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

CMS 1711-P: Medicare and Medicaid Programs; CY 2020 Home Health Prospective Payment System Rate Update and CY 2019 Case-Mix Adjustment Methodology Refinements; Home Health Value-Based Purchasing Model; Home Health Quality Reporting Requirements; Home Infusion Therapy Requirements; and Home Infusion Therapy Requirements.

Dear Ms. Verma:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, including 900 hospital-based home health (HH) agencies, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) calendar year (CY) 2020 proposed rule for the HH prospective payment system (PPS). Specifically, this letter focuses on our concerns related to the large behavioral adjustment proposed for the new HH payment model.

The AHA appreciates CMS's multi-year effort to develop an alternative to the current HH case-mix system and supports the implementation of the new patient driven groupings model (PDGM). The move from the current system's reliance on therapy volume to set payments to the new system's reliance on a patient's clinical profile is projected to improve payment accuracy for hospital-based HH agencies that treat a disproportionately large population of medically complex cases and, on average, operate with substantially negative Medicare margins. **However, we remain concerned that CMS has again proposed a large, prospective behavioral adjustment to offset what it believes will be an increase in payments under the PDGM compared to the current model.**

Proposed CY 2020 Behavioral Adjustments

The shift from the current payment approach to the PDGM is monumentally complex. The new case-mix system combined with the shortened 30-day episode of care requires providers and their partners to rethink many key operating and clinical protocols, including referrals and admissions, care planning and delivery, coding and documentation, clinical team composition, and billing. This renders impossible any attempt by policymakers and stakeholders to accurately project patient utilization of HH services in CY 2020. **As such, AHA again calls on CMS to forgo implementing a prospective behavioral adjustment in CY 2020 and wait until an evidence-based adjustment can be made. The large scale of the proposed adjustment, -8.01%, is unprecedented for a one-year offset, making it particularly inappropriate for prospective implementation, as there is significant potential for misalignment between the projected and actual behavioral response to PDPM and the 30-day episode.**

History of Inaccurate Prospective Behavioral Adjustments. There are several pertinent behavioral adjustment precedents that call into question the appropriateness of CMS's proposed adjustment.

Inaccurate HH PPS Adjustment. When policymakers have done prospective adjustments in the past, they have been inaccurate. For example, significantly inaccurate adjustments were made when the HH PPS was implemented in 2000. Specifically, the Congressional Budget Office (CBO) used behavioral assumptions and other factors to estimate that HH PPS implementation would reduce Medicare spending on HH services by $49.6 billion from 1998 through 2007, but the actual reduction for that period was far greater – $210.4 billion. In other words, CBO underestimated the field's behavioral response and the result was the closure of approximately 2,000 home health agencies (HHAs).

Inconsistency between HH and Skilled Nursing Facility (SNF) Reform Methodologies. A prospective behavioral adjustment is inconsistent with CMS's approach for the fiscal year (FY) 2020 SNF PPS reform finalized by the agency last month, an equally transformative PPS redesign, which is being implemented with *no* behavioral adjustment. In fact, in the SNF PPS final rule for FY 2019, in which CMS finalized the new case mix system known as prescription drug monitoring program (PDPM), CMS stated that, "We do not have any basis on which to assume the approximate nature and magnitude of these behavioral responses." As a result, the agency will base any future offset on actual claims data from FY 2020.

The redesign of the HH and SNF payment systems is similar in complexity and impact with both provider groups shifting from a therapy volume-driven payment structure to one that bases payment on a compilation of clinical factors. If anything, the addition of the 30-day episode change renders PDGM implementation even more complicated than the SNF redesign, and therefore even more suitable for relying on

actual data. Yet, despite the core similarities, CMS is applying highly inconsistent behavioral adjustment approaches, which is a cause for concern for AHA and the field. **There is no clear reason why the agency should be able to propose a PDGM behavioral adjustment when it lacked a basis for doing so for the PDPM.**

Finally, in its FY 2019 rulemaking for the SNF PPS, CMS acknowledged that the behavioral offset considered by the agency assumed that the provider behavioral response to PDPM would be consistent across the 12 months of the year. **We ask CMS to explain if it applied this assumption to its proposed PDGM behavioral adjustment, and if so, its rationale for doing so.** Such an explanation would expand current stakeholder insight into CMS's methodology.

