we appreciate that hospitals have the opportunity to review analyses before they are provided or sold, we are very concerned that hospitals will have to devote significant resources to multiple reviews of data analysis from multiple qualified entities and such reviews could be another administrative burden for hospitals.

Developing an Innovative Strategy for Antimicrobial Resistant Microorganisms Act of 2014 (Sec. 205)
Section 205 would utilize Medicare reimbursement to incentivize investments in antimicrobial drugs. Specifically, starting Oct. 1, 2015, an additional payment for discharges involving these drugs would be made to hospitals to recognize the costs of these new antimicrobial drugs. The AHA appreciates the Committee's efforts to encourage the development and use of new antimicrobial drugs, provided that these additional payments do not result in a reduction or adjustment to aggregate payments under the inpatient PPS. **The AHA encourages the Committee to state explicitly in the discussion draft that "new" money will be used to provide this additional payment. The AHA strongly objects to any reduction in hospital payments to pay for this provision.**

Hand Sanitation Demonstration Program (Sec. 206)
Sec. 206 would require the Secretary to establish, no later than June 30, 2015, a $100 million voluntary demonstration project for improving hand sanitation. The section also would require the Secretary to include at least one measure of hand hygiene compliance in the hospital IQR program by FY 2017, and the value-based purchasing (VBP) program by FY 2019.

The AHA agrees that hand hygiene compliance is an important issue, and believes a voluntary demonstration project may help accelerate improvements in hospital practices. However, the requirement to include measures of hand hygiene in the hospital quality reporting and pay-for-performance programs is premature. This section requires

implementation of a measure of hand hygiene compliance in the IQR program prior to the conclusion of the hand sanitation demonstration program (also to be created by Sec. 206). At present, there is no consensus on a measure of hand hygiene compliance that is appropriate for use in a public reporting program, as evidenced by the lack of any National Quality Forum (NQF)-endorsed measures of hand hygiene. Given time constraints associated with the NQF endorsement process, it is unlikely that such a NQF-endorsed measure would be available for the FY 2017 IQR program. We are concerned that, without a proven and reliable standard, the inclusion of a hand hygiene measure in IQR and VBP would introduce data collection burden without providing the public with meaningful, accurate information.

Therefore, instead of introducing a hand hygiene measure into federal programs, the Committee could instead revise Sec. 206 so that the demonstration project explicitly assesses the suitability of one or more hand hygiene measures as publicly reported standards. The Secretary could then be instructed to use the findings of the demonstration project, which are to be reported to Congress by Dec. 31, 2017, to prioritize subsequent hand hygiene measure development efforts as the most promising measure(s). Lastly, the Secretary should be asked to seek NQF endorsement of a hand hygiene measure, and submit it through the Measure Applications Partnership (MAP), the existing multi-stakeholder process used to identify the most important and rigorous measures for use by the Secretary and CMS in quality programs. This approach would enhance appropriateness of any hand hygiene measure, and ensure that its addition to quality programs is balanced with other priority issues.

Direct Supervision (Sec. 207)
The AHA supports the Committee's proposal to extend through calendar year (CY) 2015 the moratorium on the enforcement of the Medicare direct supervision requirements for outpatient therapeutic services furnished in CAHs and small rural hospitals with fewer than 100 beds. This proposal will help preserve the ability of these small rural hospitals to provide high-quality and safe patient care without hampering access through unnecessarily onerous supervision requirements. However, as this legislation applies only to CY 2015, we urge the Committee to enact a more permanent and broader solution as envisioned in the AHA-supported legislation, the Protecting Access to Rural Therapy Services (PARTS) Act (H.R. 2801/S. 1143). The PARTS Act would protect access to outpatient therapeutic services in rural hospitals by adopting a default standard of general supervision and creating an exceptions process to identify those outpatient services that merit direct supervision and ensuring that for CAHs, the definition of direct supervision is consistent with their conditions of participation.

