June 13, 2017

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1677–P
P.O. Box 8011
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 (Vol. 82, No. 81), April 28, 2017

Dear Ms. Verma:

On behalf of its 71 acute care hospital members, the New Jersey Hospital Association (NJHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) hospital inpatient prospective payment system (PPS) proposed rule for fiscal year (FY) 2018.

While we support a number of the proposed rule's provisions, we have concerns about others. In particular, NJHA has serious concerns about the agency's proposal to discontinue its policy on the imputed floor, its proposal to begin using Worksheet S-10 data to distribute Medicare DSH payments, its intention to not restore last year's larger than anticipated documentation and coding reduction, and its proposed public reporting requirements for accrediting organizations.

IMPUTED FLOOR WAGE INDEX POLICY

As we have outlined in an earlier comment letter (submitted under separate cover on May 15, 2017), NJHA is extremely disappointed that CMS has signaled its intention to discontinue its policy on the imputed floor. In the rulemaking process for the FY 2005 inpatient PPS, CMS proposed, then finalized, an "imputed" floor wage index policy for all-urban states. Part of the agency's rationale was the fact that hospitals in all-urban states with predominant labor market areas did not have any protection, or "floor," from declines in their wage index:

> In this final rule, we are adopting a variation of the policy that we discussed in the May 18, 2004 proposed rule. We note first that there are similarities among the three States that are not impacted by the rural floor. Obviously, they are urban States. In addition, each of the three States has one predominant labor market area. That, in turn, forces hospitals that are not located in the predominant labor market area to compete for labor with hospitals that are located in that area. However, because there is no ''floor'' to protect those hospitals not located in the predominant labor market area from facing continued declines in their wage index, it becomes increasingly difficult for those hospitals to continue to compete for labor. In the BBA, Congress spoke of an "anomaly" in States where hospitals located in urban areas had a wage index that was below the wage index applicable for hospitals located in rural areas. (See H.R. Rep. No. 149, 105th Cong., 1st Sess. At 1305.) **We think it is also an anomaly that hospitals in all-urban States with predominant labor market areas do not have any type of protection, or "floor," from declines in their wage index. Therefore, we are adopting the logic similar to that articulated by Congress in the BBA and are adopting an imputed rural policy for a 3-year period** (emphasis added). (69 FR 49110)

NJHA has strongly supported the policy ever since, as it creates wage index consistency and equity between states with rural areas and entirely urban states.

We would like to bring to your attention the following policy views in favor of maintaining the imputed wage index floor policy:

- **"STATUS QUO"**
  In both the FY 2014 and FY 2015 inpatient PPS final rules, CMS extended the imputed floor for an additional year, during which time the agency would continue to explore potential wage index reform. As of the publication of the FY 2018 inpatient PPS proposed rule, comprehensive reform of the Medicare wage index system has not yet occurred nor have plans to do so been announced. **CMS should maintain the status quo – including the imputed floor policy – throughout the entirety of the Medicare wage index system until such reform is achieved.**

- **TRANSFER OF PAYMENTS**
  In the FY 2018 inpatient PPS proposed rule, CMS states that:

  > …the application of the rural and imputed floors requires transfer of payments from hospitals in States with rural hospitals but where the rural floor is not applied to hospitals in States where the rural or imputed floor is applied. For this reason, in this proposed rule, we are proposing not to apply an imputed floor to wage index calculations and payments for hospitals in all-urban States for FY 2018 and subsequent years. (82 FR 19905)

  By eliminating the imputed floor wage index, CMS is alleviating only a fraction of the combined payment transfer from the application of the rural and imputed floors. According

to data in the FY 2017 inpatient PPS final rule, 18 New Jersey hospitals received the imputed floor. Combined, hospitals in the three all-urban states (New Jersey, Rhode Island and Delaware) accounted for less than 10 percent of the 397 hospitals nationally that received either the rural or imputed floor last year.

- **LOSS OF FUTURE PROTECTION / UNEVEN PLAYING FIELD**
  CMS also states that the imputed floor creates "a disadvantage in the application of the wage index to hospitals in States with rural hospitals but no urban hospitals receiving the rural floor" (82 FR 19905). However, those urban hospitals retain all the future wage index protections associated with the rural floor. Eliminating the imputed floor would create the same uneven playing field that existed prior to 2005, in response to which CMS initially established the policy. The anomaly originally cited by CMS (i.e., that hospitals in all-urban states with predominant labor market areas do not have any type of protection, or "floor," from declines in their wage index) would exist again should the imputed floor policy be discontinued.

