THE
CATHOLIC HEALTH
ASSOCIATION
OF THE UNITED STATES

July 12, 2004

Honorable Mark B. McClellan, MD, PhD
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 443-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

REF: CMS-1428-P

RE: Medicare Program; Changes to the Hospital Inpatient Prospective Payment System (IPPS) and Fiscal Year 2005 Payment Rates; Proposed Rule

Dear Dr. McClellan:

The Catholic Health Association of the United States (CHA) is pleased to submit the following comments on the notice of proposed rulemaking (NPRM) on the Fiscal Year 2005 Hospital Inpatient Prospective Payment System (*Federal Register*, Vol. 69, No. 96, page 28196) published May 18, 2004. In addition to proposing rates of increase for hospital payments and updates to Diagnosis Related Groups (DRG) weights and calibrations for FY 2004, the proposed rule includes potential changes to regulations governing several important areas affecting the care we provide to Medicare beneficiaries.

Proposed Changes to DRG Classification and Relative Weights; DRG Reclassification; Other Issues; Coronary Stent Procedures

CHA urges CMS to act quickly to ensure that cases involving the use of multiple stents are appropriately recognized and adequately reimbursed. Further, we support refinement of assigning stent-use related cases to DRGs that more appropriately reflect whether base metal or drug-eluding stents are used and whether the cases are "complex" or "noncomplex." An interim payment adjustment should be established for cases involving the use of multiple stents.

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While we appreciate that data necessary to evaluate and distinguish these situations are currently lacking and that CMS is committed to conducting a full analysis once such data are available, nevertheless providers are currently facing the financial realities of these situations.

Pending the completion of the evaluation, we would urge CMS to immediately provide an appropriate mechanism for providers to report cases in which multiple stents were used and to receive an appropriately indexed add-on payment for the respective DRG.

Proposed Changes to the Area Wage Index (AWI); Revised Labor Market Areas; Three-Year Hold Harmless Protection for Certain Hospitals

CHA urges CMS to provide at least a three-year hold harmless protection policy for any hospital that is adversely impacted by more than 10 percent in their AWI as a result of the adoption of the proposed new labor market definitions.

CMS hospital labor market areas are based on definitions issued by the Office of Management and Budget (OMB). Among other things, CMS is proposing to revise Medicare's Metropolitan Statistical Area labor market area definitions to align with the new MSA definitions adopted by OMB in June 2003.

The new MSA definitions recognize 49 new MSAs and extensively revise the construction of many of the existing MSAs. There are 1,090 counties in MSAs under these new definitions;

previously there were 848 counties. Of these counties, 737 are in the same MSA as they were prior to the changes, 65 are in a different MSA, and 288 were not previously designated to any MSA.

As a result of the new MSA definitions, according to CMS, 389 hospitals would experience a decrease of the AWI of at least 2.0 percent - 182 hospitals would suffer a reduction of between 5.0 and 10.0 percent while 45 would experience reduction of greater than 10.0 percent. On the other hand, 224 hospitals would experience an increase in their AWI of at least 2.0 percent.

The new MSA definitions have critical implications for hospitals in currently defined MSAs, which are disaggregated by the new MSAs. For example, in Michigan, the new MSA definition would result in disaggregating the current Battle Creek MSA into two MSAs-Battle Creek, MI, MSA and Kalamazoo, MI, MSA. For hospitals in the new Battle Creek, MI, MSA, this change would result in a reduction of their AWI from 1.05 to 0.9-a reduction of nearly 15 percent in their AWI. This would translate into a payment reduction of approximately 9 percent. (Reduction of the labor share from .71 to .62 would have only minimal influence on this impact.)

For currently classified urban hospitals that would become rural under the new labor market definitions, it is interesting that CMS is proposing a three-year transition period to alleviate the decreased payments. It appears inconsistent that CMS does not propose any protections to hospitals that are adversely impacted by the new MSA designations.

