HAP

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THE HOSPITAL & HEALTHSYSTEM ASSOCIATION OF PENNSYLVANIA

Carolyn F. Scanlan
President and Chief Executive Officer

June 12, 2006

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1488-P and P2
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

RE: CMS-1488-P and P2, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates; Proposed Rule.

Dear Dr. McClellan:

On behalf of Pennsylvania's 225 hospitals and health care systems, The Hospital & Healthsystem Association of Pennsylvania (HAP) welcomes this opportunity to comment on the proposed rule **"Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates,"** as published in the April 25, 2006, *Federal Register.*

The Centers for Medicare & Medicaid Services (CMS) has proposed the most significant changes to the Medicare inpatient prospective payment system since its inception in 1983. The proposed changes redistribute approximately $1.4 billion within the inpatient payment system.

While the proposed rule has many components, there are four key areas within the rule that will significantly impact Pennsylvania hospitals and health systems:

- ✔ Recalibration of Diagnosis Related Group (DRG) Weights
- ✔ Refinement of DRGs Based on Severity of Illness
- ✔ Wage Index and Occupation Mix Adjustment
- ✔ Hospital Quality of Care

HAP commends the Centers for Medicare & Medicaid Services for working toward the refinement of the inpatient prospective payment system to ensure equal opportunity for return across the DRGs, as well as to afford equal incentive to treat all types of patients and conditions. However, HAP strongly urges CMS to consider a one-year delay in implementing refinements to the Medicare inpatient prospective system. **HAP is specifically recommending a one-year delay in implementing proposed changes to the DRG weights.** While HAP supports a move to cost-based weights, we believe there are flaws in the proposed methodology, modeling, and technical data used for refining the

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DRG payment system. A one-year delay would allow time to enable a more thorough analysis and to address flaws before implementation.

HAP also believes that more work must be done to assess the need and most appropriate approach for changing the patient classification system.

In addition to a one-year delay, HAP would encourage CMS to consider a simultaneous implementation of the DRG weight changes and new classification system (after thoughtful consideration and determination that a new classification system is necessary) over a three-year transition period.

Given the regulatory process, HAP does not believe that there has been adequate time for Pennsylvania hospitals to thoroughly analyze the proposed changes and assess impact to their individual facilities. Analysis that has been done has shown that even the slightest of changes in the proposed method results in potentially large changes to a hospital payment.

In essence—there is too much change, being proposed too fast. Such changes in the payment system deserve more thoughtful consideration and due diligence to ensure the end result will be the adoption of meaningful improvements to Medicare's inpatient prospective payment system. Our hope is that given the significant impact these proposed changes will have on the hospital field as a whole, that CMS will impose a one-year delay to afford CMS and the hospital field time to work collaboratively to address concerns.

With regards to the quality provisions in the proposed rule, while HAP supports the expansion of reporting of quality data, **HAP recommends that CMS begin with third quarter 2006 discharges. HAP also suggests that CMS not include measures in the validation mix for annual payment until after one full year of reporting.** This delay will allow hospitals to learn from the review of records and feedback about data abstraction during the first year.

HAP has enclosed more detailed comments on all sections of the proposed rule, which further delineate our concerns and recommendations.

HAP appreciates the opportunity to submit these comments and recommendations. If you have any questions regarding our comments, please feel free to contact me or Melissa Speck, director, policy development, at (717) 561-5356 or mspeck@haponline.org.

Sincerely,

Carolyn F. Scanlan

CAROLYN F. SCANLAN
President and Chief Executive Officer

CFS/dd

Attachment

The Hospital & Healthsystem Association of Pennsylvania
Detailed Comments on the
FY 2007 Inpatient Prospective Payment System Proposed Rule

PROPOSED CHANGES

DRG CHANGES

In response to payment recommendations from the Medicare Payment Advisory Commission (MedPAC) to address the proliferation of physician-owned, limited-service hospitals, the Centers for Medicare & Medicaid Services (CMS) proposed the biggest changes to the calculation of diagnosis-related group (DRG) relative weights since the creation of the prospective payment system (PPS). These changes would significantly redistribute payments among the DRGs and among hospitals. Specifically, CMS proposes the use of hospital-specific relative values (HSRVs) and a modified version of cost-based weights rather than charge-based weights in fiscal year (FY) 2007. CMS also proposes an alternative patient classification system called consolidated severity adjusted DRGs (CS-DRGs), with implementation likely in FY 2008.

The hospital field supports meaningful improvements to Medicare's inpatient PPS. We believe that the hospital field and CMS share a common goal in refining the system to create an equal opportunity for return across DRGs which will provide an equal incentive to treat all types of patients and conditions. We also believe the system should be simple, predictable, and stable over time. One of the fundamental values of a *prospective* payment system is the ability of providers to reasonably estimate payments in advance to inform their budgeting, marketing, staffing and other key management decisions. Another core feature of the PPS is clinically cohesive and meaningful DRGs that are somewhat intuitive for providers and coders to follow, and that reflect similar resource use within DRGs. And, ultimately, the inpatient PPS should foster innovation and best practice in care delivery. HAP believes that these are essential characteristics of a well-functioning PPS and it is within these policy goals that we evaluate CMS' proposal.

HAP would also like to emphasize that payment changes alone not remove the inappropriate incentives created by physician self-referral to limited-service hospitals. Physicians will still have the ability and incentive to steer financially attractive patients to facilities they own, avoid serving low-income patients, practice similar forms of selection for outpatient services and drive up utilization for services. We strongly urge CMS to rigorously examine the investment structures of physician-owned, limited-service hospitals and consider our comments on the interim report on the strategic plan. It is imperative that CMS continue the suspension of issuing new provider numbers to physician-owned, limited-service hospitals until the strategic plan developed has been fully implemented and Congress has had an opportunity to consider CMS' final report.

NEW DRG WEIGHTS: HSRVCC

CMS proposes an alternative to MedPAC's approach to HSRVs and cost-based weights that could be characterized as a short cut. CMS asserts that this combined methodology, known as the HSRV cost center methodology (HSRVcc), achieves similar results in a more administratively feasible manner. But that is not the case. Specifically, the CMS proposal involves two major steps.

1. Develop, on a charge-basis, hospital-specific relative weights for each DRG. CMS established 10 cost center categories based on broad hospital accounting definitions: routine day costs; intensive care day costs; and eight ancillary cost centers. CMS calculated DRG relative weights for each of the 10 cost centers by DRG for each hospital and then used those hospital-specific weights for calculating national DRG weights. CMS' current process aggregates charges for all hospitals at the DRG level to calculate weights. CMS believes the new approach removes the variation introduced by hospital characteristics such as teaching, disproportionate share, location and size, among others.

2. "Scale" the charge-based DRG weights to "costs" using the national cost center cost-to-charge ratios (CCRs) developed from the cost report data (as opposed to using hospital-specific CCRs at the claim level). CMS believes this approach will remove the effect of different CCRs across departments within hospitals. CMS chose this methodology because the use of national average rather than hospital-specific departmental CCRs is administratively easier.

HAP supports the move to cost-based weights but believes CMS' proposed method is flawed. More work is needed to determine the best way to create cost-based weights. Hospitals are willing to work with CMS in a process to develop consensus around the right way to make this change. Below we discuss our detailed concerns and questions regarding the proposed HSRVcc methodology.

HSRVcc METHOD CONCERNS

HAP believes that more time is needed to develop a sound methodological approach to create cost-based weights and to understand their potential impact.

1. **Errors:** While analyzing CMS' proposed rule, HAP uncovered a series of data errors, inconsistencies across databases and questionable methodological choices. Further analyses commissioned by the American Hospital Association (AHA), the Association of American Medical Colleges and the Federation of American Hospitals and conducted by The Moran Company, Inc. to investigate these questions showed that small changes in method lead to large changes in DRG weights, signaling that the proposed changes are highly unstable.

   For instance, the following, more minor, inconsistencies were identified:

   - CMS inadvertently included organ acquisition costs in the data used to set weights for DRGs. These costs should be excluded. This error has a material effect on the resulting weight calculation for transplants. For example, CMS publishes a weight of 5.5466 for DRG 302 (Kidney Transplant), but with this correction The Moran Company calculates a weight of 3.0102.

   - CMS was inconsistent in its treatment of certain categories of hospitals between their calculation of the FY 2007 HSRVcc weights and the proposed CS-DRG weights, making it hard to directly compare the results. For example, hospitals in Maryland were included in the FY 2007 MedPAR data used for the HSRVcc weight calculation and excluded from the CS-DRG calculation.

- The Moran Company used transfer-adjusted charges prior to calculating weights. It was CMS' policy to do this. However, it is unclear whether the weights published for CS-DRGs included this step.

- Data cleaning steps used were not always consistent with standard CMS practices (e.g., removal of cases with 0 charges, low volume DRGs, etc.).

- The cleaning steps applied to the cost report data were not consistent with the cleaning steps applied to the MedPAR claims data, which resulted in different hospitals being included in data sets used for the calculation of the weights and the calculation of the scalers to the weights. For example, hospitals in Maryland and hospitals without cost reports for FY 2003 were excluded from the cost report data used to calculate the scalers and included in the MedPAR file used to calculate the weights.

2. **Trimming:** CMS trimmed the cost center CCRs at 1.96 standard deviations from the geometric mean. We believe that this skews the CCRs, as the hospitals with high routine charge mark-ups are systematically removed from the calculation. This results in the exclusion of 198 hospitals' routine CCRs, accounting for over 26 percent of total routine charges. It also creates a mismatch between the CCRs used and the charges they are applied to, as the hospitals that are trimmed out of the CCRs are still included in the charges that are then reduced to costs and determine the cost shares.

3. **Weighting:** CMS also hospital-weighted rather than charge-weighted the calculation of the CCRs which in turn are used to calculate the scaling factors used to convert the charge-based relative weights to "cost." There are several issues with this approach:

   - This approach gives an equal weight to each hospital in the national cost-to-charge ratio calculation even though hospitals can range in size from fewer than 25 to more than 1,000 beds.

   - This method is inconsistent with the method of averaging used to develop the cost center-specific DRG weights to which the scaling factors are applied. For this part of the analysis, CMS calculated hospital-specific DRG relative weights, but then used a case-weighted average to develop the national value.

   - The hospital-weighted approach results in a 1 percent to 54 percent difference versus a charge-weighted approach in the resulting scaling factors used for the conversion to cost.

The above errors in the calculations over-weight CMS' routine cost shares and under-weight the ancillary cost shares, creating erroneously large swings in DRG weights. Table 1 illustrates how these methodological problems affect the factors used to scale the cost center-specific relative weights. This table shows the impact of trimming the cost center CCRs at 3.0 rather than 1.96 standard deviations from the geometric mean and charge-weighting rather than hospital-weighting the calculation of the national average CCRs that are used in developing the scalers.

Table 1
Impact of Methodological Changes on "Scalers"
Published versus Revised with Methodological Changes

Scaler	CMS Published	Methodological Changes			Percent Change vs. Published
		Trimming Only	Weighting Only	Weighting/ Trimming	
Routine days	0.2881	0.2882	0.2646	0.2490	-14%
Intensive days	0.1919	0.1933	0.1668	0.1636	-15%
Drugs	0.0877	0.0884	0.0939	0.0970	11%
Supplies	0.1150	0.1142	0.1325	0.1383	20%
Therapeutic	0.0384	0.0381	0.0390	0.0388	1%
Operating room	0.0812	0.0838	0.0861	0.0888	9%
Cardiology	0.0241	0.0246	0.0351	0.0371	54%
Laboratory	0.0670	0.0659	0.0681	0.0687	3%
Radiology	0.0427	0.0437	0.0460	0.0474	11%
Other services	0.0639	0.0600	0.0677	0.0712	12%

Source: Moran Company analysis.

These methodological problems have a large impact on the relative weight calculations at the DRG level. Table 2 shows, for key DRGs, how these methodological problems affect the DRG weights and, therefore, hospital payments.

Table 2
DRG Weights with Current Methodology vs. HSRVcc with Various Corrections
High Volume DRGs with Largest Changes in Weights Due to Corrections

				New DRG Weights: Published vs. Corrected			Change vs. Old Weights		
DRG (v24)	DRG Title	Number of discharges	Current Charged-based Weights w/v24 Grouper	CMS Published HSRVcc Weight	HSRVcc w/ Technical Corrections Only	Corrected, Weighted and Trimmed CCRs	DRG Weight Change Current Method vs. Published	DRG Weight Change Current vs. Corrected, Weighted, and Trimmed	Published vs. Corrected, Weighted, and Trimmed
430	PSYCHOSES	74,874	0.6561	1.2318	1.2416	1.1110	87.7%	69.3%	[illegible]
12	DEGENERATIVE NERVOUS SYSTEM DISORDERS	56,042	0.8983	1.0105	1.0099	0.9635	12.5%	7.3%	-4.7%
475	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT	119,510	3.4630	3.8279	3.8368	3.6573	10.5%	5.6%	[illegible]
277	CELLULITIS AGE >17 W CC	118,691	0.8676	1.0015	1.0026	0.9578	15.4%	10.4%	-4.4%
87	PULMONARY EDEMA & RESPIRATORY FAILURE	99,506	1.3854	1.5310	1.5324	1.4680	10.5%	[illegible]	[illegible]
320	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W CC	224,491	0.8611	0.9538	0.9544	0.9162	10.8%	6.4%	-3.9%
294	DIABETES AGE >35	97,122	0.7750	0.8642	0.8636	0.8307	11.5%	7.2%	[illegible]
296	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W CC	246,948	0.8213	0.9041	0.9042	0.8701	10.1%	5.9%	-3.8%
79	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC	159,894	1.5939	1.7331	1.7359	1.6680	8.7%	4.6%	-3.8%
243	MEDICAL BACK PROBLEMS	100,498	0.7888	0.8680	0.8693	0.8363	10.0%	6.0%	-3.7%
554	OTHER VASCULAR PROCEDURES W CC W/O MAJOR CV DX	77,003	2.0890	1.9483	1.9560	2.0085	-6.7%	-3.9%	[illegible]
110	MAJOR CARDIOVASCULAR PROCEDURES W CC	57,436	3.8616	3.6419	3.6558	3.7563	-5.7%	-2.7%	3.1%
124	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG	119,891	1.4508	1.1670	1.1732	1.2380	-19.6%	-14.7%	[illegible]
544	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY	444,118	1.9514	1.8941	1.9047	2.0147	-2.9%	3.2%	6.4%
551	PERMANENT CARDIAC PACEMAKER IMPL W MAJ CV DX OR AICD LEAD OR GNRTR	53,717	3.0391	2.6339	2.6481	2.8453	-13.3%	-6.4%	[illegible]
552	OTHER PERMANENT CARDIAC PACEMAKER IMPLANT W/O MAJOR CV DX	81,744	2.0837	1.7670	1.7771	1.9468	-15.2%	-6.6%	10.2%
125	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG	91,848	1.1117	0.7862	0.7918	0.8717	-29.3%	-21.6%	10.9%
557	PERCUTANEOUS CARDIOVASCULAR PROC W DRUG-ELUTING STENT W MAJOR CV DX	123,550	2.8755	2.1323	2.1499	2.4236	-25.8%	-15.7%	13.7%
515	CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH	58,009	5.2591	4.1474	4.1795	4.7999	-21.1%	-8.7%	15.7%
558	PERCUTANEOUS CARDIOVASCULAR PROC W DRUG-ELUTING STENT W/O MAJ CV DX	191,677	2.1920	1.4299	1.4456	1.7238	-34.8%	-21.4%	20.6%

Source: Moran Company analysis of FY 2007 proposed inpatient PPS rule. Uses FY 2005 MedPAR.
Notes: High volume DRGs defined as over 50,000 cases. Those included in the table were those with the greatest absolute change in weight moving from the CMS published DRG weight to the DRG weight calculated by trimming CCRs at 3.0 standard deviations, using weighted CCRs, and correcting for technical errors.

These changes have a material impact on hospital payment. CMS' method for weighting and trimming redistributes $1.4 billion dollars among hospitals. Charge-weighting the CCRs and trimming them at three standard deviations would reduce the shift in dollars to $900 million—a reduction of ***half a billion dollars***, or 33 percent. This highlights the need for more work to validate each methodological step to understand how it affects payment and ensure it adds to "accuracy."