- **OTHER MEDICARE PROGRAMS ARE REDISTRIBUTIVE**
  There are many Medicare payment programs that redirect scarce Medicare funding to a class of unique hospitals. Not all states have hospitals that benefit from these programs. For example, CMS makes payments to Critical Access Hospitals (CAH) at a rate of 101 percent of their cost. New Jersey does not have any Critical Access Hospitals and therefore does not benefit from this program. While CAHs are paid outside the inpatient PPS program, the dollars continue to come from a finite Medicare trust fund. This represents a transfer of payments from hospitals in states without any CAHs into states with CAHs similar to the transfer of payments CMS cites as its rationale to discontinue the imputed floor.

While the number of hospitals benefitting from the imputed floor has declined in recent years, its importance to those receiving it remains high. In FY 2015 CMS adopted for wage index purposes the OMB's updated definitions for Core Based Statistical Areas (CBSAs) to reflect the new 2010 standards and 2010 Census data. The updated CBSAs resulted in fewer New Jersey hospitals receiving the imputed floor wage index. On average, for the three-year period (FY 2012-2014) preceding the changes in CBSA definitions, 30 New Jersey hospitals annually benefitted from the imputed floor policy. For the three-year period immediately following the CBSA changes (FY 2015-2017), 18 New Jersey hospitals, on average, benefitted annually from the floor policy.

Even with the changes to the CBSA, imputed floor hospitals cannot rely on the Medicare reclassification process to assist them should the provision be discontinued. Based on NJHA's review of CMS data, we estimate that 17 New Jersey hospitals would benefit from the imputed floor wage index in FY 2018 if the provision was extended. Of these, only 6 hospitals have a reclassification that would result in a wage index greater than the wage index of their geographical area. Even for these 6 hospitals, the reclassified wage index would be significantly lower than estimated imputed floor wage index. The remaining 11 imputed floor hospitals either do not qualify for a reclassification or have a reclassification that would result in a wage index

lower than the wage index of their geographical area. As a result, imputed floor hospitals cannot rely on reclassifications to replace the benefit of the imputed floor.

There is precedent for CMS to restore, in the final rule, policies or provisions that were scheduled for elimination or discontinuation in the proposed rule. In the FY 2012 inpatient PPS proposed rule, CMS stated that the imputed floor would expire on Sept. 30, 2011. However, in the final rule CMS announced that the imputed floor provision was extended for two additional years, through FY 2013 (Sept. 30, 2013).

NJHA and our member hospitals throughout the state have long maintained that the imputed floor wage index creates a climate of symmetry, equity and consistency in the Medicare reimbursement process. **We strongly urge CMS to rescind its proposal to discontinue the imputed floor wage index policy.**

DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENT CHANGES

TRANSITION TO WORKSHEET S-10

For several years, CMS discussed using the cost report's Worksheet S-10 data on hospital charity care and bad debt to determine the amount of uncompensated care each hospital provides, in place of the current formula of Medicaid and Medicare Supplemental Security Income (SSI) days. However, because of concerns regarding variations in and the completeness of these data, CMS had stated that it was premature to propose the use of Worksheet S-10.

In the FY 2017 inpatient PPS final rule, the agency addressed the issue again and indicated that it planned to institute certain additional quality control and data improvement measures, including an audit process, to the Worksheet S-10 instructions and data. CMS also stated that it intended to begin incorporating Worksheet S-10 data into the DSH computation once these additional measures were in place (but no later than FY 2021) and that the agency would re-propose a policy related to incorporation of these data prior to that time. However, for a variety of reasons, CMS now believes it has reached a "tipping point" with respect to the use of Worksheet S-10 data and proposes to, starting in FY 2018, begin a three-year phase in of incorporating hospitals' Worksheet S-10 data into the methodology for determining uncompensated care payments.

NJHA continues to believe that, if reported in an accurate and consistent manner, the Worksheet S-10 data have the potential to serve as a more exact measure of hospital uncompensated care costs. However, we still have concerns over the accuracy and consistency of the data.

