



June 13, 2017

Seema Verma, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
CMS-1677-P
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-1677-P; Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2018 Rates; Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Electronic Health Record (EHR) Incentive Program Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Provider-Based Status of Indian Health Service and Tribal Facilities and Organizations; Costs Reporting and Provider Requirements; Agreement Termination Notices

Submitted electronically via <http://www.regulations.gov>

Dear Administrator Verma,

Trinity Health appreciates the opportunity to comment on the proposed policy and payment changes set forth in CMS-1677-P. Our comments and recommendations to the Centers for Medicare and Medicaid Services (CMS) reflect a strong interest in public policies that support better health, better care and lower costs to ensure affordable, high quality, and people-centered care for all.

Trinity Health is one of the largest multi-institutional Catholic health care delivery systems in the nation, serving diverse communities that include more than 30 million people across 22 states. Trinity Health includes 93 hospitals, as well as 121 continuing care locations that include PACE, senior living facilities, and home care and hospice services. Our continuing care programs provide nearly 2.5 million visits annually. Committed to those who are poor and underserved, Trinity Health returns almost \$1 billion to our communities annually in the form of charity care and other community benefit programs. We have 35 teaching hospitals with Graduate Medical Education (GME) programs providing training for 2,080 residents and fellows in 184 specialty and subspecialty programs. We employ approximately 131,000 colleagues, including more than 7,500 employed physicians and clinicians, and have more than 15,000 physicians and advanced practice professionals committed to 22 Clinically Integrated Networks that are accountable for 1.3 million lives across the country.

We appreciate CMS' ongoing efforts to improve payment systems across the delivery system. If you have any questions on our comments that follow, please feel free to contact me at wellstk@trinity-health.org or 734-343-0824.

Sincerely,

Tonya K. Wells
Vice President, Public Policy & Federal Advocacy
Trinity Health

Documentation and Coding Adjustment for MS-DRG Changes

Trinity Health is concerned by the continued, significant payment reductions and adjustments in the inpatient prospective payment system, particularly because of the considerable and important investments hospitals are making in care delivery models that support the move to alternative payment. In fulfilling the American Taxpayer Relief Act of 2012 (ATRA), CMS needed to recoup \$11 billion in payments to IPPS hospitals over fiscal years (FYs) 2014, 2015, 2016 and 2017. Beginning with the FY 2014 Final Rule, CMS adopted a policy to reduce payment rates by 0.8 percent each year in FY 2014 through 2017. However, in FY 2017, CMS indicated that additional reductions were necessary to reach the \$11 billion total. From a planning and budgeting perspective, this larger than anticipated cumulative percentage reduction has been a significant challenge for hospitals. Additionally, CMS' original four-year plan was to implement the recoupment through a cumulative adjustment of 3.2 percent, and the payment rates would have been increased by 3.2 percent in FY 2018 as the recoupment would be completed and no further payment reductions required. The Medicare Access and CHIP Reauthorization (MACRA) legislation replaced that one-time FY 2018 increase with increases of 0.5 percentage points over a six year period (FYs 2018 through 2023) resulting in a cumulative 3.0 percent increase in the rates, short of the total 3.2 percent that would have been restored under prior law.

We encourage CMS to take this delayed and reduced payback schedule into account as well as the increased burden this has placed on planning and budgeting. **Trinity Health urges CMS to make every effort to interpret and apply the statutory provisions related to documentation and coding so as to fully and permanently restore all recoupment adjustments to IPPS rates by FY 2023. Specifically, we request that CMS restore the MS-DRG adjustment to the full 3.2 percent.**

Disproportionate Share Hospital (DSH) Payment Changes

Factor 2

Beginning in FY 2018, CMS is no longer required by statute to use the Congressional Budget Office (CBO) estimates to determine the FY 2013 baseline from which the percent change in the rate of uninsurance is determined. CMS is proposing to use estimates from the CMS' Office of the Actuary as part of the development of the National Health Expenditure Accounts (NHEA). **Trinity Health supports this move to use NHEA data, rather than CBO, for calculating the uninsured rate, as this data source is superior in content, accuracy and timeliness.**

Factor 3

CMS proposes to begin a three-year transition to incorporate hospitals' Worksheet S-10 data into the methodology for determining uncompensated care payments beginning in FY 2018. We have significant concerns regarding the general reliability of the Worksheet S-10 as a source of data because CMS has made limited progress in fully improving the clarity of the instructions, testing the accuracy of the results and auditing facilities with questionable data.