4. **Failure to Calculate Costs at the Claim Level:** CMS chose to use *charges* to initially calculate the relative weights at the DRG level and then a national scaler to make the conversion to "cost-based" weights. The national scaler converts the 10 cost center charge-based weights to one national weight using the actual share of costs across departments. CMS maintains that this adjusts for differential mark-ups across hospital departments. In contrast, MedPAC estimated *costs* at the claim level to calculate relative weights. CMS provided no validation of the methodological shortcut they propose.

5. **Cost Centers:** CMS aggregates charges into 10 cost centers for each DRG, then applies a cost-center level CCR (derived from the cost reports) to charge figures (from claims data). But because hospitals often report charges on the cost reports differently than charges on the claims, the cost-center level CCRs are calculated based on a different set of charges than the charges to which the CCRs are later applied. We believe this may materially distort the DRG weights and needs to be thoughtfully considered and accounted for in any methodology. If CMS is going to move to cost-based weights, regardless of the methodology, hospitals will

need time to align their mapping of cost centers into departments or cost categories for purposes of cost reporting with that of claims reporting.

6. **Validation:** As mentioned above, CMS provided no analysis to validate that the proposed changes result in better payment policy. While measuring improved payment accuracy is difficult, the large degree to which the weights fluctuate given methodological changes alone indicates the need for further analysis and study. CMS should construct a process to test the sensitivity of weights to various methodological assumptions and publicly share the result, including:

    - Compare CMS weights to MedPAC's HSRV-cost approach;
    - Compare CMS weights to an approach using standardized costs (as opposed to HSRV);
    - Compare CMS weights-to-weights calculated by estimating costs at the claims level using the 10 cost center approach;
    - Evaluate alternative methodologies for estimating costs (e.g., method used by New York state's Medicaid program);
    - Compare stability of weights over time; and
    - Determine whether payment policy is improved.

    Assessment of "payment accuracy" conducted by The Moran Company as well as The Health Economics and Outcomes Research Institute (THEORI), a division of the Greater New York Hospital Association, finds the CMS HSRVcc approach to be not at all to marginally better than the current system. Fixing the major methodological flaws yields minimal improvement, according to THEORI. CMS' HSRVcc approach actually creates new areas of care where systematic incentives for specialization could occur. This analysis raises significant questions about CMS' approach and further analysis should be conducted before any changes to the current charge-based methodology are made. These analyses will help determine the most effective and administratively feasible approach for a shift to cost-based weights in FY 2008.

NEW PATIENT CLASSIFICATION: SEVERITY OF ILLNESS

CMS also proposes moving to an entirely new patient classification system beginning in FY 2008 *or earlier*. Currently, Medicare uses 526 DRGs to classify all Medicare patients. CMS considered use of 3M's all-patient refined DRGs (APR-DRGs) as an alternative to its current DRGs, which would increase the number of categories to 1,258. However, CMS ultimately proposed refining the APR-DRG system by consolidating APR-DRGs into fewer categories. This would result in a new DRG system with 861 consolidated severity-adjusted DRGs, or CS-DRGs.

HAP believes that the need for and best approach to changing the patient classification system has not been concretely and objectively demonstrated. More careful analysis is needed, along with greater access to the specifics of CMS's methodology and the new GROUPER. Below we discuss our detailed concerns and questions about this proposal.

CS-DRG METHOD CONCERNS

1. **Validation:** It is unclear whether there is a need for a new patient classification system. More work is needed to assess the proposed system and others that might be considered. As

with the HSRVcc proposal, CMS provided no analysis that shows that the proposed changes result in an improved hospital payment system compared to the existing DRG system or APR-DRGs.

CMS must test the degree to which the variation in costs within cases at the DRG level is reduced under both CS-DRGs and APR-DRGs. Payment classifications that still exhibit a high degree of cost variation should be identified and potentially revised. We suggest comparing the distribution of the coefficient of variation at the DRG level for various grouping approaches.

For instance, CMS chooses to collapse the tier-four cases within major diagnostic categories (MDCs). It is unclear whether all of the tier-four cases are clinically cohesive enough to be combined and whether consolidation adequately considers variations in resource requirements. CMS also aggressively collapses the DRGs with low Medicare volume such as obstetrics, psychiatric and substance use services without any discussion of the potential ramifications for other payment systems, such as other Medicare PPSs, Medicaid and the private sector that often bases payment off the Medicare inpatient DRG system. CMS believes that a new patient classification system that distinguishes more-sick from less-sick patients will reduce the "cherry picking" of healthy patients, but there may be other, easier ways to accomplish this. For example, CMS embarked on a new way to differentiate patients last year based on the absence or existence of a major cardiovascular diagnosis, but did not discuss the possibility of other similar, less disruptive changes to the system as an option in this year's rule.

Even more fundamentally, today's DRG system was created to distinguish the resource use required among patients. It has been modified over time to reflect changes in clinical practice and technology. The APR-DRG system is based on severity of illness, not necessarily the resource use required. The implications of moving from a resource-based system to a severity-based payment system must be more fully explored and understood.

2. **Budget Neutrality Adjustment:** CMS suggests in the proposed rule that it would reduce payments to hospitals by instituting a budget neutrality adjustment to offset the fact that case mix may increase because of improved coding rather than actual changes in acuity. However, CMS did not propose an adjustment or even a methodology for determining an adjustment. CMS often institutes such adjustments that are based on assumptions but never checked or later corrected. We recommend that CMS hold off on such an adjustment until there is evidence that one is needed.

3. **Availability of the GROUPER:** The proprietary nature of the proposed CS-DRG GROUPER is of concern. The current DRG GROUPER logic has been in the public domain since the inception of the PPS. Without the new GROUPER logic, it is virtually impossible for the hospital field to thoroughly analyze the system and comment—without access to the new GROUPER, we have no understanding of how and why patients fall into certain CS-DRGs and cannot evaluate whether it represents policy improvement. If CS-DRGs are adopted and the GROUPER remains proprietary, HAP would be limited in our ability to educate and assist our member hospitals. Moreover, a single company's monopoly would be both more expensive and more difficult to integrate into our hospitals' existing systems. Maryland hospitals report a GROUPER price of $20,000 per hospital with the ultimate price varying based on criteria such as whether it is used on a mainframe or PC. As with all

previous and current DRG GROUPER logic, we urge CMS to place any new classification system in the public domain.

4. **Too Few Diagnoses and Procedures Considered:** We are concerned that CMS' GROUPER does not use all diagnoses and procedures that affect a patient's severity of illness and/or the resources utilized. The current DRG GROUPER only considers nine diagnoses and up to six procedures. Hospitals submit claims to CMS in an electronic format. The HIPAA compliant electronic transaction 837i standard allows up to 25 diagnoses and 25 procedures. Many fiscal intermediaries are ignoring or omitting the additional codes submitted by hospital providers since these additional diagnoses and procedures are not needed by the GROUPER to assign a DRG.

   Capturing all diagnoses and procedures meeting the definitions of reportable secondary diagnoses and procedures will provide a more complete picture of patient complexity. As CMS considers methodologies for refining the patient classification system, the number of secondary diagnoses may be an important factor in determining differences in patient characteristics. This is particularly true of patients with many chronic illnesses that add to the complexity of treating them.

HAP supports meaningful improvements to Medicare's inpatient PPS. We believe the hospital field and CMS share a common goal in refining the system to create an equal opportunity for return across DRGs which will provide an equal incentive to treat all types of patients and conditions. However, more time is needed to understand the significant proposed policy changes, which redistribute from $1.4 to $1.7 billion within the inpatient system. Analysis shows the impact of the proposed changes to be highly unstable, with small changes in method leading to large changes in hospital payment. And the validity of CMS' proposals versus potential alternatives to improve the DRG weights and classification system is uncertain. Moving forward requires thoughtful change. Specifically, HAP supports the following:

- **One-year Delay:** HAP supports a one-year delay in the proposed DRG changes given the serious concerns with the HSRVcc and CS-DRG methodology. HAP and Pennsylvania hospitals are committed to working with CMS over the next year to address these concerns.

- **Valid Cost-based Weights:** We support moving to a DRG-weighting methodology based on hospital costs rather than charges, but CMS' proposed HSRVcc method is flawed.

- **A New Classification System Only if the Need Can Be Demonstrated:** HAP does not support a new classification system at this time, as the need for a new system is still unclear. More work understanding the variation within DRGs and the best classification system to address that variation is still needed before CS-DRGs or any other system should be selected or advanced.

- **Simultaneous Adoption of Any Changes to Weights and Classifications:** If the need for a new, more effective classification system is demonstrated and developed, it should be implemented simultaneously with the new weighting system to provide better predictability and smooth the volatility created by these two, generally off-setting changes. For example, of the 2,566 hospitals that would experience an increase in payment using the HSRVcc[1] methodology alone, 48 percent would experience a net loss when CS-DRGs and HSRVcc are done together. Of the 859 hospitals that have a decrease in payment under the HSRVcc methodology alone, 33.9 percent would become overall winners when CS-DRGs and HSRVcc are done together.

- **Three-year Transition:** Any changes should be implemented with a three-year transition, given the magnitude of payment redistribution across DRGs and hospitals. We recommend that CMS provide a three-year transition with a blend of the old DRG weights and the new DRG weights. In the first year, hospitals would be paid based on an average of DRG weights: 75 percent of the old weights; 25 percent of the new weights. The second year would be 50 percent of each, and the third year would be 25 percent of the old weights and 75 percent of the new weights. Another method of transition is dampening the reduction for DRGs with significant decrease in relative weights similar to the dampening of APC weights in the outpatient PPS. Dampening could be more feasible—especially if a significant change to the classification system is made—because it does not require CMS to calculate payments using two different systems.

  We further believe that a stop loss should be instituted as part of this transition. This would be similar to the approach currently used under the inpatient psychiatric PPS whereby no hospital can receive less than 70 percent of what they would otherwise have been paid under the old system. In combination with the DRG blend or dampening, this would result in less significant losses in the first year than in the last year of the transition. To avoid having to run all claims under both DRG weights, CMS could establish a payment-to-cost ratio for each hospital in FY 2006 and use that as a base against which to compare payments under the new system.

- **Collaborative Approach to Moving Forward**: HAP commits to working with the AHA, other hospital associations and CMS to develop and evaluate alternatives for new weights and classifications.

DRG RECLASSIFICATIONS

DRGs: Pancreas Transplant. We agree with the proposed coding changes for DRG 513 (Pancreas Transplant), which removes the requirement that pancreas transplant patients also have kidney disease. This change is consistent with the newly approved National Coverage Determination (NCD) to cover pancreas transplants alone as reasonable and necessary under limited circumstances for patients with Type I diabetes.

DRGs: Dual Array Implantable Neurostimulators for Deep Brain Stimulation. We oppose CMS' recommendation to keep the implantation of dual array implantable neurostimulators for deep brain stimulation in DRG 1 (Craniotomy Age >17 with CC) and DRG 2 (Craniotomy Age >17 without CC). CMS should recognize the higher resources associated with this technology.

DRGs: Carotid Artery Stents. We oppose the proposed delay in making any changes to carotid artery stent cases. The higher costs associated with carotid stents should be recognized within the existing DRG system.

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[1] Source: Moran Company analysis of 2004 MedPAR under FY 2007 payment policies using weighted CCRs and trimming CCRs at 3.0 standard deviations.

DRGs: Cardiac Resynchronization Therapy, Defibrillators (CRT-D). We agree with the proposal to add code 37.74 (Insertion or Replacement of Epicardial Lead [Electrode] into Atrium) to the DRG logic so that all types of defibrillator devices and lead combinations would be included in the following DRGs:

- DRG 515 (Cardiac Defibrillator Implant without Cardiac Catheter);
- DRG 535 (Cardiac Defibrillator Implant with Cardiac Catheter with AMI/Heart Failure/Shock); and
- DRG 536 (Cardiac Defibrillator Implant with Cardiac Catheter without AMI/Heart Failure/Shock).

This change would bring the DRGs into alignment with the change in coding advice to assign code 37.74 in conjunction with implantation of CRT-D defibrillators.

Application of Major Cardiovascular Diagnoses (MCVs) List to Defibrillator DRGs. We oppose the proposal to delay refining defibrillator DRGs based on MCVs. We believe it is appropriate for CMS to apply a clinical severity concept similar to the approach used in FY 2006 to refine cardiac DRGs to an expanded set of DRGs (e.g., defibrillator DRGs) based on the presence or absence of an MCV.

DRGs: Hip and Knee Replacements. For FY 2006, new codes were created to differentiate between new and revised hip and knee replacements. In addition, more specific codes were created to identify the joint components replaced. After publication of the FY 2006 inpatient PPS final rule, a number of commenters advised CMS that the DRG logic for DRG 471 (Bilateral or Multiple Major Joint Procedures of Lower Extremity) included knee and hip procedures that are not bilateral or do not involve multiple major joints. We agree with CMS' proposal to remove the codes from DRG 471 that do not capture bilateral and multiple joint revisions or replacements.

DRGs: Severe Sepsis. We agree that providers have found the coding of systemic inflammatory response syndrome (SIRS), sepsis and severe sepsis confusing in the last few years. The classification of these conditions has changed several times during this period. We concur that data have not been consistent and that a new DRG for severe sepsis would be inappropriate. However, we recommend that a change be made so patients with severe sepsis associated with respiratory failure requiring mechanical ventilation may be properly recognized. The ICD-9-CM classification instructions require that these patients be coded with the systemic infection as the principal diagnosis. The infection codes do not group to DRG 475 (Respiratory System Diagnosis with Ventilator Support) despite the use of resource-intensive mechanical ventilation (procedure code 96.7). This results in a significant loss of reimbursement for these patients.

Since the change in coding sequencing of these patients, the Coding Clinic Editorial Advisory Board has discussed this issue several times. In addition, several proposals have been submitted to the ICD-9-CM Coordination and Maintenance Committee to allow the sequencing of respiratory failure as the principal diagnosis. To date, no changes have been made. At this point, reverting the sequencing instructions would be confusing to coders and would once again disrupt trend data.

Instead, we recommend considering mechanical ventilation as a pre-MDC DRG on the basis of the procedure code. If this is not possible, we recommend that CMS add systemic infections (038.xx,) as acceptable principal diagnoses for DRG 475 when reported in conjunction with mechanical ventilation or tracheostomy.

DRGs: Complications/Comorbidities (CC) Categories 403-404. Effective October 1, changes have once again been made to the definition of the fifth-digits for categories 403 (Hypertensive Chronic Kidney Disease) and 404 (Hypertensive Heart and Chronic Kidney Disease). Prior to October 1, 2005, a fifth digit of "0" indicated "without chronic renal failure," while a fifth digit of "1" indicated "with chronic renal failure." While all patients in categories 403 and 404 had chronic kidney disease linked to hypertension, only those with a fifth digit of "1" had progressed to the point of kidney failure. Effective October 1, 2005, the definition of the fifth digits changed to "with or without chronic kidney disease." This was confusing since all patients in categories 403 and 404 by definition were supposed to have a chronic kidney condition. The change also blurred the distinction between the patients with more severe kidney failure and those with less kidney damage. The most recent change for this year once again changes the meaning of fifth digit "0" to identify patients "with chronic kidney disease stage I through stage IV or unspecified," while fifth digit "1" identifies patients "with chronic kidney disease stage V or end stage renal disease." As such, Table 6E of the proposed rule has identified codes 403.10, 403.90, 404.10 and 404.90 as non-CCs. The stages of chronic kidney disease are a fairly new concept introduced into the ICD-9-CM classification last year, which physicians do not routinely document in the medical record. Many physicians still document the older and more common term "chronic renal failure," which translates into "unspecified stage" in the ICD-9-CM. More importantly, physicians differ in their opinion of what constitutes renal failure—whether it starts in the middle of stage III, stage IV or stage V.

While we understand that CMS may not want to consider a code that would include patients in the early stages of hypertensive kidney disease as a CC, because of the potential inclusion of more serious chronic renal failure patients in codes 403.10, 403.90, 404.10 and 404.90, we recommend that CMS instead rely on the supplemental code from category 585 (Chronic Kidney Disease) to recognize the CC.

Implementing a Modern Clinical Classification System. We continue to agree with CMS' assessment in the May 9, 2002, hospital inpatient PPS notice of proposed rulemaking that ICD-10 is an improvement over ICD-9-CM and will provide greater specificity and detail. We believe that CMS should continue with plans to implement ICD-10. Implementing the significant DRG changes is a temporary fix, and a more refined DRG system can only be accomplished with more specific clinical classification systems, capable of painting a more complete picture of a patient's condition and the services provided to treat that condition—namely ICD-10-CM and ICD-10-PCS.

