Nebraska Hospital Association

June 30, 2014

Marilyn B. Tavenner
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: CMS-1607-P, Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Fiscal Year 2015 Rates; Quality Reporting Requirements for Specific Providers; Reasonable Compensation Equivalents for Physician Services in Excluded Teaching Hospitals; Provider Administrative Appeals and Judicial Review; Enforcement Provisions for Organ Transplant Centers; and Electronic Health Record Incentive Program (Vol. 79, No. 94), May 15, 2014

Dear Ms. Tavenner:

On behalf of our 90 member hospitals and the nearly 43,000 individuals they employ, the Nebraska Hospital Association (NHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) hospital inpatient prospective payment system (IPPS) proposed rule for fiscal year (FY) 2015. While we support a number of the IPPS proposed rule's provisions, we have serious concerns about certain aspects of the Hospital-acquired Condition (HAC) Reduction Program proposals, the Inpatient Quality Reporting (IQR) program proposals and the proposed changes to the cost report requirements related to the jurisdiction of the Provider Reimbursement Review Board (PRRB). We also remain concerned regarding Medicare DSH funding reductions, the nationwide rural floor budget neutrality adjustment and the 96 hour rule for CAHs. As CMS requested, we also provided comments on the design of an alternate payment methodology for short inpatient hospital stays, which would supplement the existing "two-midnight" policy.

Payments for services provided to Medicare patients continue to be significantly inadequate. CMS has proposed a market basket update of 2.7 percent for FY 2015. However, as in recent years, the market basket update continues to be offset by multiple reductions in payments. Some of these payments cuts are congressionally mandated and some are proposals made by CMS. The combined estimated impact of the IPPS proposed rule for Nebraska hospitals results in an increase in Medicare inpatient payments of only .7 percent for FY 2015. Nebraska's PPS hospitals currently have a negative 17.5 percent margin related to providing inpatient services to Medicare patients. Further reductions cannot be sustained and will continue to deplete scarce resources making hospitals' mission of providing high quality care to patients even more challenging. Our concerns and recommendations are explained in detail below.

MEDICARE SEVERITY DIAGNOSIS-RELATED GROUP (MS-DRG) DOCUMENTATION AND CODING ADJUSTMENT

The Centers for Medicare & Medicaid Services (CMS) proposes a cut of 0.8 percentage point in fiscal year (FY) 2015 to fulfill part of the American Taxpayer Relief Act of 2012 (ATRA) requirement that CMS *recoup* what the agency claims is the effect of documentation and coding changes from FYs 2010, 2011 and 2012 that CMS says do not reflect real changes in case-mix. This is in addition to the cut of 0.8 percentage points that was finalized by CMS for FY 2014. **While we continue to believe these congressionally mandated adjustments are not warranted, we appreciate the agency's proposal to help mitigate extreme annual fluctuations in payment rates and provide hospitals with additional time to manage these sizeable cuts.**

In addition, although CMS proposes no additional documentation and coding cuts for FY 2015, it does indicate that its previously proposed *prospective* cut of 0.8 percentage points related to hospitals' documentation and coding in FY 2010 may be appropriate in future rulemaking. We continue to believe that this documentation and coding cut is inappropriate. We remain troubled that CMS continues to compare hospitals' documentation and coding practices in FY 2010 to their documentation and coding practices under an entirely different system in FY 2007. **We urge CMS not to propose any documentation and coding cuts, beyond those required by ATRA, in future rulemaking.**

DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENT CHANGES

The Affordable Care Act (ACA) requires that, beginning in FY 2014; hospitals initially receive 25 percent of the Medicare DSH funds they would have received under the DSH formula in place prior to FY 2014 – "empirically justified DSH payments" – with the remaining 75 percent flowing into a separate funding pool for DSH hospitals – "additional DSH payments."

CMS proposes to continue distributing empirically justified DSH payments in the exact manner in which DSH payments were distributed prior to FY 2014, but at 25 percent of the amount of what otherwise would have been paid. CMS estimates that the empirically justified Medicare DSH payments for FY 2015 will be $3.551 billion (25 percent of the total amount estimated). CMS also proposes, as it did in FY 2014, that it will continue to cost-settle these payments at the appropriate level on the cost report.

CMS is decreasing the 75 percent pool by the national change in the uninsured rate. The decrease is justified by CMS by the thought that uninsured rates would decrease throughout the nation as a result of the marketplace and Medicaid expansion. However, CMS is once again using Medicare SSI and Medicaid days to distribute the 75 percent pool. In doing so, states that expand Medicaid eligibility will receive a greater portion of the pool than states in which Medicaid eligibility is not expanded. For those states that do not expand coverage, they will receive a reduction to the national pool based on the national change in the uninsured rate and be penalized a second time due to the number of Medicaid days remaining relatively flat.

In the FY 2014 inpatient PPS final rule, CMS discussed the alternative of using Worksheet S-10 of the Medicare cost report to determine the amount of uncompensated care each hospital provides. However, CMS did not propose to use these data to determine the uncompensated care costs at that time because of concerns regarding variations in the data reported on Worksheet S-10 and the completeness of these data. In this proposed rule, CMS indicates that it would be premature to propose to use the Worksheet S-10 for FY 2015.

The NHA agrees that the S-10 uncompensated care data are not appropriate for use in FY 2015. However, if reported in an accurate and consistent manner, these data have the potential to serve as a more exact measure of the treatment costs of uninsured patients. We urge the agency to take action to revise and improve both the Worksheet S-10 and the instructions, while taking into account stakeholder feedback

The NHA continues to be concerned regarding the impact of Medicare DSH payment cuts to Nebraska hospitals. The proposed DSH cuts would further reduce payments to Nebraska hospitals by nearly $3.2 million. DSH cuts were intended to be offset by coverage expansions in the Medicaid program and through the insurance marketplace. Coverage expansions have not yet been recognized in Nebraska. Medicaid expansion has not been implemented and the impact of the insurance marketplace is still unknown. **Cutting Medicare DSH payments without coverage expansions is inappropriate and places a significant strain on hospitals' ability to provide care to patients that need it the most.**

NATIONWIDE RURAL FLOOR BUDGET NEUTRALITY ADJUSTMENT

The NHA continues to oppose the continued application of a nationwide rural floor budget neutrality adjustment as described in the proposed rule. As CMS is aware, this policy was instigated by the orchestrated conversion of a single facility in Massachusetts — Nantucket Cottage Hospital — from a critical access hospital to an inpatient prospective payment system hospital. Coupled with the application of nationwide budget neutrality through section 3141 of the ACA, the conversion initiated a policy that unfairly skews Medicare payments. Payments to thousands of hospitals across the nation are diverted to produce gains for hospitals predominately located in Massachusetts.