We urge CMS to delay use of the Worksheet S-10 in calculating DSH payments by one year (i.e., begin using the S-10 data in FY 2019 rather than FY 2018). Such a delay would provide CMS with an important opportunity to further educate hospitals about how to accurately and consistently complete the S-10, including allowing them to correct their data retroactively if necessary. We also strongly urge the agency to have an audit process for the S-10 data in place by this time to ensure the data are sufficiently accurate and consistent.

In addition, CMS should implement a phase-in approach of at least three years when transitioning to the Worksheet S-10 data. A stop-loss policy should also be implemented to protect hospitals that lose more than 10 percent in DSH payments in any given year as a result of transitioning to the Worksheet S-10. This stop-loss should extend beyond the transition to help hospitals with decreasing uncompensated care payments adjust to their new payment levels.

CHANGES TO ENSURE THE ACCURACY AND CONSISTENCY OF THE WORKSHEET S-10 DATA

- **Uncompensated Care.** CMS proposes that, beginning in FY 2018, uncompensated care costs would be defined to include line 30 of the Worksheet S-10, which includes the cost of all charity care and non-Medicare bad debt. However, the agency also proposes that Medicaid shortfalls (i.e., the unreimbursed costs of Medicaid, State Children's Health Insurance Program, and other state and local government indigent care programs) reported on line 19 of Worksheet S-10 would *not* be included in the definition of uncompensated care. **NJHA continues to recommend that the definition of uncompensated care be broad based and include all unreimbursed and uncompensated care costs, including not only charity care and bad debt but also the unreimbursed costs of Medicaid, State Children's Health Insurance Program (SCHIP), and other state and local government indigent care programs) reported on line 19 of Worksheet S-10.** This broad definition of uncompensated care costs will be important in accurately measuring a hospital's unreimbursed costs, and it will ensure the most appropriate basis for calculating future uncompensated care payments.

- **Discounts.** The ACA directed the uncompensated care pool to account for the uncompensated costs of the "uninsured." Yet, Worksheet S-10 does not comprehensively account for the costs incurred by hospitals in treating the uninsured. Specifically, while line 30 includes charity care and non-Medicare bad debt, as CMS itself has indicated in previous rulemaking, there is variation in how different States, provider organizations and federal programs define uncompensated care. We have heard from hospitals that they incur costs of treating uninsured patients that are not categorized as either charity care or non-Medicare bad debt and, therefore, are not appropriately captured on the S-10. **Consistent with our recommendation that CMS adopt a broad definition of uncompensated care costs, we also recommend that these discounts (regardless of whether they are called "discounts" or some other term) for uninsured individuals be included in the definition of uncompensated care in the Worksheet S-10.** They are clearly costs that hospitals incur in providing treatment to the uninsured – not including them would inappropriately penalize these hospitals and run contrary to the underlying intent of uncompensated care payments under the ACA.

- **Revisions to the CCR for Worksheet S-10.** The ratio of cost to charges calculation on line 1 of Worksheet S-10 flows from Worksheet C, column 3 (costs) and column 8 (charges). Column 3 costs do not include the cost of training residents (direct graduate medical education (GME) costs), but Column 8 charges do inherently include the cost of training residents. Therefore, the numerator and denominator of the CCR are not consistent. **NJHA recommends that the formula calculating the CCR for Worksheet**

S-10 be modified to include GME costs. This could be accomplished easily by using costs from Worksheet B, column 24, line 118.

PROPOSED DSH PAYMENTS FOR FY 2018

For FY 2018, CMS estimates that the total amount of Medicare DSH payments that would have been made under the pre-FY 2014 formula is $16.003 billion. Therefore, it proposes that hospitals would initially receive 25 percent of these funds, or $4.001 billion, as empirically justified DSH payments. The remaining $12.002 billion would flow into the 75-percent pool. To calculate what portion of the 75-percent pool is retained, CMS determined that the percentage of uninsured for FY 2018 would be 8.15 percent. After inputting that rate into the statutory formula, it proposed to retain 58.21 percent – or $6.962 billion – of the 75-percent pool in FY 2018. This amounts to an increase of about $1 billion in Medicare DSH payments in FY 2018 compared to FY 2017. **We are supportive of this proposal.**

TRANSPARENCY RELATED TO DSH CALCULATION

NJHA continues to be concerned about the agency's lack of transparency with regard to how CMS and the Office of the Actuary (OACT) are calculating DSH payments. This is particularly troubling because Congress has generally foreclosed subsequent review, making the adequacy and completeness of notice-and-comment rulemaking that much more important from a constitutional due process perspective. We urge CMS to provide additional information related to all DSH calculations.