Trinity Health agrees with having a transition period, but recommends—as we have previously—that CMS adopt a longer transition timeframe. **Specifically, Trinity Health recommends a five-year transition period to incorporate hospitals' Worksheet S-10 data for the reasons articulated below related to ensuring consistency, accuracy, auditing and avoiding wide swings in hospital payment from year to year.** Trinity Health supports the proposed three-year rolling average where an average of data from three cost reporting periods would be used instead of one cost reporting period.

While Trinity Health appreciates the updates that CMS has made to the S-10 Worksheet instructions, we believe that these instructions are still not being implemented consistently across

hospitals, and that such inconsistency compromises the validity and utility of the resulting data. Additionally, FY 2014 S-10 Worksheet data—the year being used to calculate uncompensated care payments—was collected before the S-10 Worksheet instructions were updated and clarified. Lastly, under CMS’ proposal, FY 2014-FY 2016 Worksheet S-10 data will not be subject to any desk review or audits. This further compromises the consistency and comparability of the data from one site to another. One to two years of audits and desk reviews are important to ensuring accuracy. **Trinity Health urges CMS to use Worksheet S-10 data from a year when further auditing and compliance has taken place in order to ensure consistency and fairness in payments. This also affirms the need for a longer, five-year transition.**

CMS also indicates that it does not anticipate making any further modifications to the Worksheet S-10 instructions at this time. While Medicaid and SSI days are clear, measurable and verifiable, data collection via the S-10 Worksheet is still too subjective in nature. We therefore recommend that CMS continue to work with hospitals and other stakeholders to improve consistency of the data compiled and recorded in the S-10 Worksheet. **Specifically, we urge CMS to engage in more robust education efforts with hospitals and continue to assess improvements to the instructions.**

Finally, Trinity Health believes the S-10 Worksheet should capture the broad array of uncompensated care provided by inpatient hospitals. **Trinity Health opposes the CMS proposal to exclude Medicaid shortfalls from the definition of uncompensated care as reported on the S-10 Worksheet.** We believe that uncompensated care should also include the unreimbursed costs of public health care programs, including Medicaid, the Children’s Health Insurance Program and state and local indigent care programs. Broadening the definition to include Medicaid shortfalls and other forms of unreimbursed costs of public health care programs would help make the allocation more equitable.

Wage Index – Imputed Rural Floor and Rural Census Tract

In FY 2005, CMS temporarily adopted an “imputed” rural floor policy by establishing a wage index floor for those states that did not have rural hospitals. CMS subsequently extended this policy through FY 2017. However, CMS does not propose to extend the policy again for FY 2018. Trinity Health is disappointed that CMS is not extending the imputed rural floor in the absence of more comprehensive area wage index reform. As the country moves to payment for value and alternative payment models (APMs) the importance of these policies will be lessened; but, currently the wage index remains an important component of fee-for-service payments.

The imputed rural floor is an equitable measure established by CMS which provides relief to hospitals in all-urban states. This long-standing policy has reduced volatility and increased the equitability of the wage index system. We do not believe that CMS should remove the imputed rural floor from all-urban states. Regarding CMS’ concern with the payment impact from the existing imputed floor policy to states with rural hospitals which do not have urban hospitals that benefit from a rural floor, we believe this should be reviewed as part of a comprehensive review of the Medicare wage index system rather than an isolated component. **Trinity Health recommends that CMS allow the industry to consider all recommended changes to area wage index reform, and have a chance to provide input to CMS prior to finalizing any decisions regarding elimination of the imputed rural floor. This elimination would greatly impact our Trinity Health safety-net hospitals in Trenton and Camden, New Jersey. If there is a decision made to eliminate the imputed rural floor, the decision should include a two year notification period to allow impacted hospitals appropriate planning time. CMS has extended such advance notice, including in changes concerning the wage index, for this purpose in the past.**

Furthermore, CMS has also disadvantaged providers in all-urban states through its refusal to recognize rural census tracts in all-urban states as a rural area. This occurs via application of Sec. 412.103 which states “Hospitals that are geographically located in States without any rural areas are ineligible to apply for rural reclassification in accordance with the provisions of 42 CFR 412.103.”

