



A Passionate Voice for Compassionate Care

June 20, 2011

Donald M. Berwick, M.D., M.P.P.
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-1518-P

RE: 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 Fiscal Year 2012 Rates; Proposed Rule

Dear Dr. Berwick:

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 2012 Rates*. *Federal Register* Vol. 76, No. 87, pages 25788 – 26084 (May 5, 2011).

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.

CHA does, however, have concerns about several aspects of the proposed rule.

- **Proposed FY 2012 Medicare-Severity Diagnosis-Related Group (MS-DRG) Documentation and Coding Adjustment.**

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 0.6 percentage points in FY 2008 and negative 0.9 percentage points in FY 2009 for a cumulative FY 2009 negative prospective adjustment of 1.5 percentage points. CMS subsequently determined however that it believes 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. 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.

In the final FY 2011 rule, CMS recovered about one-half of the overpayments by reducing the IPPS standardized amounts by 2.9 percentage points in FY 2011. This reduction was a one-time, temporary adjustment that is to be restored to the FY 2012 standardized amount.

For FY 2012 CMS, using the same calculations that it applied in rulemaking for FY 2011, has again determined that the appropriate prospective adjustment for fiscal years 2008 and 2009 is negative 5.4 percentage points, of which an adjustment of negative 1.5 percent has previously been applied, leaving a negative 3.9 percentage points adjustment that CMS says is required to eliminate the full effect of documentation and coding changes on future payments. In addition, CMS again estimates that a total retrospective adjustment of negative 5.8 percent is required for recoupment of payments made in FY 2008 and 2009. Half of this amount (2.9 percentage points) was applied to payments for FY 2011.

Combining the remaining prospective and retrospective adjustments, CMS finds a remaining negative adjustment totaling 6.8 percentage points (\$6.3 billion) is required. Under the proposed rule, the bulk of the remaining documentation and coding adjustment estimated by CMS would be made in FY 2012. Specifically, CMS proposes that an additional negative 3.15 percent prospective adjustment be applied to the standardized amounts for FY2012, along with a 2.9 percentage point cut to recover payments made in FYs 2008 and 2009 which will offset the restoration of the FY 2011 2.9 percentage point reduction in the standardized amount.

CHA is deeply concerned about the harmful effects of these cuts on hospitals and believes CMS is using a flawed methodology that has overstated the effect of documentation and coding changes, and therefore cannot support CMS' proposed adjustments to the standardized amount.

P.L. 110-90 requires the Secretary to make adjustments in FYs 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 negative 0.6 percent and negative 0.9 percent which were applied under the legislation in the respective years. To determine the adjustment for FY 2012, CMS adhered to the methodology followed in analyses for the proposed and final rules for FY 2011. CHA is disappointed that CMS did not revise its methodology to address the issues that we and other commenters raised during the FY 2010 and FY 2011 rulemakings. CHA is particularly concerned that CMS makes no allowance for real case-mix increase as required by the statute.

The draft rule for FY 2012 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 MS-DRG grouper for determining IPPS payment amounts. CMS proposes a negative 3.15 adjustment to the payment rates for future years and a 2.9 percent cut to finish most of the recoupment 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 this amount is based 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.

The American Hospital Association (AHA) and other commenters on the FY 2010, FY 2011 and now the FY 2012 IPPS/LTCH proposed rules 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 again 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 negative 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.

We would like to again point out that it is not possible 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.

We also draw your attention to the study and report by a nationally recognized expert on health economics and payment policy which corroborated that CMS' methodology is flawed. Joseph P. Newhouse, Ph.D., the John D. MacArthur Professor of Health Policy and Management at Harvard University and Faculty Research Associate of the National Bureau of Economic Research, as reported by AHA, found that the methodology CMS has employed cannot separate documentation and coding effects from the true case-mix change because it uses claims data alone. Dr. Newhouse says that "[w]hat can be determined from claims data alone is an estimate of the *combined* effect of documentation and coding and true change, but the size of the estimated combined effect is sensitive to whether one uses initial or final year groupers in the calculation. . . . I believe looking at the problem as one of calculating index numbers allows one to calculate values that one can interpret as upper and lower bounds on the sum of the documentation and coding and true case mix change."

In summary, because the proposed cut is based on a flawed analysis and is substantially overstated CHA again joins other commenters in opposing CMS' proposed FY 2012 cuts to address increases related to documentation and coding changes. 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.

- **Proposed Hospital Readmissions Reduction Program.**

In this rule, CMS is proposing that the readmission measures for three conditions, Acute Myocardial Infarction (AMI), Heart Failure (HF) and Pneumonia (PN) be used for the Hospital Readmission Reduction Program under section 1886(q) of the Act, as added by Section 3025 of the Affordable Care Act. That section establishes the "Readmission Reduction Program" effective for discharges from an "applicable hospital" beginning on or after October 1, 2012, under which payments to certain hospitals will be reduced to account for excess readmissions. The statute requires that measures used in the program be endorsed by the NQF and exclude readmissions unrelated to the prior discharge, planned readmissions or transfers to another hospital.

CMS proposes to implement the readmissions reduction program over two years. This year's IPPS rulemaking addresses the conditions and readmissions for the program's first program year FY 2013, the readmission measures and methodology for calculating the readmission rates and payment adjustments, and public reporting of the readmissions data.

CMS proposes to adopt, without revision or modification, the exclusions for unrelated admissions set forth in the existing NQF-endorsed measures.

