

June 11, 2007

Honorable Leslie Norwalk
Acting 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, D.C. 20201

REF: CMS-1533-P

RE: Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment System and Fiscal Year 2008 Payment Rates; Proposed Rule.

Dear Ms. Norwalk:

The Catholic Health Association of the United States (CHA) is pleased to submit the following comments on the notice of proposed rulemaking (NPRM) for the Fiscal Year 2008 Hospital Inpatient Prospective Payment System (*Federal Register*, Vol. 72, No. 85) published May 3, 2007.

The hospital inpatient prospective payment system (IPPS) FY 2008 NPRM would continue the process begun in the FY 2007 proposed and final rules to make significant changes in the diagnostic related group (DRG) classification system and the methodology used to calculate the DRG relative weights.

In last year's final rule (FY 2007), CMS began a 3-year transition from charged-based weights to weights based on estimated costs. In a significant change from the FY 2007 proposed rule, the hospital-specific relative value methodology was not included in the final rule. Instead, cost-based DRG relative weights were computed using *national average* cost-to-charge ratios (CCRs) rather than hospital-specific ratios

In developing the cost-based weights, national average CCRs were computed for 13 cost centers, as opposed to the 10 named in the proposed rule.

In the FY 2007 final, CMS also decided not to implement its proposed new severity-based patient classification system, although CMS took another step toward severity-adjusted DRGs by creating 20 new CMS-DRGs, deleting 8 DRGs and modifying 32 others across 13 different clinical areas involving nearly 1.7 million cases.

I. DRG Reform and Proposed MS-DRGs

CMS proposes to implement a Medicare severity (MS)–DRG system on October 1, 2007. The agency said that it believed the proposed MS-DRGs represented a substantial improvement over the current CMS-DRGs in their ability to differentiate cases based on severity of illness and resource consumption. This belief, however, has not been confirmed by the RAND Corporation (RAND), which had been retained by CMS to evaluate alternative classification systems. CMS said that while RAND has not had an opportunity to evaluate the MS-DRG system, nonetheless, the agency was proposing to implement the MS-DRG system effective October 1, 2007. CMS, however, went on to say that “although we are proposing to adopt the MS-DRGs for FY 2008, this decision would not preclude us from adopting any of the systems being evaluated by RAND for FY 2009.”

CHA supports the adoption of a new or revised DRG classification system to better account for differences in patient severity

The fact, however, that CMS is proposing to implement a major DRG severity-based refinement methodology without the benefit of an independent review alarms us. Given the potential for heightened administrative burdens as well as financial consequences it would seem prudent that CMS invest the needed time and energies to confirm whether its beliefs can, in fact, be validated.

Accordingly, we urge a one year delay in the implementation of MS-DRG in order for RAND to complete an evaluation of such a system and to allow time for CMS to review the findings and make any appropriate revisions.

As an alternative, we also urge CMS to evaluate interim steps. One such interim step could use the existing CMS-DRG system with the “revised CC list” to classify a patient based on his or her severity.

II. DRGs: Relative Weight Calculations

As noted above, in the FY 2007 IPPS final rule, CMS did not adopt the proposed hospital specific methodology to calculate cost-based DRGs weights. One concern was the potential bias in hospital specific cost weights due to “charge compression,” which is the practice of applying a lower percentage markup to higher cost services and a higher percentage markup to lower cost services. CMS retained RTI International (RTI) to study several issues with respect to the cost weights and to review a proposed statistical model for adjusting weights to account for charge compression.

RTI completed a draft of the study's findings, but CMS does not proposed to implement all or some of the recommendations due to the limited time CMS had to evaluate the recommendations.

The NRPM invites public comment on whether CMS should proceed to adopt the RTI's recommended changes for FY 2008 in the absence of a detailed analysis of how the relative weights would change if CMS were to address charge compression while simultaneously adopting a hospital specific relative value cost center (HSRVcc) methodology together with the proposed MS-DRGs.