LONG-TERM CARE HOSPITAL (LTCH) DRGS

HAP is very concerned about the proposed reweighting of the long-term care hospital (LTCH) DRGs for FY 2007. The projected payment cut resulting from the reweighting—1.4 percent—in combination with the payment cut resulting from the recent LTCH PPS final rule for 2007—7.1 percent—will cause substantial volatility for LTCH providers, and ultimately restrict access for patients needing long-term acute care services. It would be extremely difficult for any provider group to withstand an 8.5 percent cut in one year. By pursuing these changes, CMS is misinterpreting MedPAC's estimate of 2006 Medicare margins for LTCHs and creating an extremely unstable regulatory environment for LTCHs. MedPAC projected a 7.8 percent Medicare margin for LTCHs in 2006 and recommended no market basket update for FY 2007. However, this MedPAC projection does not include two major policy changes that also decrease Medicare margins for LTCHs: the projection excludes the impact of the "25% Rule" limiting payments to co-located LTCHs and the new reductions associated with the LTCH short-stay outlier policy. Therefore, CMS goes too far with this proposal to reduce Medicare payments even further.

Given these considerations, we urge the agency to forgo the proposed 1.4 percent cut and instead implement the reweighting in a budget-neutral manner.

This would appropriately redistribute allocated funds among the payment categories to reflect current costs and omit the inappropriate modification of total payments due to unrelated considerations. **It is irrational to treat the LTCH PPS differently than other Medicare payment systems by failing to reweight the LTCH PPS in a budget-neutral manner.**

At this time, CMS should focus on developing further patient and facility criteria for LTCHs to ensure that patients who are clinically suitable continue to have access to the LTCH setting. We strongly support CMS' pursuit of a scientific foundation for these expanded criteria and are eager to review the recommendations currently under development by CMS' contractor the Research Triangle Institute.

HOSPITAL QUALITY DATA

In accordance with the requirements in the Deficit Reduction Act of 2005 (DRA), the Centers for Medicare & Medicaid Services (CMS) has proposed expansion of the 10 quality measure starter set and linked the reporting of a total of 21 quality measures to the CMS data warehouse to the hospital annual payment update (APU) for FY 2007. The focus areas of the 11 additional measures are acute myocardial infarction, heart failure, pneumonia, and surgical infection prevention (SIP). The SIP measures include administration of an antibiotic within one hour of incision and the discontinuation of antibiotics within 24 hours after the surgery has been completed.

The rule also proposes that the data collection for the expanded set of quality measures begin with discharges occurring in the first calendar quarter of 2006—January 1, 2006, discharges. This data must be submitted to the CMS data warehouse by no later than August 15, 2006 for hospitals paid under the CMS prospective payment system to receive their full market basket update. Failure to submit the data on these additional measures in the time frame proposed will result in those hospitals receiving the full market basket update minus 2 percent.

Timeframe Concerns – In reviewing the proposed rule, HAP would like to submit the following comments for consideration.

- The rule was published in the *Federal Register* on April 25, 2006, well after hospitals had finished or were finishing most of the abstraction for 1st quarter 2006 discharges and had already or were nearly ready to transmit that data to their respective performance measurement vendors.
- Comments on the rule are not due to June 12, 2006, but hospitals have to comply with the rule at or about the time comments are due in order to meet the requirements in the rule to have the first quarter discharge information in the warehouse by mid-August in order to qualify for the update.
- In order to meet the deadlines proposed in this rule, hospitals have to enter into agreements with their performance measurement vendors in order institute a process that requires them to reabstract medical records for the additional measures. The SIP measures are particularly problematic given that only 25 percent of all Pennsylvania hospitals eligible for the annual payment update are presently collecting and reporting these measures to the data warehouse. HAP believes that approximately another 25 percent of hospitals have been collecting the data but have not authorized their performance measurement vendors to transmit that data to the warehouse. The remaining 50 percent of Pennsylvania hospitals have not been collecting the data. With the proposed rule, the majority of these hospitals have put processes in place to collect the required data beginning with 2nd quarter 2006 hospital discharges, but these hospitals will need to go back and retrieve the necessary data from medical records for 1st quarter 2006 discharges. Hospitals will incur additional expenses that include costs associated with the work required by their respective performance measurement vendors and overtime costs that are required for staff needed to perform this work under an expedited timeframe.
- Although data is not required to be in the data warehouse until August 15, 2006, hospitals must have their data submitted to their performance measurement vendors no later than sometime between June 15 and June 30 depending on the performance measurement vendor. Performance measurement vendors have had to move back their cutoff dates to allow hospitals sufficient time to abstract medical records. At least 80 of the 163 eligible PPS hospitals have only been given about six weeks to meet the timelines in this proposed rule.
- Pennsylvania hospitals that under these tight timeframes to collect and report additional measures, particularly the SIP measures, are concerned about the education and training of medical record abstractors. They do not believe that they have been given sufficient time to ensure appropriate training of their medical record staff to ensure a high degree of accuracy in the data abstraction.

RECOMMENDATIONS:

In light of these identified problems with the retroactive nature of the proposed rule, **HAP requests that CMS require the submission of the additional measures, specifically the SIP measures, begin with 3rd quarter 2006 discharges and that the annual payment update be tied to successful transmission of the additional measures beginning with 3rd quarter discharges. HAP also recommends that these measures not be included in the formal validation process for the annual payment update until after one full year of reporting of**

the additional measures. HAP does support a review of the records by the Clinical Data Abstraction Center for these additional measures, especially the SIP measures to permit hospitals to obtain feedback about the data abstraction for learning purposes during the course of the year.

Since the DRA calls for further expansion of the measures reported to the data warehouse, HAP recommends that CMS develop a process that affords organizations sufficient time prospectively to begin collection and reporting of any additional measures that will be considered in an annual payment update or part of a value-based purchasing program for hospitals.

Chart Validation – HAP recognizes the importance of ensuring that the data reported by hospitals to the data warehouse is accurate and appreciates the volume of charts that must be reviewed by the CDAC in order to ascertain whether the reported data is reliable and valid. In the proposed rule, CMS has indicated that hospitals must pass validation of a minimum of 80 percent reliability based on the CMS chart-audit validation process for the first three quarters of data from calendar year 2005. CMS has combined the chart samples for the first three quarters of 2005, or a total of 15 charts into a single stratified sample to determine whether the 80 percent reliability is met. CMS has requested comments on its passing threshold, confidence interval, and sampling approach. The following comments were provided by Pennsylvania hospitals in response to the request for comments.

- Pennsylvania hospitals indicated a comfort level with the present number of medical records selected each quarter for validation as well as the random selection of those charts, meaning that in the five charts selected there may be more requests for one disease/condition than another.
- Pennsylvania hospitals also agreed with the minimum threshold passing score established by CMS. However, given that CMS is proposing to combine the chart samples over several quarters in this rule and may propose the same in subsequent years, Pennsylvania hospitals strongly believe that they should have the opportunity to appeal all mismatches that they have with the CDAC and not just those situations where they have failed to meet the 80 percent threshold. Pennsylvania hospitals view this as vitally important to being able to ensure that they meet the 80 percent threshold in order to ensure a higher score in any one quarter than might compensate for lower score in another quarter.
- Pennsylvania hospitals also believe that the ability to challenge any mismatch between their organization and the CDAC represents an important learning opportunity for the organization. Specifically, Pennsylvania hospitals has indicated that having this ability to challenge mismatches may permit them to identify a problem, concern, issue, or pattern that could be rectified to prevent the same from occurring in subsequent quarters.
- CMS should consider a validation method that would exempt hospitals from having to undergo chart validation in some quarters if the hospital has consistently achieved very high validation scores in previous quarters. Potentially then, CMS could utilize some of its resources to request greater numbers of records for chart validation from those hospitals that are not consistently meeting the required 80 percent validation threshold.
- At a minimum, CMS should prospectively establish and communicate to the field which quarters will be used in the calculation of the validation threshold as this as critically important to receiving the APU as submission of the measures to the data warehouse in the required timeframes.

RECOMMENDATIONS

Pennsylvania hospitals strongly encourage CMS to allow hospitals to challenge any mismatches in the chart validation that they may have with CDAC in order to score as high as they possibly can in any quarter, learn from the process, and remedy any identified problems to prevent them from occurring in subsequent quarters. Additionally, Pennsylvania hospitals recommend that CMS consider a validation process that would focus more resources on those hospitals that are having difficulty in passing the validation thresholds on a consistent basis. Finally, going forward, CMS should prospectively establish and communicate to the field which quarters will be used in the calculation of the validation threshold.

Reconsideration Process

CMS has indicated that hospitals that do not meet the APU requirements for the applicable fiscal year may appeal this determination to the Provider Reimbursement Review Board and that any such requests for FY 2007 must be made by no later than November 1, 2006. CMS has also proposed that the November 1, 2006 deadline apply to FY 2005 and FY 2006 APU decisions and that a November 1 deadline would apply in all future fiscal years. Further, CMS is seeking public comment on the need for a more structured reconsideration process to precede any Provider Reimbursement Review Board appeal for FY 2008 and subsequent years.

RECOMMENDATIONS

Pennsylvania hospitals are supportive of a process that could potentially consider the reasons why a hospital was not able to meet the APU requirements for the applicable fiscal year and allow the hospital to meet the requirements to qualify for the APU. HAP believes that such a reconsideration process should be requested in writing by a senior level official of the organization, such as the chief executive, chief operating officer, and/or chief financial officer for the hospital. Specific reasons for these reconsiderations should include: the inability to timely submit data to the data warehouse as a result of CMS or vendor transmission failures; identification of information that may have been communicated inaccurately to CMS; and issues related to final chart validation scores as when the wrong chart was sent to the CDAC for validation and/or the charts sent to the CDAC were misplaced or lost which may have significantly adversely affected the validation scores for a particular quarter. HAP believes that Quality Improvement Organization staff could be extremely helpful to hospitals and to CMS in implementing any reconsideration process.

Future Measures

The DRA requires the expansion to other quality measures starting with FY 2008. The types of measures that may be added include: the HCAHPS® patient perception of care survey findings; structure measures as detailed in the recent Institute of Medicine report *Performance Measurement: Accelerating Improvement;* and outcome measures, specifically 30-day mortality for acute myocardial infarction and heart failure patients.

RECOMMENDATIONS

Hospital-specific patient outcomes reports have been publicly available in Pennsylvania for over 20 years. These hospital performance reports cover over 30-based code conditions and 19 DRGs. Outcomes included in these reports which are updated on a quarterly basis and available to the public include: risk-adjusted in-hospital mortality; risk-adjusted length of stay; risk-adjusted readmissions for any reason; risk-adjusted readmissions for complications, including infections; average hospital charge; and the percent of cases transferred to another acute care facility. HAP does not believe that use of a 30-day risk-adjusted mortality for acute myocardial infarction and heart failure patients represents the best outcome measures that could be selected by Medicare to represent the quality of care delivered to patients in hospitals. HAP would strongly suggest that Medicare work with the Hospital Quality Alliance partners to identify outcome measures that better reflect the quality of hospital care. Additionally, use of the 30-day risk-adjusted mortality for acute myocardial infarction is not congruent with the in-hospital mortality measure that is part of the Joint Commission on Accredited Healthcare Organizations (JCAHO) core measures for acute myocardial infarction and an outcome measure that was used in the Premier Hospital Quality Incentive Demonstration project.

OUTLIER PAYMENTS

The rule proposes establishing a fixed-loss cost outlier threshold equal to the inpatient PPS rate for the DRG, including indirect medical education (IME), disproportionate share hospital (DSH), and new technology payments, plus $25,530. While this is not a particularly sizable increase from the FY 2006 payment threshold of $23,600, we remain very concerned that the threshold is too high. According to our analyses, actual outlier payments for FY 2006 are estimated to be 0.47 percentage points lower than the 5.1 percent of funds withheld from hospitals to fund outlier payments. CMS spent only 3.8 percent, or $1.15 billion less than set aside in FY 2005, and only 3.5 percent, or $1.3 billion less than the funds withheld in 2004.

In the rule, CMS proposes to use a one-year average annual rate-of-change in charges per case from the last quarter of 2004, in combination with the first quarter of 2005, to the last quarter of 2005, in combination with the first quarter of 2006, to establish an average rate of increase in charges. This results in a 7.57 percent rate of change over one year, or 15.15 percent over two years.

HAP appreciates that CMS is proposing this methodology in an effort to avoid using data from 2003 when charges may have been atypically high. **However, using the proposed charge inflation methodology will only result in an inappropriately high outlier threshold and a real payment cut to hospitals. HAP strongly opposes using this methodology to estimate the outlier threshold.** The AHA conducted a series of analyses to identify a more appropriate methodology. Below is the AHA proposed methodology which HAP encourages CMS consider adopting. The methodology incorporates both *cost* inflation and *charge* inflation. We believe the use of more than one indicator will make the threshold calculation more accurate and reliable.

1. Inflated 2005 charges by 15.71 percent (the inflation factor used by CMS in the proposed rule) and then reduced the charges to costs.
2. Instead of using the cost-to-charge ratios (CCRs) from the CMS Impact File, the CCRs from the March 31, 2006 HCRIS release are used.
3. Take into account the nine-month lag from the end of a cost-reporting period until the FI is able to update the CCR. This is accomplished by projecting forward from the most recent fiscal period in the March 31 HCRIS update to the fiscal period(s) expected to be used for the calculation of the CCR(s) determining federal FY 2007 outlier payments.

The cost inflation factor for projecting CCRs was determined from the cost reports of a cohort of 3,253 matched hospitals for periods beginning in federal FYs 2002, 2003, and 2004. All three cost reports were available for each hospital from the recent update of HCRIS. The 2002-2004 aggregate annual rate of increase in the cost per discharge for these hospitals was 5.69 percent[2]. This cost inflation factor and the CMS charge inflation factor of 7.57 percent were used to project CCRs over the time periods described above. The projected CCRs were applied to projected federal FY 2006 charges to simulate the determination of costs for FY 2007 outlier payments. **The estimated fixed-loss amount that would result in 5.1 percent outlier payments under this methodology is $24,000.**

HAP strongly urges CMS to adopt this methodology, which is applicable regardless of what DRG changes are made or not made in FY 2007. We estimate that the fixed-loss threshold necessary to achieve 5.1 percent in FY 2006 should have been set at $21,275 as compared to the $23,600 actually utilized. We believe CMS underspent the funds set aside for outliers by an estimated $3 billion over FYs 2004, 2005, and 2006. **This is a real cut in payments to hospitals that cannot be recouped. If CMS leaves the threshold at $25,530, rather than dropping it to $24,000, we believe that CMS will again significantly underspend by over $300 million.** We urge CMS to adopt our recommended methodology to lower the outlier threshold.

Core-based Statistical Areas (CBSAs)

In adopting the Core-based Statistical Areas (CBSAs) in FY 2005, a small number of hospitals that were classified as urban in FY 2004 became classified as rural in FY 2005. Because moving from a Metropolitan Statistical Area (MSA) to the rural statewide average would have resulted in a significant decline in these hospitals' wage indexes, CMS implemented a three-year transition period (FYs 2005-2007). **HAP supports the continued transition for these hospitals to give them the opportunity and time to reclassify.**

Occupational Mix Adjustment

The Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 requires CMS to collect data every three years on the occupational mix of employees from hospitals subject to the inpatient PPS in order to construct an occupational mix adjustment to the wage index to control for the effect of hospitals' employment choices—such as greater use of registered nurses (RNs) versus licensed practical nurses or certified nurse aides—rather than geographic differences in the costs of labor.

CMS initially stated in the proposed rule that it would again limit the occupational mix adjustment to 10 percent because of concerns regarding the validity of the data and the potential financial impact on hospitals. However, as a result of the decision handed down by the U.S. Court of Appeals for the Second Circuit on April 3 in *Bellevue Hospital Center v. Leavitt*, CMS on May 12 released a proposed rule revising the occupational mix adjustment portion of the FY 2007 inpatient PPS proposed rule. Under the court ruling, CMS must collect new data on the occupational mix of hospital employees and fully adjust the area wage index (AWI) for FY 2007.

Hospitals are required to collect the hours and wages for employees from January 1 through June 30, 2006. Data initially was supposed to be collected by July 31; however, hospitals were

[2] An audit adjustment was applied to costs from "as submitted" cost reports. The audit adjustment was determined by comparing 2,729 "as submitted" cost reports from the December 31, 2003 HCRIS database with the settled reports of the same hospitals in the March 31, 2006 HCRIS update.

required to submit data by June 1 for the first calendar quarter of the year and by August 31 for the second calendar quarter. Data from the first quarter will be used to adjust the FY 2007 AWI, while data for the full six months will be used to adjust the AWI for FYs 2008 and 2009.

