

June 18, 2010



Marilyn Tavenner  
Acting Administrator  
Centers for Medicare & Medicaid Services  
Department of Health & Human Services  
Room 445-G  
Herbert H. Humphrey Building  
200 Independence Avenue, SW  
Washington, DC 20201

REF: CMS-1498-P

RE: Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Fiscal Year 2011 Rates.

Dear Ms Tavenner:

The Catholic Health Association of the United States (CHA) is pleased to submit these comments on CMS's proposed rule entitled *Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Fiscal Year 2011 Rates; Effective Date of Provider Agreements and Supplier Approvals; and Hospital Conditions of Participation for Rehabilitation and Respiratory Care Services Medicaid Program: Accreditation Requirements for Providers of Inpatient Psychiatric Services for Individuals under Age 21*, Federal Register Vol. 75, No. 85, pages 23851- 24362 (May 4, 2010). We appreciate your staff's ongoing efforts to administer and improve the payment systems for acute inpatient hospital services and long-term care hospital services, especially considering the agency's many competing demands and limited resources.

- **Proposed FY 2011 Medicare-Severity Diagnosis-Related Group (MS-DRG) Documentation and Coding Adjustment.**

**Background:** In order to correct for any overpayments made as a result of documentation and coding changes in connection with the transition to Medicare-Severity Diagnosis-Related Groups, the Transitional Medical Assistance, Abstinence Education, and Qualifying Individuals Programs Extension Act of 2007 (P. L. 110-

90) required the Centers for Medicare & Medicaid Services (CMS) to make prospective adjustments of negative of 0.6 percentage points in FY 2008 and negative 0.9 percentage points in FY 2009 for a cumulative FY 2009 prospective adjustment of 1.5 percentage points. CMS now estimates, however, that the actual documentation and coding increase in FY 2008 was 2.5 percent and in FY 2009 was 2.9 percent, so that the total effect from documentation and coding increases CMS believes to be unrelated to real changes in case mix for FY 2009 was 5.4 percent.

P.L. 110-90 also requires CMS to recover excess payments made as the result of the documentation and coding changes. CMS reports that the total amount of excess payments to be recovered is 5.8 percent – or about \$9.1 billion plus interest. This reflects the sum of 1.9 percent, the amount by which the 2.5 percent actual increase found by CMS for FY 2008 exceeded the 0.6 percent prospective adjustment for that year, plus 3.9 percent, the amount by which the cumulative increase of 5.4 percent found by CMS for FY 2009 exceeded the 1.5 percent cumulative prospective adjustment made for that year.

CMS now proposes to recover about one-half of the overpayments by reducing the IPPS standardized amounts by 2.9 percentage points in FY 2011.

**Discussion. CHA opposes the adjustments that CMS propose to make to the standardized amounts pursuant to P. L. 110-90.** P.L. 110-90 requires the Secretary to make adjustments in FY 2010 to 2012 based on the difference between the actual documentation and coding-related increase occurring in FY 2008 and FY 2009 and the prospective adjustments of 0.6 percent and 0.9 percent which were applied under the legislation in the respective years. To determine the adjustment for FY 2011, CMS used primarily claims data from FY 2009 and adhered to the methodology followed in analyses for the proposed and final rules for FY 2010. CHA is disappointed that CMS did not revise its methodology to address the issues that other commenters raised during the FY 2010 rulemaking. CHA is particularly concerned that CMS makes no allowance for real case-mix increase as required by the statute.

The draft rule for FY 2011 sets out a large proposed cut to adjust for additional payments made due to alleged changes in documentation and coding that occurred when CMS changed to the Medicare-Severity Diagnosis-Related Group (MS-DRG) grouper for determining inpatient PPS payment amounts. CMS proposes a 2.9 percent cut to recoup half of the payments made in FYs 2008 and 2009 that CMS claims were due to documentation and coding changes that did not reflect real changes in case mix. The determination of the amount to be recovered is dependent on what CHA believes to be a flawed methodology that attributes none of the increase to real CMI change. Existence of an upward trend in real case-mix would be expected as the Medicare population ages and as less severely ill cases are treated in ambulatory settings but CMS ignores this effect despite numerous indicators confirming it. We urge CMS to modify its methodology to account for the historical trend in case mix growth.

CMS states that the increase in payments it found could not be due to “real” case-mix change because its analysis looks at only one set of patient claims, and was run through the old and new groupers. However, we believe that an increase, as calculated in this manner, cannot be deemed entirely to be a change in documentation and coding because, again, the analysis only looks at

one set of patient claims, which by definition are coded identically. Analyzing a single year of claims is not an appropriate methodology for determining whether there was a change in documentation and coding practices relative to prior years. The change in case-mix from one year to the next comprises three components: real change in the distribution of patients' diagnoses and procedures, change in documentation and coding of patients with the same diagnoses and procedures, and change introduced by technical differences in the new grouper compared to the prior grouper. The CMS methodology of using the old and new grouper on the same claims data cannot determine what portion, if any, of the change is real. CMS departs from its same data/two grouper methodology to determine the portion of the change that is caused by technical differences in the groupers.