Long-term Care Hospital (LTCH) Reform Implemented without Behavioral Adjustment. In addition, during implementation of Medicare Severity Long Term Care Diagnosis-Related Groups (MS-LTC-DRGs) for the LTCH PPS in FY 2008, CMS noted that "due to the complexity of the interactions"[1] involved in that transition, the agency was unable to determine the extent to which the new MS-LTC-DRGs would see case-mix improvements in documentation and coding. This would be required to estimate an appropriate behavioral adjustment. In fact, CMS concluded that:

> "The question is not *whether* documentation and coding will improve, resulting in higher case mix and payments, rather, the question is only *how* much will coding change when the incentives to code particular secondary diagnoses change…"[2]

Ultimately, CMS withdrew its proposal for a prospective behavioral adjustment for LTCHs and instead decided to monitor actual claims data to identify any future, data-based behavioral adjustments that might be needed. **Based on this pertinent LTCH policy decision by the agency, it is unclear how the agency has overcome the forecasting limitations cited in this case example.**

Inpatient PPS Reform Modified to include Retrospective Adjustment. Finally, for the FY 2008 shift of the inpatient PPS to MS-DRGs, CMS initially implemented a -4.2% prospective adjustment to be applied over three years (-1.2% in FY 2008 and -1.8% in both FYs 2009 and 2010). Subsequent to that final rule, to ensure an evidence-based adjustment, Congress intervened to instead mandate that prospective cuts be phased in with lower amounts per year, coupled with a subsequent retrospective adjustment based on actual claims history.

Given the track record of inaccurate prospective behavioral adjustments and related policy events where CMS noted its inability to project future provider behavioral responses, we urge the agency to withdraw its proposed

[1] Federal Register, August 22, 2007, page 47298.
[2] Ibid.

prospective PDGM behavioral adjustment. It should instead use actual experience under the new model to evaluate the need for any adjustment. Further, consistent with these precedents cited above and the legislative remedy currently proposed in H.R. 2573, we support an annual cap of 2.0 percentage points on any adjustment, with any additional amount applied in increments in future years.

Expand Transparency for Proposed Behavioral Adjustment. We appreciate the proposed rule's explanation of CMS's rationale and methodology for calculating the behavioral adjustment, as it exceeds the level provided in last year's rulemaking. However, despite the Bipartisan Budget Act of 2018 (BiBA) requirement for CMS to explain its behavioral adjustment assumptions, the rule's level of detail falls short of the scope needed for stakeholders to fully understand the agency's proposal. Unfortunately, the rule only provides a short *summary of the outcome* of CMS's calculation for the three proposed adjustments that comprise the cut. It does not discuss the actual methodology and calculations that led to the outcome. The rule also cites a prior example of HH coding behavior that increased nominal case mix by 2% per year from 2002 through 2007, but never translates how this case example led to or supports the proposed 8.01% cut for CY 2020.

In addition, the rule does not adequately explain another behavioral adjustment assumption – that PDGM would result in HHAs selecting a higher-paying principal diagnosis code for 100% of their claims, relative to current coding. In fact, AHA data analysis of patients transferring from general acute-care hospitals, LTCHs and inpatient rehabilitation facilities (IRF) to HH, calls this assumption into question. Specifically, FY 2018 Medicare Provider Analysis and Review (MedPAR) data for these three types of hospitals show substantial portions of patients transferred to HH already fall in high-acuity clinical categories, as indicated by the population of patients with major and extreme severity levels under 3M's All Patients Refined (APR)-DRG Severity of Illness (SOI) ranking, as shown in this table:

Hospital Patient Severity of Illness Levels, By Discharge Destination

Severity of Illness Level	Inpatient PPS Hospital Discharges to Home Health	IRF Discharges to Home Health	LTCH Discharges to Home Health
Level 1 (minor)	11%	9%	2%
Level 2 (moderate)	34%	43%	15%
Level 3 (major)	43%	42%	50%
Level 4 (extreme)	11%	6%	34%

Source: FY 2018 National MedPAR data (March 2019 Update), CMS; 3M™ APR-DRG Software, 3M Health Information Systems, Inc.