Definitions and Covered Employees. In filling out the interim-survey, our members found that the placement of certain employees caused confusion. Examples include surgical technicians, paramedics who are employed by the hospital and usually work in the emergency department, and unit secretaries who are also known as ward clerks. CMS clarified after the proposed rule was released that these employees should be placed in the "all other" category for the interim-collection. Moving forward, CMS should re-evaluate where these employees belong. **However, such changes should not be made to the ongoing collection, as it would necessitate the resubmission of the first calendar quarter's data to ensure that both quarters could be used for FYs 2008 and 2009.** If CMS believes that such changes are warranted, then the hospitals will need notification prior to the release of the final inpatient PPS rule in order to meet the August 31 deadline for submissions.

Cost Centers. We agree with CMS' "bright line" clarification for this collection that only nursing personnel within the cost centers listed should be included in that category for the purposes of consistency. It is significantly less work for hospitals to focus on certain cost centers, and we continue to support this methodology. **We believe that the vast majority of nursing personnel within a hospital fall within these cost centers and do not believe that CMS should include every cost center that may have a few nursing personnel included in it.**

However, CMS should consider refining the list for future collections. Every hospital has a different method for attributing costs to the cost centers, thus there are probably a few cost centers that contain a significant number of nursing personnel for certain hospitals that were not captured for this collection. Given the shortened comment period in combination with the magnitude of the other changes proposed by CMS in the inpatient PPS rule this year, we were unable to extensively research which cost centers CMS should add. We suggest that CMS accept comments on any potential changes to the cost center list before making such changes. **In addition, we believe that additional cost centers should *not* be added to the ongoing collection as it would necessitate the resubmission on the first calendar quarter's data to ensure that both quarters could be used for FYs 2008 and 2009.** If CMS believes that such changes are necessary for the current collection, then hospitals would need notification prior to the release of the final inpatient PPS rule in order to meet the August 31 deadline for submissions.

Non-responsive Hospitals. Because data from all hospitals is needed to construct an accurate national average hourly wage, full participation is critical. There is a general sentiment that hospitals that do not participate should not benefit from the participation of others. However, given the expedited collection and general confusion around the interim-collection, we believe that, to the extent possible, **CMS should substitute data from the previous survey for hospitals that did not turn in their data for the first calendar quarter of 2006.**

However, hospitals will have plenty of notice and time to submit data for the second calendar quarter in August. Thus, moving forward, CMS could consider a methodology that penalizes hospitals that do not participate. We caution CMS not to simply substitute unfavorable data for these hospitals, as it also will impact other area hospitals that conscientiously reported data. CMS could alternatively substitute the national average hourly wage for non-responsive hospitals in calculating an area's wage index, and then require hospitals that did not turn in data to use something lower than their area's wage index. This would avoid CMS having to create an extensive hospital-specific wage index table and would minimize the effects on the other hospitals in the area. **We urge CMS to construct an application of the occupational mix adjustment that encourages hospitals to report but does not unfairly penalize neighboring hospitals.**

Corrections. **HAP urges CMS to allow hospitals to turn in both calendar quarters of data in August whether for the first time or with corrections.** Again, as this collection has been rushed, the idea is to allow hospitals to improve the data for the FYs 2008 and 2009 adjustment. For hospitals that were previously non-responsive, the submission of the first calendar quarter would remove any penalty, while those that continue to be non-responsive will continue to incur a penalty.

Comment Timeframe. Hospitals must now provide occupational mix data on an extremely expedited timeline, with little or no time for review, and no ability to see how the data will affect their FY07 payment rates. While we understand that CMS is under severe time pressure due to the timing of the court's decision, we do not believe that the 30-day comment period was sufficient, as hospitals were busy during this time trying to meet the new survey deadline and answering requests for information from the FIs. HAP is also concerned that a three-month period may not be sufficient to provide the "robust" data set necessary for valid basis for calculations. In addition, we believe it would be appropriate for CMS to take comments on the calculation after the initial results of the survey are tabulated and posted. The results of the survey could be material. For instance, if the segregation of RNs who are management versus RNs who are staff does not produce a reliable result, CMS might consider consolidating the two for the purposes of the calculation. While CMS might not have time to make such changes for FY 2007, it could entertain comments on the implementation for FYs 2008 and 2009. We are concerned about the collective affect these changes will have on hospital payments and recommends that CMS provide opportunities for review, comment, and adjustment to the occupational mix data (including the ability to appeal or amend bad data), as needed, to the extent allowable under the Court order. **Thus, we urge CMS to publish the occupational mix adjustment changes as an interim-final rule in August with an associated comment period.**

Adverse Effect on Quality/Efficiency Initiatives. As an additional comment, we note that the existing wage index and occupational mix process has the effect of penalizing hospitals that invest in quality/efficiency at the very time that Congress is seeking to improve quality/efficiency under the Medicare program. For example, by utilizing higher levels of Registered Nurses (RNs), hospitals are improving the quality of care provided to seniors, yet they are penalized by the CMS' refusal to recognize these higher above-average costs under the wage index.

The effect of the wage index and occupational mix on these hospitals will reduce or eliminate the annual Medicare inflation increase provided to address the increasing costs these hospitals face. This reduction is not recognized as savings under the Medicare program, but is unfairly redistributed in part to hospitals that arguably have not been as efficient, nor as focused on quality improvement. As a result, these hospitals are placed at a competitive disadvantage that adversely impacts services and limits their capacity to recruit and retain employees and to invest in new technologies.

HOSPITAL REDESIGNATIONS AND CLASSIFICATIONS

Section 508 Reclassifications. Section 508 of the *Medicare Modernization Act* (MMA) provided $900 million over three years for a one-time geographic reclassification opportunity, which expires March 31, 2007. Because the 508 reclassifications expire mid-year and hospitals may not receive Section 508 funding at the same time as any other form of reclassification, CMS has proposed special provisions for accepting or denying partial-year reclassifications for FY 2007.

In FY 2006, CMS stated that individual hospitals reclassified under Section 508 would be allowed to request regular reclassification for the portion of the three-year period that the hospital is not receiving Section 508 funding, or to turn down the Section 508 reclassification for the first half of FY 2007 and receive regular individual reclassification for the full three years.

CMS also stated that Section 508 hospitals that would like to be part of a group reclassification could turn down their 508 reclassification for the first half of FY 2007 and join a group for the full three-year period. Or the hospitals could maintain Section 508 reclassification while the rest of the group gets their "home wage index" for the first half of the year. The entire group then could reclassify together for the rest of the three-year period.

In the proposed rule, CMS clarifies that "home wage index" means that hospitals could receive the wage index they otherwise would have, absent the group reclassification. For some hospitals, this might literally be the wage index for the area in which they are located. For others, this may mean an individual reclassification to another area.

Section 508 hospitals, and those involved in a group reclassification with a Section 508 hospital, would normally have been required to accept or reject reclassification within 45 days of the publication of the proposed rule; however, the complications with the occupational mix adjustment will prevent this. **We appreciate and support CMS' flexibility around the expiration of Section 508 and the reclassification deadlines given the unusual circumstances this year.** Further, HAP supports CMS exploring alternatives to rectify fiscal consequences for those hospitals that qualified under section 508 but did not receive funds.

GEOGRAPHIC RECLASSIFICATIONS

Multi-campus Hospitals. Payment is determined using the wage index value for the MSA in which a campus is located, even though the organization may have other campuses located in different labor market areas. Because multi-campus hospitals submit a single cost report that does not break down wage data by campus, an individual campus historically has been unable to seek reclassification. For FYs 2006-2008, CMS authorized individual campuses to use the average hourly wage data of the entire multi-campus hospital system to seek geographic reclassification to the labor market area in which the other campus(es) are located. CMS also stated in the FY 2006 rule that, in the future, it would continue to consider mechanisms to collect the data necessary for geographic reclassifications that are not unduly burdensome for providers. However, CMS now proposes rescinding this option, as there was only one hospital in the country that was affected by this situation and, after the change in labor market areas in FY 2005, it has subsequently joined an urban county group that is reclassified to the area in which it was previously reclassified using the multi-campus hospital rule.

HAP opposes CMS' proposal to remove this option. While CMS may know of only one hospital at this point, there may be others, and additional hospitals may be affected after the next census collection and subsequent changes in labor market definitions. In addition, the need for this provision has not subsided as CMS suggests. This hospital will need to use either campus-specific or hospital-wide data for its next reclassification, whether group or individual, and lack a method to do so.

CMS suggests that each campus should disaggregate and receive its own provider number. A multi-campus hospital with a single provider number provides certain health and treatment benefits to patients, such as the ability to move among campuses for various aspects of treatment. Each campus may specialize in a particular service (oncology, cardiology, etc.) and patients can move among the campuses with one medical records system, one billing system, and a unified medical staff. Economies of scale reduce costs for the whole system. **Thus, we do not believe it is a realistic or appropriate option to force these campuses to apply for individual provider numbers.**

We recommend that CMS continue to allow multi-campus hospital systems to use the data from all campuses as a proxy for individual campuses to reclassify to an area where another one of the campuses is located given how few hospitals are expected to use this option.

This is a reasonable request as most multi-campus hospital systems likely pay equal or similar wages at each campus. If CMS finds that the situation becomes more prevalent, it could require the manual completion of the campus-specific Schedule S-3 for those hospitals that do not have the appropriate individual campus data. However, if CMS moves to a campus-specific S-3, CMS still needs to extend the current special rule for five years until the new campus-specific data is useable for an application.

<u>Urban Group Reclassifications.</u> HAP supports CMS' proposal to allow hospitals located in counties that are in the same core-based statistical area (CBSA) as the county in which they seek redesignation to be considered to have met the proximity requirement. **Given that CBSAs are actually more refined classifications than Combined-statistical Areas, we believe that the inclusion of CBSAs in the proximity criteria would be consistent with CMS' policy goals and protect hospitals from unintended consequences.**

<u>Critical Access Hospitals in Lugar Counties.</u> As a result of changes in the labor market area definitions made in response to the results of the 2000 census, counties in which a number of Critical Access Hospitals (CAHs) are located became "treated" as urban instead of rural under the inpatient PPS because of a statutory provision modifying the status of rural counties with certain commuting patterns to metropolitan areas. In its FY 2005 final rule, CMS interpreted this provision as applying to CAHs located in these counties (Lugar counties) and allowed these facilities a grace period to seek reclassification as rural in order to retain their CAH status.

While accommodating CAHs in this manner, the agency also took the position that any CAH being reclassified would no longer be eligible for pass-through payments for the services of certified registered nurse anesthetists (CRNAs). Its reasoning was that the facility was no longer "located in a rural area (as defined for purposes of section 1886(d) of the Social Security Act)" as the pass-through statute requires, but were only reclassified as rural.

In response to comments received on the FY 2006 proposed rule, CMS announced a policy change in the final rule for FY 2006 stating that Lugar county designation would not affect a CAH's rural status because the statutory provision creating such counties only applies to hospitals paid under the inpatient PPS (CAHs are paid under a separate, cost-based system). This policy change had the effect of eliminating the need for these CAHs to seek either geographic reclassification or a waiver of the Lugar statute (which CMS has maintained it has no authority to do). **In effect, under this new reading of the law, the provision creating Lugar counties does not apply *at all* for purposes of CAH eligibility.**

Despite this policy change, CMS continues to maintain that a CAH located in a newly-designated Lugar county cannot qualify for CRNA pass-through payments. This position is at odds with the agency's view that *it is geographic reclassification that renders a CAH ineligible for such payments*—since, under CMS' revised policy, a CAH located in such a county need not seek geographic reclassification to be a CAH. Apparently, it is CMS' view that these CAHs can never qualify for CRNA pass-through payments, whether they have sought reclassification (under the old policy) or not (under the new policy). **We believe that all CAHs located in a newly-designated Lugar county should receive pass-through payments, regardless of whether they sought reclassification, and urge CMS to revise its regulations accordingly.**

Wage Index Budget Neutrality

CMS eliminates the CAH data from the wage index file it uses to compute the national average hourly wage (NAHW). For FY 2007, 1,191 CAHs representing approximately 24 percent of all inpatient PPS hospitals (as of FY 2000) – 55 percent of all rural hospitals in FY 2000 – have been eliminated from the file. Because CAHs have lower average hourly wages (AHWs) than the average PPS hospital, the elimination of this data results in an overstated NAHW. While the NAHW has been increasing, the systematic withdrawal of low-wage hospitals has artificially inflated the NAHW to some extent. This artificial increase is included in the negative budget neutrality adjustment that consequently reduces payment, resulting in the national inpatient PPS operating payments being understated by an estimated $1.52 billion over five years (2003-2007). **Thus, we believe that CMS should apply a positive budget neutrality adjustment in FY 2007 to compensate for the underpayments.** The understatement increases each year as more hospitals become CAHs and more data are eliminated from the wage index data. However, we believe that this could be a one-time adjustment as we expect very few hospitals to convert to CAH status now that the necessary provider designation is no longer an option.

Low-volume Hospital Payment Adjustment

Section 406 of the MMA created a payment adjustment under the inpatient PPS to account for the higher costs per case of low-volume hospitals. The law defined eligible hospitals as those located more than 25 miles from another facility with fewer than 800 total discharges annually. The rule proposes to maintain a 25 percent increase, the maximum allowable, in payments to hospitals with fewer than 200 discharges. For those hospitals that have between 200 and 800 discharges, CMS proposes to maintain its current policy, applying no payment increase. Only two hospitals will receive this adjustment in FY 2007 according to CMS estimates. **HAP is concerned that CMS is ignoring congressional intent and denying a group of hospitals—those with more than 200 discharges but fewer than 800 discharges—access to this necessary payment increase.**

SCH/MDH Changes in Qualification Status

The proposed rule would require an approved sole community hospital (SCH) or Medicare dependent hospital (MDH) to notify the appropriate CMS Regional Office of any change affecting its classification as such. To date, it has been the FIs responsibility to evaluate hospitals' continuing qualification for SCH or MDH status. CMS expects the hospital to now self-disclose any material changes in circumstances or potentially face a retroactive cancellation of their designation once an FI discovers its ineligibility.

This appears to be an inappropriate shift of the burden from the FIs to hospitals. For instance, hospitals are neither involved in, nor have any control over, the building of new roads or new hospitals and thus should not be accountable to report such changes. It also would be very difficult for hospitals to know when and for how long there were prolonged severe weather conditions that closed area roads, or to note changes to posted speed limits and traffic patterns. In addition, some of the qualifying criteria, such as inpatient admissions at other regional hospitals, would be hard to monitor as the hospitals do not have this sort of data on their competitors. Requiring hospitals to constantly monitor whether they continue to meet these requirements would impose a tremendous and unreasonable administrative burden on hospitals. **HAP recommends that this function remain a responsibility of the FIs, who are in a better position to monitor these circumstances. If CMS requires hospitals to report changes in circumstances, then the specific types of situations should be noted and should only include aspects of their operation that are within their control (e.g., number of beds).**

CMS' proposal to retroactively withdraw SCH or MDH status if a hospital does not appropriately self-report a change in circumstances could be financially devastating. CMS should at minimum give consideration to whether the hospital had knowledge of the disqualifying circumstance. Hospitals should not have to repay CMS based on the difference between the inpatient PPS or outpatient PPS payment and the SCH or MDH payment when they did not know that they no longer qualified for the program. Instead CMS should develop a prospective process for withdrawing the hospitals' SCH or MDH status. We believe that a 30-day timetable for losing SCH/MDH status is unrealistic given the financial implications of such a change and the inability for a hospital to plan for this outcome. **CMS should re-evaluate the proposed timetable for canceling SCH/MDH status when a hospital is found to be disqualified or self-reports disqualification and consider revoking the hospitals' status as of the following cost-reporting period.**

SCH/MDH Volume Decrease Adjustment

An SCH or MDH may apply for special payments if it experiences a decrease of 5 percent or more in its total number of inpatient discharges that was out of its control from one cost-reporting period to another. If the hospital qualifies, it must demonstrate that it took measures to scale back its nursing force commensurately. The adjustment is intended to cover the fixed costs that the hospital is unable to reduce in the year following the volume decrease. CMS believes that only "core staff and services" should be covered by these special payments. To date, CMS has used the AHA's HAS/Monitrend Data Book to compare the hospital's staffing to other similar hospitals in the area to determine if the hospital is staffing its routine and intensive care units appropriately. However, the Data Book has not been updated since 1993. CMS has been using the 1989 publication. Thus, CMS proposes using the occupational mix adjustment data currently being collected for wage index purposes to calculate nursing hours per inpatient day for a hospital in question and local peer hospitals.