NATIONAL HEALTH EXPENDITURES ACCOUNT (NHEA) DATA

CMS proposes to change its data source for calculating the uninsured rate from the Congressional Budget Office to estimates produced by its Office of the Actuary as part of the development of the National Health Expenditures Account (NHEA). The agency considered a variety of data sources before selecting the NHEA data, but indicates it believes the comprehensive and integrated structure of the NHEA creates an ideal tool for evaluating changes to the health care system, such as the mix of the insured and uninsured. For FY 2018, the NHEA data produces a significantly smaller reduction in the uninsured, thereby increasing the total available dollars for uncompensated care. **NJHA supports CMS's proposal to change its data source for calculating the uninsured rate from CBO to NHEA data.**

DOCUMENTATION AND CODING ADJUSTMENT

The American Taxpayer Relief Act of 2012 (ATRA) required the Centers for Medicare & Medicaid Services (CMS) to make adjustments to the standardized amount to recoup $11 billion that the agency claims is the effect of documentation and coding changes from FYs 2010 – 2012 that CMS says do not reflect real changes in case mix. In FYs 2014 through 2016, the agency projected that these cuts would equate to a 3.2 percentage point cut that would spread over the mandated four-year period. CMS then instituted a 0.8 percentage point cut in each of FYs 2014, 2015 and 2016. Instead of acting in accordance with its projections and instituting a 0.8 percentage point cut for FY 2018, however, the agency finalized a cut of 1.5 percentage points to

inpatient PPS payments. This was almost two times what it had originally planned and what lawmakers had expected.

The ATRA cuts were recoupment cuts; as such, Congress intended that the cumulative 3.2 percentage point cut projected by CMS (0.8 percentage points for each of FYs 2014-2016, plus 0.8 percentage points in FY 2017) would be restored in FY 2018 through a one-time increase in inpatient PPS payments. Congress altered the timing for recoupment of these funds when it passed the Medicare Access & CHIP Reauthorization Act (MACRA) of 2015. Specifically, relying on CMS's actuaries' estimate that the final ATRA cut would be 0.8 percentage points in FY 2017, Congress dedicated the anticipated 3.2 percentage point restoration in FY 2018 to help generate savings to pay for a permanent fix to the sustainable growth rate for physician payments under Medicare. MACRA spread the restorative adjustments over six years – hospitals were to receive an increase of 0.5 percentage points for discharges occurring during each of FYs 2018 – 2023. In total, these adjustments would restore 3.0 percentage points of the 3.2 percentage point cut from hospitals for ATRA. The 21st Century Cures Act then modified this restoration slightly, but the intent remained.

Because CMS implemented a cut of 1.5 percentage points in FY 2017, the agency will, in total, remove 3.9 percentage points from the standardized amount. Yet, MACRA and the 21st Century Cures Act allow for only 3.0 percentage points to be returned to hospitals by FY 2023. Consequently, CMS's cut leaves hospitals with a permanent cut of 0.9 percentage points instead of the 0.2 percentage point cut that Congress intended. This additional 0.7 percentage point cut is inconsistent with Congress' intent in the ATRA, MACRA and 21st Century Cures Act, which, together, required restoration of most of the documentation and coding cuts. **This excessive cut will take effect in FY 2018. NJHA urges the agency to restore the cut to help ensure that hospitals have sufficient resources to be able to care for their communities.**

PUBLIC REPORTING REQUIREMENTS FOR NATIONAL ACCREDITING ORGANIZATIONS

In the proposed rule, CMS will be requiring all accredited organizations (The Joint Commission, DNV, etc.) to make their accreditation reports public on their websites, along with all hospital corrective plans. These reports would be required to remain on the website for three years. CMS believes that posting accreditation organizations' survey reports and acceptable plans of correction would address concerns and disparity between serious deficiency findings, and provide health care consumers a more comprehensive view.