Critical Access Hospital Relief Act of 2014 (Sec. 208)
This section would remove the 96-hour criterion of the physician certification requirement as a condition of payment for CAHs. CAHs would still be required to satisfy the other physician certification requirements as well as the condition of participation requiring CAHs to maintain a 96-hour annual average length of stay per patient. **The AHA strongly supports Sec. 208, which would allow CAHs to provide access to services, as necessary, to treat Medicare beneficiaries in rural communities.**

Making the Education of Nurses Dependable for Schools Act (Sec. 209)
The AHA supports Sec. 209, which includes a technical fix that would allow certain nursing programs to continue to receive hospital pass-through payments. The AHA previously has provided a letter of support on H.R. 5227 that had been introduced in the 113th Congress. The AHA's letter in support of H.R. 5227 is available at: http://www.aha.org/advocacy-issues/letter/2014/140904-let-pollack-schock.pdf.

Puerto Rico Hospital HITECH Amendments Act of 2013 (Sec. 210)
The AHA supports inclusion of Puerto Rico hospitals in the Medicare EHR Incentive Payment Program. However, the language in the discussion draft fails to change the program dates that would apply to Puerto Rico hospitals to accommodate for the fact that implementation of the Medicare incentives for other hospitals has been ongoing since 2011, and positive incentives will end in FY 2016. The AHA urges the Committee to revise the final language to provide additional time for hospitals in Puerto Rico to earn meaningful use incentives, so that they can be treated fairly under the program. Puerto Rico is a U.S. territory, its residents are U.S. citizens, and its hospitals provide care for nearly 3.8 million Puerto Rican U.S. citizens. These changes would not only bring equity to Puerto Rico hospitals, but would help modernize Puerto Rico hospitals and enable better coordination of care for their patients. The AHA previously provided a letter of support for H.R. 1379 that was introduced in the 113th Congress. This letter is available at: http://www.aha.org/advocacy-issues/letter/2013/130802-let-pollack-camp.pdf.

Protect Patient Access and Promote Hospital Efficiency Act (Sec. 212)
The AHA supports this proposal to allow nurse practitioners, clinical nurse specialists, physician assistants or certified nurse-midwives to meet documentation requirements for ordering a hospital stay. This provision would not affect the scope of practice laws of any state.

Comprehensive Care Payment Innovation Act (Sec. 213)
The AHA supports the continued testing of four bundled payment models through CMS's Bundled Payments for Care Improvement (BPCI) Initiative. CMS launched four BPCI demonstrations to develop and refine new ways of reducing Medicare expenditures while preserving or enhancing the quality of care for beneficiaries. Section 213 of the discussion draft identifies two bundled payment approaches that mirror two of BPCI's bundling models. **The AHA opposes the premature designation in legislation of a particular bundled payment model while BPCI and its provider partners are in the midst of testing multiple forms of the bundling mechanism.** We are particularly concerned that Section 213 does not include, and could preemptively discourage further study and testing of, a post-acute only bundled payment approach. Under CMS's leadership, the post-acute only bundled payment demonstration grew significantly in 2014 with the addition of 2,600+ providers, and now includes more than 4,500 participants. With this sizeable group helping lead the effort to improve the Medicare program, now is not the time to favor one of the BPCI models, which will continue to be in development through 2018. Rather, Congress should support the full execution of the BPCI, including, upon its conclusion, the identification of key lessons on all four bundled payments models and how

these lessons may be used to further the important goals of the triple aim – better patient care, more efficient care, and healthier communities.