CHA Comments:

- 1. CHA is very concerned over the possibility of administrative and financial dislocations caused by rapid changes in adoption of major changes to the relative weight determination methodology and the simultaneous adoption of the MS DRGs.**
- 2. Accordingly, CHA does not support the adoption of RTI's recommendations until CMS has completed a detailed analysis of how the relative weights would change if CMS address charge compression while simultaneously adopting an HSRVcc methodology together with the proposed MS DRGs.**
- 3. Assuming the detail analysis supports the adoption of the RTI recommendation, CHA urges CMS to implement such recommendations so as to anticipate and minimize administrative/financial disruptions from such changes.**

VI. Proposed Case-mix Adjustment

CMS anticipates that implementation of CS-DRGs will be accompanied by increases in average case-mix due to improved coding of secondary diagnoses to qualify for a CC or MCC classification and gain the higher payment amounts.

Based on its prediction of coding-related increases of 4.8 percent, the proposed rule includes a 2.4 percent reduction in the standardized amounts each year for two years, FY 2008 and FY 2009.

CHA strongly opposes the proposed prospective behavior offset. Such a prospective reduction assumes a level of coding practices that is not supported by experience. The FY 2007 policy changes along with the proposed policy changes for FY 2008 have the potential to bring substantive administrative and financial dislocations to many hospitals. The seemingly arbitrary behavior offset would compound these adverse consequences.

Accordingly, we strongly urge CMS not to finalize the proposed behavior offset but rather to monitor hospital behavior and, if appropriate, to make retrospective adjustments based on sound analytical evaluations.

IV. DRGs: Hospital-Acquired Conditions.

The Deficit Reduction Act of 2005 required the selection, by October 1, 2007, of a least two conditions that are (a) high cost or high volume or both, (b) result in the assignment of a case to a DRG that has a higher payment when present as a second diagnosis, and (c) could reasonable have been prevented through the application of evidence-based guidelines. For discharges occurring on or after October 1, 2008, hospitals will not receive additional payment for cases in which one of the selected conditions was not present on admission.

CMS, working with Centers for Disease Control and Prevention (CDC), developed certain criteria to assist in their analysis of the above conditions. Based on these criteria CMS rank ordered each of the 13 conditions that were raised as possible candidates for selection during the public comment process for FY 2007. CMS proposed to select the first six rank-ordered conditions. The six conditions include:

1. Catheter associated urinary tract infections,
2. Pressure ulcers,
3. Serious preventable event – object left in surgery,
4. Serious preventable event – air embolism,
5. Serious preventable event – blood incompatibility, and
6. Staphylococcus aureus septicemia

CMS and CDC also collaborated on developing a process for hospitals to submit a Present on Admission (POA) indicator with each secondary condition. The statute requires the collection of this information as of October 1, 2007.

CHA Comments:

1. **As regards the proposed hospital acquired conditions, such a policy, if adopted, will require hospitals to test every patient transferred from another acute care or post acute care facility. This, in turn, will drive up costs. How will the POA reporting requirements reflect whether a patient was transferred from another facility?**
2. **As regard the reporting whether one or more pressure ulcers were present on admission, such a condition doesn't manifest itself until a few days after it begins to form. Thus, a patient who is evaluated upon admission may not present with a pressure ulcer, but such a pressure ulcer will manifest itself a few days following admission. Thus, CMS should allow a POA revision/update for this particular**

situation. For instance, a hospital should be allowed up to three (???) days to revise a POA report that a patient was not admitted with pressure ulcer when after few days one or more appear.

V. Application of Rural Floor Budget Neutrality Adjustment

In the 1997 Balanced Budget Act (BBA), Congress required CMS to apply a “rural floor” to any metropolitan statistical area's (MSA's) Medicare wage index that was lower than the state's rural wage index. The result is that no MSA's wage index can be lower than that state's rural wage index. Reportedly about one-half of the states across the country have hospitals whose wage index was increased because of this provision.

The BBA required that CMS implement the floor on a budget neutral basis. Since FY 1998, CMS has applied the budget neutrality adjustment to the standardized amount to ensure that payment remained constant to payments that would have occurred in the absence of the rural floor. For FY 2008, however, CMS is proposing to apply the budget neutrality adjustment to the wage index; not the standardized amount. CMS said that such an adjustment to the wage index would result in a substantially similar payment as an adjustment to the standardized amount.