While NJHA supports efforts to improve transparency, we do not believe that publicly reporting these reports and plans of correction will not improve the public's understanding of a hospital's quality of care. **NJHA does not support the CMS's proposal to require accredited organizations to publish on their own website the survey reports and corrective action plans for all surveyed organizations.**

We agree with The Joint Commission's opinion that this proposal is contrary to Congress' Limits on Public Disclosure of accredited organization reports. The HHS Secretary must treat these reports as confidential, with two narrow exceptions, so this proposal is at odds with the authority Congress has granted HHS to disclose these reports. We also believe that these reports would not provide any meaningful information to consumers, in a clear and understandable manner, and could possibly have a negative effect on improving quality and patient safety. NJHA's Health Research and Educational Trust has been the recipient of CMS contracts for the Hospital Engagement Network work, and now for the Hospital Improvement Innovation Network, and we have seen significant improvements by our members in reducing harm and improving quality and safety. Publicly reporting these accreditation reports would not be beneficial to our work, and could result in less openness and willingness to continue to work closely with us to reduce harm.

LABOR-RELATED SHARE

Current law requires CMS to adjust the proportion of the standardized amount that is attributable to wages and wage-related costs (the labor-related share) by a factor that reflects the relative difference in labor costs among geographic areas (the area wage index). For FYs 2014-2017, CMS used the labor-related share of 69.6 percent for those hospitals with wage indices greater than 1.0. For FY 2018, CMS proposes to rebase and revise the inpatient PPS market basket to reflect 2014 data. As a result, the agency proposes a labor-related share of 68.3 percent for those hospitals with wage indices greater than 1.0 – this is approximately 1.3 percentage points lower than the current labor-related share of 69.6 percent. The labor share for hospitals with wage indices less than 1.0 will remain at 62 percent, as specified in current law.

NJHA is concerned about the methodology CMS used to determine the new the labor-related share and urges the agency to continue to investigate alternative methodologies for determining the proportion that is labor-related before implementing any changes. CMS should also consider an approach that will mitigate significant decreases in inpatient payments to hospitals as a result of the decreased labor share.

HOSPITAL READMISSIONS REDUCTION PROGRAM (HRRP)

The HRRP imposes penalties of up to 3 percent of base inpatient PPS payments for having "excess" readmissions rates for selected conditions when compared to expected rates. CMS proposes only minor updates to the HRRP for FY 2018. For FY 2019 penalties, however, CMS proposes to implement the socioeconomic adjustment approach mandated by the 21st Century Cures Act of 2016.

FY 2019 SOCIOECONOMIC ADJUSTMENT

For the FY 2019 HRRP, CMS proposes to implement the socioeconomic adjustment approach mandated by the 21st Century Cures Act. Starting in FY 2019, the agency must implement a budget-neutral methodology in which readmission penalties are based on hospitals' performance

relative to other hospitals with a similar proportions of patients who are dually eligible for Medicare and Medicaid. CMS proposes to place each HRRP-eligible hospital into five peer groups (or quintiles) based on the proportion of Medicare fee-for-service (FFS) and Medicare Advantage (MA) dual-eligible patients it treats. The agency would then calculate each hospital's readmissions performance relative to the median of its quintile, applying a budget-neutrality modifier to ensure aggregate penalties across all hospitals are equivalent to the current approach. CMS has the authority to move away from a peer-grouping and use other risk-adjustment approaches after FY 2020.

NJHA applauds Congress for mandating a vitally important first step to improving the fairness of readmission penalties. We have long urged CMS to implement socioeconomic adjustment in the HRRP because of the significant body of research showing that readmissions performance is impacted by poverty, availability of resources and other social risk factors beyond hospitals' control. We believe the proposed approach will provide relief to many hospitals caring for large numbers of patients facing socioeconomic challenges.

However, NJHA also recommends that CMS take steps to improve the transparency of the proposed approach by making more data available on how it determines peer groupings. In addition, the 21st Century Cures Act affords CMS and all stakeholders the opportunity to improve the adjustment approach after FY 2020. This flexibility will be especially useful as the science of capturing and adjusting for socioeconomic and other social risk factors continues to evolve. **We urge CMS to continually evaluate its adjustment approach, and to engage with the field on ensuring its adjustment approach keeps up with the science.**

PROPOSED FY 2018 PERFORMANCE PERIOD

NJHA is concerned that the proposed FY 2018 HRRP performance period – July 1, 2013 through June 30, 2016 – combines data collected under both ICD-9 and ICD-10. We urge CMS to provide further empirical analysis in the final rule demonstrating that measure reliability and validity are not compromised by using these two different coding systems. We also urge CMS to ensure that the ICD-10 versions of the measures in the HRRP are endorsed by the National Quality Forum (NQF).