If CMS considers all or certain subgroups of HH patient populations to be susceptible to coding changes under PDGM, it bears the responsibility to share with stakeholders a full evaluation of baseline coding practices relative to projected changes in coding behavior. Such evaluation should particularly account for how patients with major and extreme severity (such as SOI Level 3 and 4 patients) could actually be coded higher than current levels.

These concerns with the inadequate level of transparency for the agency's rationale and methodology for the proposed behavioral adjustment prevent AHA and other stakeholders from fully understanding, and therefore meaningfully commenting on, this critical element of the rule. **This insufficient level of transparency is a second basis for withdrawing the proposed behavioral adjustment. However, if CMS elects to advance with a prospective behavioral adjustment in CY 2020, we strongly urge the agency to include with the final rule its full analyses of the proposed behavioral adjustment and to address the above transparency concerns.**

CMS Has Authority to Forgo a Behavioral Adjustment in CY 2020. The BiBA requires CMS to ensure that the PDGM is implemented in an overall budget-neutral manner. The law also gave CMS the discretion to determine the amount and nature of adjustments needed to achieve budget neutrality: positive or negative adjustments and a blend of permanent and temporary adjustments. Given that it is virtually impossible for a prospective CY 2020 cut to align with actual behavioral changes, we urge CMS in the CY 2020 final rule to use its BiBA authority to achieve budget neutrality by 1) determining that at this time the agency lacks the capacity to calculate a reliable prospective adjustment, therefore choosing an adjustment of zero; and 2) finalizing a plan to use one or more evidence-based adjustments in the future to align the adjustments with the field's actual PDGM CY 2020 behavior changes.

Streamline the Proposed Notice of Admission (NOA)

CMS proposes to require a NOA for each new HH patient, which updates the Common Working File to signal to CMS that services have commenced. NOAs would be required within the first five days of care, with a penalty for late submissions. As the NOA is not used in the payment-setting process, we recommend a more simplified NOA that includes only those items essential to begin care, and we suggest that the hospice NOA be used as a model. Doing so would make the NOA less redundant with existing Medicare claims filing, plan of care and quality reporting requirements. In addition, by accelerating the NOA completion process in this manner, agencies could redirect resources toward patient care in alignment with the agency's "patients over paperwork" campaign.

Additional PDGM Education is Needed

Given the scope of the HH and SNF PPS transitions in 2020, as well as other significant reforms underway for LTCHs and inpatient rehabilitation hospitals and units, next year is a critical time for education. Our communication with hospitals on their relationships with their post-acute providers point to the remaining need for additional CMS outreach and training on PDGM reforms for all relevant stakeholders, including general acute care hospital discharge teams, physicians, Medicare contractors and auditors.

In particular, as the PDGM case-mix system requires information on patients' principal and secondary diagnoses – details that are given far less attention in the current payment model – information about the prior hospital stay will become even more important to HH practitioners. Further, PDGM is more reliant on proper documentation and coding of medical complexity, which also may contribute to the evolution in the relationship between referring hospitals and HH agencies, as both benefit from more frequent exchange of clinical information and joint case management. Given these anticipated developments, home health service delivery will be enhanced with greater awareness among hospitals of PDGM's design and objectives – and AHA is prepared to partner with CMS to advance such awareness.

HH Quality Reporting Program (QRP)

Section 1895(b)(3)(B)(v)(II) of the Social Security Act requires that CMS establish the HH QRP. Starting in CY 2007, HHAs that fail to meet all HH QRP quality data submission and administrative requirements are subject to a 2.0 percentage point reduction in payments.

In this proposed rule, CMS proposes to add two measures to the CY 2022 HH QRP and remove one measure and one survey question regarding pain. In addition, CMS would require HHAs to collect certain standardized patient assessment data beginning with HHA admissions on or after Jan. 1, 2021 to meet additional Improving Medicare Post-Acute Care Transformation (IMPACT) Act requirements.

While the AHA appreciates that the proposed measures are intended to address important aspects of care transitions and have undergone significant improvements over the past few years, we continue to encourage CMS to only adopt measures that have received endorsement by the National Quality Forum (NQF). Furthermore, we urge CMS to reconsider its proposal to adopt the dozens of standardized patient assessment data all at one time and determine whether it is necessary or useful for post-acute care (PAC) providers to collect all of the proposed data.