CMS recognizes the problems and inequities raised by this nationwide rural floor budget neutrality factor, which contradicts the agency's stated wishes in applying wage indexes. In its CY 2012 OPPS final rule, CMS expressed concern that allowing a change in hospital status, such as the one in Massachusetts, distorts wage indexes across the nation:

"…In recent years, we have become concerned that hospitals converting their status **significantly inflate wage indices** across a State…Hospitals in Massachusetts can expect an approximate **8.7 percent increase** in IPPS payments due to the conversion and the resulting increase of the rural floor. Our concern is that the **manipulation of the rural floor** is of sufficient magnitude that it requires all hospital wage indices to be reduced approximately 0.62 percent as a result of nationwide budget neutrality for the rural floor (or more than a 0.4 percent total payment reduction to all IPPS hospitals)." (Emphasis added)

In its proposed rule, CMS publishes the projected state-specific effect of the nationwide rural floor budget neutrality standard in FY 2015. The agency notes that Massachusetts hospitals are

estimated to receive approximately a 4.9 percent increase in IPPS payments due to the application of the proposed rural floor. The estimated amount of windfalls to Massachusetts from the manipulation of the wage index is $157.8 million for FY 2015. In addition to Massachusetts, California is now a large beneficiary of the manipulation and the agency estimates a windfall of more than $196 million.

The NHA appreciates CMS' work to publish the state-specific impact table. The NHA urges CMS to include in its final IPPS rule an updated detailed state-specific analysis of the effects of nationwide rural floor budget neutrality. Also, we ask that CMS build on its earlier analytical work on this issue by publishing tables showing the cumulative state-specific and aggregate inpatient and outpatient payment distortions produced by nationwide rural floor benefit neutrality in recent years and also projecting the estimated 10-year state-specific effects of continuing the current policy.

The adverse consequences of nationwide rural floor budget neutrality have been recognized and commented upon by CMS, the Medicare Payment Advisory Commission and many others over the past several years. That the policy continues into a fourth year is disconcerting at best. Until this policy is corrected, the Medicare wage index system cannot possibly accomplish its objective of ensuring that payments for the wage component of labor accurately reflect actual wage costs.

TWO-MIDNIGHT POLICY – SHORT STAY PAYMENT METHODOLOGY

CMS finalized its "two-midnight" policy in the FY 2014 inpatient PPS final rule. Under this policy, CMS will generally consider hospital admissions spanning two midnights as appropriate for payment under the inpatient PPS. In contrast, hospital stays of less than two midnights will generally be considered outpatient cases, regardless of clinical severity. **Although we appreciate CMS's attempt to clarify what is required for payment of inpatient hospital services under Medicare Part A, the two-midnight policy is an arbitrary time-based benchmark that clouds the role of physician judgment.**

An inadequate period of time was initially provided by CMS for implementation of the two-midnight policy. Hospitals needed additional time to evaluate and change internal policies, update existing electronic medical record systems, alter work flow processes and provide extensive education to hospital staff and physicians to ensure compliance with the new policy. CMS needed additional time to issue clear, detailed and precisely written guidance to hospitals and Medicare review contractors. Fortunately, CMS and Congress agreed that more time was necessary and both have issued partial enforcement delays that now postpone enforcement of the two-midnight policy through March 31, 2015. **The NHA appreciates these partial enforcement delays, which have allowed hospitals, Medicare review contractors and CMS additional time to implement this complex policy. We recommend that CMS extend these partial enforcements delays until it implements an alternate payment methodology for short inpatient hospital stays.**

The two-midnight policy fails to provide adequate reimbursement for beneficiaries who require an inpatient level of care, but who do not meet the two-midnight benchmark for admission. Specifically, CMS reimburses for this care under the outpatient PPS, which does not cover the

cost of the inpatient level of care that is provided and typically results in a higher cost-sharing burden for the beneficiary.

The NHA strongly believes that CMS must appropriately and adequately reimburse hospitals for the care they provide. As stated above, the two-midnight policy does not provide appropriate and adequate reimbursement for medically necessary inpatient stays that span less than two midnights. However, we believe that a short-stay payment (SSP) policy, which would supplement the existing two-midnight policy, could reimburse hospitals more accurately for the resources used to treat beneficiaries during these short stays and would alleviate some problems regarding beneficiary cost-sharing.

With both the two-midnight policy and the SSP policy in place, physicians would continue to determine whether patients should be admitted to the hospital as inpatients, in accordance with their clinical and medical judgment, as they would have prior to the two-midnight policy. The two-midnight and SSP policies would govern how admissions are paid. As a result, if the beneficiary meets the two-midnight threshold, the hospital will receive full Medicare Part A payment under the two-midnight policy. Alternatively, if the beneficiary does not meet the two-midnight threshold, the hospital will receive a reduced inpatient PPS rate under the SSP policy.

The following are guiding principles that have been developed by the American Hospital Association (AHA) and are also supported by the NHA:

- 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;

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

- The SSP policy should be budget neutral;

- The SSP policy could be designed similarly to CMS's longstanding transfer policy, which reimburses hospitals a graduated per-diem rate, instead of a full DRG payment rate, to approximate the reduced costs of transfer cases;

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

- 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;

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

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

The specific design of a SSP policy is something that must be addressed in detail and with additional input from potential stakeholders. These details include, but are not limited to, the definitions of a short inpatient hospital stay and an observation stay; the DRGs that may be included or excluded from the SSP policy; how such a policy would apply to non-IPPS hospitals that are subject to the two-midnight rule (e.g., critical access hospitals); and the tools a physician may use in determining whether a patient needs inpatient hospital services.

In addition to implementing an SSP policy, we encourage CMS to evaluate the adequacy of the outpatient PPS rates Medicare pays for observation care, which is the type of care hospitals often provide while making a determination of whether inpatient admission is appropriate. We do not believe the observation care rates cover hospitals' costs.

We look forward to working with CMS to further consider these issues of great importance to hospitals and the Medicare program as well as other potential alternatives that do not compromise the integrity of the DRGs and the PPS.