CHA is aware that that there are a number of hospital group appeals across the country, which challenge the rural floor budget neutrality adjustment as being too high because CMS failed to remove the impact of prior years rural floor budget neutrality adjustment. This purported error affects the standardized amounts used under the acute care inpatient DRG system. Therefore, all hospitals paid on that basis are potentially affected. This would include facilities that are now critical access hospitals (CAH), but were previously subject to IPPS prior to obtaining CAH status. It has been estimated that the FY 2007 standardized amount is believed to be understated by approximately 0.4 percent or \$431 million nationwide.

CHA strongly supports the rights of the affected hospitals to appeal for appropriate relief. Accordingly, while the proposal to apply the budget neutrality adjustment to the wage index instead of the standardized amount doesn't appear to compromise such an appeal, nonetheless, CHA opposes any change that would weaken a hospital's appeal rights.

VI. Occupational Mix Adjustment – Hospital-Specific Penalty for Hospitals That Do Not Respond to Occupational Mix Survey.

CMS invited comments and suggestions for a hospital-specific penalty for hospitals that do not submit occupational mix survey data.

Generally, CHA supports a modest penalty for non-responding hospitals, however, the Secretary should use his authority to provide an exception for hospitals that are unable to respond due to a lack of appropriate resources or systems. We believe small hospitals, especially rural hospitals, may not have the appropriate information system necessary to respond to the occupational mix survey. Such hospitals should not be penalized.

VI. Hospital Quality Data

CMS is proposing to add 1 outcome measure and 4 process measures to the existing 27 measures to establish a new set of 32 quality measures to be used for the FY 2009 annual payment determination. The proposed new quality measures include:

- Pneumonia 30-day Mortality
- SCIP Infection 4: Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose
- SCIP Infection 7: Colorectal Patients with Immediate Postoperative Normothermia
- SCIP Infection 6: Surgery Patients with Appropriate Hair Removal
- SCIP Cardiovascular 2: Surgery Patients on a Beta-Blocker Prior to Arrival Who Received a Beta-Blocker during the Perioperative Period.

CHA greatly appreciates the significant lead time represented by the early posting of the above proposed additional quality measures.

CHA understands that the proposed measures have been put forth by the Hospital Quality Alliance (HQA) for inclusion in its public reporting set, contingent on endorsement by the National Quality Forum (NQF). CMS said it expects the NQF will endorse these measures prior to the publication of the FY 2008 IPPS final rule. CHA strongly supports the position of CMS that any measure that has not been endorsed by the NQF by the time will not be included in the final rule.

VIII. IME Adjustment

In the FFY 2007 IPPS final rule, CMS clarified their policy with respect to the time that residents spend in non-patient care activities as part of approved residency programs, amending regulations to state *“In order to be counted, a resident must be spending time in patient care activities . . .”* Based on this clarification, CMS has received numerous questions regarding whether full time equivalent (FTE) resident time spent on vacation or sick leave, or in orientation activities, should be counted for purposes of indirect medical education (IME) payment. Historically time spent by residents on vacation or sick leave and in initial orientation activities has been included in the FTE resident count for IME and direct graduate medical education (GME).

CMS is proposing to remove vacation and sick leave from the total time considered to constitute a full time equivalent (FTE) resident for purposes of indirect medical education (IME) and graduate medical education (GME) payment effective for FY 2008. CMS, however, will continue to count time spent by residents in orientation activities for both IME and GME payment.

CHA strongly opposes the proposal to remove vacation and sick leave from the total time considered to constitute a FTE resident for purposes of IME and GME payment. Historically, such time has been included in the FTE resident count for IME and GME.

