THE
CATHOLIC HEALTH
ASSOCIATION
OF THE UNITED STATES

June 21, 2005

Honorable Mark B. McClellan, MD, PhD
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

REF: CMS-1500-P

RE: Medicare Program; Changes to the Hospital Inpatient Prospective Payment System and Fiscal Year 2006 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 2006 Hospital Inpatient Prospective Payment System (*Federal Register*, Vol. 70, No. 85) published May 4, 2005, as revised by the June 1, 2005 Centers for Medicare and Medicaid Services (CMS) notice "FY 2006 Inpatient Hospital Prospective Payment System Table Changes." In addition to proposing rates of increase for hospital payments and updates to Diagnosis Related Groups (DRG) weights and calibrations for FY 2006, the proposed rule includes potential changes to regulations governing several important areas affecting the care we provide to Medicare beneficiaries.

Hospital Market Baskets; Proposed Update for Hospital Inpatient Prospective Payment System (PPS) Rate
CHA is very appreciative that CMS is proposing an FY 2006 inpatient PPS rate increase equal to the full market rate—a measure of hospital inflation—for those hospitals submitting the required 10 quality measures. Such an increase is crucial to maintaining our ability to serve, and be competitive in recruiting and retaining health care professionals. Regarding CMS's proposal to reduce the labor-related share of the area wage index (AWI) from 71.1 percent to 69.7 percent, to ease the financial impact of this change, CHA would ask CMS to phase in this change for affected (those with an AWI greater than 1.0) over a period of at least two years.

Postacute Care Transfers; Proposed Expansion of Postacute Care Transfer Policy
CHA opposes the proposed revisions of the selection criteria for including a DRG within the post acute care transfer policy and urges CMS to withdraw these criteria, which appear to be founded solely on cost/utilization parameters, rather than clinical grounds. We feel CMS's institution of its post acute transfer policy is in direct conflict with CMS's rationale for implementing DRGs—i.e., paying hospitals based upon average costs and lengths of stay, thereby providing a built-in incentive to be more efficient and reduce unnecessary inpatient days. Yet, the post acute transfer policy does just the opposite—it penalizes hospitals for such care efficiency, and creates an incentive to retain inpatients longer, rather than expedite their transfer to a more appropriate, less costly post-acute care setting. As such, CHA opposes any expansion of the number of DRGs subject to CMS's post-acute transfer policy, with related comments provided below.

If adopted in the final rule, according to CMS, the proposed revision would expand the number of DRGs subject to the transfer payment policy from the current list of 30 DRGs to 231 existing DRGs as well as another 47 proposed DRGs. CMS projects that such a change would reduce aggregate payments to hospitals about $880 million per year, which is a 1.1 percent reduction in total hospital payments.

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Background: The statute gives the Secretary of the Department of Health and Human Services (DHHS) the authority to make a DRG subject to the postacute care transfer policy based on a "high volume of discharges to postacute care facilities and a disproportionate use of postacute care services." Accordingly, in the FY 2004 IPPS final rule, CMS adopted qualifying criteria providing that to be included in the transfer—DRG list, a DRG must have, for both of the two most recent years for which data are available:

- At least 14,000 postacute care transfer cases;
- At least 10 percent of its postacute care transfers occurring before the geometric mean length of stay;
- A geometric mean length of stay of at least 3 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 5 year period of at least 7 percent.

In the FY 2005 IPPS NPRM, CMS proposed alternative eligibility criteria for DRGs that failed to meet the above criteria. According to CMS, the alternative criteria were developed to address situations where there remained substantial grounds for inclusion of cases within the postacute care transfer policy, although one or more of the original criteria may no longer apply.