In the FY 2014 inpatient PPS final rule, CMS finalized a *permanent* prospective 0.2% reduction to the operating PPS standardized amount as a result of the agency's belief that the two-midnight policy would increase inpatient PPS expenditures by $220 million. **The NHA continues to believe that this *permanent* prospective payment reduction is inappropriate, and we strongly urge the agency to reverse these reductions.**

Finally, it is very clear that even upon implementation of an SSP policy, the two-midnight policy will continue to fail if it is not combined with comprehensive reform and management of the RAC program. Such reform must address the systemic issues that have led to avoidable claim denials and appeals. Without such reform, RACs will continue to second guess the medical judgment of the treating physicians, leading to inappropriate and excessive denials, and resulting in significant strain on hospitals and the appeals process.

We urge CMS to:

- Codify in regulation that the treating physician's judgment is paramount in making the admission decision;

- Impose a financial penalty on RACs when a denial is overturned on appeal – not just to recoup their contingency fee – to provide some check on the strong financial incentive RACs have to improperly deny claims;

- Eliminate application of the one-year timely filing limit to rebilled Part B claims;

- Codify in regulation its assertion in the preamble of the FY 2014 inpatient PPS final rule that RACs are limited to using the medical documentation available *at the time the*

admission decision was made when determining whether an inpatient stay was medically necessary;[1] and

- Limit RAC approval for auditing approved issues (such as short inpatient stays) to a particular defined time period, instead of approving them indefinitely, as is now the practice.

In addition, CMS could take these additional actions to mitigate the impact on hospitals of the lengthy delays in the Medicare appeals system. These have included, but are not limited to, the following:

- When a hospital appeals to the administrative law judge level (ALJ), CMS should not recoup the disputed funds until after the hospital has received an ALJ determination;

- CMS should enforce the statutory timeframes within which appeals determinations must be made by entering a default judgment in favor of the provider if an appeal has not been heard within the required time period; and

- CMS should provide a mechanism for erroneous denials to be reversed outside of the appeals process.

CMS also must improve oversight of the RAC program to ensure, among other things, that hospitals have an opportunity to avoid appeals by having an adequate and effective discussion period; problems with submitting documentation to RACs in response to additional documentation request are resolved; and claims for procedures on the "inpatient-only list" are no longer wrongly denied by RACs.

CRITICAL ACCESS HOSPITALS (CAHs)

We appreciate CMS's proposal to allow greater flexibility for physician certification of expected discharge or transfer within 96 hours of admission. However, this policy is misguided. The issue at hand concerns the impossible task physicians have been given with regards to CAH inpatient admissions. When the 96 hour certification is coordinated with the two-midnight policy, a physician admitting an inpatient to a CAH must certify their "prediction" that the patient will require a stay encompassing two midnights, but will not exceed 96 hours. **We recommend that CMS pursue authority that aligns the physician certification in a way that the current Condition of Participation requirement of an annual average length of stay not to exceed 96 hours remains the standard.** We believe this can be accomplished by requiring the physician to certify the CAH has the appropriate staff and resources to care for the inpatient.

CMS proposes a two-year transition for facilities currently designated as CAHs that may be redesignated from rural to urban as a result of the new OMB labor market delineations. This proposal will automatically provide the two-year transition period and will allow CAHs an opportunity to seek reclassification to maintain their CAH status. **The NHA supports this proposal.**

[1] 78 Fed. Reg. 50495, 50952 (Aug. 19, 2013)

AREA WAGE INDEX (AWI) – NEW LABOR MARKET DELINEATIONS

CMS proposes to apply the most recent labor market areas in the FY 2015 inpatient PPS wage index. The most recent delineations were issued by the OMB on Feb. 28, 2013 in OMB Bulletin No. 13-01, and include an updated list of CBSAs that reflect the OMB's new 2010 standards and 2010 Census data. In addition to using the new OMB labor market delineations, CMS proposes to continue to treat Micropolitan Areas as "rural" and to include the Micropolitan Areas in the calculation of each state's rural wage index. The NHA supports these proposals.

Because this update will result in a number of significant changes to the existing labor markets, CMS also proposes wage index transition periods applicable to all hospitals that experience negative impacts due to the proposed implementation of the new OMB labor market delineations. For urban counties that have become rural, the agency proposes to continue to apply the urban wage index value of the CBSA where the hospitals are physically located in FY 2014 for a period of three fiscal years. CMS also proposes to use a one-year blended wage index for all hospitals that would experience a decrease in their actual payment wage index *exclusively due* to proposed implementation of the new OMB labor market delineations. These proposed transitions are consistent with those made the last time the agency updated the CBSAs used in the wage index for FY 2005. **The NHA supports these proposals and appreciates CMS's attempts to mitigate the negative effects of the application of the new OMB labor market delineations on hospitals.**

CMS proposes changes to the wage index timetable – the process by which hospitals may review and request revisions to CMS's wage index data files – for FYs 2016 and 2017 to allow hospitals, MACs and CMS more time to review CMS's wage index data files and ensure a more accurate wage index. The NHA appreciates this proposal.

However, we believe the changes to the FY 2017 wage index timetable would be more effective if hospitals were provided additional time to review the preliminary public use file (PUF) after CMS posts this file. Specifically, we recommend changing the FY 2017 deadline for hospitals to request revisions to the preliminary PUF to early September 2015, as opposed to early August 2015, as CMS proposes. In most cases, hospitals have limited cost-reporting personnel capabilities, which may be further limited by staff availability during the summer months. This short, one-month extension would ensure hospitals can devote sufficient cost-reporting capabilities and resources to reviewing wage index data, and as a result, will lead to more accurate wage index data. This change would apply to future years as well and CMS would need to adjust the remainder of the dates accordingly to allow sufficient time to complete the remaining steps in the AWI timetable.

HOSPITAL-ACQUIRED CONDITION (HAC) REDUCTION PROGRAM

As mandated by the ACA, for FY 2015, CMS will implement the HAC Reduction Program, which imposes a 1 percent reduction to Medicare payments for hospitals in the top quartile of risk-adjusted national HAC rates. **Nebraska's hospitals are committed to reducing preventable patient harm, and support quality measurement and pay-for-performance programs that effectively promote improvements in patient safety.** We urge CMS to adopt measures that accurately and fairly assess hospital performance on critically important and

potentially preventable patient safety issues. CMS has indicated that the measures in the program allow for hospitals to be assessed on a variety of patient safety issues. The three measures in the FY 2015 HAC program also are used in the hospital value-based purchasing (VBP) program, and CMS suggests that the commonality of measures with the VBP program promotes alignment of quality improvement efforts. However**, the overlap of measures between the HAC and the hospital VBP programs creates the potential for unfair double payment penalties and we request that CMS eliminate the overlap in measures between the VBP and HAC programs.** We recommend that CMS retain CLABSI and CAUTI in the HAC program, while retiring both measures from the VBP program. CLABSI and CAUTI are well-established HAI measures on which hospitals have been focused for several years. We also recommend that CMS use surgical site infection (SSI), *Methicilin-resistant Staphlococcus aureus* (MRSA) and *Clostridium Difficile (C. Difficile),* which will be added to the HAC program in FY 2016 (SSI) and FY 2017 *(*MRSA and *C. Difficile)*, in the VBP program before putting them into the HAC program.