CY 2022 Measurement Proposals

Transfer of Health Information to the Provider – PAC. CMS proposes to add this process measure to the CY 2022 HH QRP. The measure assesses the proportion of patient stays with a discharge assessment indicating that a current reconciled medication list was given to the subsequent provider at the time of discharge or transfer from the patient's current PAC setting. The same measure was recently finalized for inclusion in the SNF, IRF and LTCH QRPs as well. If finalized, HHAs would be required to submit measure data beginning with Jan. 1, 2021 admissions and discharges.

The AHA agrees with CMS that sharing patient information in a timely manner is vital to smooth transitions of care and better patient outcomes. The measure also fulfills an IMPACT Act quality measure domain requirement, and its specifications have undergone significant improvements since it was first introduced as a concept several years ago. **However, we urge that the measure receive NQF endorsement before it is adopted in the HH QRP.** We acknowledge NQF endorsement is not required of HH QRP measures, and appreciate the agency's intent to "submit the proposed measure to NQF for consideration of endorsement when feasible." Nevertheless, CMS should only adopt measures that have already undergone this robust evaluation process and received endorsement. The multi-stakeholder NQF endorsement process determines whether measures meet basic criteria to indicate suitability for use in QRPs and may highlight areas where the measure's specifications may be tweaked to improve reliability, accuracy and feasibility.

In addition, we question the ability of this process measure to meaningfully improve care. In this case, high performance would only mean that providers are sending a reconciled medication list — not that the subsequent provider received it, or that the list was accurate, or that patients experienced fewer adverse events. As a result, the measure could become a "check-the-box" proxy measure for high-quality care. Although we understand how timely information sharing is associated with improved outcomes, it is hard to imagine how providers — or CMS — could determine whether this measure actually has any effect.

Transfer of Health Information to the Patient – PAC. CMS proposes to add this process measure to the CY 2022 HH QRP. The measure assesses the proportion of patient stays with a discharge assessment indicating that a current reconciled medication list was given to the patient, family or caregiver at the time of discharge to the home; the same measure was finalized for inclusion in the SNF, IRF and LTCH QRPs as well. If finalized, HHAs would be required to submit measure data beginning with Jan. 1, 2021 admissions and discharges.

We reiterate our recommendation above that **CMS wait until this measure receives NQF endorsement before adopting it into the HH QRP.** In addition, we urge CMS to use the field's experience with transferring information to patients and reporting on this measure to disseminate best practices about how to best convey the medication

list. This includes any formats and/or informational elements that are particularly helpful for patients and families. In order to achieve the goals of this measure, merely printing off a list or transmitting it through an electronic health record (EHR) would not ensure that the patient has any more ability to use the list for early detection and seek care for a potential adverse event before more serious sequelae.

Update to the Discharge to Community Measure. CMS proposes to exclude baseline nursing facility residents — that is, patients who have an HH episode following a long-term nursing facility stay with no intervening community discharge between the nursing facility stay and hospitalization prior to HH start of care — from calculation of the Discharge to Community measure. Based on public comment suggesting that these patients are far less likely to return to the community, CMS found that the rates of discharge to the community were significantly lower for baseline nursing facility residents compared with patients who did not come from a nursing facility, suggesting that including these patients in measure calculations unfairly skews performance. **The AHA appreciates CMS's willingness to consider feedback on this measure's calculation and supports the proposed change to this measure.**

Request for Feedback on Expanding Outcome and Assessment Information Set (OASIS) Reporting to All Patients. In the CY 2018 HH PPS proposed rule, CMS sought input from commenters on whether the agency should require data reporting on all HH patients, regardless of payer. In the FY 2020 proposed rules for the IRF and SNF PPSs, CMS proposed that providers in those facilities collect and report patient assessment data used for each setting's QRP for all patients regardless of payer; the agency stated in those rules that most facilities already collect the data for all patients and thus the requirement would not increase burden.

CMS notes, however, that many providers use different assessments in the HH setting for private payers, and thus requiring the collection and reporting of OASIS data for all patients might result in additional burden. While CMS "plan[s] to propose" to expand OASIS reporting in future rulemaking, in this proposed rule the agency is merely seeking input on whether there is a need to collect OASIS data on all patients, on what proportion of patients HH providers do not report OASIS data, differences between patients for whom HH providers collect OASIS data and those assessed with other tools, and any other considerations on the burden such a proposal might entail.