To properly evaluate whether and to what extent the introduction of the MS-DRGs changed hospitals' coding practices, CMS must consider historical trends by analyzing multiple years of patient claims.

Additionally, CMS should compare the predicted to the actual growth rate in CMI from FY 2007 to FY 2009.

CHA believes that if CMS conducts this analysis, it will demonstrate that a significant portion of the change CMS found and attributed to documentation and coding is actually the continuation of the historical trend in case mix growth, rather than the effect of documentation and coding changes due solely to MS-DRG implementation.

The American Hospital Association (AHA) and other commenters on the FY 2010 proposed rule presented analyses of historical data demonstrating that there is a pattern of steady annual increases of 1.2 to 1.3 percent in real case mix. We believe that these results remain valid and that these findings and conclusions would be validated by CMS in a comparable analysis. We note that CMS' contradictory inference that real case mix declined was based on a residual analysis and not a direct determination. We urge CMS to conduct additional analyses exploring case-mix trends.

In the FY 2010 final rule CMS presented a table of total case-mix change from 2000 to 2007 ranging from -0.7 percent to +1.4 percent and argued that the low and negative increases call into question the assertion that real case-mix growth is a steady 1.2 to 1.3 percent per year. CHA is concerned that CMS dismissed the issue raised by commenters in a preemptory manner without conducting more robust analyses of its own preliminary and inconclusive findings.

CHA notes that it is impossible to ascertain exactly which portion of the case-mix increase experienced during the implementation of MS-DRGs is due to changes in the acuity of patients versus changes in documentation and coding. While CMS attempted reasonable analyses to differentiate between the two, CMS did not directly study changes in patient acuity and real case mix and instead established a conclusion concerning real case mix using an inference based on its estimate of documentation and coding and total case-mix change. CHA believes that this conclusion is not robust and that it is contradicted by many other indicators suggesting an

upward trend in real case-mix due to changes in patient acuity over time. CHA urges CMS to consider these indicators because we believe they confirm that real case mix is increasing. Accordingly, we believe that a smaller portion of the increase in case-mix should be attributable to documentation and coding than CMS has proposed.

**In summary, CHA joins other commenters in strongly urging CMS not to implement its proposed FY 2011 cut of 2.9 percent to recoup half the alleged overpayments made in FYs 2008 and 2009.** The proposed cut is based on a flawed analysis and is substantially overstated. An unwarranted cut of this magnitude would significantly and negatively impact our member hospitals' ability to provide high-quality patient care while meeting new demands for health information technology and delivery system reform.

- **Reporting of Hospital Quality Data for Annual Hospital Payment Update**

Under the Reporting of Hospital Quality Data for Annual Payment Update (RHQDAPU) program, hospitals that do not meet requirements for reporting specific quality information for a payment year receive a 2 percentage point reduction in that year's inpatient hospital payment update factor.

#### Quality Measures for FY 2011 – Elimination of One Measure

The quality measures to be used for the FY 2011 payment determination under the RHQDAPU were finalized in the FY 2009 IPPS final rule, totaling 46 measures. CMS now proposes to retire one of those measures, the AHRQ composite measure on Mortality for Selected Surgical Procedures, leaving 45 measures that will be used for FY 2011 payment determinations. CMS indicates that following NQF evaluation of the AHRQ composite surgical mortality measure in June 2009, the AHRQ issued guidance indicating that the measure is not recommended for comparative reporting due to significant evidence gaps. CMS thus proposes to retire this measure, meaning that it will not be calculated for the FY 2011 payment determination or displayed on the Hospital Compare website.

In addition, in response to a CMS request, some commenters recommended 11 measures for retirement for varying reasons. As CMS noted, seven of these measures were recommended for retirement based on their performance being uniformly high nationwide, with little variability among hospitals.

**CHA supports this proposal and recommends that similar attention be focused on the eleven other RHQDAPU program measures reported by CMS as being recommended for retirement by commenters in the FY 2010 IPPS final rule (75 *Federal Register* 43865).**

#### Proposed Expansion Plan for Quality Measures for the FY 2012, FY 2013 and FY 2014 Payment Determinations

In the proposed rule for FY 2011 IPPS/LTCH-PPS, CMS departs from its past practice of identifying quality measures for a single payment year, and instead proposes a three-year plan

for expanding quality measures required under RHQDAPU. The nature of RHQDAPU necessitates identifying the quality measures on an advanced basis, but CMS has only ever done so for a single year. Now, CMS proposes quality measures for FY 2012, FY 2013 and FY 2014 payment determinations. In taking this multi-year approach, CMS believes hospitals will have greater certainty in planning to meet future reporting requirements, and CMS will have more time to prepare the infrastructure to collect data on the measures and make payment determinations.