The occupational mix adjustment was only partially implemented in its first three years, primarily due to the questionable data and results. The current collection, which is occurring again under rushed circumstances, may also result in questionable data. **We do not believe that it is wise to assume that the occupational mix adjustment data will be appropriate for this use. HAP believes that the data within the AHA annual survey should be sufficient for CMS to determine the nursing levels per patient day.**

RURAL REFERRAL CENTERS

If a hospital wants to become a Rural Referral Center (RRC) but does not have 275 or more beds, it must meet two mandatory alternative criteria plus one of three additional criteria. The proposed rule would update the alternative criteria for RRC designation in FY 2007.

Until recently, the median case-mix index values were very stable. The chart below illustrates the volatility over the past few years in the values for two regions:

Region 7 West South Central	
FY 2005	1.1371
FY 2006	1.3532
FY 2007	1.2445
Region 6 West North Central	
FY 2005	1.0855
FY 2006	1.2252
FY 2007	1.2856

While it is not clear why this is occurring, it does suggest a possible methodological problem. **Thus, we recommend that CMS undertake additional analyses to determine the cause of the recent fluctuations.** This is particularly important given the possible disruption to case-mix patterns as a result of a new patient classification system such as the CS-DRG proposal.

CRITICAL ACCESS HOSPITALS (CAHS)

On November 14, 2005, CMS issued interpretive guidelines on the relocation of CAHs as a follow-up to the FY 2006 inpatient PPS final rule that established the "75% test"—serving 75 percent of the same population, providing 75 percent of the same services and employing 75 percent of the same staff—for necessary provider CAHs. The guidelines not only extended the 75% test to *all* CAHs, but it also altered the definitions of "mountainous terrain" and "secondary road."

We believe that these guidelines go well beyond the regulations included in the FY 2006 rule that provoked numerous critical responses from individual CAHs, associations and congressional representatives. The "mountainous terrain" and "secondary road" definitions are overly prescriptive and the 75% test does not provide reasonable flexibility based on natural variation in demographics, patient needs distribution patterns, normal employee and board attrition, and necessary changes in services to meet community needs. **Rural hospitals that move a few miles are clearly the same providers serving the same communities.**

Many CAHs are planning to rebuild in the near future to improve site safety and quality of care by adding fire and smoke barriers, upgrading infrastructure to support utilities and air handling, modernizing telecommunications to support health information technology, or making other essential upgrades. Facilities expect to relocate when they rebuild for a multitude of reasons: to be closer to a highway, to connect to municipal water and sewer, because of seismic safety concerns, or other similar concerns. **Such improvements will undoubtedly result in higher quality care, better patient outcomes and more efficient service, yet CMS' guidelines discourage these improvements.**

CMS' guidelines will not only impose an unnecessary burden on CAHs, but will preclude many of them from securing financing for needed capital improvements. The hospitals themselves, their hospital districts and their lenders cannot risk investing in a hospital that will be unsure of its status until a year after moving. **CMS should create a preliminary approval process to give assurances to those involved in the project that the CAH relocation will be approved if it meets the assertions made in the attestation submitted to CMS.**

Again this year, almost 60 congressional representatives signed a letter to CMS showing their support for their CAHs and urging changes to these guidelines. We agree with their recommendations and reiterate our suggestion from last year that a safe harbor be established for hospitals relocating within five miles of their existing locations. These providers are not only clearly serving the same communities, but trying to improve the quality of and access to needed health care services. A safe harbor will reduce the administrative burden on not only the hospitals, but CMS and the state survey agencies as well. **We urge CMS to create a safe harbor for CAHs moving a short distance and to make significant changes to these guidelines based on the feedback from CAHs around the nation as detailed in our letter under separate cover to Thomas Hamilton, director of the survey and certification group.**

GRADUATE MEDICAL EDUCATION (GME) PAYMENTS

Exclusion of Didactic Training. The proposed rule states that resident training that occurs at non-hospital sites must be related to patient care if a hospital wishes to count that time for direct medical education (DGME) and indirect medical education (IME) payment purposes. Resident time spent in didactic activities that often occur in associated medical schools—such as educational conferences, journal clubs and seminars—would specifically be excluded. CMS noted that its statement in a previous letter on this topic "implying that didactic time spent in non-hospital settings could be counted for direct GME and IME ... was inaccurate." CMS also noted that time spent in these activities could be counted for DGME purposes if they occur in a hospital; however, the counting prohibition applies for IME payments regardless of where the educational activity occurs.

We strongly urge CMS to rescind the purported "clarification" in the proposed rule that excludes medical resident time spent in didactic activities in the calculation of Medicare DGME and IME payments. The stated rationale for the exclusion of this time is that it not "related to patient care." This position is in stark contrast to CMS' position as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include "scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty."[3]

We strongly agree with CMS' 1999 position. The activities cited are an integral component of the patient care activities engaged in by residents during their residency programs. In addition, it would be very difficult to separate out time spent at these activities. **We urge CMS to withdraw this change in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.**

EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT (EMTALA)

Definition of "Labor." **HAP supports CMS' proposal to modify the definition of "labor" at 489.24(b) to allow a certified nurse-midwife or other qualified medical personnel operating under their scope of practice, as defined in hospital medical staff bylaws and in state law, to certify that a woman is in false labor.** This change recognizes that licensure and scope of practice should remain under the purview of state law and regulation. Further, this change provides hospitals with the staffing flexibility needed to maintain access to and the efficiency of vital obstetrical services, particularly in hospitals located in areas of the country that may find it difficult to attract and retain physicians, such as rural areas.

Hospitals without Dedicated Emergency Departments (ED). Under the proposed rule, a hospital with "specialized capability" is required to accept appropriate transfers under EMTALA regardless of whether it has a dedicated ED. **Guidance is still needed on the definition of specialized capability.** The EMTALA technical advisory group (TAG) has the ability to make recommendations for clarifying guidance, and we look forward to working with its members on this topic. In addition to questions related to the availability of on-call physicians and inpatient psychiatric resources, this proposed regulation calls into question application to inpatient rehabilitation facilities and long-term acute care hospitals.

HAP agrees that a physician-owned, limited-service hospital should be treated as a hospital "with specialized capability or facilities" under EMTALA without regard to whether it has an ED. However, in the DRA-mandated HHS interim report to Congress on its development of a strategic plan regarding physician investment in specialty hospitals, the Secretary suggested that this interpretation of EMTALA "may result in an increase in the number of specialty hospitals accepting transfers of emergency patients on nights and weekends." (CMS uses "specialty" to mean the hospitals covered under Congress's moratorium, i.e., physician-owned, limited-service hospitals providing primarily cardiac, surgical or orthopedic services.) **HAP believes it is unlikely that this will result in improved access for patients to the specialty care they need.**

It is important to separate the capabilities of the practicing physicians from the capabilities of the facility in which they are practicing. While the physician expertise housed in the physician-owned, limited-service facility could be capable of meeting the needs of community hospital patients, the facility is seldom designed or operated in a manner to support this level of practice. Although physician-owned, limited-service hospitals hold themselves out as "hospitals," many of these facilities actually have a range of capabilities more similar to a hospital department or

[3] September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins.

ambulatory surgical center. These hospitals often do not have emergency capabilities, as they are geared toward elective cases of minor severity. Their capabilities are typically limited to a single major diagnostic category, and they staff for minimal inpatient capacity. Many of these facilities minimize resource consumption by being almost a Monday through Friday operation. For these reasons, it generally would not be in the best interests of community hospital patients to be transferred to these facilities.

At the same time, many physician-owned, limited-service hospitals have withdrawn specialist services from the community at-large. As these physicians maintain an increasing amount of their practice at these hospitals or other sites outside the community hospital (e.g., ambulatory surgical centers), they are much less willing to accept on-call responsibility for the broader community's emergency needs. While withdrawing specialist services from on-call coverage, these same physician-owned, limited-service hospitals presume to rely on the community hospital for back-up in the event of complications requiring around-the-clock access to emergency care and inpatient admission to the community hospital. With the change in physician practice patterns and the increased number of physicians requesting only courtesy admitting privileges at community hospitals, relying only on the professional obligations attached to admitting privileges is not sufficient to assure appropriate transfer arrangements and the availability of physicians to provide emergency specialty capacity. **Every physician-owned, limited-service hospital that relies on the community's emergency services capacity should be obligated to support it by assuring on-call coverage for the community's hospitals emergency departments.**

In addition, this policy does not address the problem of patients at physician-owned, limited service hospitals who suffer from complications appearing in a hospital ED with no warning call, no medical history, no operative report, no information on the anesthesia used and, often, no ability to reach the treating surgeon for consultation. **Physician-owned, limited-service hospitals should be required to have transfer agreements with the community hospitals they plan to rely on in the event that they do not have the capacity to treat a particular patient.**

Specifically, HAP recommends the following:

- **A physician-owned, limited-service hospital should be required to have a pre-existing transfer agreement with the community hospital(s) it intends to rely on for emergency back-up services.**

- **The Secretary should establish the terms that must be addressed by a transfer agreement, including:**

  - **Procedures for an appropriate transfer for patients not covered under EMTALA** (e.g., inpatient or outpatient whose condition develops into an emergency beyond the capability of the limited-service hospital and consequently needs to be transferred to a full-service hospital);
  - **Continuity of care** (e.g., telephone consultation with the receiving hospital and physician, sending the patient's medical records along when transferred, etc.); and
  - **Support for maintaining full-time emergency capacity at the community hospital, including on-call coverage** (e.g., physician-owned, limited-service hospital physicians serve in on-call panels at the community hospital, or the physician-owned, limited-

service hospital provides financial support to the community hospital to maintain on-call coverage).

NEW TECHNOLOGY

Section 503 of the MMA provided new funding for add-on payments for new medical services and technologies and relaxed the approval criteria under the inpatient PPS. This important provision was enacted to ensure that the inpatient PPS would better account for expensive new drugs, devices and services. However, CMS continues to resist approval of new technologies and considers only a few technologies a year for add-on payments. **HAP is disappointed that CMS has not increased the marginal payment rate to 80 percent rather than 50 percent, consistent with the outlier payment methodology, as previously was requested by the AHA.**

Moreover, we are concerned about CMS' ability to implement add-on payments for new services and technologies in the near future. Recognizing new technology in a payment system requires that a unique procedure code be created and assigned to recognize this technology. The ICD-9-CM classification system is close to exhausting codes to identify new health technology and is in critical need of upgrading.

Since the early 1990s, there have been many discussions regarding the inadequacy of ICD-9-CM diagnoses and inpatient procedure classification systems. ICD-10-CM and ICD-10-PCS (collectively referred to as ICD-10) were developed as replacement classification systems.

The National Committee on Vital and Health Statistics (NCVHS) and Congress, in committee language for the MMA, recommended that the Secretary undertake the regulatory process to upgrade ICD-9-CM to ICD-10-CM and ICD-10-PCS. Congress' call for action recognized that procedure classification codes serve to identify and support research and potential reimbursement policies for inpatient services, including new health technology, as required under the *Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000.*

To date, despite these recommendations, as well as the recommendations of several federal health care agencies and offices and health care trade and professional associations, HHS has not yet moved forward to adopt the ICD-10 classification upgrades. We believe that absent a switch to ICD-10 soon, there will be a significant data crisis in the U.S. This coding crisis will affect the efficiency of the current coding process, adding significant operational costs. In addition, failure to recognize this looming problem will only impede the efforts to achieve President Bush's goal for an electronic health record by 2014.

At the April 2005 ICD-9-CM Coordination and Maintenance (C&M) committee meeting, there were many impassioned discussions on the need to start limiting the creation of new procedure codes in order to allow the classification system to last at least two more years. ICD-9-CM procedure code categories 00 and 17 were created to capture a diverse group of procedures and interventions affecting all body systems. The establishment of these code categories represented a deviation from the normal structure of ICD-9-CM and a stopgap measure to accommodate new technology when no other slots in the corresponding body system chapters (e.g. musculoskeletal system, circulatory system, etc.) were available. The plan was to use codes in chapter 00 first and then begin populating chapter 17.

Category 00 is now full, and the C&M committee is entertaining proposals for codes in category 17. At the April C&M meeting a proposal was presented that would in effect leave only 80 codes available in this category. Many of the specific body system chapters are already filled (e.g., cardiac and orthopedic procedures). In recent years, as many as 50 new procedure codes have been created in a single year. This means that it is possible for ICD-9-CM to completely run out of space in one-and-a-half years. We concur with the NCVHS recommendation to issue a proposed rule for adoption of ICD-10. We also would support an implementation period of at least two years following issuance of a final rule.

HAP recommends that the Secretary undertake the regulatory process to replace ICD-9-CM with ICD-10-CM and ICD-10-PCS expeditiously. HHS should take the necessary steps to avert this crisis and avoid being unable to create new diagnosis or procedure codes to reflect evolving medical practice and new technology. It is easier to plan for this migration than respond to a crisis that will likely result in unreasonable implementation timeframes. It is imperative that the rulemaking process start immediately.

OTHER FUTURE CONCEPTS

TRANSPARENCY OF HEALTH CARE INFORMATION

The proposed rule includes the introduction of a proposed initiative to expand the public availability of consumer information on health care quality and pricing. HHS intends to identify several regions in the United States with high health care costs where there is significant interest in reducing those costs and improving health care quality.

Significant progress has been made in making quality information more transparent. The AHA, the Federation of American Hospitals and the Association of American Medical Colleges partnered with CMS and others to form the Hospital Quality Alliance (HQA). The work of the HQA has led to the voluntary reporting and sharing with the public of 21 quality measures on the *Hospital Compare* Web site, and more measures of hospital quality and patient satisfaction are planned for the future. This effort has been tremendously successful, with nearly all inpatient PPS hospitals voluntarily reporting quality information. **Efforts to further expand public availability of hospital quality information must continue to be pursued through the HQA.**

While progress has been made regarding quality transparency, similar information on hospital pricing is less accessible. In the proposed rule, CMS details four options for providing pricing information to health care consumers, including:

- Publishing a list of hospital charges, either for every region of the country or selected regions of the country;
- Publishing the rates that Medicare actually pays to a particular hospital for every DRG, or for selected DRGs, which could be adjusted to account for the hospital's labor market area, teaching hospital status and DSH status;
- Establishing conditions of participation for hospitals that relate to the posting of prices and/or the posting of their policies regarding discounts or other assistance for uninsured patients; and
- Posting total Medicare payments for an episode of care. Under this proposal, CMS could include the costs for an inpatient hospital stay, physician payments (including the surgeon and the anesthesiologist), and payments for post-acute care services such as those

provided in an inpatient rehabilitation facility, skilled nursing facility or LTCH for a certain service (such as hip replacement).

People deserve meaningful information about the price of their hospital care. Hospitals are committed to sharing information that will help people make important decisions about their health care. Sharing pricing information, however, is more challenging because hospital care is unique. Hospital prices can vary based on patient needs and the services they use; prices reflect the added costs of hospitals' public service role—like fire houses and police stations—serving the essential health care needs of a community 24 hours a day, seven days a week; and most hospitals cannot yet provide prices that reflect important information from other key players like the price of physician care while in the hospital or how much of the bill a patient's insurance company may cover. But more can, and should, be done to share hospital pricing information with consumers.

Providing *meaningful* information to consumers about the price of their hospital care is the most significant challenge hospitals, and CMS, face in increasing transparency of hospital pricing information. Objectives for improving pricing transparency should include:

- Presenting information in a way that is easy for consumers to understand and use;
- Making information easy for consumers to access;
- Using common definitions and language to describe pricing information for consumers;
- Explaining to consumers how and why the price of their care can vary; and
- Encouraging consumers to include price information as just one of several considerations in making health care decisions.

The AHA recently released a position statement on hospital pricing transparency outlining steps to be taken to improve the pricing information available to health care consumers which HAP supports. The following four steps provide a recommended roadmap for pricing transparency.

1) A federal requirement for states, working with state hospital associations, to expand existing efforts to make hospital charge information available to consumers.

- Thirty-two states already have statutes requiring hospitals to report pricing information that is made available to the public either by posting to a hospital, hospital association or government Web site, issued in a government or hospital association report, or made available to consumers upon request; five additional states voluntarily do so.