PSI-90 MEASURE ISSUES

A recent review of PSI 90 by the patient safety measure review committee of the National Quality Forum (NQF) revealed additional concerns about the reliability and validity of the measure.[i] The committee did not recommend the measure, as currently written, for continued NQF endorsement. PSI 90 is comprised of individual PSIs reflecting different patient safety issues, and each component PSI is assigned a weight towards calculating the total measure score. The committee noted that the weights assigned to each component may not reflect the relative importance or preventability of each component. For example, the committee expressed concern that PSI 15, which reflects the rates of accidental punctures or lacerations during surgery, has too high a weight. The committee also recommended that the weighting used more explicitly consider "the degree of preventability or actionability by a healthsystem [sic] to reduce it."[ii] Lastly, the committee "expressed apprehension about the use of the measure in payment applications."[iii] In response, the measure developer has indicated that the measure will be revised and re-submitted to the committee for review.

The NHA strongly supports the use of NQF-endorsed measures in federal quality reporting and pay-for-performance programs, including the HAC Reduction Program. The NQF endorsement process is designed to bring together multiple stakeholders to assess whether measures are important, scientifically sound, useable and feasible to collect. We agree with the NQF Patient Safety Committee suggestion that PSI 90 will require significant changes in order to be suitable for continued endorsement; we believe this is a strong indication that the measure is inappropriate for the HAC program.

We urge CMS to identify alternative measures that could be used in the HAC Reduction Program in place of PSI 90. In identifying alternative measures for the HAC program, we recommend that the agency use the following guiding principles:

- CMS should identify measures that address a variety of quality and safety issues relevant to a broadest possible range of hospitals. This will help ensure that hospitals do not experience HAC penalties simply because of the types of patients they treat.

- CMS should use only NQF-endorsed measures in the HAC Reduction Program.

- Before proposing measures for the HAC program, the agency should use the formal pre-rulemaking process of the Measure Applications Partnership (MAP). The ACA requires that measures for most CMS quality reporting and payment programs be reviewed by the multi-stakeholder MAP before they are proposed for programs. While the HAC program does not specifically require MAP review, we believe the MAP's perspective is critical to facilitating agreement among all stakeholders about which measures are the most important for national quality efforts.

- CMS should report measures publicly for at least one year before incorporating them into the HAC Reduction Program so that any unintended consequences of measurement and reporting can be addressed. Further, if the safety issue addressed by the measure is important, but it is unclear whether effective strategies exist through which a hospital could effectively reduce the incidence of harm, CMS should consider including the measure in the VBP program before moving it to the HAC program.

HOSPITAL READMISSIONS REDUCTION PROGRAM (HRRP)

The HRRP assesses penalties on hospitals for having "excess" readmission rates when compared to expected rates. For FY 2015, CMS proposes to increase the maximum payment penalty to 3 percent of Medicare base operating payments, as required by the ACA. CMS also proposes modifications to how it calculates its total hip and total knee arthroplasty (THA/TKA) measure, as well as how it excludes planned readmissions from the five 30-day readmissions measures used in the program – heart failure (HF), pneumonia (PN), acute myocardial infarction (AMI), chronic obstructive pulmonary disease (COPD), and total hip and total knee arthroplasties (THA/TKA). **The NHA is concerned that CMS has again failed to propose a process for excluding readmissions unrelated to the initial reason for admission in calculating the measures, as mandated by the ACA. We also are very concerned that the agency has again failed to propose to adjust the program's measures for sociodemographic factors.**

The NHA supports the draft recommendations from the NQF expert panel on sociodemographic adjustment, and urges the agency to adopt them as soon as possible. As noted by the expert panel, it has long been known that patient outcomes, such as readmissions, are influenced by factors other than the quality of the care provided. In the context of quality measurement, risk adjustment is a widely accepted approach to account for some of the factors outside the control of providers when one is seeking to isolate and compare the quality of care provided by various entities. NQF's current measure endorsement criteria require that when there is a conceptual relationship and evidence demonstrating a link between an outcome and *clinical* factors such as age, severity of illness and co-morbid conditions, those factors should be included in risk adjustment. Without risk adjustment, provider performance on most patient outcomes reflects differences in the patients being served, rather than true differences in the underlying quality of services provided.

Early experience with the hospital readmissions program demonstrates that hospitals caring for the poorest patients are disproportionately more likely to incur penalties under the program because the measures are not adjusted for sociodemographic factors. Data from the FY 2014 inpatient PPS final rule show that approximately 77 percent of hospitals in the top decile of DSH payments, which reflects how many impoverished patients hospitals treat, incur a readmissions

penalty. By contrast, only 36 percent of hospitals in the lowest DSH decile will receive a penalty. If hospitals are to be expected to take on new roles and responsibilities to prevent readmissions, it is imperative that those serving the most economically challenged patients have resources to assist them, and this penalty program deprives them of those exact resources. The NQF expert panel report includes useful guidance on potential adjustment approaches, and we urge CMS to use it to improve the readmissions measures.

HOSPITAL VBP PROGRAM

As noted in our comments on the HAC Reduction Program, the NHA is concerned about the overlap of measures between the VBP and HAC programs given the different construction and goals of each program. We urge CMS to ensure the programs do not provide hospitals with conflicting signals or double payment penalties by using measures in either the VBP or the HAC program, and not both.

HOSPITAL IQR PROGRAM

CMS proposes substantial changes to the IQR program beginning in FY 2017. The agency proposes new criteria for determining which IQR measures have "topped out" and are, therefore, suitable for removal from the program. It then uses these criteria to propose the removal of 15 chart-abstracted measures for FY 2017. CMS also proposes to add 11 measures to the IQR program.