NOTICE Act (Sec. 216)
Sec. 216 would require hospitals to provide adequate oral and written notification to a Medicare patient who has been in outpatient observation or "similar status" for more than 24 hours. The notification must explain: (1) what outpatient observation status means and why the patient has been placed in that status; and (2) the implications of outpatient observation status on the patient's eligibility for coverage of items and services in the hospital and for skilled nursing facility (SNF) care and on cost-sharing requirements for hospital and SNF care. Notification must be given within 36 hours of the patient's classification in observation status. There must be a record of who provided the oral notification and when it was provided. Any written notification must be signed by the patient or his/her representative. Noncompliance with Sec. 216 could result in termination of a hospital's Medicare Provider Agreement or exclusion from the Medicare program. This requirement would be effective six months after the date of enactment.

The AHA appreciates that hospitals and practitioners need to communicate clearly with the patient and his/her family about patient status in the hospital. Patient status is a difficult and confusing issue for patients and families. Many of our members already have similar processes in place regarding notification of observation status and its cost-sharing responsibilities and implications for coverage of subsequent SNF stays. In addition, some states already have laws requiring patient status notification. For example, New York State's observation status law went into effect earlier this year and requires all hospitals to inform patients who are assigned to observation status that they are not admitted to the hospital, but are under observation status. Maryland and Connecticut also have passed similar laws.

However, we believe Sec. 216 fails to address several critical issues:

- There is no exceptions process for situations that are beyond the hospital's control, such as when a patient is unable, due to his/her medical or mental condition, to receive and sign the acknowledgment and no patient representative is available. A patient may refuse to sign the acknowledgement or leave the hospital without signing the acknowledgement. The AHA requests that the Committee create an exceptions process that waives the patient status requirement for these rare types of situations.

- Notification under Sec. 216 includes explaining the reason why the patient has been assigned to observation status. This explanation could be especially onerous since in most cases it would need to be made by a physician or other clinician, rather than administrative staff, because patient status is a complex determination that involves explaining Medicare's wide-ranging rules related to medical necessity. This is especially necessary in today's world where RACs continually second-guess physicians' judgment.

- Hospitals do not have access to specific coverage and cost-sharing information involving items and services furnished to a patient at the time hospitals would be required to provide this notification to patients. Hospitals do not have access to this information until after the patient has been discharged and the claim submitted. The AHA recommends that the Committee modify the notification requirement to allow a more general notification to the patient about Medicare policy regarding co-payments for outpatient services and eligibility requirements for SNF care. The use of a standard document describing such Medicare policy in an easy-to-understand format should be permitted.

- Sec. 216 requires this notification be provided to patients in observation status as well as those in "any other similar status." We do not understand what "any other similar status" means and suggest that "any other similar status" be removed from the draft or defined explicitly.

Establishing Beneficiary Equity in the Hospital Readmission Program Act (Sec. 217)
The AHA applauds the committee's interest in improving the fairness and effectiveness of the Hospital Readmissions Reduction Program (HRRP) and supports Sec. 217. This section makes revisions to the AHA-supported H.R. 4188 introduced earlier this year, but still would require the Secretary to incorporate sociodemographic adjustment into the calculation of penalties under the HRRP. The AHA continues to believe such adjustment is critical to ensuring hospitals serving disadvantaged communities are not unfairly penalized, as they are now, and supports an approach based on either dual eligible patient status or on U.S. Census data.

We offer below some technical recommendations to enhance the effect of this adjustment, and allow for the adjustment to adapt to evolving quality measurement science. Moreover, we also encourage you to consider addressing the "multiplier effect" in the statutory penalty formula that provides a long-term disincentive to improving performance.

Sociodemographic adjustor. As we understand it, Sec. 217 would require the Secretary to use the proportion of dual-eligible patients hospitals treat as the sociodemographic adjustor for FYs 2016 and 2017. The Secretary would then be expected to change the adjustment approach based on the findings of the reports on socioeconomic factors required in the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014. The AHA agrees with this reasonable approach and suggests several technical changes:

- **For FYs 2016 and 2017, provide the Secretary with the option of using Census data to adjust penalties instead of dual-eligible status.** The ideal data for use in sociodemographic adjustment should have a conceptual and statistical relationship to readmission rates, be readily available, and be collected in a consistent way using standardized definitions. For these reasons, dual-eligible status is an attractive risk adjustor, which is why we remain supportive of its use in adjusting readmission penalties.

