Catholic Health Association of the United States

A Passionate Voice for Compassionate Care

June 25, 2012

Ms. Marilyn Tavenner
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-1588-P

Re: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2013 Rates; Hospitals' Resident Caps for Graduate Medical Education Payment Purposes; Quality Reporting Requirements for Specific Providers and for Ambulatory Surgical Centers: Proposed Rule

Dear Ms. Tavenner:

The Catholic Health Association of the United States (CHA) is pleased to submit these comments on the Centers for Medicare & Medicaid Services' (CMS) proposed rule entitled *Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2013 Rates; Hospitals' Resident Caps for Graduate Medical Education Payment Purposes; Quality Reporting Requirements for Specific Providers and for Ambulatory Surgical Centers.* (77 *Federal Register* 27870-228192, May 22, 2012).

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 offers the following comments on several aspects of the proposed rule.

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

CHA strongly opposes the adjustments to the FY 2013 standardized amounts that CMS proposes to make due to alleged changes in documentation and coding following implementation of

Medicare-Severity Diagnosis-Related Groups (MS-DRGs). In its rulemaking in every year since implementation of MS-DRGs, CMS has claimed that all increases in case-mix have been due solely to changes in documentation and coding, and not to any changes in patients' actual severity of illness. As a result, CMS has cut nearly $10 billion out of hospitals' payments over the past five years, asserting that these reductions represent overpayments due solely to coding inflation. CMS' adjustments ignore analyses and comments made by the Medicare Payment Advisory Commission (MedPAC) and by CHA and other hospital associations. They also ignore the fact that more and more patients are successfully treated in outpatient settings, meaning that those who are admitted to hospitals as inpatients are more severely ill.

To avoid and correct for overpayments due to documentation and coding changes in connection with the transition to MS-DRGs, the Transitional Medical Assistance, Abstinence Education, and Qualifying Individuals Programs Extension Act of 2007 (P. L. 110-90) required 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. The statute also directed CMS to determine the actual changes in documentation and coding that occurred during FY 2008 and FY 2009 and if they differed from the 0.6 and 0.9 percentage point adjustments that were applied prospectively, to make additional adjustments to the standardized amounts for subsequent fiscal years in order to eliminate the effect of coding or classification changes. Finally, the law instructed CMS to recover any overpayments made as a result of coding and documentation changes.

Using claims data for FYs 2008 and 2009, CMS estimates that the actual documentation and coding increase in FY 2008 was 2.5 percent and in FY 2009 was 2.9 percent, in both cases greater than the adjustments actually made in those years. CMS has reduced the standardized amount in subsequent years to adjust for this difference gradually, and proposes to complete the prospective portion of the statutorily required adjustments by applying a -1.9 percent adjustment to the standardized amount for FY 2013 to fully account for the documentation and coding effects that CMS believes occurred in FY 2008 and FY 2009.

CMS also estimated the amount of overpayments that occurred due to the documentation and coding changes exceeding the 0.6 percent prospective adjustment in FY 2008 and the 1.5 percent cumulative prospective adjustment in FY 2009. CMS adjusted for this in two steps, making one-time temporary adjustments of 2.9 percentage points in FY 2011 and FY2012 to fully recoup the overpayments. Because of the temporary nature of the FY 2012 reduction, CMS proposes to restore 2.9 percentage points to the standardized amount in FY 2013.

For FY 2013, CMS also proposes to apply an additional adjustment to account for documentation and coding changes that it believes occurred in FY 2010. Using an analysis similar to that applied in previous years' rulemaking to examine case-mix index changes occurring in FY 2008 and FY 2009, CMS analyzed case-mix index changes in FY 2010. CMS reports that the analysis showed an estimated increase in documentation and coding-related case-

mix index of 0.8 percentage points in FY 2010 and proposes a prospective adjustment of – 0.8 to the standardized amount in FY2013 to eliminate this increase.

CHA believes CMS has used and continues to use a flawed methodology that has overstated the effect of documentation and coding changes and is deeply concerned about the harmful effects of the payment cuts on hospitals. The proposed adjustments for FY 2013 again adhere to the methodology followed in analyses for the proposed and final rules for FYs 2011 and 2012. CHA is disappointed that CMS did not revise its methodology to address the issues that we and other commenters raised during rulemaking for FY 2011 and FY 2012. CHA is particularly concerned that CMS makes no allowance for real case-mix increase as required by the statute.