However, CMS's proposed measure additions and removals have taken on greater complexity because the agency also proposes to retain and expand the option for hospitals to report electronic versions of IQR measures, thereby receiving credit in both the IQR and Medicare EHR incentive programs. While CMS proposes to remove 15 chart-abstracted measures for the FY 2017 IQR program because their performance is topped out, it also proposes to retain the electronic versions of 10 of them to support the voluntary electronic reporting option.
The NHA supports CMS's proposed removal of the 15 chart-abstracted measures, the cardiac surgery participation measure, and the four previously suspended measures from the IQR. However, we do not support its proposal to retain the electronic versions of 10 of them to support the voluntary electronic reporting option.

FY 2017 PROPOSED MEASURE ADDITIONS

We are very disappointed that four of the five measures proposed by CMS are not NQF-endorsed. The NHA urges CMS to use only NQF-endorsed measures in federal quality reporting programs, NQF endorsement provides assurance that the measure has been tested, can reliably and accurately collect data, is feasible to implement, and is usable. We also note that the MAP only conditionally supported these measures, and urged that they receive NQF endorsement before being placed into the IQR program.

CABG Readmissions. CMS proposes to add a measure assessing the rate of hospital readmissions within 30 days for patients discharged following CABG surgery. It is the same measure that CMS also proposes for the HRRP. **The NHA does not support this measure for either the HRRP or the IQR.** As noted in our comments on the HRRP, we urge CMS to

incorporate an adjustment for sociodemographic factors and obtain NQF endorsement of the measure before finalizing it for the program.

CABG Mortality. CMS proposes to add a measure assessing risk-adjusted hospital mortality rates within 30 days for patients discharged following CABG surgery. The measure is not yet NQF-endorsed, and the MAP supported the measure only on the condition that it receives NQF endorsement before being added to the program. **The NHA agrees with the MAP's assessment of the measure, and does not support its inclusion in the IQR until it has obtained NQF endorsement.**

Heart Failure (HF) Payment per Episode of Care. This non-NQF-endorsed proposed measure calculates total payments for Medicare fee-for-service patients with a primary discharge diagnosis of HF from the date of the initial hospital admission through 30 days post-admission. Payments for the initial hospitalization are included in the measure, as are payments for a broad range of subsequent care, including inpatient, outpatient, physician, laboratory and post-acute care services. The measure is being proposed for hospital-level quality measurement despite the fact that it reflects the actions of a multitude of health care entities, some of which are beyond hospitals' control. **While the NHA agrees that well-designed measures of cost that assist with assessing the value of care are needed we oppose the adoption of this particular measure at this time.**

Pneumonia (PN) Payment per Episode of Care. This measure is constructed in a very similar manner to the proposed HF payment per episode of care measure, and the finalized AMI payment measure. **For the same reasons outlined above the HF measure, the NHA does not support CMS's proposal to add the PN payment per episode of care measure to the IQR program**.

Severe Sepsis and Septic Shock Management Bundle (NQF #500). CMS proposes to add a chart-abstracted measure assessing whether hospitals implement certain care processes that may lead to decreased mortality for patients with severe sepsis and septic shock. The NQF's Patient Safety Measure Committee undertook an *ad hoc* review of the sepsis bundle in April 2014.[iv] While the measure has been endorsed since 2008, there has been considerable controversy over one aspect of it. Specifically, the measure specifications require that if patients do not respond to the administration of fluids or vasopressors to raise arterial blood pressure, then the physician should measure central venous pressure and oxygen levels. Performing this step requires the insertion of a central line. However, the insertion of central lines carries a risk of infection. Therefore, some experts have expressed ongoing concerns about the sepsis bundle measure. Recent evidence suggests that the measurement of central venous pressure does not lead to improved outcomes. If the agency chooses to implement NQF #500, then at a minimum, it should remove the element of the bundle requiring the measurement of central venous pressure and oxygenation per the recommendation of the Patient Safety Measure Committee.

NHSN Data Reporting. CMS proposes to expand the scope of required data reporting in the NHSN system to include patient-level data such as patient date of birth and gender. CMS also would require information on clinical details such as specific symptoms or test results. CMS also proposes to receive access to any data submitted voluntarily into NHSN, including patient name and race identifying information. CMS indicates that CDC would share these data with CMS for the purposes of monitoring and evaluation, measure validation, appeals review,

program impact evaluation and future measure development activities. **The NHA is very concerned by this proposal, and urges CMS not to adopt it.** The sharing of such sensitive personal information carries substantial security risks. CMS fails to describe the intended purposes of collecting these data beyond the vague terms provided in the proposed rule. CMS also does not indicate who in the agency would be authorized to access the data – is it CMS staff only, or also CMS contractors? Such sensitive information is not used by the CDC to calculate HAI measure performance. Lastly, we strongly disagree with CMS's claim that this information is necessary for measure validation. CMS's validation process for HAI measures in the IQR pre-dates these proposed requirements.

ICD-10 MS-DRGs

We appreciate CMS making available the Version 31.0-R ICD-10 MS-DRG software and Definitions Manual. These tools will be useful as hospitals prepare for ICD-10 implementation.

The NHA supports implementation of ICD-10-CM and ICD-10-PCS on October 1, 2015 without any further delays. Hospitals in Nebraska have invested significant financial and human resources in preparing for the transition to ICD-10. Our members have told us that they are ready, or nearly ready, to start external testing with CMS and others. We are concerned that CMS cancelled its plans for further testing during 2014. **We urge CMS to formalize its ICD-10 testing plans to ensure that end-to-end testing begins no later than January 2015 and be made available to all hospitals.** We appreciate the agency's efforts to offer extensive educational opportunities for providers. However **extensive end-to-end testing of both the electronic transaction and the adjudication of the claim by Medicare contractors and state Medicaid agencies will be needed to ensure a smooth transition from ICD-9 to ICD-10.**

VALIDATION PROCESS UPDATES

Number of Charts Required for Validation. CMS proposes that hospitals will need to submit 10 charts per quarter for HAI measures, and eight charts per quarter on clinical process of care measures. This lowers the number of charts required for a full year of data from 96 to 72 charts. CMS proposes this change because it is also proposing the removal of a significant number of clinical process of care measures from the IQR beginning with the FY 2017 IQR program. Moreover, CMS indicates that is can lower the number of charts it collects each year while still yielding an adequate sample size. **The NHA supports this proposal.**