This Section clearly identifies rural census tracts within urban areas as a rural area for purposes of applying Section 412.103. **CMS should allow providers in all-urban states, which have rural census tracts in urban areas, to utilize Section 412.103.** New Jersey, for example, has multiple rural census tracts spread over 5 counties and comprising over 100,000 in population. These federally identified rural areas and classifications are not insignificant in either area or population and should be recognized by CMS for purposes of applying Section 412.103. This suggested handling would be congruent with current law, congruent with other federal programs recognizing these areas as rural, create a more equitable wage index system, and provide a potential relief mechanism to those providers disadvantaged by the removal of the imputed rural floor.

Changes to Instructions for the Review of the Critical Access Hospital (CAH) 96-Hour Certification Requirement

As a condition of payment for inpatient services provided at a Critical Access Hospital (CAH), statute requires that a physician certify that an individual may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the CAH. CMS indicates that it does not have discretion to modify the physician certification requirement through regulation, but has reviewed it to determine if there are ways to reduce its burden on providers. **Trinity Health appreciates and supports CMS' proposal to make this requirement a low priority for medical record reviews conducted on or after October 1, 2017 in the absence of any concerns around probable fraud, waste or abuse of the coverage requirement. Furthermore, we urge CMS to finalize this proposal on a permanent basis to provide CAHs with certainty that the agency will not begin to audit the 96-hour hour certification requirement in the future.** We appreciate CMS' recognition that this condition of payment creates challenges for the ability of CAHs to ensure access to certain important services that have standard lengths of stay greater than 96 hours.

Eliminating Inappropriate Medicare Payment Differentials

Referencing MedPAC's June 2015 Report to Congress where MedPAC stated "the high profitability of one-day stays under the inpatient prospective payment system (IPPS) and the generally lower payment rates for similar care under the outpatient prospective payment system (OPPS) have heightened concern about the appropriateness of inpatient one-day stays," CMS is seeking comments on transparent ways to identify and eliminate inappropriate payment differentials for similar services provided in the inpatient and outpatient settings.

Trinity Health believes it is important to recognize that when physicians use clinical judgment to admit a patient, they are considering the acuity of the patient among other factors and steer the more difficult cases to the inpatient setting. It is not enough to simply know what DRG a patient would have been grouped under in the IPPS instead of OPPS. It is critically important to also understand what the differences are in the patients and the services they received in one setting versus another. While we appreciate CMS seeking comments on this subject before making a formal proposal, the lack of clarity around this request makes it very difficult for us to substantively comment on potential policy solutions. **Any proposal to equalize Medicare payment for inpatient and outpatient services based solely on reducing inpatient payments would not adequately take the above considerations into account.**

Overall Hospital Quality Reporting and Pay-for-Performance Programs

Measuring Outcomes, Not Process

Trinity Health encourages CMS to remove redundancy when selecting measures across programs and evolve all quality reporting to focus on outcome rather than process measures. Harmonization across quality reporting programs, including utilization of the same definitions, is important. **We strongly believe that quality measurement should be focused on a small number of metrics that emphasize patient-reported and patient-generated data. Trinity Health urges CMS to**

focus on outcomes-based measures that are meaningful to patients and reflect successful performance against the desired outcomes of better health, better care and lower costs.