NJHA also urges 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 the field about any potential unintended biases and measure performance changes resulting from the use of the new codes. The data also would provide insight on whether it is actually appropriate to mix data collected using ICD-9 with data collected using ICD-10.

HOSPITAL VALUE-BASED PURCHASING (VBP) PROGRAM

As required by the ACA, CMS proposes to fund the FY 2018 VBP program by reducing base operating DRG payment amounts to participating hospitals by 2.0 percent. The VBP program is budget neutral; all funds withheld must be paid out to hospitals. CMS proposes to change the

scoring approach for the cost/efficiency measure domain for FY 2021, add one new cost measure to the FY 2022 VBP program and update the claims-based patient safety indicator (PSI) measure for the FY 2023 program.

NJHA continues to support several aspects of the VBP program. In general, we favor pay-for-performance programs, such as VBP, that assess multiple aspects of care, and that score providers on the better of achievement versus national benchmarks and improvement versus baseline performance. We believe this incentive structure can provide greater inducement for providers to work collaboratively to continually improve performance.

However, we remain concerned about the overlap of measures between the VBP and Hospital-Acquired Conditions (HAC) Reduction programs given the different construction and goals of each program. The VBP program uses all three of the current HAC measures but employs a different methodology to delineate good and bad performance. The measure overlap has created "double penalties" for some hospitals, while assessing disparate scores on the same measures for other hospitals. 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.

FOCUSING THE HOSPITAL INPATIENT QUALITY REPORTING (IQR) PROGRAM

NJHA believes there is work to be done to ensure the ICR Program achieves its foundational goals of providing accurate and comparable information to the industry. We recommend that CMS work with industry stakeholders to streamline and focus the measures in the IQR and all other measurement programs on "measures that matter." NJHA supports the following list of priority measurement areas as identified by the American Hospital Association:

1. Patient Safety Outcomes
    - Harm Rates
    - Infection Rates
    - Medication Errors
2. Readmission Rates
3. Risk Adjusted Mortality
4. Effective Patient Transitions
5. Diabetes Control
6. Obesity
7. Adherence to Guidelines for Commonly Overused Procedures
8. End of Life Care According to Preferences
9. Cost per Case or Episode of Care
10. Behavioral Health
11. Patient Experience of Care / Patient Reported Outcomes of Care

MEDICARE AND MEDICAID ELECTRONIC HEALTH RECORD (EHR) INCENTIVE PROGRAM

EHR CERTIFICATIONS

NJHA urges CMS to not require hospitals to have 2014 Edition EHRs that are certified to support all the electronic clinical quality measures (eCQMs) available for IQR reporting for FY 2019. Considering the time frames, this puts undue burden to safely install this EHR version and continue to comply with all other staged requirements.

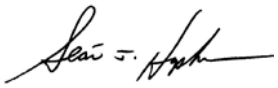
There is also an inconsistency with eCQM reporting between 2014 and 2015 Edition EHR versions with respect to Stage 2 and 3 reporting requirements. NJHA recommends that CMS work with the ONC and EHR Vendors to ensure the 2015 Edition of the EHR certification specification is capable of supporting hospital Stage 2, Stage 3 and eCQM reporting. Navigating this inconsistency is burdensome for hospitals. EHR eCQMs equipped editions should also be consistent with any eCQMs that are available to report in the IQR.

90-DAY EHR ATTESTATION REPORTING

NJHA supports the Medicare and Medicaid EHR Incentive Program reporting period in CY 2018 to a continuous 90 day period. We also recommend that CMS extend the 90-day reporting period for CY 2018 to all future year reporting periods.

The New Jersey Hospital Association appreciates the opportunity to comment on the CMS's hospital inpatient prospective payment system proposed rule for FY 2018. If you have any questions, please contact me at 609-275-4022 or shopkins@njha.com, or Roger Sarao, vice president, Economic & Financial Information, at 609-275-4026 or rsarao@njha.com.

Sincerely,



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