Further there is no “patient care activities” requirement for purposes of including time spend by residents in the hospital setting in the IME intern and resident-to-bed ratio. The IME adjustment is simply a proxy payment for additional, unidentifiable patient care costs associated with operating a teaching hospital. While the payment is a proxy for additional patient care costs, it utilizes a formula to measure the level of teaching activity at the hospital in order to calculate this proxy. Fringe benefits, including vacation and sick time, which are part of every approved residency program are certainly part of the “teaching activity” occurring at the hospital and, as noted above, were historically included in the FTE count for IME purposes when the adjustment was adopted.

We do not understand the claim by CMS that if the proposed change was adopted the impact in some cases would lower the FTE count and in other cases would result in a higher FTE count. If the proposed change is adopted, it would only have an adverse impact because time that had been formerly included in the determination of a FTE count would no longer be included in such determination. While the lowering of the FTE count, if such a proposed change was adopted, is intuitively obvious, it’s hard to conceive that the loss of such time would, in fact, result in a higher FTE count.

(NOTE: WE DID NOT INCLUDE THE COMMENT ABOUT THE MEDICARE INTERN AND RESIDENT INFORMATION SYSTEM (IRIS) REPORTS AS CMS SAID THAT SUCH REPORTS “DO NOT CONSTITUTE PROPER EVIDENCE/DOCUMENTATION OF A HOSPITAL’S RESIDENT COUNT. INSTEAD, CMS “EMPHASIZED THAT ROTATION SCHEDULES OR OTHER SIMILAR DOCUMENTATION SHOULD STAND AS THE PRIMARY EVIDENCE TO SUPPORT THE HOSPITALS’ RESIDENT COUNTS.”

VIII. Capital IPPS

Based on the results of a Medicare capital margin analysis, CMS proposes to:

- Freeze the FY 2008 and FY 2009 standard Federal capital rate for urban hospitals and give rural hospitals a 0.8 percent update for the same period.
- Eliminate, for FY 2008 and beyond, the 3.0 percent additional payment that has been provided to hospitals located in large urban areas.

In addition, based on its capital margin analysis, CMS said it was considering reducing or even eliminating the annual update to the standardized Federal capital rate for teaching hospitals and disproportionate share hospitals.

Finally, for FY 2008 and FY 2009 CMS is proposing to reduce the standardized Federal capital rate the same 2.4 percent as it proposed to apply to the operational standardized amount as a behavior offset in anticipation of the new MS-DRGs.

CHA is surprised that CMS would propose to freeze the capital rate update for all urban hospitals and proposed to eliminate the special adjustment for hospitals in large urban areas. One reason is that we are very suspicious about the validity of CMS's capital profit margin analysis. CMS did not provide any details about the methodology used to develop these capital margins. Without sufficient details and data files, we cannot confirm the alleged findings. The absence of such details, given the proposed magnitude of the payment reductions, leads us to question why such details were not provided to substantiate the proposed action.

The proposed across the board freeze for urban hospitals implies that all urban hospitals had relatively high profit margins. We're reasonably certain that this, in fact, is not the case at all. The fact is that each hospital has a multi-year capital expenditure cycle. The cycle involves a period of replacing/accumulating capital reserves and another period of making substantive capital expenditures. This cycle runs over the course of years, not annually.

Further the proposed urban hospital capital update freeze and the elimination of the 3.0 percent adjustment for large urban hospitals fails to reflect the real world hospital capital demands. For instance, in California alone, it is estimated that it will cost hospitals in excess of \$110 billion to adequately respond to the requirement that no later than January 1, 2008 (or January 1, 2013 if an extension has been granted) every hospital building must meet specific construction standard established to keep those building standing after a major earthquake.

Finally, the proposed freeze of the urban standardized federal rate update for two years and the elimination of the 3.0 percent adjustment for large urban hospitals will disproportionately disadvantage non-profit hospitals in relation to investor-owned hospitals. The former hospitals are unable to

access the private equity markets that are available to investor-owned hospitals. Investor-owned hospitals, which are competing against non-profit hospitals for market share, will certainly benefit from the proposed policy changes.

In closing, thank you for the opportunity to share these comments in regard to the proposed FY 2008 IPPS rule. We look forward to working with you on these and other issues that continue to challenge and make stronger the country's hospitals.