Furthermore, as quality reporting shifts from manually abstracted data to electronic reporting, we especially encourage CMS to focus efforts on development and refinement of outcome measures rather than process measures. Definition changes and electronic health record (EHR) vendor-specific challenges result in considerable effort and re-work to obtain specified data on process measures from the EHR. Once data can be obtained, the value of it in accurately representing the clinical process is questionable. Measure exclusions and clinical process specificity is often not retrievable in a way that compares with the manually abstracted data. The exercise of producing the data is extensive; however because of the challenges noted above, the value of the data produced and the ability to utilize the data to improve care is minimal. For example, the sepsis bundle (SEP-1) initiated in October of 2015 continues to be a very labor intensive measure. With over 60 abstracted fields covering seven process components of care, abstraction burden is considerable. Many vendor systems are unable to reflect compliance within the components of care and are only able to reflect compliance of the bundle measure. A hospital can be unaware if their primary problem exists with timing of blood cultures versus fluid resuscitation since the abstraction tool output reflects only overall bundle compliance. Again, CMS should, instead, focus these measures on the outcome not the process to make it meaningful, care improvement data.

Accounting for Social Risk Factors

Trinity Health takes a holistic view to caring for each patient – we are not only assessing the disease process but working diligently to understand the role that each patient's environment and social determinants play in his or her health status. We believe this is essential to delivering people-centered care. Trinity Health agrees with findings that current policy is unintentionally weakening the network of providers that serve disadvantaged populations, which could have the unintended consequence of worsening health disparities. Sociodemographic risk adjustment would level out the factors that are not under the control of the provider yet at the same time hold all providers accountable for high-quality care. In the absence of sociodemographic risk adjustment, quality measures reflect the underlying disparities of the populations served instead of the relative quality of the services delivered. **Trinity Health has long advocated that quality measure data be risk-adjusted for sociodemographic factors. Significant factors include: income, education, race (including ethnic background), payer type, patient travel distance (derived from their zip code), homelessness and language proficiency, all of which have been shown to have a significant relationship to a person's health outcomes.**

Implementing HCAHPS Pain Management Changes

Trinity Health remains very concerned by the staggering toll of the opioid epidemic on communities across our country and we are taking steps to build awareness and education internally and externally on this important matter. We commend CMS for previously removing the Hospital Consumer Assessment of Healthcare Providers and Services (HCAHPS) survey questions related to pain management from the Hospital Value Based Purchasing (VBP) Program. Removing the questions from scoring in the VBP Program was an important step in eliminating any perceived expectation that pain management should always include the use of powerful prescription drugs such as opioids. While removing the questions from VBP scoring, CMS retained these questions in the HCAHPS for purposes of the Inpatient Quality Reporting (IQR) Program. If finalized, the new "Communication about Pain" questions would be applicable to patients beginning with January 1, 2018 discharges, and public reporting of HCAHPS measures require four consecutive quarters of data, meaning that the first public reporting of the new measure on Hospital Compare would be in October 2019 with the last public reporting of the current "Pain Management" questions would be in October 2018.

Trinity Health believes that CMS needs to focus on overall patient satisfaction, rather than the granular level of detail currently included in many of the HCAHPS questions, and encourages CMS to leave this level of patient satisfaction data to providers to determine and measure. If CMS moves forward with this level of detail, we do believe these new pain questions—focused on effective communication about pain during the hospital stay—represent significant improvement in capturing the patient's perception of the care team's awareness of their pain and treatment options. However, these alternative questions need to be studied for their potential effect on clinician behavior and patient outcomes. We urge CMS to complete this work as quickly as possible because pain management is an important part of patient experience and the healing process. **Trinity Health urges CMS to seek National Quality Forum (NQF) endorsement for the revisions and to continue to work with the Measure Applications Partnership (MAP) to address concerns about the reliability and validity of the new questions before they are finalized and implemented in the IQR Program.** The NQF endorsement and MAP processes allow the measure to be publicly vetted, and often these processes identify the need for major specification changes or minor refinements that will make for more effective implementation and results.

CMS also states that if this proposal to adopt the new "Communication about Pain" composite measure is not finalized, the current "Pain Management" composite would continue to be used in the HCAHPS survey for the IQR Program. We support retention of the pain questions in the HCAHPS survey, thus providing hospitals and CMS with important patient experience data. **However, if a measure is believed to have significant unintended consequences—as has been the case with the link between these questions and the opioid crisis—we believe that those questions should be removed from both payment programs (e.g., VBP) as well as public reporting programs (e.g., IQR) until the new questions are properly examined and tested.**

Hospital Readmissions Reduction Program (HRRP)

FY 2018 Performance Period and ICD-9 versus ICD-10 Data

Trinity Health encourages CMS to undertake analyses of any performance differences resulting from the transition to ICD-10 for all of the measures used in all of its public reporting and pay-for-performance programs. The results of those analyses should be made available publicly. Such data would help inform hospitals about any potential unintended biases and measure performance changes resulting from the use of the new codes. The data would also provide insight on whether it is actually appropriate to mix data collected using ICD-9 with data collected using ICD-10.