Selection of the Measures and Sampling of Charts in Validation. For FY 2017, CMS proposes to continue validating all of the HAI measures in the IQR, but would modify how it validates the process of care measures. Because the agency proposes the removal of chart-abstracted versions of the AMI, HF, PN and SCIP measures, CMS proposes to validate only the chart-abstracted versions of the stroke, VTE, ED, immunization (IMM) and proposed sepsis measures. Additionally, across all hospitals selected for validation, CMS proposes to select the process of care validation charts using a "systematic random sample" across all the topic areas except IMM. This means that each hospital could be validated on different topics. **The NHA supports this proposal.**

EHR INCENTIVE PROGRAM

ALIGNMENT OF HOSPITAL IQR PROGRAM REPORTING AND SUBMISSION TIMELINES WITH EHR INCENTIVE PROGRAM REPORTING AND SUBMISSION TIMELINES

The NHA supports the proposal to incrementally shift the Medicare EHR Incentive Program reporting and submission periods for eCQMs from fiscal year reporting to calendar year reporting and only for hospitals using an electronic submission option in CYs 2015 and 2016.

The NHA believes that it is premature to require quarterly reporting of eCQMs for the Medicare EHR Incentive Program beginning in CY 2015. Given the implementation delays with 2014 CEHRT for meaningful use and the anticipated change in the attestation requirements for meaningful use in 2014, we recommend that CMS not propose quarterly reporting of eCQMs prior to the FY 2016 IPPS rule.

ECQM REPORTING FOR 2015

CMS proposes to require that eligible hospitals and CAHs that seek to report eCQMs electronically under the Medicare EHR Incentive Program use the most recent version of the e-specifications for the eCQM and have a certified EHR that is tested and certified to the most recent version of the e-specifications for the CQMs. The NHA recommends that CMS clarify how eligible hospitals and CAHs will meet this requirement if CEHRT are not required to be re-certified for conformance to updated e-specifications in order to maintain their EHR certification status. In addition, we would appreciate clarification of how this proposal aligns with the rule's proposal to require quarterly reporting of electronically reported CQMs for the Medicare EHR Incentive Program to align with the currently established quarterly electronic CQM reporting periods for the Hospital IQR Program. Annual e-specification updates of hospital eCQMs are published at the beginning of April. The two proposals will require hospitals to use an EHR that is certified to one set of e-specifications and then re-certified to a different set of e-specifications within a given reporting year in order to satisfy the quarterly reporting requirement. Given the updates in logic, codes and corrections in the annual e-specification updates, it will be important for CMS to explain its understanding of how hospitals and CAHs would operationalize both proposals.

CLARIFICATION ON ZERO DENOMINATORS REPORTED IN ECQMS FOR THE EHR INCENTIVE PROGRAM AND THE HOSPITAL IQR PROGRAM

The NHA supports the clarification on zero denominators in a particular eCQM due to the absence of data. CMS proposes that if the certified EHR is certified to an eCQM, but the eligible hospital or CAH does not have patients that meet the denominator criteria of that eCQM, the eligible hospital or CAH can submit a zero in the denominator for that eCQM. Submitting a zero in the denominator will count as a successful submission for that eCQM for both the EHR Incentive Program and the IQR program. This flexibility will permit hospitals to report eCQM data that are relevant based on their patient population. The NHA requests that CMS clarify whether the clarification of this zero denominator policy is effective in CY 2015 or upon publication of the final rule.

CASE THRESHOLD EXEMPTION POLICY

The NHA supports the change in the case threshold exemption policy so that if an eligible hospital or CAH qualifies for an exemption from reporting on a particular eCQM, the exemption will count toward the 16 eCQMs required for reporting in the EHR Incentive Program. Eligible

hospitals or CAHs with five or fewer discharges during the relevant EHR reporting period or 20 or fewer discharges during the year should have the opportunity to report data for the 15 eCQMs for which the case threshold exemption does not apply and invoke a case threshold exemption for the eCQM for which the exemption does apply. This flexibility recognizes that the hospital or CAH may not meet the case threshold of discharges for a particular eCQM. .

OUTLIER

Outlier payments are reserved for high-cost outlier cases. Each year, CMS establishes a fixed-cost threshold that needs to be met before an outlier payment can be added to the base MS-DRG payment. CMS is proposing to increase this threshold by 18.6 percent, from $21,748 to $25,799. In order to continue this payment stream on which hospitals rely to care for high-cost outlier cases, hospitals are incentivized to increase their charges by the same rate of cost outlier change. In addition, the agency sets the fixed cost outlier threshold based on a percentage of total payments. **Historically, the actual outlays have been lower than the estimation and no effort is made to correct the forecasting errors**. The NHA encourages CMS to re-evaluate and lower the final fixed outlier threshold so hospitals can keep charge inflation as neutral as possible and ensure that the estimated outlier payments from CMS are actually paid.

PROPOSED MS-DRG RECALIBRATION BUDGET NEUTRALITY ADJUSTMENT FACTOR

The NHA believes CMS has miscalculated the MS-DRG recalibration BNA factor for FY 2015. Specifically, Section 1886(d)(4)(C)(iii) of the Act states that, beginning in FY 1991, the annual DRG reclassification and recalibration of the relative weights must be made in a manner such that aggregate payments to hospitals are not affected. CMS normalizes the recalibrated MS–DRG relative weights by an adjustment factor so that the average case weight after recalibration is equal to the average case weight before recalibration. However, since payments to hospitals are affected by several factors other than just the average case weight, budget neutrality is not necessarily achieved by this normalization alone.

The NHA strongly believes that the MS-DRG recalibration budget neutrality adjustment factor has been miscalculated and urges CMS to examine and make necessary corrections in the FY 2015 final rule.

CHANGES TO MS-DRG CLASSIFICATIONS

In general, the NHA has no objections to CMS's proposed changes to the MS-DRG classifications and the Medicare Code Editor, which seem reasonable given the data and information provided.

CODE FREEZE

The NHA continues to support CMS's recommendations to continue limited code updates to ICD-10-CM/PCS to capture new technologies and diseases through FY 2015. For FY 2015, there are no proposed new, revised or deleted ICD-9-CM diagnosis or procedure codes. **However, we recommend that no updates occur during the first year of ICD-10**

implementation, FY 2016. If new or revised codes can still be introduced into ICD-10-CM/PCS in FY 2016, it will make the resolution of any issues all the more complex and costly. Specifically, successful implementation of ICD-10-CM/PCS will require significant planning, education and systems modifications. While the adoption of ICD-10-CM/PCS is welcome and long overdue, implementation of the new system must be carefully orchestrated to minimize the administrative burden on providers. At a time when the health care field, all payers and other stakeholders are struggling to meet deadlines to change their systems and test their changes with all their trading partners, we believe it would be catastrophic to have to make additional changes during nationwide implementation of ICD-10.