- State efforts on price transparency vary, from making individual hospitals' master list of charges available to the public (e.g., California), to making pricing information on frequent hospital services available to the public (e.g., Missouri, Florida, Nevada, North Carolina), to making information on all inpatient services available to the public (e.g., Colorado, Kentucky, Oregon, Pennsylvania, Wisconsin).

2) A federal requirement for states, working with insurers, to make available in advance of medical visits, information about an enrollee's expected out-of-pocket costs.

- This information is especially important to the majority of consumers who already have some type of health insurance coverage. Their likely interest is in knowing the amount for which they personally are financially responsible. This information is provided today to consumers by their insurance company—it is called an "explanation of benefits, or EOB—but is only given after care is provided. To help inform consumers in advance of their out-of-pocket obligations, insurers could provide an "advance EOB." This information could be shared with an insured individual by phone or electronically through an insurer's Web site. Aetna is currently piloting a project like this for physician services in Cincinnati.

3) A federal-led research effort to better understand what type of pricing information consumers want and would use in their health care decision-making.

We have learned much based on research about what kind of information consumers want about the quality of their health care. But we know less about what consumers may want to know about pricing information. Consumers need different types of price information, depending on whether and how they are insured. The following illustrates different consumer needs:

- **Traditional Insurance.** Because traditional insurance typically covers nearly all of the cost of hospital care, people with this type of coverage are likely to want information about what their personal out-of-pocket cost would be if they receive care at one hospital versus another.

- **Health Maintenance Organization (HMO) Insurance.** People who have HMO coverage will have even more specific price information needs. They have agreed, in advance, to adhere to certain limits on their choice of physician or hospital in exchange for broad-based coverage of their health care needs. A person with HMO coverage typically faces no additional cost for care beyond their premium and applicable deductibles and copayments, but must agree to use physicians and hospitals that are participating in that HMO plan. These individuals likely have little, if any need for specific price information.

- **High-Deductible or Health Savings Account (HSA) Insurance.** People with HSAs have more interest than a typically insured person in price information. These types of plans are designed to make consumers more price-sensitive and to encourage consumers to be prudent "shoppers" for the care they need. A typical plan of this type has a deductible of $2,500. However, consumers with HSA coverage are likely to be more interested in price information for physician and ambulatory care than for inpatient hospital care for several reasons:

  - Many patients admitted to the hospital were first seen on an emergency basis in the hospital emergency department. These are not price-shopping patients, but patients who found themselves in need of emergent care and either came or were brought to the nearest hospital emergency department.
  - For patients admitted to the hospital for a scheduled or elective procedure, inpatient hospital price information may be less important because most, if not all, hospital admissions result in a cost that exceeds the typical HSA deductible of $2,500, and therefore, are covered by most HSA plans.
  - People with HSA coverage may be most interested in comparing prices and shopping for care to be delivered that leads up to meeting their deductible (typically $2,500). People with this type of coverage may be most interested in

prices for physician office visits and other ambulatory care for which they are likely to be responsible for paying the full cost.

- **Uninsured Individuals of Limited Means.** People without insurance who have limited means for paying for the health care services they have received need to know how much of their hospital or physician bill they may be responsible for. In the case of hospital care, the information they need must be provided directly by the hospital, after the hospital can ascertain whether a patient may qualify for state insurance programs of which they were unaware, free care provided by the hospital, or other financial assistance.

4) A hospital-led effort to create consumer-friendly pricing "language"—common terms, definitions and explanations to help consumers better understand the information provided.

More can be done to explain pricing information to consumers clearly and consistently. Hospitals will lead an effort to create common terms, definitions and explanations of complex pricing information. This will include sharing innovative and understandable ways for displaying pricing information for use by consumers.

The four points of this roadmap include an appropriate role for HHS, which should provide incentives to the states to improve transparency at the state and local level. HHS, through the Agency for Healthcare Research and Quality (AHRQ), is in the best position to complete research on what consumers want and would use in purchasing health care services.

HOSPITAL VALUE-BASED PURCHASING

Plan for Implementing Hospital Value-Based Purchasing in FY 2009 – In the proposed rule, CMS describes several of its efforts over the past several years to improve the quality and efficiency of care delivered to Medicare beneficiaries in America's hospitals, including CMS' participation in the Hospital Quality Alliance as a strategy to encourage hospital accountability by making comparative information about hospital performance publicly available and the testing of innovative approaches to improving quality through pilot project such as the Premier Hospital Quality Incentive Demonstration. Pennsylvania hospitals have actively participated in both projects.

CMS also notes in the proposed rule that "all providers to which a specific Medicare payment system applies receive the same amount for a service, regardless of its quality or efficiency. As a result, Medicare's payment systems can direct more resources to hospitals that deliver care that is not of the highest quality or include unnecessary services (duplicative tests and services or services to treat avoidable complications)." Consequently, CMS has indicated that it is examining the concept of "value-based purchasing," which may use a range of incentives to achieve identified quality and efficiency goals as a means of promoting better quality of care and more effective resource use in the Medicare payment systems. And, the DRA of 2005 has directed CMS to develop a plan to implement value-based purchasing beginning with FY 2009.

CMS is requesting public comment on the various components that the plan must cover, including measure development and refinement; data infrastructure; incentive methodology (structure of the incentive; level of incentive required; source of the incentives; form of the incentives; timing of incentives; and development of composite scores); and public reporting. Without a specific proposal to react to, HAP has carefully reviewed the construct of the Premier Hospital Quality Incentive Demonstration pilot project and the recommendations made by the Medicare Payment Advisory Committee (MedPAC) in developing some initial comments to share with CMS.

Some of our initial thoughts are shared below.

- As already mentioned, HAP believes that there needs to be ongoing discussion with the partners in the Hospital Quality Alliance with regard to which measures should be added and which measures should be deleted from inclusion in any pay-for-performance measurement system. Although the National Quality Forum has endorsed specific measures, there may be strong preferences to include certain measures in a value-based purchasing system over others. HAP strongly believes that the measures selected should be those that hospitals have the capacity to improve.
- It is clear in the CMS proposed rule, the MedPAC report, and the President's FY 2007 Budget that new monies will not be invested in the Medicare program to be used as a quality incentive payment pool. Rather, it appears that a small proportion of Medicare hospital payments (1-2 percent of payments) will be set aside to fund a quality incentive payment pool in order to maintain budget-neutrality. CMS has indicated that its ability to measure quality improves, the amount of money set aside to reward quality performance should increase significantly. Further, MedPAC has recommended that any quality incentive program reward hospitals for improvement and attaining/exceeding certain benchmarks. HAP supports the concept of rewarding hospitals both for improvements and attaining/exceeding certain benchmarks. HAP understands the effort that needs to be invested by hospitals to make quality improvements in processes of care and in ensuring that those improvements are sustained at the highest levels. However, HAP is not convinced that setting aside 1-2 percent of Medicare payments is sufficient to make meaningful awards to hospitals for making improvements and attaining certain benchmarks. For instance, while there were significant improvements made by those hospitals that participated in the Premier Hospital Quality Incentive Demonstration project, only those hospitals with the best quality scores (top 2 deciles) received a bonus incentive payment.
- Pennsylvania hospitals strongly support the development of a composite score for a particular disease category or measure set. HAP and Pennsylvania hospitals believe that composite scoring may assist in improving consumer understanding of the processes/dimensions of care as well as assist hospitals in communicating with its clinical teams. In the proposed rule, CMS describes the "opportunity model" composite score methodology employed in the Premier Hospital Quality Incentive Demonstration project and the "appropriate care measure" composite scoring currently being used by QIOs in the 8th scope of work. Of the two methods described, HAP strongly prefers the use of the "opportunity model" used in the Premier Hospital Quality Incentive Demonstration project to the "appropriate care measure" concept. HAP believes that the "opportunity model" provides the flexibility needed to accommodate more individual process and/or outcome measures and the ability to determine whether and how to assign more weight to various measures. CMS notes that there are other proprietary composite measures, including those used by Solucient, Healthgrades, and CareScience. HAP would be interested in responding to other composite scoring methodologies under consideration by CMS, including proprietary methodologies. Additionally, HAP supports the

combination of measures within a particular disease category but is not sure that it could support rolling up disparate dimensions of care into an overall composite score without having a specific proposal(s) to react to in this regard.

- Should CMS choose to implement a program that ranks hospitals in some sort of descending order as was the case in the Premier Hospital Quality Incentive Demonstration project to determine which hospitals will receive bonus incentive payments, it will be extremely critical that CMS have an infrastructure in place that allows hospitals to compare their performance against other hospitals on an ongoing basis. HAP believes that it would be extremely important to engage in discussions with performance measurement vendors to determine collaboratively how quick performance feedback to hospitals can be accomplished.

RECOMMENDATIONS

HAP believes that it is essential that CMS work with its Hospital Quality Alliance partners in developing quality incentive proposals that could be shared in the near future with the hospital community for comment given the short-time frame that has been mandated by Congress to begin a Medicare value-based hospital purchasing program. HAP also believes that this should be an iterative process whereby the hospital community has sufficient opportunity to comment on a proposal(s) and modifications to the proposal(s) based on the comments received. This is a process that will need to be repeated several times to prepare the hospital community for the value-based purchasing program and obtain consensus with regards to the value-based hospital purchasing program that CMS selects to implement. HAP recommends that CMS consider implementing a process similar to that used jointly by CMS and the Agency for Healthcare Research and Quality (AHRQ) in shaping the HCAHPS® perception of care survey/ survey methodology to develop the Medicare value-based purchasing program for hospitals. This is a process that involved multiple opportunities for public comment.

HEALTH INFORMATION TECHNOLOGY (IT)

The proposed rule states that it "supports the adoption of health IT as a normal cost of doing business to ensure patients receive high quality care." It also notes that the quality and efficiency benefits of health IT may provide a policy rationale for promoting the use of health IT through the Medicare program. Consequently, CMS asks for comments on:

- Its statutory authority to encourage adoption and use of IT;
- The appropriate role of IT in any value-based purchasing program; and
- The desirability of including use of certified health IT in hospital conditions of participation.

HAP believes that health IT is a very important tool for improving the safety and quality of health care, and Pennsylvania hospitals are committed to adopting IT as part of their quality improvement strategies. They also view IT as a public good that requires a shared investment between the providers and purchasers of care.

Health IT is very costly, requiring both upfront and ongoing spending. A 2005 AHA survey of hospitals and health systems found that the median amount hospitals invested on health IT in one year was more than $700,000, 15 percent of total capital expenses. Hospitals spent even greater amounts – a median of $1.7 million or 2 percent of all operating expenses—on operating costs. Survey respondents identified the upfront and ongoing costs of IT as the greatest barriers to further adoption. The survey also found that hospitals with negative margins and those with lower revenues use less IT.[4]

The proposed rule highlights the anticipated benefits of health IT as laid out by the RAND Corporation. However, it overlooks another of the study's major findings—that the financial benefits of IT investments accrue more to the payers and purchasers of care than the hospitals and health systems that pay for them.[5]

Simply put, hospitals have not seen financial returns greater than the costs of implementing clinical IT systems, particularly in the short term. They adopt clinical IT because it is the right thing to do for improving patient safety and quality of care, not because it saves them money. Thus, while IT may be a "normal cost of doing business," it systematically raises those costs. **Given that they reap many of the financial benefits of IT, HAP believes that the payers and purchasers of care should share in the costs of IT.**

Finally, we learned through the HIPAA process that efficient health information exchange requires all parties to upgrade their systems and work from a common set of standards. As we moved toward implementation of health IT in hospitals, payers—including the federal government—must modify their own systems to accept electronic data.

Statutory Authority. The broad question of whether CMS has statutory authority to encourage adoption and use of health IT will depend on the specific mechanisms it selects. For example, CMS has some authority to pursue demonstration projects. However, more systematic approaches, such as value-based purchasing or payment adjustments, would require legislative action.

Value-based Purchasing. HAP believes that any value-based purchasing program should not be punitive. **With regard to IT, only programs that add funds to the inpatient PPS should be pursued because IT is costly, requiring both upfront and ongoing expenditures.** Decreasing payments to those that have not been able to afford IT further limits their ability to invest. A budget-neutral approach also ignores the reality that health IT systematically increases hospitals' costs.

HAP also believes that value-based purchasing programs should build off the consensus measures endorsed by the broad spectrum of organizations—including CMS—that participate in the HQA. In general, the HQA favors measures that address quality outcomes, rather than the tools used to get there.

Health IT can play a role in reducing the burden of quality reporting. Presently, electronic health records (EHRs) and other clinical IT systems do not automatically generate quality measures. Most hospitals still require special calculations—including expensive manual chart abstraction and use of third-party contractors—to submit quality data. CMS could advance the quality

[4] "Forward Momentum: Hospital Use of Information Technology." Washington, DC: AHA (2005).
[5] R. Hillestad, J. Bigelow, A. Bower, F. Girosi, R. Meili, R. Scoville, and R. Taylor. "Can Electronic Medical Record Systems Transform Health Care? Potential Health Benefits, Savings, and Costs," *Health Affairs*, September 1, 2005; 24(5): 1103 - 1117.

agenda by investing in the development of algorithms for the calculation of the quality measures it wants reported from EHRs and encouraging vendors to include them in their products.

Rather than including health IT in a value-based purchasing program, **CMS could support adoption of health IT through a payment adjustment funded with new money.** For example, it could increase payments to hospitals that use health IT that improves the safety and quality of care by 1 percent. This kind of payment adjustment represents Medicare's share of the necessary investment to achieve this goal and would recognize the greater costs of a "wired" health care system. HAP supports and will pursue legislation in collaboration with the AHA authorizing such a payment adjustment. Other mechanisms, such as loan guarantees and grant funds, are needed to help hospitals finance the upfront costs of implementing health IT.

Conditions of Participation. HAP does not believes that **CMS should include health IT in the Medicare conditions of participation (COP) for hospitals.** The COPs address the basic, essential infrastructure needed to ensure patient safety and must be clearly understood. Successful implementation of quality-enhancing IT requires careful planning and changes to work processes. The hospital field is still developing its understanding of how to implement these systems correctly. In addition, the commercial health IT applications available do not always meet hospitals' needs. The evidence on health IT does not yet support this level of requirement and would amount to an unfunded mandate. A recent report supported by the AHRQ found that the existing research on the quality benefits of health IT is limited to a handful of leadership institutions that generally developed their own systems. And, while promising, the results are not yet generalizable to the average community hospital using the vendor systems currently on the market.[6]

While HAP appreciates the efforts of the Certification Commission on Health Information Technology (CCHIT) to provide the market with better confidence in vendor product, we do not believe those efforts are sufficiently advanced to warrant inclusion in any adoption incentives CMS might pursue. CCHIT is only at the beginning stages of looking into certification of hospital inpatient products. CCHIT's work on ambulatory products is more advanced but, while it shows promise, has not yet proven itself in the marketplace.

Reducing Hospital Payment for Preventable Complications – Under the Medicare diagnosis-related group (DRG) based inpatient prospective payment system (IPPS), payments to hospitals can increase when a post-admission complication occurs. Because of the current design of the current DRG system, hospitals with low complication rates could be viewed as being financially penalized because they receive less reimbursement for providing quality care.

Most pay-for-performance systems provide retrospective financial bonuses to hospitals if specific process and/or outcome standards are met. As another aspect of its value-based purchasing plan, Congress has determined that hospitals should not receive higher amounts of reimbursement when post-admission complications occur. Congress, through the DRA, (1) directs CMS to identify at least two conditions that are high cost/high volume or both that result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis code that reasonably could have been prevented though the application of evidence-based guidelines by October 1, 2007; (2) requires hospitals submit the secondary

[6] "Costs and Benefits of Health Information Technology." Agency for Healthcare Research and Quality Publication No. 06-E006 (April 2006).

diagnoses that are present at admission on inpatient claims for discharges on or after October 1, 2007; and (3) obligates CMS to lower reimbursement to hospitals for discharges on or after October 1, 2008, for cases in which one of the selected conditions was not present on admission. CMS is requesting input about which conditions and which evidence-based guidelines should be selected.

It would appear that there is a strong indication from Congress that either one or both conditions be hospital-acquired infections and that hospitals not receive additional payment for treatment of these infections that could have likely been prevented if the hospital had implemented evidence-based guidelines. Pennsylvania hospitals have been required to report hospital-acquired infections since January 2004 to the Pennsylvania Health Care Cost Containment Council (PHC4). HAP would like to share with CMS what HAP has learned from Pennsylvania hospital experiences with hospital-acquired infection (HAI) reporting over the past two years.