FY 2019 Adjustment for Social Risk Factors in the HRRP

As included in the 21st Century Cures Act passed by Congress last year, CMS is required to change the HRRP payment adjustment methodology beginning in FY 2019. Specifically, the Secretary is directed to assign hospitals to peer groups based on the proportion of Medicare inpatients who are full-benefit Medicare and Medicaid dual eligibles, and to develop a methodology that allows for separate comparisons for hospitals within these groups. **Trinity Health applauds CMS for this important step to taking socioeconomic status into account in the HRRP. While accounting for dual-eligible status is a reasonable first step, Trinity Health encourages CMS to lay out a longer-term effort for testing and refining additional variables when accounting for social risk factors as discussed in our earlier comments regarding the wide range of variables that impact a person's health outcomes.** The NQF and the National Academy of Medicine both have reports identifying the types of socioeconomic factors that may influence performance on readmissions. One particularly promising set of data is census-tract data on poverty rates and income, both of which are readily available and could be mapped to a hospital's patient population using zip codes. The dual-eligible population is just one type of high-cost/high-risk patient. While they are an important area of focus, Trinity Health believes that focusing only on dual-eligibles is not enough and that other factors should be included in efforts to create risk tiers used to identify high-cost/high-risk patients. **Furthermore, Trinity Health also urges CMS to ensure full transparency**

on the proposed FY 2019 approach by making more data available on how the agency determines peer groupings, confirming those groupings are a statistically valid population size per hospital, and providing hospitals a confidential report to support hospitals' understanding of this new methodology.

Hospital Value Based Purchasing (VBP) Program

Starting with the FY 2019 VBP Program, CMS proposes to remove the current ICD-9 based version of the claims-based patient safety indicator (PSI) composite because it does not yet have the software to calculate it in ICD-10. However, CMS would reintroduce a revised version of the PSI composite based on ICD-10 data as part of the FY 2023 VBP program. **Trinity Health is pleased that CMS removed the PSI-90 measure. This measure is an important example of CMS focusing too much on process measure reporting that requires too many discrete data points, and measures that often do not provide accurate, meaningful data. This is particularly problematic when included in the VBP Program. If re-visited, we encourage CMS to do so in future rule-making and to further ensure that hospitals have the opportunity to review performance and inform CMS and the measure developer of any implementation concerns.**

CMS proposes to add a hospital-level, risk standardized 30-day pneumonia episode of care payment measure to the VBP Program for FY 2022 payment. This measure overlaps with the Medicare Spending per Beneficiary (MSPB) measure and as discussed previously it is not risk adjusted for socioeconomic status. **Trinity Health has concerns about adding this measure to the VBP Program as this condition-specific payment measure does not provide additional information and is duplicative to the MSPB measure. CMS could retain this measure in the IQR Program and explore methods for pairing the payment and cost measures so that they signal value to beneficiaries.**

Inpatient Quality Reporting (IQR) Program

Electronic Clinical Quality Measures

Trinity Health very much supports the use of quality metrics that can be derived from electronic health records (EHRs) and submitted to CMS electronically, but we also want to ensure these electronic measures are accurate and reliable, the timeline for submission is realistic, and that the CMS submission portal is effectively operating for hospitals to be able to reliably submit and fulfill requirements in a timely manner. **We have previously urged CMS to: develop a long-term eCQM strategy that focuses on a small number of metrics that emphasize patient-reported outcomes and patient-generated data; articulate that strategy in a step-wise process further in advance, rather than only for the next implementation year; and build that timeline to include performance measurement in future years so vendors and hospitals can begin planning now. We continue to encourage this of CMS. Additionally, we urge CMS to further collaborate with hospitals in the identification and sharing of successful practices in data mapping, data validation, and test production file submission.**