CMS' determination of the extent of documentation and coding is based on what CHA believes to be a limited, narrow 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. CHA urges 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 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 to supplement the analyses on which CMS relies. We again urge CMS to conduct additional analyses exploring case-mix trends.

CMS has 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 findings. CMS did not consider that the hospital associations' analyses used a constant grouper in each year in order to make comparable year-to-year comparisons. CMS, on the other hand, determined the case-mix in each year using that year's grouper.

CHA would like to again point out that 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. This also is the conclusion of the Medicare Payment Advisory Commission (MedPAC), as stated in its comment letter to CMS on the FY 2012 proposed rule.

In its comment letter on the FY 2012 proposed rule, MedPAC stated that CMS may have overestimated the documentation and coding effect by as much as 0.36 percentage points.

Independent analyses of the hospital associations conclude that CMS' overestimate of the extent of documentation and coding change in FYs 2008 and 2009 is at least 1.8 percentage points. CHA strongly urges CMS to make corrections in the FY 2013final rule. For FY 2013, CMS proposed a net documentation and coding adjustment to the FY 2013 standardized amounts of 0.2 percentage points.[1] After correction for CMS' overestimate of the extent of documentation and coding change in FYs 2008 and 2009, the final rule should apply a net adjustment to the standardized amounts of .92 percentage points to 3.6 percentage points, as shown in the table below. **CMS should accept the conclusions reached by MedPAC and the independent hospital analyses and for the FY 2013 final rule should determine the exact adjustment that would be appropriate consistent with these analyses and conclusions.**

	Lower Bound of CMS Overestimate	**Upper Bound of CMS Overestimate**
Amount of CMS overestimate of required statutorily required recoupment for FYs 2008 and 2009	.36 percentage points	1.8 percentage points
Amount of CMS overestimate of required statutorily required prospective adjustment due to documentation and coding changes in FYs 2008 and 2009	.36 percentage points	1.8 percentage points
Subtotal (combined recoupment and prospective adjustment overestimates)	.72 percentage points	3.6 percentage points
CMS documentation and coding adjustment in FY 2013 proposed rule	0.2 percentage points	0.2 percentage points
FY 2013 coding adjustment after correction	0.92 percentage points	3.8 percentage points

While CMS attempted reasonable analyses to differentiate between real case-mix change and documentation and coding-related change, 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 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.

[1] This is the result of adding the three proposed adjustments: final prospective adjustment for FY2008-FY2009 (-1.9), the proposed prospective adjustment for FY 2010 (-0.8) and the restoration of the one-time temporary recoupment adjustment (+2.9).

In summary, because the proposed reductions for FY 2013 are based on a limited analysis and are significantly overstated, **CHA joins other commenters in opposing CMS' proposed FY 2013 cuts to address increases related to documentation and coding changes. CHA also strongly urges CMS to apply a correction of 0.92 to 3.8 percentage points as described above. Unwarranted reductions 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.**

- **Sole Community Hospitals**

Generally, classification of a hospital as an SCH remains in effect unless a change specified in regulations occurs or unless the hospital becomes aware of a change that would affect its status. Failure to report a change will result in retroactive loss of SCH status to the date of the change or the hospital's awareness of the change, subject to reopening rules. CMS notes that its regulations do not address circumstances where a hospital that never met the criteria was nonetheless granted SCH status, and CMS proposes to clarify what it describes as its current authority to make the withdrawal of SCH status for such a hospital retroactive for the entire time period of its SCH classification, again subject to reopening rules. **We believe that retroactive loss of status is only appropriate in cases where a hospital knowingly accepted an inappropriate SCH designation. However, if the hospital was not aware that SCH status was mistakenly granted at the time it received that determination, revocation of improperly granted SCH status should be prospective only.**

- **Labor and Delivery Beds in Disproportionate Share Hospital and Indirect Medical Education Payments**

CHA does not support the proposal to include labor and delivery beds in the count of available beds used in the indirect medical education (IME) calculation. While we acknowledge CMS' general practice of treating the counting of beds and patient days similarly, we believe labor and delivery services should be an exception, as is the case with healthy newborn nursery services. This differentiation is justified because Medicare does not generally pay for women undergoing labor and delivery services.