PENALTY FOR FAILING TO MEET MEANINGFUL USE

Under statute, both IPPS hospitals and CAHs are subject to Medicare payment penalties in FY 2015 and later years if they fail to meet meaningful use, with the size of the penalty increasing over time. However, the two types of hospitals have different penalty structures based on different performance periods. All hospitals must meet either meaningful use or receive a hardship exception each and every year to avoid penalties.

The NHA is very concerned that CMS has not offered any policies or explanation in the proposed rule regarding how the agency will identify and notify the appropriate hospitals that they are subject to the significant payment penalties for failure to meet meaningful use. Given the magnitude of the penalties, and the newness of the program, the NHA believes it is crucial for the agency to be transparent and fair in its process for applying the penalties, as it has done for the quality reporting programs.

Based on CMS data on meaningful use attestations through December 2013, it is estimated that more than 500 hospitals could be subject to the penalty, leading to approximately $100 million in penalties. This is a substantial cut to hospitals that must be accompanied by a fair and transparent process for hospitals to be notified of penalties. PPS hospitals and CAHs must be provided the opportunity to ask for reconsideration and appeal a determination if the hospital disagrees.

We note that CMS has established a robust, timely process for hospitals to be notified of penalties under various quality programs, including the annual payment update (APU) determination process used for the IQR program, and similar programs for inpatient psychiatric and rehabilitation facilities. All of these processes are in place to ensure fairness, and in recognition that unintentional errors may occur.

We urge CMS to clearly outline a process for both IPPS hospitals and CAHs in subregulatory guidance as quickly as possible that:

- **Explains in detail the data and methods CMS will use to identify hospitals subject to the penalty;**
- **Describes how hospitals will be notified that CMS has identified them as subject to the penalty, including to whom the notification will be sent and how it will be sent;**
- **Provides specific and sufficient mechanisms for a hospital to ask for reconsideration of the penalty based on its own documentation (such as proof of attestation or hardship**

exception), and provides hospitals with at least 30 days, after receiving notification, to ask for such reconsideration;

- **Provides specific and sufficient mechanisms for a hospital to appeal the agency's determination after reconsideration, with at least 30 days after receiving the determination, to appeal; and**
- **Ensures that these mechanisms are widely communicated to the hospital community and accompanied by adequate timelines for a hospital to use them.**

We believe that the first year of any payment program is most likely to have unintentional errors, and the meaningful use program is no exception. In fact, a number of aspects of the meaningful use program may increase the risk of unintentional errors, heightening the need for a reconsideration process. These include the various timelines for attestation (those in their first year of meaningful can attest up to July 1, 2014), the introduction of a hardship exception program, the use of both national provider identifiers (NPIs) and CMS certification numbers (CCNs) in the attestation process, and issues with the attestation system.

REQUIREMENT FOR TRANSPARENCY OF HOSPITAL CHARGES UNDER THE ACA

The ACA requires each hospital to establish, update and make public a list of its standard *charges* for items and services it provides. In the proposed rule, CMS reminds hospitals of this obligation and indicates that it will provide hospitals with the flexibility to determine how they make their list of standard charges public. Specifically, CMS indicates that hospitals must either make public a list of their standard charges (whether that be the charge master itself or another form) or their policies for allowing the public to view a list of those charges in response to an inquiry. The NHA appreciates the additional flexibility CMS has granted to hospitals.

COST REPORT REQUIREMENTS AND PRRB JURISDICTION

The NHA urges CMS to abandon its proposal to require a provider to include all items on its cost report for which it is requesting payment as a condition for payment for those items. We also urge it to withdraw its proposal to eliminate the current provision that permits a provider either to claim reimbursement on its cost report for a specific item or to self-disallow the item and file the cost report under protest in order for the PRRB to have jurisdiction over that item. Under CMS's proposal, the requirement to include all items on the cost report would apply even if the provider believes the payment requested may not comply with Medicare policy. However, if a provider does not include an appropriate claim for an item in its cost report, it would not receive payment for that item and also would lose the ability to appeal that item to the PRRB. CMS proposes to apply this requirement to cost reporting periods that begin on or after the effective date of the final IPPS rule.

CMS's proposed change would inappropriately limit hospitals' ability to exercise their appeal rights based solely on the discretion of Medicare Administrative Contractors (MACs). Specifically, under the proposed change, while a provider that fails to include an item on its cost report could file an amended cost report or request a reopening by its MAC to add the excluded item, whether to accept an amended cost report or issue a reopening is entirely at the MAC's discretion under current Medicare regulations. Further, the MAC's decision to not accept an

amended report or to reopen a cost report is not subject to judicial review. Therefore, if a hospital does not correctly list an item on its cost report, its only avenue for correction would be to file an amended report or request reopening and hope that the MAC is amenable to the request. If the MAC is not, the hospital, under the changes proposed by CMS, would have no further administrative remedy.

The proposal unduly vests the MACs with overly broad authority over hospitals' right to appeal items on the cost report. In the preamble to the proposed rule, CMS states that it anticipates that providers and MACs will engage in a back-and-forth process to resolve issues that might currently end in appeal, and that this would help alleviate the workload of the PRRB. However, even assuming that reducing the PRRB's workload is an appropriate goal, it is wholly inappropriate to do so by limiting providers' appeals rights in such a manner. CMS presents no evidence that the MACs are equipped and prepared to engage in this type of back-and-forth process. Moreover, hospitals report that MACs routinely decline to accept an amended or reopen a cost report rather than making a considered decision after a thorough assessment of the facts.

In light of these concerns, the NHA strongly urges CMS not to adopt this proposal. However, in the event that CMS wants to require that all items for which payment is requested be included on the cost report, it should reissue for comment a revised proposal that addresses some additional issues to ensure that the requirement remains fair and is not unduly burdensome for providers' appeal rights. Such a revised proposal must at least:

- Include clear and uniform standards for MACs to apply when determining whether to accept an amended report or reopen a cost report;

- Address how CMS will monitor and enforce the MACs' exercise of their authority to make such decisions about amendments and reopening to ensure that they are fairly and consistently applying the standards for all providers; and

- Allow for exceptions in instances where a provider did not and – even exercising due diligence – could not have known information that it later discovers should have been listed on its cost report. Such situations appropriate for an exception might include cases where the hospital relies on information that it does not control to complete portions of the cost report, as well as situations where the hospital only discovers information after the fact has had a material impact on the cost report.