- Pennsylvania hospitals have been expected to report HAIs in a field on the Uniform Bill. PHC4 has compared what hospitals have reported as HAIs using the Centers for Disease Control and Prevention (CDC) definitions against what secondary diagnoses codes on the Uniform Bill that are indicative of an infections. There is a tremendous variation between what hospitals have reported as an HAI and what is included on the Uniform Bill as a secondary diagnoses code. In 2004, the number of secondary diagnosis codes included on all Pennsylvania hospital claims was 115,631 versus a total of 11,668 reported HAIs.
- Many Pennsylvania hospitals have audited all or a sample of their medical records to determine whether those with a secondary diagnosis code indicative of infection should have been reported by the hospital as an HAI. In all of the reviews, hospitals have found that somewhere between 10-18 percent of all cases with a secondary diagnosis code indicative of infection are truly HAIs. Most hospitals that have reviewed medical records with a secondary diagnosis code indicative of infection have discovered that they have only overlooked a few cases that should have been reported to PHC4 as a HAI.
- As a result of the emphasis on infection as a complication, Pennsylvania hospitals have relayed to HAP that medical records coders will use physician documentation in the record for suspected infection to code for an infection even if there is no confirmed infection. In a recent hip and knee report issued by PHC4, hospitals and physicians were asked to sign off on records with codes that were indicative of infection. Upon review of these records, hospitals and physicians noticed that medical records personnel used a secondary diagnosis code that indicated an infection because the patient was receiving antibiotics for a possible or suspected infection at the time of discharge. Following discharge, results of laboratory specimens collected while the patient was hospitalized conclusively determined that there was no infection. According to hospital compliance officers, making any changes to the medical record based upon what you know following discharge versus what you know at the time of discharge raises compliance issues in and of itself since coding should reflect what you know at the time of discharge. This again points out some of the weaknesses in using secondary diagnosis codes to indicate the presence of a true hospital-acquired infection.
- In a recent article, "Administrative Data Fail to Accurately Identify Cases of Healthcare-Associated Infection," published in the April 2006 *Infection Control and Hospital Epidemiology,* Children's Hospital of Philadelphia concluded, "... review of administrative data failed to provide accurate data on 4 of the most common HAIs (central-line associated bloodstream infection, catheter-associated urinary tract infection,

ventilator-associated pneumonia, and surgical site infections). Most of the cases classified as HAIs by review of administrative data were misclassified. Although review of administrative data had a sensitivity of 61 percent (compared to 76 percent for targeted surveillance), its positive predictive value for identifying cases of HAI was 20 percent as compared to 100 percent for targeted surveillance."

- Children's Hospital of Philadelphia also found that the most common reasons for HAI misclassification in billing data was that no laboratory-confirmed infection was present. Many misclassified HAIs occurred in patients with no exposure to devices (central venous catheters, urinary catheters, ventilators) or surgical procedures. And, finally hospital billing data misidentified many outpatient infections as HAIs. This latter issue could be addressed in part but not completely by having hospitals identify patients with known infections as being present on admission.
- In another study performed by a Pennsylvania hospital, the hospital determined that use of secondary diagnoses codes to predict the presence of a urinary tract infection was a poor predictor of the presence of actual urinary tract infections. In this same study, the hospital found that most patients diagnosed by physicians were probably just colonized with bacteria—not infected. Additionally, this investigation found that for most patients diagnosed with a hospital-acquired urinary tract infection, there was little impact on their hospitalization. Although catheter-associated urinary tract infection may account for a substantial volume of HAIs, HAP does not believe that this is a condition that should be considered by CMS because of its limited impact on patient mortality and morbidity. Furthermore, it does not appear that the presence of a urinary tract infection would bump a case into a higher paying DRG.
- With respect to other HAIs that may be candidates for consideration by CMS to implement the provisions included in the DRA, probably the best conditions to consider would be central-line associated bloodstream infections and/or surgical site infections because there are evidence-based guidelines that should be utilized to prevent the occurrence of these infections in hospitals. Additionally, the occurrence of these infections can lead to costly treatment, longer lengths of stay, and increased patient morbidity and mortality. Unfortunately, there are also drawbacks to using these conditions, namely that there is not a distinct secondary diagnosis code for a central-line associated bloodstream infections. Because of the shorter hospital lengths of stay, surgical site infections may not manifest until after the patient is discharged. Treatment of these surgical site infections may be able to be managed as outpatients. Some patients with surgical site infections might require hospital readmission for treatment, but the patient may not necessarily present to the same hospital where the surgical procedure was performed for treatment.
- The other HAI that is receiving considerable attention as a preventable infection is ventilator-associated pneumonia. Ventilator-associated pneumonia carries with it the potential for substantial morbidity and mortality, but these infections are difficult to detect accurately. Even though a CDC definition exists, many in Pennsylvania's infection control community continue to express concern over the high level of subjectivity that exists in making a determination of ventilator-associated pneumonia. And, as is the case with central-line associated bloodstream infections, there is not a specific secondary diagnosis code for ventilator-associated pneumonia.
- Complications are harmful events or negative outcomes that result from the processes of care and treatment rather than a natural progression of the underlying illness. Complications do not necessarily represent medical errors, since they are not always preventable even with optimal care. Even if the use of secondary diagnosis codes was an

accurate way to detect HAIs, not all HAIs are preventable in every patient. For instance, trauma, burn, organ transplant, and cancer patients may be more susceptible to infection simply because of their disease or condition and not necessarily a result of poor care. Furthermore, while there is consensus that using evidence-based guidelines reduces hospital-acquired infections, it is not clear to what level (80 percent, 90 percent, 100 percent) such infections can be reduced through strict adherence to the guidelines. In order to implement this model, CMS will need to do extensive work to subject the reimbursement schema only to those potentially preventable complications.

RECOMMENDATIONS

While there is merit in looking at this concept in order to increase hospital evidence-based guidelines to prevent unnecessary patient complications, HAP remains gravely concerned about actual implementation given the weaknesses in using secondary diagnosis codes as an indicator of a true hospital-acquired complication. As a result of the extensive work that Pennsylvania hospitals have done in the area of HAI reporting, HAP can say that secondary diagnoses codes indicative of infection serve as poor proxies in identifying actual HAIs. Given the proposal outlined by CMS, HAP believes that many hospitals would be penalized in using secondary diagnosis codes as they were developed for use in hospital billing. As already stated, in order to implement these provisions in the DRA, CMS will need to do extensive work to subject the reimbursement schema only to those potentially preventable complications.

Without further investigation, HAP is not certain whether there may be other conditions, such as the development of deep vein thromboses or pressure ulcers that may be more clear-cut and more easily identifiable using secondary diagnosis codes than HAIs and in helping CMS meet the provisions in the DRA of 2005.

MedPAC has also suggested that CMS identify a subset of events that should never happen (for example, wrong site surgery) and either deny payment or pay less for care associated with the event. HAP recommends that CMS explore whether reductions in hospital payments for defined "never events" might be more easily and quickly accomplished and whether implementing reduced payment for cases in which a "never event" occurred would satisfy the requirements in the DRA of 2005. Since there is a uniform standard protocol that should be used by hospitals to prevent wrong-site surgery, reduced payment for performing wrong-site surgery may meet the intent of the DRA provisions.

Finally, as in the previous recommendations related to bonus incentives, this provision will require the involvement of many stakeholders and many opportunities for extensive public comment. HAP recommends that CMS consider a smaller-scale demonstration projects to test any methodology with hospitals before a national implementation.

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June 8, 2006

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1488-P and P2
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

RE: CMS-1488-P and P2, Medicare Program; Proposed Changes to the PPS

Dear Dr. McClellan:

The proposed regulations pertaining to relative weights and transplant reimbursement have many potential flaws. Disparity with regard to patient complexity and severity, types of services provided and disparity in the organ pool all must be considered prior to approving changes to the current payment system.

Please consider delaying the proposed DRG changes for a minimum of one year to allow appropriate review and analysis of the complex factors associated with transplantation. This delay would also allow time to prepare a more valid cost-based weighting system that addresses and responds to all the unique factors specific to transplant reimbursement.

If you have any questions about my remarks , you may reach me at 515 241-4131.

Sincerely,

Jean Shelton, Executive Director

CC: Diane Messer, Nurse Manager; Cass Franklin, M.D., Medical Director

St. Alexius Medical Center
PrimeCare

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June 8, 2006

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1488-P and P2
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

RE: CMS-1488-P and P2, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates; Proposed Rule.

Dear Dr. McClellan:

This letter serves as St. Alexius Medical Center's response to the Centers for Medicare & Medicaid Services (CMS) request for comments on the fiscal year (FY) 2007 inpatient prospective payment system (PPS) and occupational mix adjustment proposed rules.

The rule proposes substantial changes in the calculation of diagnosis-related group (DRG) relative weights, by creating a version of cost-based weights using the newly developed hospital-specific relative values cost center methodology (HSRVcc). It further proposes refining the DRGs to account for patient severity.

The rule also updates the payment rates, outlier threshold, hospital wage index, quality reporting requirements, and payments for rural hospitals and medical education, among other policies. While we have serious concerns related to the outlier threshold and the wage index, our primary concern relates to the changes to the DRG weights and classifications.

The impact of the proposed changes would lead to a significant negative impact in hospital payment. We would like to see CMS delay implementation of these changes until more study has been conducted to validate the methodology.

We also are extremely concerned about the impact the proposed rule would have on cardiac subspecialties. At St. Alexius Medical Center, the detrimental results of these changes would be severe. Final FY2006 estimates for reimbursement compared to those proposed for 2007 would result in the following negative percent change in cardiology procedures:

Electrophysiology	(18.0%)
Cardiac Cath	(28.1%)
Cardiac Surgery	(4.5%)

"Let all be received as Christ."

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When we examine specific cardiac surgical DRGs, we find the following negative percent change:

106: Coronary artery bypass w/PCTA	(12.6%)
515: Cardiac defibrillator implant w/o cardiac cath	(22.6%)
518: PCI w/o coronary artery stent or AMI	(28.9%)
535: Cardiac defibrillator implant w/cardiac cath w/AMI/HF/Shock	(23.8%)
536: Cardiac defibrillator implant w/cardiac cath w/o AMI/HF/Shock	(22.2%)
551: Cardiac pacemaker implant w/maj. CV DX or AICD lead or GNTR	(12.5%)
552: Other permanent cardiac pacemaker implant w/o maj. CV DX	(13.3%)
555: PCI w/maj. CV DX	(21.0%)
556: PCI w/ non drug-eluting stent w/o maj. CV DX	(34.1%)
557: PCI w/drug-eluting stent w/maj. CV DX	(23.5%)
558: PCI w/drug-eluting stent w/o maj. CV DX	(33.4%)

Because of this negative impact, we support the following AHA recommendations:

• **One-year Delay:** Delay implementation for one year to address the serious concerns with the HSRVcc and CS-DRG methodology. We would be happy to volunteer to work with AHA and CMS to address these concerns.

• **Valid Cost-based Weights:** We support moving to a DRG-weighting methodology based on hospital costs rather than charges, using methodology other than the HSRVcc. However, while we believe change of some kind is warranted, the proposed conversion factor of a 0.25 cost-to-charge ratio is flawed.

• **A New Classification System Only if the Need Can Be Demonstrated:** Considering how long the current classification system has been in place, it seems that more study of the variation within DRGs should be done before moving to the CS-DRGs or any other new classification system.

• **Simultaneous Adoption of Any Changes to Weights and Classifications:** If the need for a new, more effective classification system is demonstrated and developed, it should be implemented simultaneously with the new weighting system to provide better predictability and smooth the volatility created by these two, generally off-setting changes.

• **Three-year Transition:** Any changes should be implemented with a three-year transition, given the magnitude of payment redistribution across DRGs and hospitals.

Thank you for your attention to this matter. We appreciate your support of hospitals.

Sincerely,

Andrew L. Wilson
President and Chief Executive Officer

c: US Senator Kent Conrad
US Senator Byron Dorgan
US Representative Earl Pomeroy

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Baystate Health

Springfield, Massachusetts 01199 413-794-0000 baystatehealth.com

June 9, 2006

Mark McClellan, MD, Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Attn: CMS – 1488 – P and P2
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

RE: CMS – 1488 – P and P2 Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates; Proposed Rule

Dear Dr. McClellan:

On behalf of Baystate Medical Center, Franklin Medical Center and Baystate Mary Lane Hospital, hospital members of Baystate Health, we appreciate the opportunity to submit comments on the fiscal year (FY) 2007 inpatient prospective payment system. We support the Centers for Medicare & Medicaid Services' (CMS) efforts to enhance the DRG weights from a charge to cost basis. However, we do not agree with your hospital-specific relative values cost center methodology. We believe the Medicare Payment Advisory Commission's approach is more accurate and would result in better reflection of the cost differences between DRGs. We support CMS's effort to include a severity adjustment to the DRG. We believe the DRG weight changes and severity adjustment should be implemented at the same time. We ask CMS to re-analyze both its new cost weights and the severity-adjusted DRGs to consider the hospital industry concerns and comments before any implementation.

We strongly disagree with the proposed exclusion of didactic training from graduate medical education payment. We urge CMS to rescind the "clarification" in the proposed rule that excludes medical student time spent in didactic activities in the calculation of Medicare DGME and IME payments. CMS's stated rationale for the exclusion of this time is that it is not "related to patient care." Didactic training is an integral component of the patient care activities engaged in by residents at Baystate Medical Center and other teaching hospitals during their residency programs. We urge CMS to withdraw the proposed rule related to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

We appreciate the opportunity to submit these comments. If you have any questions, please feel free to contact me at 413-794-7924.

Sincerely,

Jerry A. Johnson

Jerry A. Johnson
Director, Payment Systems

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NDHA
North Dakota Healthcare Association

Vision
The North Dakota Healthcare Association will take an active leadership role in major healthcare issues.

Mission
The North Dakota Healthcare Association exists to advance the health status of persons served by the membership.

June 7, 2006

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1488-P and P2
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

RE: CMS-1488-P and P2, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates; Proposed Rule.

Dear Dr. McClellan:

On behalf of our member hospitals and health care systems, we appreciate the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) on the fiscal year (FY) 2007 inpatient prospective payment system (PPS) and occupational mix adjustment proposed rules.

<u>New DRG Weights: HSRVCC</u>
The proposed changes calculating diagnosis-related group (DRG) relative weights are the most significant since 1983. Additional study is needed on these significant changes.

The proposal creating cost-based weights using the newly developed hospital-specific relative values cost center methodology (HSRVcc) is flawed by the HSRVcc methodology. The CMS proposal appears to be a short-cut to the MedPAC approach to HSRVs and cost-based weights.

The NDHA believes more time is needed to allow for developing a sound methodology approach to create cost-based weights and to understand their potential. One of the concerns is the CMS weighting approach gives equal weights to each hospital in the national cost-to-charge ratio calculation. Hospitals in ND may range in size from less than 25 beds to 500 beds.

We question the need for changing the patient classification system. If there is a need for change, a more careful analysis is needed. There needs to be greater access to the specifics of CMS' methodology and the new GROUPER.

The NDHA requests that there be a one-year delay in the proposed DRG changes. We have serious concerns with the HSRVcc and CS-DRG methodology.

PO Box 7340 Bismarck, ND 58507-7340 Phone 701-224-9732 Fax 701-224-9529

We do not support a new classification system at this time. Additional work and understanding of the variation within the DRGs and the best classification system to address that variation is needed before CS-DRGs or any other system is to be considered.

If additional work and study indicate the need for a new, more effective classification system, it should be implemented at the same time as changes to weights. The simultaneous adoption will provide better predictability and smooth the volatility created by the two, generally off-setting changes.

Finally, if changes are implemented, we recommend that CMS allow a three-year transition with a blend of the old DRG weights and the new DRG weights. This transition will lessen the magnitude of payment redistribution across DRGs and hospitals. The American Hospital Association (AHA) is submitting recommendations for the transition process. AHA is committed and willing to work with CMS in the development and evaluation alternatives for new weights and classifications.

Long-Term Care Hospital (LTCH) DRGs

Long-term care hospitals are a very important patient care setting in North Dakota. They fill the needed services for many very ill and severely injured patients. The projected payment cut resulting form reweighting – 1.4 percent – in combination with the payment cut resulting from the recent LTCH PPS final rule for 2007 – 7.1 percent – will cause substantial volatility for our LTCH providers. This volatility will eventually restrict access for patients needing long-term acute care services. This will mean a total of an 8.5 percent cut in one year. The LTCHs will not have a 7.8 percent Medicare margin as MedPAC projected in 2006. The MedPAC projection does not include the impact of the "25% Rule" and the new reductions associated with the LTCH short-stay outlier policy.

