

June 2, 2006

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-1488-P and CMS-1488-P2

RE: Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment System and Fiscal Year 2007 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) for the Fiscal Year 2007 Hospital Inpatient Prospective Payment System (*Federal Register*, Vol. 71, No. 79) published April 25, 2006, as revised by the May 17, 2006, Centers for Medicare and Medicaid Services (CMS) notice "Medicare Program; Hospital Inpatient Prospective Payment Systems Implementation of the Fiscal Year 2007 Occupational Mix Adjustment to the Wage Index." We also note the notice of the two typographical clarifications published May 9, 2006, on the CMS website.

The proposed rule, if adopted as proposed, would make the most significant changes to the hospital inpatient prospective payment system (IPPS) since its implementation.

The major factors in the proposed rule include:

1. Significant changes in the methodologies used to calculate the relative weights of the diagnostic related groups (DRGs). Such weights determine Medicare's payments for hospital inpatient services. The proposed changes include a move, beginning FY 2007, to an estimated "cost-based" system, rather than a charge-based system (used since 1983), for determining the payment weights for each diagnostic category.
2. Changes in the method for identifying the variation in patients' severity of illness. CMS said that the latter change would be implemented in FY 2008, but possibly earlier.
3. The court-mandated expansion of the occupational mix adjustment to apply to 100 percent of the wage index. The initial proposal for FY 2007 would have applied the occupational mix adjustment to 10 percent of the wage index, however, the May 17, 2006, revision to the initial proposed rule would apply the occupational mix adjustment to 100 percent of the wage index.

These changes, due to their re-distributional impact, will certainly bring as many as three potentially major de-stabilizing factors (if implemented simultaneously) to bear on the financial situation of many hospitals. Our recommendations and comments on these and other aspects of the proposed rule are as follows:

DRG Reclassifications

1. **We recommend that CMS postpone until at least FY 2008 implementation of the proposed hospital specific cost-based DRG relative weight determination policy. During this extended period, CMS should complete an analysis, which**

includes a parallel pilot test of the proposed changes in order to identify any unintended consequences.

- 2. We further recommend that the proposed hospital specific cost-based DRG relative weight determination policy and the proposed severity adjustment policy be implemented simultaneously but no earlier than FY 2008. This simultaneous implementation approach should help to insure that redistribution of hospital payments is not unduly disruptive to selected individual hospitals.**
- 3. Finally, we recommend that CMS provides at least a three year transition period of the proposed policies during which hospitals are protected from major payment disruptions.**

This recommendation for postponement also reflects our concerns regarding the need for an appropriate lead time to modify hospitals' coding systems.

And, recognizing that the court mandate limits CMS implementation flexibility of the proposed FY 2007 occupational mix adjusted wage index, the above recommendation also reflects our desire to minimize the impact of the potentially disruptive major policy changes on hospitals.

The proposed hospital specific DRG relative value weight policy change would base the DRG relative weights on the estimated cost of providing care. Such weights would be based on the national average of the hospital specific relative values for each DRG. CMS says that the purpose of the proposed change is to help reduce the bias by accounting for the differences in charge markups across cost centers. The proposed change was initially recommended by the Medicare Payment Assessment Commission (MedPAC), however, while agreeing with MedPAC, CMS did not accept MedPAC's proposed methodology. Instead, CMS asked for comments on an alternative methodology, which it proposed to fully implement October 1, 2006.

While we appreciate CMS's concern with MedPAC's recommended methodology, i.e., the administrative burden on hospitals to develop and maintain, we are concerned that the alternative methodology being proposed by CMS has not been thoroughly evaluated. For instance, the CMS methodology assumes a uniform hospital markup—but in fact, markups vary from product to product. In addition, the proposed changes would further distort the estimation of accurate costs by combining multiple costs centers on hospital cost reports into ten CMS-designated cost centers. CMS would then determine ten national average cost-to-charge ratios for each of the designated costs centers, however, such ratios would not be weighted by each hospital's Medicare charges. This would allow very small hospitals to have just as much of an impact on the national cost-to-charges ratios as larger hospitals. These and other methodological issues seem reason enough to invest additional time and energies in the assessment and, as appropriate, further refinement of this proposed change.

In addition, CMS is proposing to implement October 1, 2007, if not earlier, another major payment policy change to refine DRGs based on severity of illness. And here again, while accepting a MedPAC recommendation, CMS did not propose to adopt the already widely applied All Patients Refined DRGs (APR DRGs) endorsed by MedPAC, but rather proposed to adopt a CMS-developed Consolidate Severity-Adjusted DRGs (CSA DRGs).

And, as regards the latter, we are concerned about the implications related to the subject of adjusting for case-mix "creep." While not specifically saying that it would impose an across-the-board behavior adjustment offset in response to or anticipation of case-mix increases stemming from improved documentation and coding, CMS nonetheless left an impression that it would include a behavioral adjustment offset when the severity adjustment is implemented. Rather than impose such an adjustment on all hospitals, we urge that such offsets be applied

on a case-by-case basis. This will prevent all hospitals from being arbitrarily penalized for the practices of a relative few.