This inconsistency needs to be corrected through the application of at least a three-year hold harmless provision for such hospitals.

Outlier Payment Adjustment Factor; Threshold; Assume a Lower Rate of Inflation in Hospital Charges

CMS proposes to increase the outlier threshold from $31,000 in FY 2004 to $35,085. The proposed outlier threshold for FY 2005 is significantly higher than expected in view of the policy changes implemented October 1, 2003. CMS notes in the proposed rule that a significant factor in the higher than expected threshold may be the two-year average annual rates of change that it is using to update charges in the Medicare Payment Advisory Commission (MedPAC) data from FY 2003 to FY 2005. CMS is utilizing the two-year average annual rate of change in charges per case from FY 2001 to FY 2002, and from FY 2002 to FY 2003, which is 14.5083 percent annually, or 31.1 percent over two years. These rates of increase derive from the period before the October 1, 2003, policy changes, when some hospitals were increasing charges at the most rapid rate. Therefore, they represent rates of increase that likely are higher than the rates of increase under the new policies.

CHA strongly urges CMS to revise its assumptions concerning the rate of increase in charges. We understand that CMS prefers to use historical data rather than projections, but we believe that an exception is warranted in this situation.

Expansion of Postacute Care Transfer Payment Policy; Justification for the Use of Alternative Criteria

Because CMS is proposing to replace DRG 483 with two new DRGs that better differentiate the respective cases that are currently assigned to this DRG, it is proposing to eliminate DRG 483 from the list of 29 DRGs that are currently subject to the postacute care transfer policy. The cases that would have been put into DRG 483 would now be split into two proposed new DRGs: DRG 541 (Tracheostomy with Mechanical Ventilation 96+ Hours or Principal Diagnoses Except Face, Mouth, or Neck Diagnoses With Major OR Procedure) and DRG 542 (Tracheostomy with Mechanical Ventilation 96+ Hours or Principal Diagnoses Except Face, Mouth, or Neck Diagnoses Without Major OR Procedures).

As directed by the implementing legislation, CMS developed a set of criteria for purposes of expanding the postacute care transfer policy above the initial 10 DRGs. The criteria required that a DRG must meet, for both of the most recent two years for which data are available, are the following:

- At least 14,000 postacute care transfer cases
- At least 10 percent of the postacute care transfers occurring before the geometric mean length of stay
- A geometric mean length of stay of at least three days, and
- If a DRG is not already included in the policy, a decline in its geometric mean length of stay during the most recent five-year period of at least 7 percent.

Neither of the proposed new DRGs (541, 542) would, however, have enough cases to meet the first criterion for inclusion in the postacute care transfer policy. As a consequence, CMS is proposing, for the first time, "alternative criteria" which it proposes to use in situations where there "remain substantial grounds for inclusion of cases within the transfer policy." And, not surprisingly, using the "alternative criteria" qualifies the new DRGs for inclusion in the postacute care transfer policy.

CHA is very concerned about the apparent arbitrary manner in which this approach was developed and applied. There is no analytical support for the new criteria. CMS should provide analytical support and rationale in the application of any new criteria. Absent that, we believe the "alternative criteria" provision should be withdrawn in the final rule.

Payment Adjustments for Low-Volume Hospitals; Include All Qualified Hospitals

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) added a new provision to provide for a new payment adjustment to account for the higher costs per discharge of low-volume hospitals under the IPPS. A "low-volume hospital" is defined in the law as an IPPS hospital located more than 25 road miles from another IPPS hospital and having less than 800 total inpatient discharges during the fiscal year. CMS, however, is proposing a payment adjustment formula that would exclude hospitals with greater than 500 total inpatient discharges during the fiscal year.

While CMS justifies this discrepancy from public law based on its empirical analysis, the fact is that the law specifically defines, as regards discharges per fiscal year, such low volume hospitals as having less than 800 total inpatient discharges during a fiscal year.