CMS is proposing two electronic clinical quality measure (eCQM) reporting requirement modifications for the calendar year (CY) 2017 reporting period and FY 2019 payment determination and the CY 2018 reporting period and FY 2020 payment determination. First, hospitals will report on at least six of the available eCQMs, instead of eight; and secondly, hospitals will submit two self-selected quarters of data, instead of one full calendar year of data. **Trinity Health applauds CMS for the reduction in the number of measures to report and the reduction in the number of quarters that are required to be reported as this was our recommendation in last year's IPPS proposed rule.** Trinity Health supports these modifications starting in 2017 and greatly appreciates CMS consideration of the many challenges faced by hospitals in the 2016 requirement for eCQM submission. The number of measures to report matches the Joint Commission requirement which supports alignment among the many programs that are required of hospitals, another

recommendation we have continually sought and appreciate. However, there is still an additional reporting burden as the data must be submitted separately. We urge CMS and the Joint Commission to work together to provide a single submission platform and reduce the burden to a single submission to meet requirements of both regulatory bodies. **We also believe it is important to note that hospitals experienced significant issues with CMS' portal. Trinity Health urges CMS to address those issues and if they persist, additional flexibilities must be provided with this process.**

CMS is proposing modifications to a number of policies for eCQM validation. Trinity Health supports the following proposals: to adjust the sample size of data needed for validation, to expand all the exclusions defined for the selection of hospitals and selection of cases for 2017 and 2018 reporting, and for the accuracy of the eCQM validation not to affect the hospital's validation score for IQR through 2021. Because of the portal issues described above, Trinity Health is concerned with how the validation will be satisfied. **Therefore, Trinity Health urges CMS to improve the capacity of the QualityNet system to receive QRDA-I files and send a submission summary and performance reports before increasing the number of QRDA-I data files that hospitals must submit.** Furthermore, much of the data required in the QRDA-I format is coded to the standards defined in the value sets and the codes will not necessarily be "printed" in the PDF version. We, therefore, also encourage CMS to further clarify how the agency will do some of this validating. For example, the code for RXNorm is actually found on a background table in our database, so will the agency be validating the actual drug form, dosage and frequency which will show up in the list of medications given to the patient, or will the agency be looking for the RxNorm code? This requires clarification.

CMS proposes to require hospitals to have their EHR technology certified to all eCQMs that are available for hospitals to report in order to meet the eCQM reporting requirements. This would be applicable for the CY 2017 and CY2018 reporting periods and applicable for 2014 Edition and 2015 Edition certified technology. **Trinity Health supports the proposal to require certified functionality for all of the eCQMs that can be reported. However, we do not support the use of a combination of 2014 and 2015 certification due to the complex deployment this would create. Instead, we urge CMS to require the use of either 2014 or 2015. Further, we urge CMS to work with the Office of the National Coordinator (ONC) and health IT vendors to ensure that the 2015 Edition is capable of supporting hospitals eCQM reporting, including reporting any of the eCQMs that are available to report in IQR.**

Other Proposed Measures

CMS is proposing to include an assessment of stroke severity in the risk-adjustment model of the stroke mortality measure. Trinity Health applauds CMS for incorporating the National Institutes of Health (NIH) stroke scale into the measure as this is consistent with current clinical guidelines and the single most accurate measure for stroke functional outcomes and mortality. However, we urge CMS to fully test the measure using ICD-10 codes and to ensure that the measure is endorsed by the NQF before moving forward. CMS is also proposing to adopt a Hybrid Hospital Wide Readmission (HWR) measure as a voluntary measure for the CY 2018 reporting period. We do have some concerns with the data reporting requirements of this measure and potential unintended consequences. While we support reporting of core clinical data elements of vital signs, we have concerns about the potentially unnecessary diagnostic studies that are required to have at least 50 percent of the index population in these results. Furthermore, this data may not be able to be captured electronically for reporting, nor be within the time frame specified as within 24 hours. Lastly, CMS proposes potential future inclusion of seven measures (one measure related to the quality of informed consent documents, four measures that evaluate end-of-life processes and outcomes for cancer patients, and two measures that evaluate nursing skill mix); and additional eCQMs that assess opioid prescribing practices, tobacco use, and substance use. **Trinity Health strongly encourages CMS against adding any measures to the IQR that require manual chart abstraction and encourages the agency to ensure that only eMeasures be added to the**