We are concerned about the potential unintended consequences and implications of such unproven and essentially untested payment changes on hospitals. Given obvious potential impact on hospitals' payments, we respectfully urge CMS to postpone implementing both these proposals pending thorough analysis. Such analysis should include running the proposed changes side-by-side with the current payment policies in order to better track and discern any unexpected patterns or impact.

This postponement is all the more essential in light of the newly proposed, but court-mandated, occupational mix adjustment to the area wage index.

Implementation of Proposed FY 2007 Occupational Mix Adjustment (as published in the *Federal Register*, May 17, 2006)

While we understand the unusual restraints stemming from the court-mandated order as regards the application of the occupational mix adjustment to 100 percent of the wage index, we strongly urge CMS to use its discretionary authority to insure that implementation is not unduly disruptive to selected individual hospitals. That could be addressed by the use of a multi-year transition or the use of corridors, as CMS has utilized in the past.

Obviously we are concerned about the implications of the court-mandated application of the occupational mix adjustment to 100 percent of the wage index beginning FY 2007. Previously, CMS applied the occupational mix adjustment using only 10 percent of the adjustment factor in calculating the wage index values.

To comply with the court's order, CMS is proposing to use the first three months (January 1, 2006, through March 31, 2006) of the survey data collected on the 2006 Medicare Wage Index Occupational Mix Survey and apply that adjustment to 100 percent of the FY 2007 wage index. Hospitals are required to submit this occupational mix data no later than June 1, 2006. Thus, while CMS will use new data to apply a 100 percent occupational mix adjustment factor, such adjustments will only be as accurate as the data reported. Considering the very short time frame to report the new data, make adjustments, and the fact that this is only the second time such data are being requested, accurate information and results could still pose a problem.

Value-Based Purchasing

CMS noted that the Act required it to develop a plan to implement value-based purchasing beginning with FY 2009. CMS went on to say that the plan must consider a number of issues, including an incentive methodology, and asked a number of questions.

Before addressing these incentive methodology questions, we wanted to raise a more fundamental question—"What is the goal of value-based purchasing?" Is it to improve quality of care? Or is it to reduce Medicare spending? We feel the goal should be to improve the overall quality of care. And, if in the process, Medicare savings are realized, then such savings should be considered an unexpected value, but one that does not take precedence over the primary goal.

The above perspective is what guides our responses to the incentive methodology questions that follow. Our recommendations follow the statement of the respective question posed by CMS:

1. "How should incentives be structured?" *Hospitals should be rewarded for continued improvement over time.* This approach is preferred over one that sets an absolute

standard of performance. Use of the latter option could either discourage hospitals, especially small and rural hospitals, because it failed to reflect the hospital's unique situation and/or it failed to appropriately stimulate other hospitals.

2. "What level of incentive is needed?" ***We concur with the use of a 1 to 2 percent bonus incentive but feel strongly that penalties for "poor performance" would not be in keeping with the quality improvement spirit.*** And if such penalties are adopted, they should not, however, be determined based on only one year of performance. Rather, such a determination should consider a hospital's continued improvement over more than one year because one year may just be too short of an evaluation period to obtain a reliable performance determination.
3. "What should be the source of the incentives?" ***We encourage CMS to examine the possibilities of improving care coordination as an incentive funding source.*** In particular, CMS, as it noticed in the proposal, would need to determine whether such an effort could produce measurable savings and whether some of the savings generated in one payment system could be used (as incentive payments) in another.
4. "What should the form of incentives be?" ***We believe, for simply practical purposes, that the incentive payments should be made on a periodic, lump sum, quarterly basis.*** First the logistics of making incentive payments on a per-service basis would, we believe, add an increased administrative burden on hospitals and could fracture a hospital's systemic effort to improve quality. Rather, a lump sum payment would serve to reward the entire hospital for its achievements. And setting up monthly lump sum payments would be inviting delays and complaints. It's better to take a little more time, i.e., every quarter, to get it right and on time
5. "What should the timing of the incentives be in relation to performance?" (*See #4 above.*)
6. "How should we develop composite scores?" ***We endorse the use of the highlighted composite scoring methodology currently being used for the Premier Hospital Quality Incentive Demonstration.*** We like this approach because it weighs individual measures by the volume of opportunities for the associated intervention by a particular hospitals; missing values for a particular aspect of care provided by an individual hospital would not prevent that hospital from being represented in a public report; and composite measures may easily accommodate the addition of individual measures.

In closing, we want to thank you for the opportunity to comment on the proposed FY 2007 IPPS rule. If enacted as proposed, this rule will have the largest impact on hospitals since the inception of the IPPS in 1983. Not only does the rule propose major changes to the DRG weight determination process but also proposes substantive severity of illness refinements. And if these changes were not enough, the rule, responding to a court mandate, also proposes to substantially revise the methodology for calculating the occupational mix adjustment of the hospital area wage index. Given these proposed changes we again urge CMS to defer implementation of the DRG related changes for at least a year in order to better assess the potential unintended consequences.

Sincerely,



Michael Rodgers
Senior Vice President, Public Policy and Advocacy