CHA urges CMS to revise the formula to include the benefit of a payment adjustment to all such qualifying low volume hospitals. One option, if supported by empirical analysis, could provide differential payment adjustments: one for hospitals with 500 discharges or less, and another for hospitals with greater than 500 but less than 800 discharges per year.

The important policy issue, however, is that all hospitals that qualify under the law should receive a payment adjustment.

Graduate Medicare Education; Redistribution of Residency Slots; Minimize Administrative Complexity

MMA provided for reductions in the statutory resident caps under Medicare for certain hospitals and authorized a "redistribution" of the FTE resident slots resulting from the reduction in the FTE resident caps to other hospitals.

While the proposed process for reducing the resident cap for specific hospitals is relatively simple, the CMS process for redistributing the pool of resulting residents among eligible hospitals is exceedingly complex and convoluted. CHA is concerned that the multiple layers of assessment criteria will not only be confusing, but also may unintentionally inhibit the full, intended benefit of this provision.

While we expect other organizations to comment on this matter with certain details, CHA urges CMS to take pains to minimize the complexity of the redistribution process so as to ensure that all eligible hospitals are able to quickly assess the opportunities.

Hospital-Within-a-Hospital (HWH); Criteria for Classification

CHA is strongly opposed to the proposed universal requirement that would impose a 25 percent cap on admissions referred by the host hospital to a long-term care hospital-within-a hospital (LTC-HWH). While we understand and appreciate the underlying reasoning, such an approach, if adopted, instead of targeting the small subset of hospitals that may be abusing such referral options, would arbitrarily penalize the many more hospitals that are not abusing the privilege. Even more important, the restrictions would severely curtail the availability of such care to Medicare beneficiaries-forcing hospitals and patients' families to seek out alternative and less-optimal service options.

Catholic hospitals are deeply concerned that if such a proposal is implemented, it will significantly impact their Medicare beneficiaries who need the care and services that can be given in these co-located facilities. Such a restriction will limit the availability of such services to any beneficiary when the threshold is exceeded. If such services were not available in the community, there could be a situation where beneficiaries could not be admitted to the LTC-HWH even though beds were available.

Currently, a HWH must meet Medicare's separateness and control criteria and at least one of three basic hospital functions criteria. Out of concern that the current criteria do not sufficiently protect the Medicare program from potential abuses in which the HWH functions more as a hospital unit, particularly in the case of long-term care HWHs, CMS is proposing to delete two of these three criteria and to require that no more than 25 percent of the admissions to the HWH be referred from the host hospital.

In addition, CMS is proposing to preclude common ownership (wholly or in part) of HWHs and host hospitals. CMS is, however, proposing to grandfather HWHs that were under common ownership with their hospitals as of June 30, 2004, so long as such HWHs comply with the proposed mandatory 25 percent criterion.

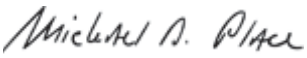
CHA strongly urges CMS to re-evaluate its policy options in relation to its concerns. If CMS remains concerned about the criteria's ability to protect the Medicare program from certain abuses, CHA urges CMS to better target its policy changes to address just those situations, rather than using a broad policy approach that adversely impacts all hospitals with co-located HWHs.

To this end, we would urge CMS to explore appropriately revising the qualifying criteria for LTC hospitals to better target the services and care such facilities provide. Such an approach is now under consideration by MedPAC. While specifics are not available, conceptually such an approach would still preserve the host hospital's discharge options while better addressing CMS concerns.

We also draw your attention to MedPAC's recommendation, adopted at its April 2004 meeting, that the Medicare program review the medical necessity of patient admissions to co-located LTC hospitals through the Quality Improvement Organizations, which Congress authorized to perform such functions.

In closing, thank you for the opportunity to comment on the proposed hospital Inpatient Prospective Payment System rule. We look forward to working with you on the above issues.

Sincerely,



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