program as described earlier in our comments. Additionally, as described elsewhere in our comments, we expect measures to be nationally endorsed by a multi-stakeholder organization; developed with the input of providers, purchasers, payers, and other stakeholders; aligned with best practice; and vetted through the MAP process with NQF endorsement for all measures.

Changes to the Medicare and Medicaid EHR Incentive Program

Trinity Health has long advocated for a 90-day reporting period in all Meaningful Use program years and **applauds CMS for this proposal to include a 90-day reporting period for IPPS and CAHs in the 2018 program year.**

We appreciate CMS' recognition of the need for flexibility in 2018 related to certification requirements. As stated above, however, we do not support the use of a combination of 2014 and 2015 certification due to the complex deployment this would create. Instead, we urge CMS to require use of either 2014 or 2015 and for CMS to work with the ONC and health IT vendors to ensure that the 2015 Edition is capable of supporting hospitals eCQM reporting, including reporting any of the eCQMs that are available to report in IQR.

In our above comments related to eCQM validation for the IQR Program, we discussed concerns related to the functionality of the QualityNet portal in order to support an increase in the number of eCQM data files reported. **We also urge CMS to provide information and clarity on how the status of the electronic uploads will be presented in the EHR Incentive portal for Meaningful Use attestation as well as the timing for those updates.** QualityNet and the Meaningful Use attestation portal are separate portals that communicate. After the two portals communicate, a file is sent to the multiple state Meaningful Use Incentive program portals—for Medicaid—to indicate that a site has completed the Meaningful Use attestation at the Medicare level. However, neither QualityNet nor the Meaningful Use attestation portal for Medicare could previously give a timeframe for when this communication and update would be complete and this was a significant issue in previous Meaningful Use attestation as it is part of the Medicaid attestation requirement and in many cases had to be done within a few weeks of the attestation due date. **Again, we urge CMS to provide further clarity on the status of information uploaded in the EHR Incentive portal as well as the timing related to communication of that information among all stakeholders.**

Changes to Survey and Certification Requirements

CMS proposes to require accrediting organizations (AOs) with CMS-approved accreditation programs to make hospital survey reports and acceptable plans of correction public. Under the provisions of the proposed rule, each national AO that applies or reapplies for CMS approval of its Medicare provider or supplier accreditation program must agree to make all Medicare provider or supplier final accreditation survey reports, including deficiency information and plans of correction, publicly available on its website. AOs must post the information, which would cover the most recent three years, within 90 days after it is available to facilities.

Trinity Health strongly supports transparency efforts and public reporting that is done in a manner that provides meaningful information to consumers in a format that is understandable and easily accessible. Furthermore, Trinity Health believes that coupling measurement based on outcomes with transparency tools allows the marketplace to drive providers to develop and continuously improve upon the most effective care processes. We have worked diligently to help identify and provide the most useful, valid and reliable information to the public. Trinity Health does not believe this proposal would serve the important goal of educating consumers and providing them with meaningful information on quality of care. These survey reports are not health care quality data; but rather, they are quality improvement tools for health care providers, which is an important distinction.

Making these lengthy reports publicly available would be extremely confusing for consumers. Additionally, there is no evidence to suggest that it would improve patient safety or quality. And, furthermore, public release of these full reports would very likely have the opposite effect and disrupt this important quality improvement process. **Therefore, Trinity Health strongly encourages CMS not to finalize this proposal.** We urge the agency to; instead, work with AOs, hospitals, other health care provider organizations, and experts on transparency to determine what information, if any, can be derived from these surveys that would be useful to patient and family decision-making. Then, together, these stakeholders can assess whether this additional information is worthy of being added to the vast amount of data and other information CMS already provides on *Hospital Compare*, and other similar websites, to create a more complete picture of quality for the public.