**CHA supports the proposed expansion of the timeline for identifying quality measures from one-year to three-years. Such an expansion, assuming no intervening changes, should indeed provide greater certainty for hospitals in their planning process.**

#### General Discussion of Adding Quality Measures.

With respect to adding measures generally, CMS cites its continued interest in expanding and updating quality measures while minimizing reporting burden, use of registries as an alternative to direct hospital submission of data for RHQDAPU, and the possible use of electronic health records (EHRs) and all-payer claims data in the RHQDAPU program.

**CHA strongly supports CMS' focus on minimizing the reporting burden of the current as well as proposed addition of quality measures on hospitals. We note that if all of the proposed measures are adopted, absent the future retirement of any measures, the RHQDAPU measures set for FY 2014 would total between 63 and 78 quality measures, depending on the respective hospital's chosen registry topic. At the minimum this would be a 40 percent increase and at the maximum this would represent over a 73 percent increase from what is proposed for FY 2011.**

#### Use of Registry Measures in RHQDAPU and Implications for Public Reporting

In the FY 2011 proposed rule for the IPPS/LTCH PPS, CMS proposes that hospitals be required to choose one of the four topic areas and report the identified measures to a qualified registry. Hospitals would direct the registry to calculate the measure results and release the results and other required information to CMS for the RHQDAPU program. Data reporting for all of these measures would begin with January 1, 2011 discharges and CMS would provide a list of qualified registries prior to that date.

While we appreciate that CMS is looking for alternatives to reduce the reporting burden on providers, we do not believe this is the way to accomplish that goal, CHA has consistently expressed concerns about the use of registries. We are concerned that the proprietary nature of private registries could diminish the transparency of the program. Public reporting of quality measures is only meaningful if the measures used are reliably comparable across all reporting institutions, which requires that institutions follow identical data collection protocols that are well specified. Consistent, identical data collection processes can only occur if the measure

reporting and calculation mechanism is transparent and understood by all participants and by the public at large.

We are also concerned that adding data submissions through registries will place yet another data abstraction burden on hospitals, even if they are already participating in the required registries.

In addition, we remain concerned regarding the possibility that hospitals, particularly small and rural facilities may be required to participate in proprietary registries in the future. These hospitals simply do not have the resources to participate in registry-based data collection initiatives. Our smaller and rural hospitals view these proprietary registries as costly and labor intensive because many registries require chart abstraction. Further, we are concerned that while registries may be useful for monitoring quality, many data field collected by registries are not related to quality measures.

**For these reasons, CHA urges CMS to reconsider the proposed mandated use of proprietary registries in the RHQDAPU program.**

#### Meaningful Use and RHQDAPU

The proposed rule acknowledges the overlap between the RHQDAPU program and the HITECH Act (Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (ARRA) (P.L. 111-5), together with Title XIII of Division A of the ARRA). CMS says that the RHQDAPU program and the HITECH Act have “. . . important areas of overlap and synergy with respect to the reporting of quality measures using electronic health records (EHRs).” CMS went on to say that it believed that “. . . financial incentives under the HITECH Act for the adoption and meaningful use of certified EHR technology by hospitals will encourage the adoption and use of certified EHRs for the reporting of clinical quality measures under the RHQDAPU program.”

The HITECH Act authorizes payment incentives under Medicare for the adoption and use of certified EHR technology beginning FY 2011 (October 1, 2010). Hospitals are eligible for these payment incentives if they meet requirements for meaningful use of certified EHR technology, which include reporting on quality measures using certified EHR technology. Yet, according to the NPRM, CMS anticipates that the testing of accepting data from EHRs on certain quality measures will not begin, at the earliest, until the summer of 2011. Given the imagined lead time of such testing, including the collection and synthesis of appropriate data, and the tabulation of results could take well into the following year – well after the payment incentives availability date. Thus, through no fault of their own, hospitals may be denied the opportunity to participate in the new program.

**CHA urges CMS to ensure that the expansion and development of quality measures in both RHQDAPU and the “meaningful use” program under HITECH be coordinated and consistent.**

Marilyn Tavenner

June 18, 2010

Page 7

In closing, thank you for the opportunity to share these comments in regard to the proposed FY 2010 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.

Sincerely,

A handwritten signature in black ink that reads "Michael Rodgers". The signature is written in a cursive style with a long horizontal flourish extending to the right.

Michael Rodgers  
Senior Vice President  
Public Policy & Advocacy