REGULATIONS GOVERNING USE/RELEASE OF MEDICARE ADVANTAGE RISK ADJUSTMENT DATA

In Sec. 422.310, CMS is proposing to expand the allowable uses and reasons for disclosure of risk adjustment data submitted to CMS by Medicare Advantage Organizations (MAOs), including clarification that disclosure would be permitted to contractors or other agents that conduct activities or analysis on behalf of CMS. The NHA is not fundamentally opposed to the additional purposes for disclosure of data used in determining Medicare Advantage risk adjustment as proposed. **We do, however, have significant concerns regarding the broad nature of these provisions, the potential risks associated with releasing sensitive and proprietary data even when aggregated, and the potential expansion of disclosures for**

commercial purposes. Price and charge data should not be collected, released or used since they are not relevant to risk adjustment.

The existing purposes for which CMS may use or disclose these data are to:

- determine risk adjustment factors used to adjust MA payments;
- update risk adjustment models;
- calculate Medicare DSH percentages;
- conduct quality review and improvement activities; and
- determine Medicare coverage.

CMS proposes to add the following purposes:

- conduct evaluation and other analysis to support the Medicare program (including demonstrations) and to support public health initiatives and other health care related research;
- activities to support the administration of the Medicare program;
- activities to support program integrity; and
- purposes permitted by other laws.

The proposal also would allow other HHS agencies, other federal executive branch agencies, states and external entities to obtain and use these data from CMS, but only for one of the specified purposes. The notice states that CMS "anticipates that nongovernmental external entities would generally only gain access to risk adjustment data in connection with public health initiatives and health care related research…"

CMS also proposes conditions for the release of the risk adjustment data. The data could not include medical records and other data collected for purposes of risk adjustment data validation (RADV) audits. Rather, CMS proposes to authorize use or release of encounter data records, including contract, plan and provider identifiers, but not payment information, and seeks comment on approaches to aggregating payment data for release as well as whether releasing payment data at the level of an encounter record would reveal proprietary negotiated payment rates. However, we note that while the limitations on specifications of several of these conditions are codified in the current or proposed regulations, the restrictions on "commercially sensitive data" are only listed in the preamble.

CMS proposes to release the least amount of data required to accomplish the goal for a project. Additionally, data would be released subject to federal law and regulations, CMS data sharing practices, aggregation of payment data (to protect commercially sensitive data), and protection of beneficiary identifier elements and confidentiality. While not proposing any revisions to the rules, CMS also asks for comments on whether the rules should address disclosure of these data for commercial purposes.

NHA's specific concerns related to this section include:

Proposed release of aggregated payment data. NHA recommends that Sec. 422.310 (f)(2)(iv) should be revised to prohibit the disclosure of plan or provider identifiable payment data outside the federal government. Such releases could create distortions in competition or inflation and could trigger antitrust concerns within both the health plan and provider communities. We recognize that CMS is trying to moderate this potential by proposing that such data be released only in the aggregate, but there are many circumstances that would make aggregated information identifiable for a specific plan or provider.

Recently, the Healthcare Financial Management Association formed a Price Transparency Task Force with broad stakeholder participation that included consumer, provider, health plan, watchdog, and quality improvement representatives. In describing the policy considerations when forming the task force's recommendations, they noted:

> Among the unique features of the U.S. healthcare marketplace is the existence of a business-to-business marketplace between providers and private health plans... From a consumer perspective, as a general rule, the more transparency the better. But within a business-to-business marketplace, some healthcare economists and the federal antitrust enforcement agencies have noted that public transparency of negotiated rates could actually inflate prices by discouraging private negotiations that can result in lower prices for some buyers. Within the privately insured market, these considerations suggest than an approach to transparency that emphasizes out-of-pocket payments for insured patients instead of full transparency of negotiated rates may be preferable.

The NHA supports this approach.

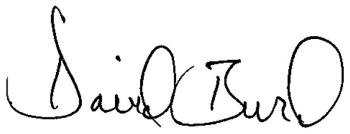
Further, in its August 1996 "Statements of Antitrust Enforcement Policy" (http://www.ftc.gov/sites/default/files/documents/reports/revised-federal-trade-commission-justice-department-policy-statements-health-care-antritrust/hlth3s.pdf), the Federal Trade Commission and the Department of Justice laid out several conditions for an antitrust safety zone (pages 44-45) related to the collective release of negotiated provider payment rates, noting that there would be instances where negotiated rates possibly could be discerned, such as areas with a dominant private payer.

Potential Use of Data for Commercial Purposes. CMS has specifically asked whether Sec. 422.310(f)(1) should be further expanded to address the disclosure of data for commercial purposes. It is difficult to offer comment on this issue when there is no proposed definition or explanation of what CMS would consider commercially sensitive data, and no discussion of what CMS would consider an appropriate commercial purpose or even an example of what a commercial purpose might include. We assume that CMS will publish proposed regulatory language if this issue is further pursued. In general, the NHA cautions against 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.

Needed clarifications. NHA recommends that CMS clarify Sec. 422.310(f)(1)(ix) regarding the allowable use and release of data for "purposes permitted by other laws." This provision is overly broad and must be further defined. For example, it does not distinguish federal from state or local laws, nor does it limit those laws to health care programs. We believe it is unwise to throw open the door this wide.

The NHA appreciates the opportunity to submit these comments on the proposed rule. Please feel free to contact us if you have any questions or if we can provide any additional information or clarification.

Sincerely,



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[i] See National Quality Forum, *NQF-Endorsed Measures for Patient Safety: Draft Report for Comment,* May 28, 2014. Available at http://www.qualityforum.org

[ii] See National Quality Forum, *NQF-Endorsed Measures for Patient Safety: Draft Report for Comment,* May 28, 2014. Available at http://www.qualityforum.org , page 55.

[iii] See National Quality Forum, *NQF-Endorsed Measures for Patient Safety: Draft Report for Comment,* May 28, 2014. Available at http://www.qualityforum.org , page 56.

[iv] See National Quality Forum. *NQF-Endorsed Measures for Patient Safety: Draft Report for Comment,* May 28, 2014. Available at: http://www.qualityforum.org.

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