In response to this proposal, on July 12, 2004, CHA commented that it was "very concerned about the arbitrary manner in which this approach was developed and applied." CHA went on to say that:

"[The proposal] has all the appearances of essentially backing into a policy by the use of criteria which seem to fit the situation. There is no analytical support for the new criteria. CHA is left to wondering what CMS will do the next time it feels a certain DRG should be subject to the postacute care transfer policy, but doesn't meet the primary criteria or the "alternative criteria," if adopted. Will there be another iteration of the "alternative criteria" approach? *CMS should provide analytical support and rationale for the new criteria—otherwise the apparent arbitrary nature of such an alternative policy will become more firmly grounded in providers' perception."*

In the FY 2005 final rule, however, CMS elected not to adopt the proposed alternative criteria. Instead, CMS adopted a policy of simply grandfathering, for a period of two years, any cases that were previously included within a DRG that has split when the split DRG qualified for inclusion in the postacute care transfer policy for both the previous two years.

FY 2006 Proposed Expansion. The dramatic proposed expansion of DRGs subject to the post-acute transfer policy, from the current 30 to 231, reflects a quantum relaxation of CMS's criteria for determining which DRGs qualify:

- The DRG has at least 2,000 postacute care transfer cases;
- At least 20 percent of the cases in the DRG are discharged to postacute care;
- Out of the cases discharged to postacute care, at least 10 percent occur before the geometric mean length of stay for the DRG;
- The DRG has a geometric mean length of stay of at least 3.0 days;
- If the DRG is one of a paired set of DRGs based on the presence or absence of a comorbidity or complication, both paired DRGs are included if either one meets the first three criteria above.

CMS has not provided the requisite underlying justification for how these criteria satisfy congressional statutory intent in identifying DRGs with high post-acute transfer rates. What is lacking is a scientific, clinically sound basis for setting these criteria, rather than CMS's bias of basing them solely on utilization, average length of stay, and cost. Regrettably, these proposed criteria in no way reflect the efficiency and quality of care rendered. In CHA's opinion, this is a major oversight.

Ensuring patients receive the right care in the right setting at the right time should be the primary driver of Medicare's inpatient reimbursement system, not arbitrary utilization cut-offs that yield a predetermined level of savings—at the possible expense of quality. As such, CHA respectfully urges CMS to withdraw the proposed expansion of the postacute care DRG transfer list until it can analytically and clinically support such an expansion and it is in keeping with the statutory guidance.

DRG Reclassifications; DRG Refinement; All-Patient Refined DRGs and Severity Cases
While not an issue in the FY 2006 IPPS NPRM, nevertheless given the recent Medicare Payment Assessment Commission's (MedPAC's) endorsement of a refined inpatient classification system that better reflects severity variations followed by your submitted testimony May 14, 2005 before the House Energy and Commerce Committee in which you wrote, "CMS will propose changes to the DRGs to better reflect severity of illness", CHA believes it is worthwhile to clearly signal our mixed anxiety in regard to such effort. On the one hand we strongly support and encourage refinements to the inpatient DRG system that better captures cost variations among Medicare patients. On the other hand, we are very concerned about the redistributive implication such an effort would have on the Medicare payments to hospitals. As such, CHA feels it is critical that CMS evaluate DRG case mix severity outside a "budget neutrality" environment.

As regards the latter concern, we are encouraged by your above noted testimony, in which you acknowledged that a refined DRG system "could have a substantial effect on all hospitals, [and that] CMS believes we must thoroughly analyze these [DRG refinement] options and their impact before advancing a proposal."

We strongly urge that this process be open and inclusive. In particular, we would like to work with you in this on-going analysis so that if and when CMS proposes such a DRG refinement that we do not learn about the specifics for the first time as we read the NPRM.

We assume that such analysis will include an assessment of the impact of any proposed DRG refinement methodology on different categories of hospitals. Obviously we are very concerned about the impact on Catholic hospitals and the communities we serve. We also assume the evaluation process will thoroughly exam how these proposed changes would achieve the goal of leveling the playing field between full service community hospitals and single service specialty hospitals.

Finally, given your advance notice of caution as regard the potential impact of this change on hospitals, we encourage CMS to build in an extended phase-in period of at least five to six years.