However, there is variation in the generosity of state Medicaid program benefits, and in the long run, the adjustor may be sensitive to differences in state-level decisions to expand Medicaid. Dual-eligible status also may not fully reflect the poverty in communities. The recently completed work of the NQF's expert panel on sociodemographic adjustment, as well as additional recent research, suggests that the use of census data on poverty rates and income also can be used to perform risk adjustment. Census variables like poverty rate and income are readily available.

To be clear, we believe the language in Sec. 217 on dual-eligible adjustment and the use of the IMPACT Act study should remain in the bill. However, the inclusion of Census data as an option to perform the adjustment simply provides the Secretary with more than one plausible path forward.

- **Provide a mechanism for the Secretary to use an alternative adjustment in the future beyond the IMPACT Act study.** As the NQF expert panel's findings show, the science of quality measurement is dynamic. While we think it is absolutely critical to incorporate a viable sociodemographic adjustment into the program now, we also recommend building in flexibility for the future so that if better mechanisms of adjusting the measures are found in the future, they can be incorporated into the program. This could be accomplished through statutory language allowing the Secretary, in a period of three to five years after the IMPACT Act report, to use alternative adjustment mechanisms to account for sociodemographic factors.

Patient non-compliance coding using V codes. Sec. 217 would require the Secretary, beginning in FY 2017, to consider the use of V codes from Medicare billing data to exclude from the calculation of excess readmissions those patients that are not compliant with treatment. **The AHA supports the inclusion of this provision, but recommends that the legislative language be broadened to include more than just V codes.**

Under the current ICD-9 coding system, patient non-compliance codes are included in V codes. However, hospitals will be transitioning to ICD-10 CM on Oct. 1, 2015. ICD-10 CM includes additional codes that could be used to address non-compliance, such as whether a patient took a smaller dose of a medication than prescribed, or did not follow diet instructions. Moreover, the patient compliance codes in ICD-10 are not part of a single range of codes. As a result, we recommend making the language a bit more generic. For example, subparagraph (v) on page 4 could read as follows (the changes are underlined):

> *(v) CONSIDERATION OF EXCLUSION OF NON-COMPLIANT PATIENT CASES BASED ON ~~V CODES~~.ICD-10 CM Codes. —In promulgating regulations to carry out this subsection for the applicable period with respect to fiscal year 2017, the Secretary shall consider the use of ~~V codes~~ relevant ICD-10 CM codes for potential exclusions of cases in order to address the issue of non-compliant patients."*

Addressing the Multiplier Effect. In its June 2013 *Report to Congress,* MedPAC found that the readmissions penalty formula has a "multiplier effect" which results in: 1) readmissions penalties that far exceed the cost of excess readmissions, and 2) an inverse relationship between national readmission rates and hospital penalties. That is, as readmission rates drop across the nation, the magnitude of the penalty could stay the same or grow. Over the long run, this threatens the goal of the program – real reduction in readmissions that mean better care for patients at lower cost.

The multiplier effect is, in part, due to a technical issue with the readmissions penalty formula. The intent of the formula is to recoup the money paid to hospitals for readmissions determined to be "excess readmissions" for each condition in the program. But, the formula specified under paragraph (4)(a) multiples the per-admission payment by the number of *all* admissions for that condition, not merely the number of readmissions. This allows Medicare to recoup a payment amount that is far greater than the payments made for the excess readmissions. This could be corrected by a simple change in paragraph 4(a)(ii) replacing "admissions" with "expected readmissions." This modification would provide some important relief, but it would not entirely address the inverse relationship between the national readmission rate and hospital penalties. We would welcome the chance to work with you to make additional changes to the formula to ensure the field has a long-term incentive to reduce avoidable readmissions.