- AMI readmission measure. The measure does not count as readmissions admissions after discharge that include PTCA or CABG procedures, unless the principal discharge diagnosis for the readmission is heart failure, acute myocardial infarction, unstable angina and cardiac arrest.
- HF and PN readmission measure. Because during the development of the IQR measures, clinical experts did not identify planned procedures as occurring commonly after admissions for HF or PN, there are no exclusions for these diagnostic measures of readmissions.

CHA does not believe CMS has met the statutory requirements concerning excluded readmissions. While CMS asserts that the three NQF-endorsed readmission measures have exclusions for certain unrelated admissions when determining the number of readmissions under the measures that are adequate to satisfy the statute, we do not agree. The AMI measure does include a limited set of exclusions, but the HF and PN measures do not. CMS has also proposed to exclude transfers to other hospitals and discharge against medical advice. This very narrow set of exclusions is not consistent with the legal requirement or the goal of the payment policy.

CHA supports policy aimed at reducing excess, preventable readmissions. However it makes no sense to target planned, necessary readmissions or admissions unrelated to the prior hospital stay. For example, staged surgeries or admissions for chemotherapy, trauma, burns, end stage renal disease, maternity, and substance abuse should always be excluded. By definition, these are not preventable readmissions. **We urge CMS to identify and exclude both common planned readmissions for the proposed measures (and do the same for measures added in the future) and admissions for conditions unrelated to the initial hospital stay, as required by the statute.**

- **Hospital Inpatient Quality Reporting (IQR) and Value Based Purchasing (VBP) Programs**

CHA appreciates that CMS has taken a longer view for the IQR program, articulating principles for measure selection and using a multi-year approach to proposing the addition of measures to the program. The number of quality programs and measures that hospitals must meet is growing rapidly. CHA supports this focus on quality, and urges CMS to continue to work to harmonize these requirements to ensure that they are successful in improving quality of care received by patients without imposing on hospitals unduly burdensome reporting requirements. **Alignment of the measures used in Medicare programs such as IQR, value based purchasing, EHR meaningful use, and accountable care organizations, and coordination with the objective of the National Quality Strategy, are essential.**

Measures used in quality programs should include adjustment methods that reflect all factors relevant to the patient mix. CHA believes that these factors should include age, race, sex, socioeconomic status, severity of illness, and the type of services involved. The measures used in quality performance programs must reflect the reality and needs of our increasingly diverse population. Care must be taken to avoid unintended consequences, such as exacerbating existing care disparities or decreasing access to care for the uninsured or vulnerable populations. Risk adjustment methodologies should not put at a disadvantage hospitals with special challenges, such as high disproportionate share hospitals. **CHA recommends that CMS develop risk adjustment methodologies for the IQR, VBP, and readmissions programs that appropriately incorporate all relevant beneficiary characteristics and demographic and socioeconomic factors.**

CHA has concerns about the inclusion in the IQR and VBP programs of the Medicare spending per beneficiary efficiency measure. First, we believe the proposed assessment period of three days pre-discharge to 90 days post-discharge is too long as a measure of hospital efficiency. While CHA strongly supports efforts to improve care transitions and to hold providers accountable for patient outcomes, not all spending during this lengthy time period is under the hospital's control. **We recommend CMS consider a post-discharge time period for the Medicare spending measure that is more likely to encompass a genuine connection to the quality and efficiency of the hospital care received by the beneficiary.** Second, as articulated above, we believe **all measures should be adjusted for appropriate demographic and socioeconomic factors**, including age, sex, race and severity of illness. This must be done in a manner that ensures that these factors are considered appropriately without inadvertently contributing to existing disparities in care. Finally, we note that the ACA requires measures in the VBP be posted on Hospital Compare for one year prior to a performance period. Given that the proposed performance period for this measures begins May 15, 2012 and there has been, to our knowledge, no posting on Hospital Compare, **CMS should delay adopting the proposed efficiency measure for the hospital IQR and VBP programs until the appropriate measure specifications and risk adjustors can be thoroughly developed, tested and NQF endorsed.**

- **Proposed Adjustment in Light of Court Decision in Cape Cod v. Sebelius.**

The rural floor budget-neutrality adjustment was the subject of a recent District of Columbia Court of Appeals decision in *Cape Cod Hospital, et al. v. Kathleen Sebelius, Secretary, United States Department of Health and Human Services*. The Court of Appeals remanded the matter to CMS. While CMS indicates the remand proceedings are not complete, it has included a proposal in response to the decision to allow for comment. CMS proposes to increase the standardized amount by 1.1 percent and to increase the SCH and MDH hospital-specific rates by 0.9 percent to correct the methodology previously used. **CHA is pleased with CMS' proposal to remedy this problem in accord with the Court of Appeals' ruling. We believe this is the correct policy outcome. However, we urge the agency to identify and release the methodologies and data necessary for hospitals to verify the agency's calculation of the 1.1 and 0.9 percent**

Dr. Donald M. Berwick

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corrections. CMS has asked for comments on this proposal, however, the hospital community needs the appropriate methodology and data in order to make informed comments on the details of the proposal.

In closing, thank you for the opportunity to share these comments in regard to the proposed FY 2012 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. If you have any questions about these comments or need more information, please do not hesitate to contact me or Kathy Curran, Senior Director Public Policy, at 202-721-6300.

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 and Advocacy