In addition, comments on the SNF and IRF proposals raised several questions regarding the burden associated with collecting the data, patient privacy, and the administrative complexities such a requirement would entail. In response, CMS did not finalize its proposal to require SNFs and IRFs to collect and report patient assessment data on all patients, regardless of payer; while the agency is not currently proposing a similar requirement for HHAs, we urge CMS to provide significantly more details on how such data may be used prior to any future proposals.

Removal of Pain Items. As part of the agency's "roadmap" to fight the opioid crisis, and in an effort to avoid any potential unintended over-prescription of opioid medications, CMS proposes to remove the Improvement in Pain Interfering with Activity measure from the HH QRP and question 10 — which asks "in the last 2 months of care, did you and a home health provider from this agency talk about pain?"— from the Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) survey. **While we appreciate CMS's ongoing efforts to combat this national scourge, we have a few questions and concerns regarding these proposals.**

First, as part of its proposals to add several standardized patient assessment data elements to the HH patient assessment instrument (detailed below), CMS would adopt data elements that ask about pain interference with several activities. In the proposed rule, CMS notes that the latter elements, which ask about the frequency with which pain interferes with sleep, daily activities and therapy activities, "are not associated with any particular approach to management," suggesting that they are different in kind from the measure proposed for removal. We find this reasoning unconvincing, and we recommend that CMS be consistent in its approach to addressing pain with patients.

With that in mind, we also request insight into the future of CMS's strategy regarding pain management. Across several various QRPs —not limited to PAC— the agency has removed any measure or question that references pain in an abundance of caution. While we understand the motivation behind these changes, we note that CMS itself acknowledges the lack of empirical evidence demonstrating a link between any of these items and prescribing behavior. In addition, pain management is a vital aspect of the patient experience, and appropriately addressing pain and discomfort using a variety of approaches is a key provider responsibility. A lack of nationally standardized measures or survey questions on pain management may limit the field's ability to identify opportunities to improve how well patients' pain issues are being addressed. **We urge CMS to either develop or share its plans to address pain management in QRPs in the future after the related measures and data elements are removed.**

Standardized Patient Assessment Data Element (SPADE) Reporting

In addition to requiring the adoption of standardized and interoperable quality measures, the IMPACT Act requires that, for FY 2019 and each subsequent year, PAC providers must report SPADEs. The reporting of these data is required in the PAC QRPs, and as a result, failure to comply with the requirements results in a payment reduction. The SPADEs must satisfy five domains: functional status, cognitive function, special services, medical conditions and comorbidities, and impairments.

In the CY 2018 HH PPS proposed rule, CMS proposed to adopt SPADEs that would satisfy all five domains. However, the agency did not finalize most of these proposals in response to the concerns raised by AHA and other commenters regarding the speed and magnitude of the additions to already lengthy patient assessment instruments. Stakeholders also were concerned that the data elements had not been tested for use in each specific PAC setting. That is, CMS proposed to adopt for all four settings data elements that were only tested in one PAC setting without determining whether those elements provided reliable and valid data in other settings. Instead, CMS finalized the adoption of SPADEs in just two categories (functional status and medical conditions and comorbidities) based on data elements already finalized for adoption in the various instruments.

In this year's proposed rule, CMS asserts that HHAs have had sufficient time to familiarize themselves with other new reporting requirements adopted under the IMPACT Act. In addition, CMS cites the results of a recent National Beta Test of the proposed data elements conducted by its contractors to suggest that SPADEs are now tested adequately. Based on these developments, CMS proposes to add 18 new SPADEs to OASIS and modify or replace six existing elements, which providers would be required to report beginning Jan.1, 2021. Many of these SPADEs would satisfy the domains required by the IMPACT Act; others would be added under a newly proposed domain on social determinants of health (SDOH).
While comparatively less burdensome than the additions proposed in other PAC settings — as several of the elements are already collected in some form through the OASIS — we urge CMS to be cautious in its implementation of some of the SPADEs, specifically those associated with SDOH.