New Technology Payments
Section 503 of the Medicare Modernization Act provided new money for add-on payments for new medical services and technologies under the inpatient PPS, and lowering the cost threshold for new technologies to qualify for new technology payments. CHA is disappointed CMS is proposing to reject all eight applications for new technology payments (six new and two reevaluations) and only maintain payment for one currently approved technology. CHA would ask CMS to reconsider its decision to increase the marginal payment rate for new technology to 80 percent rather than 50 percent, which it has the administrative discretion to do.

Critical Access Hospitals; Proposed Policy Change Relating to Designation of CAHs as Necessary Providers

CHA urges that CMS delete the timing thresholds from the criteria used to determine whether a relocated CAH with a grandfathered necessary provider designation should be allowed to retain such a designation.

Background. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) terminated, effective January 1, 2006, a State's authority to waive the location requirements for a CAH by designating the CAH as a necessary provider. CAHs that were designated by a State as necessary providers prior to January 1, 2006 would be grandfathered. However, the statute does not address the situation where the CAH is no longer the same facility due to replacement, relocation, or cessation of business.

In light of this, CMS is proposing a two-part test to determine whether a CAH designated by the state as a necessary provider before January 1, 2006 and which relocates after January 1, 2006 may retain such designation.

Part 1—Determination of the Relocation Status of CAH.

1. Replacement in the Same Location. CMS proposes, in situations in which the replacement of a CAH is at the same location or on land that is within 250 yards of the current CAH, that the necessary provider designation would continue to apply regardless of when the construction work commenced and was completed. Such a replacement of the same provider is not considered relocation.

2. Relocation of a CAH. CMS wants to ensure that the provider who relocates (i.e., does not build at the same location or within 250 yards of the existing location) is essentially the same provider in order to operate under the same provider agreement. If CMS determines a rebuilding of the facility in a different location to be a relocation, the provider agreement would continue to apply to the CAH at the new location.

3. Cessation of business at one location. If the CAH relocation results in the cessation of furnishing services to the same community, CMS would not consider this to be a relocation, but instead would consider it a cessation of business at one location and establishment of a new business at another location.

Part 2—Relocation of a CAH Using a Necessary Provider Designation to meet the Conditions of Participation (CoP) for Distance.

If CMS determines that a CAH has relocated, in order to retain its necessary provider designation it must meet several proposed conditions:

1. The relocated CAH must have submitted an application to the State for relocation prior to the January 1, 2006 sunset date.

2. Such an application must include:

    a. Demonstration that the CAH will meet the same State criteria for the necessary provider designation that were established when the waiver was originally issued.

    b. Assurances that after the relocation the CAH will be servicing the same community and will be operating essentially the same services with essentially the same staff. This would require the CAH to demonstrate that it is servicing at least 75 percent of the same service area, with at least 75

percent of the same services offered and staffed by 75 percent of the same staff.

c. Assurances that the CAH will remain in compliance with all of the CoPs in the new location.

d. And, a demonstration that construction plans were "under development" prior to the effective date of MMA—December 8, 2003.

The requirement that a CAH with a grandfathered necessary provider designation must have submitted an application for a relocation prior to January 1, 2006, and that it must also be able to demonstrate that construction plans were "under development" prior to the passage of the MMA (December 8, 2003) in order to retain such a designation does not adequately reflect the real world pressure confronting such CAHs.

Consider a typical example: A CAH with a necessary provider designation that is still five or more years from the need to replace itself. Such a CAH wouldn't have undertaken development plans by December 8, 2003, or submitted a relocation application to the state by January 1, 2006. Yet it is committed to serving essentially the same community with generally the same service profile provided by essentially the same staff. The problem confronting the hospital and the community it serves is that without the necessary provider designation it would no longer qualify as a CAH and hence the higher Medicare reimbursement rates. Such a consequence would obviously have to be weighed in balance with other replacement factors, but the loss of the higher Medicare reimbursement could make the relocation economically unfeasible. The loss to the community of a new facility would arbitrary deny the rural community the quality of care benefits such a new facility would bring.