CMS should focus on developing further patient and facility criteria for LTCHs to ensure that patients who are clinically suitable continue to have access to the LTCH setting. In North Dakota our LTCHs are appropriately admitting and maintaining their treatment of patients.

Emergency Medical Treatment and Active Labor Act (EMTALA)

The NDHA supports CMS' proposal allowing qualified medical personnel operating under their scope of practice and defined in the hospital bylaws and included in state law, to certify that a woman is in false labor. This change provides flexible staffing and the needed access in rural communities.

New Technology

Section 503 of the MMA provided new funding for add-on payments for new medical services and technologies with less stringent criteria under the inpatient PPS. This add-on payment and new criteria ensured that the inpatient PPS would better account for expensive drugs, devices and services. Even with the less stringent criteria, CMS considers only a few technologies a year for add-on payments. Due to the rapid and changing advances in health care, and patient's expectations, the demands are much greater on our hospitals to provide new services and technologies. NDHA is requesting that CMS increases the marginal payment rate to 80 percent rather than 50 percent consistent with the outlier payment methodology. The AHA has previously made this request.

The ability to implement add-on payments for new technologies and services in the future requires that a unique procedure code be created and assigned to recognize new technology. The current ICD-9-CM system will soon be exhausted and needs upgrading. It is imperative to plan for a transition to replace the ICD-9-CM with ICD-10-CM and ICD-10-PCS.

Health Information Technology (IT)

Health IT is a very costly tool that requires both upfront and continued budgeting. Our large health systems in the state anticipate they need to spend approximately $5 million a year for the next five years.

IT needs to be a shared investment between providers, payers and purchaser of health care. Our hospitals recognize it is the right thing to do because it improves patient safety and quality. However, when we surveyed our hospitals, they indicated cost is the greatest barrier to further progress. Perhaps CMS could support the adoption of health IT through a payment adjustment funded with new money. Another alternative for assisting our hospitals with the cost is the possibility of loan guarantees or grant funds.

The NDHA is not in favor of including health IT in the Medicare conditions of participation (COP) for hospitals. The COPs address basic, essential infrastructure needed to ensure patient safety and must be clearly understood. If IT is to be successfully implemented it requires careful planning and many changes to work processes.

The NDHA appreciates the opportunity to submit our comments to CMS on these proposed rules. We encourage you to engage the AHA in ongoing discussion in the planning process. Moving forward requires thoughtful well-planned change.

Sincerely,

ARThomas

Arnold R. Thomas
President

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DELAWARE VALLEY HEALTHCARE COUNCIL
of The Hospital & Healthsystem Association of Pennsylvania

Submitted Electronically, Temporary Comment Number 84536

June 12, 2006

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1488-P2
P.O. Box 8012
Baltimore, MD 21244-8012

RE: Medicare Program; Hospital Inpatient Prospective Payment Systems Implementation of the Fiscal Year 2007 Occupational Mix Adjustment to the Wage Index; (71 Federal Register 28644) May17, 2006, file code CMS 1488-P2.

Dear Dr. McClellan:

On behalf of the Delaware Valley Healthcare Council of HAP (DVHC) which represents more than 150 member hospitals, health systems and other health related organizations in Southeastern Pennsylvania, Southern New Jersey and Delaware, I am writing to convey our grave concerns on the Centers for Medicare and Medicaid Services' (CMS) revisions to the occupational mix survey as proposed in the *Federal Register* on May 17, 2006. In order to ensure continued access to high quality health care for Medicare beneficiaries to hospitals in the Delaware Valley, adequate hospital payments under the Medicare Prospective Payment System (PPS) is critical and the occupational mix adjustment to the wage index component is a key element affecting those payments.

The subject of this comment letter is the next adjustment that CMS has proposed for fiscal year (FY) 2007. In general, as per our comments to the proposed rule regarding the Occupational Mix Survey in October of 2005, DVHC appreciates CMS' efforts to streamline the occupational mix survey. We support the inclusion of both the paid hours associated with the employees in question and the wages paid. We believe there is value in calculating the national average hourly wage rates based on wage data collected at the same time as the hours paid, and that this data will improve the soundness of the occupational mix adjustment to the inpatient area wage index.

We are keenly aware of the fact that on April 3, 2006, in *Bellevue Hosp. Ctr v. Leavitt,* the Court of Appeals for the Second Circuit ordered CMS to apply the occupational mix adjustment to 100 percent of the wage index effective for FY 2007. In that Court Order, CMS was instructed to "immediately....collect data that are sufficiently robust to permit full application of the occupational mix adjustment" and that all "data collection and measurement and any other preparations necessary for full application be completed by September 30, 2006." Despite the

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fact that CMS is under the Bellevue Court's order to proceed with a 100 percent implementation of the occupational mix adjustment for FFY 2007, we have several concerns about how CMS proposed to implement this change. We have problems with the shortened comment period, limited data sample and the timing of the data collection. This letter formally conveys our specific recommendations in the following aspects of the proposed rule:

1. **Development of the Data for the Proposed Occupational Mix Adjustment -** The DVHC has serious concerns that CMS is proposing that the data used for the occupational mix adjustment to the wage index for FY 2007 would be only three months of data from the first quarter of 2006. In order to have a meaningful occupational mix adjustment, CMS must use a full 12 months of data.
2. **Timeline** - The proposed survey deadline does not allow sufficient time for submission of accurate data. Hospitals need at least 90-days post the collection period to complete the occupational survey with contract labor information and to prepare it for submission to the fiscal intermediary.
3. **Calculation of the Proposed FY 2007 Occupational Mix Adjustment** - CMS should use the unadjusted wage data for hospitals that do not submit occupational mix data.
4. **Waiver of 60-day Comment Period** - We do not think that a 30-day comment period was sufficient particularly in light of the fact that hospitals were in the process of responding to an expedited timeline for data submission and were trying to comply with the comment deadline for the Medicare Inpatient Prospective Payment rule. Thus, we recommend that CMS publish the occupational mix adjustment changes as an interim-final rule in August with an associated comment period.

Background

As you know, Congress, with little discussion or debate included the occupational mix adjustment as section 304(c) of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). We understand that it requires the Secretary to collect data every three years on the occupational mix of hospital employees for each short-term, acute-care hospital participating in the Medicare program in order to construct an occupational mix adjustment to the inpatient area wage index. This adjustment controls for the effect of hospitals' employment choices – such as the use of registered nurses versus licensed practical nurses, or the employment of physicians – rather than geographic differences in the costs of labor. The adjustment appears to provide a financial incentive to substitute less skilled personnel for more highly skilled personnel to obtain a more favorable adjustment to the Medicare wage index. The expected effect of the Medicare occupational mix adjustment was to increase the Medicare payments to small and rural hospitals that were believed to use fewer skilled personnel (as a percentage of total personnel) than larger more sophisticated hospitals offering an array of specialized services. Analysts expected a decrease in the occupational mix adjusted wage index for areas with tertiary care and teaching facilities, and increases in the area wage indexes for areas with primarily small and rural hospitals. In reality for FFY 2006, 34 percent of statewide rural wage index areas experienced decreases in wage indexes caused by the occupational mix adjustment and some major urban areas experienced increases in wage indexes as a result of the occupational mix adjustment. Because of the unanticipated results of the occupational mix survey data for FFY 2005, CMS decided not to adjust the entire wage index by the occupational mix but employed only a 10 percent occupational mix adjustment to the wage index for FFY 2005 and FFY 2006.

According to the Federal Register publication on April 25, 2006, CMS proposed to continue to apply only a 10 percent occupational mix adjustment to the wage index for FY 2007 as the plan was to rely on the same survey data as was used for FFY 2005 and FFY 2006 wage indices. However as we have previously mentioned, due to the Bellevue Court's order, CMS published a revision to the final rule in the May 17th publication of the Federal Register that proposed that CMS proceed with a 100 percent implementation of the occupational mix adjustment for FFY 2007 and that the adjustment would be based on data collected from the first quarter of 2006.

The following comments are DVHC's specific recommendations regarding the occupational mix adjustment that CMS has proposed for fiscal year (FY) 2007:

Development of the Data for the Proposed Occupational Mix Adjustment

As already stated, the DVHC appreciates CMS' efforts to streamline the occupational mix survey and we support the inclusion of both the paid hours associated with the employees in question and the wages paid. However, in our comments to the proposed rule regarding the Occupational Mix Survey that was published on October 14, 2005, the DVHC recommended there be a year's worth of data collected rather than only six-months of data so that the data collected would ensure that seasonal and other variations do not skew the results and that the data collected would easily tie back to the payroll system. In the FY 2005 Medicare inpatient prospective payments system final rule CMS noted that the "optimum data" would reflect wages and hours from a one-year period for all hospitals. We agree with CMS' stated position because a one-year time frame would improve the accuracy of the data as it could be compared with W-2 and other Internal Revenue Service (IRS) filings. Therefore **we have serious concerns that CMS is proposing that the data used for the occupational mix adjustment to the wage index for FY 2007 would be only three months of data from the first quarter of 2006.** This data would in no way reflect the seasonal changes in staffing patterns.

Timeline

As was previously mentioned, in CMS' proposal hospitals were required to make an initial submission of data from the first quarter of 2006 to the fiscal intermediaries by June 1, 2006, only fourteen days after the rule was published in the federal register. Needless to say this did not provide hospitals with sufficient time to prepare accurate submission of data. Likewise, the second set of data is expected to be submitted by August 31, 2006, which is only 62 days after the end of the second quarter. We believe that expecting hospitals to respond to a survey with such short notice when the results of the survey would have a significant impact on Medicare reimbursement for inpatient services is unreasonable and unacceptable. Furthermore, given that data regarding contract labor is included in the survey, providers need time to receive invoices from their contractors and integrate that information into their systems and report it accordingly on the occupational mix survey. **We argue that the survey deadline for data submission was unacceptable and that hospitals need at least 90-days post the collection period to complete the occupational survey with contract labor information and to prepare it for submission to the fiscal intermediary.**

In addition to revising the deadline for completion of the Occupational Mix Survey, in the proposed rule CMS shortened the time frame that hospitals have to review the data after the fiscal intermediaries (FI) have made adjustments to it. Normally hospitals have at least 30 days to review data that is published by CMS in the public use file whereas this proposes that hospitals submit requests to their fiscal intermediaries for corrections to their interim occupational mix data within 2 weeks of the publication on the CMS website. The proposed rule indicates that the deadline for CMS to publish the data is June 29th and the deadline for hospitals to submit corrections is July 13th and during the brief period that hospitals would be given to review their data and submit corrections there is the national holiday of Independence Day when businesses are closed. Furthermore, we have a problem with the fact that not only does CMS propose a shortened time frame for hospitals to review their data and submit corrections, but also CMS proposes to penalize hospitals that fail to meet the deadline by denying them a right to appeal to the Provider Reimbursement Review Board. In the proposed rule, CMS states "hospitals that do not meet the procedural deadlines set forth above would not be afforded a later opportunity to submit occupational mix data corrections or to dispute the FI's decision with respect to requested changes." **In light of the condensed time to complete the Occupational Mix Survey the DVHC urges CMS to provide the hospitals with more time to submit corrections to the data.**

Calculation of the Proposed FY 2007 Occupational Mix Adjustment

For the FY 2005 and the FY 2006 final wage indices, the CMS used the unadjusted wage data for hospitals that did not submit occupational mix survey data. For calculation purposes, this equates to applying the national nursing mix to the wage data for these hospitals, because hospitals having the same mix as the Nation would have an occupational mix adjustment factor equaling 1.0000. For the FY 2007 wage index, CMS proposed to use 1 of 4 options for treating the occupational mix data for non-responsive hospitals: (1) Assign the hospital an occupational mix adjustment factor of 1.0000 as was done for FY 2005 and FY 2006; (2) assign the hospital the average occupational mix adjustment factor for its labor market area; (3) assign the hospital the lowest occupational mix adjustment factor for its labor market area; or (4) assign the hospital the average occupational mix factor for similar hospitals, based on factors such as, geographic location, bed size, teaching versus non-teaching status and case mix. It is impossible to evaluate the potential impact of implementing some of the suggested options for treating the occupational mix data for non-responsive hospitals because the Occupational Mix Survey that is being conducted is so different from the one conducted previously. Therefore, we recommend that CMS use the same method for treating the occupational mix data for non-responsive hospitals as was used for the FY 20005 and FY 2006 final wage indices. **For the FY 2007 Wage Index, the DVHC suggests that CMS use the unadjusted wage data for the hospitals that do not submit occupational mix survey data.**

Waiver of 60-Day Comment Period

To be in compliance with the proposed rule, hospitals had to provide occupational mix data on an extremely expedited timeline, with little or no time for review, and no ability to see how the data will affect their FY07 payment rates. While we understand that CMS is under severe time pressure due to the timing of the court's decision, we do not believe that the 30-day comment period was sufficient, as hospitals were busy during this time trying to meet the new survey deadline and answering requests for information from the Fiscal Intermediaries. We feel strongly that CMS should take comments on the calculation after the initial results of the survey are tabulated and posted. The results of the survey could be material. For instance, if the segregation of Registered Nurses (RNs) who are management versus RNs who are staff does not produce a reliable result, CMS might consider consolidating the two for the purposes of the calculation. While CMS might not have time to make such changes for FY 2007, it could entertain comments on the implementation for FYs 2008 and 2009. We are concerned about the collective effect these changes will have on hospital payments and recommend that CMS provide opportunities for review, comment, and adjustment to the occupational mix data (including the ability to appeal or amend bad data), as needed, to the extent allowable under the Court order. **Thus, we urge CMS to publish the occupational mix adjustment changes as an interim-final rule in August with an associated comment period.**

Thank you for the opportunity to express our views on the occupational mix adjustment to the Medicare wage index as it will impact hospital services received by Medicare beneficiaries in the Philadelphia area as well as other parts of the Commonwealth and the nation. If you or your staff needs further clarification of our views, please do not hesitate to contact me at (215) 575-3737 or Pamela Clarke, DVHC's Vice President of Managed Care at (215) 575-5755.

Sincerely,

Andrew Wigglesworth

Andrew Wigglesworth
President

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Illinois Hospital Association

June 2, 2006

IHA

Dr. Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.,
Washington, D.C. 20201

ATTN.: CMS-1488-P2

Re: Medicare Program; Hospital Inpatient Prospective Payment Systems Implementation of the Fiscal Year 2007 Occupational Mix Adjustment to the Wage Index; Proposed Rule, Federal Register, Volume 71, No. 95, Wednesday, May 17th, 2006

Dear Dr. McClellan:

On behalf of our approximately 200 member hospitals and health care systems, the Illinois Hospital Association (IHA) is taking this opportunity to formally comment on the proposed rule revising the methodology for calculating the FY 2007 occupational mix adjustment. IHA commends the Centers for Medicare and Medicaid Services (CMS) for its thorough analysis and step-by-step process for computing the adjustment that are contained in this rule. In accordance with instructions in this rule, the Illinois Hospital Association presents the following comment for your consideration:

- **"WITHDRAWING RECLASSIFICATIONS":** The proposed rule recommends that the current regulation which allows hospitals that have been reclassified for FY 2007 to withdraw their reclassification status within 45 days of the publication of the final rule be suspended. CMS is suggesting this approach because of the tight statutory deadlines that govern the submission, review and publication of occupational mix data for FY 2007. The agency proposes to make its own reclassification withdrawal determinations "...based on what we perceive would be most advantageous to the hospital based on the 100 percent occupational adjusted wage index data and the out-migration adjustment, if applicable." The rule then states that affected hospitals would have 30 days in which to review CMS' decision and submit *in writing* to the agency any requests to reverse CMS' decision. **The Illinois Hospital Association supports this approach by CMS with one addition. For those hospitals whose reclassification status is ultimately withdrawn by CMS and that wish to contest the findings, CMS should allow those hospitals two methods of responding: either directly to CMS in writing or through a comment section set up by CMS on its website.** (There is a precedent for website responses; the agency accepted comments on its recently proposed revision to Medicare's coverage for outpatient cardiac rehabilitation services in this manner.) As the process of reviewing and evaluating the wage index and occupational mix data for many facilities is a time-consuming, detailed process, any time that can be saved by responding directly online would be appreciated.

Dr. McClellan, thank you again for the opportunity to comment. The Illinois Hospital Association welcomes the opportunity to work with your agency in the continued development and refinement of the Medicare payment system.

Sincerely,

Thomas A. Jendro

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