SDOH Elements. In addition to the five domains mandated by the IMPACT Act, CMS proposes to add a new domain related to SDOH, also known as social risk factors. Each of the data elements proposed was identified in the 2016 National Academies of Sciences, Engineering, and Medicine (NASEM) report "Accounting for Social Risk Factors in Medicare Payment: Identifying Social Risk Factors," which was commissioned by the Department of Health and Human Services Assistant Secretary for Planning and Evaluation. In this report, NASEM identified these factors as having impact on care use, cost and outcomes for Medicare beneficiaries.

The AHA does not oppose the concept of collecting SDOH data elements. If implemented appropriately, such data could be useful in identifying and addressing health care disparities, as well as refining the risk adjustment of outcome measures. **However, we urge CMS not to finalize the proposed policy until it can address several important issues around the potential future uses of these elements and the requirements around data collection for certain elements**.

First, the IMPACT Act requires CMS to assess "appropriate adjustments to quality measures, resource measures and other measures, and to assess and implement appropriate adjustment to payment under Medicare … after taking into account

studies conducted by Assistant Secretary for Planning and Evaluation (ASPE) on social risk factors." CMS does not state explicitly in the rule whether it anticipates the SDOH SPADEs will be used in adjusting measures, but we believe the IMPACT Act's requirements make it likely the SPADEs will be considered for use in future adjustments. Going forward, **we urge CMS to be circumspect and transparent in its approaches to incorporating the data elements proposed in payment and quality adjustments. In part, this can be accomplished by using processes like "dry runs" of any adjustments and by collecting stakeholder feedback before implementing any adjustments.** It is important to understand and account for the impact social risk factors have on patient outcomes and costs without unfairly penalizing providers who care for vulnerable populations or excusing poor care by pointing to patient characteristics.

Next, CMS notes that, if finalized, HHAs would only need to submit data on the Race and Ethnicity SPADEs with respect to admission and would not need to collect and report again at discharge, as it is unlikely that patient status for these elements will change. We believe that a patient's preferred language, need for an interpreter, health literacy, access to transportation, and social isolation are also unlikely to change between admission and discharge. In the SNF, IRF and LTCH PPS FY 2020 final rules, CMS finalized collection of preferred language and interpreter services items at admission only; the agency declined to change the health literacy, access to transportation and social isolation items, stating that "[patient] circumstances may have changed over the duration of their admission," and might change the answers to these question. We disagree; health literacy, for example, is the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions. It is difficult to see how these elemental skills would change over the course of a month-long HH episode. **Thus, we encourage CMS to apply the collection requirements consistently across these items and only require collection of all SDOH SPADEs with respect to admission only.**

Finally, we are unsure that the response options under the Race data element are the right ones. From our research, it appears that some of these categories are not consistent with those used in other government data collection practices, like the US Census or the Office of Management and Budget (OMB). In addition, these select categories are not consistent with the recommendations made in the 2009 Institute of Medicine (IOM) report on Standardized Collection of Data on Race, Ethnicity, and Language, even though CMS cites this report in explaining its proposals. Specifically, the IOM report recommends using the broader OMB race categories (Black or African American, White, Asian, American Indian or Alaska Native, Native Hawaiian or Other Pacific Islander, and some other race) and granular ethnicities chosen from a national standard set that can be "rolled up" into those categories, and ideally the granular options would be tailored to the local market. In addition, the report recommends that each set of categories should include an "Other, please specify: ___" option to allow individuals to self-identify. It is unclear how CMS chose

the 14 response options under the race data element and the five options under the ethnicity element, as they do not match the minimum categories used by OMB or the process for capturing granular data recommended in the IOM report.

We worry that these response options will add to the confusion that may already exist for patients about what terms like “race” and “ethnicity” mean for the purposes of health care data collection. In fact, the IOM report states that “[a] lack of standardization of race, ethnicity, and language categories has been raised as one obstacle to achieving more widespread collection and utilization of these data.” **CMS should confer directly with experts in the issue to ensure patient assessments are collecting the right data in the right way before these SDOH SPADEs are finalized.**

We thank you for the opportunity to comment on this proposed rule. If you have any questions concerning our comments, please feel free to contact me, or have a member of your team contact Rochelle Archuleta, director of policy, at rarchuleta@aha.org regarding the payment provisions, or Caitlin Gillooley, senior associate director of policy, at cgillooley@aha.org, pertaining to the quality reporting provisions.

Sincerely,

/s/

Thomas P. Nickels
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