Limiting the continuation of the necessary provider designation to only those CAH that replace themselves (as opposed to relocating) essentially takes away the option for these facilities to relocate at a different site, regardless of the fact that such a relocation could enhance the availability and accessibility of the CAH's necessary health care services to the Medicare beneficiaries in the communities it serves. Such a perverse incentive would also mean that the accessibility of the CAH's health care services would be severely limited, if not unavailable during the time it takes to build the on-site replacement facility. Construction of a new facility can take up to two years.

And then there is the unique situation in which a town is relocated as part of a flood control project by the Army Corps of Engineers. Such a situation is currently facing Our Lady of the Way Hospital in Martin, KY. Under the CMS proposal, because the move is still a few years away, the CAH would fail to meet the timing conditions for development of the plans and application to the state thus losing its necessary provider designation. The hospital cannot survive without the small payment improvements provided by the CAH. And there will always be unique situations across the country.

Finally, the proposed time line conditions unfairly penalize CAHs that have delayed replacement plans due to poor financial resources that the recently improved CAH payment policies were designed by Congress to address.

Accordingly, we urge that CMS delete the timing thresholds from the criteria used to determine whether a relocated CAH with a grandfathered necessary provider designation should be allowed to retain such a designation. We feel the remaining conditions will more than adequately ensure that such CAHs are not moving to new markets without seeking new CAH approval.

Outliers; Accurate Projections of Outlier Spending
The statute requires that outlier payments for any year are projected to be not less than 5

percent nor more than 6 percent of total operating IPPS payments. Since the inception of the IPPS, outlier payments as a proportion of total operating IPPS has varied above and below this standard, sometimes significantly. CMS has recently taken two steps to reduce this variability—one addressed the problem stemming from how a hospital specific cost-to-charge was determined and the second provided a more timely methodology for determining the outlier threshold. As a result of these changes, in August 2004 CMS finalized an FY 2005 IPPS outlier threshold of $25,800 after proposing $35,085 in the May 18, 2005 FY 2005 IPPS NPRM. In the FY 2006 IPPS NPRM CMS estimated that outlier payments for FY 2005 would be approximately 4.4 percent of actual DRG payments.

For FY 2006, using an even more timely methodology (compared to the methodology used for determining the FY 2005 threshold) for determining the outlier threshold, CMS proposes that the FY 2006 outlier threshold be set at $26,675. If finalized, this proposed threshold would be a 3.4 percent increase compared to FY 2005. CMS projected that this proposed threshold would result in outlier payments that would equal about 5.1 percent of total DRG payments.

In light of the new threshold determination methodology along with a preliminary CMS estimate that FY 2005 outlier payments will be about 4.4 percent of total DRG payments, we are concerned that the proposed FY 2006 outlier threshold will again result in total outlier payments for FY 2006 that are less than 5.0 percent of total DRG payments.

Accordingly, CHA urges CMS to better ensure that the proposed outlier threshold more closely results in outlier payments that meet the statutory requirements in terms of total DRG payments of at least 5 percent but no more than 6 percent.

Medicare Definition of a Hospital in Connection with Specialty Hospitals
Pursuant to this component of the proposed rule, CHA commends CMS's decision (announced by Dr. McClellan at a May 12, 2005, congressional hearing) to suspend, for at least six months, the issuance of new Medicare hospital provider numbers to limited-service hospitals while the agency reviews its procedures for evaluating such requests. The goal is to ensure limited-service hospitals fully meet the Medicare definition of a hospital.

CHA is hopeful these steps by CMS will help protect community hospitals' ability to provide a full range of services, including critical emergency care as well as provide a safety net for the uninsured.

In closing, CHA thanks you for the opportunity to comment on the proposed hospital inpatient Prospect Payment System rule. We look forward to working with you on the above issues.

Sincerely,

Michael Rodgers
Interim President and CEO