We do not object to the inclusion of labor and delivery patient days in the calculation of the Medicare DSH formula because the DSH Patient Percentage (DPP) is greatly dependent upon Medicaid inpatient days and Medicaid covers a large portion of labor and delivery services. Given the large percentage of Medicaid births, and the fact that the DSH percentage is based on Medicaid patient days, it is sensible to include labor and delivery patient days in the DSH calculation.

However the inclusion of labor and delivery beds in the calculation of the Medicare IME formula is a different matter. The IME adjustment is based on a hospital's ratio of residents-to-beds. Including labor and delivery beds in this Medicare adjustment is unreasonable, because Medicare

pays for less than 1 percent of all births. We urge CMS to maintain the current policy established in the FY 2010 final rule, including labor and delivery patient days in the DSH calculation and but excluding labor and delivery beds from the IME calculation.

The estimated reduction in IME payments detailed in the proposed rule of $170 million and the corollary reduction in resident to bed ratio will put hospitals and patient care at risk at a time when many teaching hospitals are already struggling.

- **Proposed Hospital Readmissions Reduction Program**

In the FY 2010 rule, CMS finalized the readmission measures for the 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 adopted, 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 reiterates its concern that CMS has not 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.

In responding to comments on the FY 2012 proposed rule, CMS acknowledged that there could be additional readmissions that properly might be excluded from the readmission measures, and stated that it would further explore whether there are any such readmissions. CMS indicated that if it determined that changes should be made to the measures used for the readmissions reduction program in FY 2013, it would bring them to NQF for review for continued endorsement and would subsequently propose revisions in future rulemaking. **CHA urges CMS to fulfill this commitment and to identify and exclude both common planned readmissions for the proposed measures (and do the same for measures added in the future) as well as admissions for conditions unrelated to the initial hospital stay, as required by the statute**.

CHA also is concerned that CMS' methodology for risk-adjusting the readmissions measures is inadequate and would disadvantage hospitals serving a high percentage of low-income patients by imposing unnecessary and inappropriate payment reductions. CMS should include additional patient characteristics beyond the medical diagnosis, age and gender currently included in the NQF-endorsed risk adjustment methodology. **CHA believes that patient race, language, life circumstances, environmental factors, and socioeconomic status (SES) should be included in the risk-adjustment methodology because these factors also have an impact on health outcomes.** Absent these adjustment factors, the readmissions reduction program may disproportionately affect hospitals serving the most disadvantaged and vulnerable patients and could exacerbate existing disparities in health care.

The proposed rule includes a table showing the projected impact of the readmissions reduction program by decile of disproportionate share (DSH) patient percentage and demonstrates that hospitals with the highest levels of low income patients would experience greater reductions under the program. We are concerned that the table underestimates this effect and urge CMS to recalculate it. **CHA urges CMS to include an adjustment in the final rule to ameliorate this unwarranted and unintended negative effect on DSH hospitals**. Such an adjustment should be adopted in FY 2013 while CMS works to improve the risk-adjustment methodology. For future years, we urge CMS to consider a patient-level adjustment based on dual-eligible status as a proxy for socioeconomic status.

- **Base Operating DRG Payment Amount**

Under both the Readmissions Reduction program and the Value Based Purchasing program, required payment adjustments are made based on a hospital's base operating DRG payment amount. CMS has proposed to define this term in the same way for both programs, as wage-adjusted operating payments excluding per the statute adjustments for indirect medical education (IME), disproportionate share (DSH), outliers, low-volume hospitals, and additional payments made due to status as a sole community hospital or Medicare-dependent small rural hospital. Using its discretion, CMS proposes to include new technology add-on payments in the payments

that are adjusted as these are additional payments for specific technologies provided as part of the service that will eventually be captured in the DRG weight itself. **CHA supports the exclusion of IME, DSH, outliers, low-volume adjustment, additional payments made due to status as a sole community hospital per the law, and the inclusion of new technology add-on payments, in the definition of base operating DRG payment amount.**

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

CHA supports the proposed removal of 17 measures from the IQR program, namely the eight Healthcare Acquired Condition (HAC) measures recommended for removal by the Measure Applications Partnership (MAP), eight measures from the Agency for Healthcare Research and Quality (AHRQ), and one clinical process of care measure. We agree with CMS's analysis that the specific measures proposed for removal are redundant with others included in the IQR program, or in the case of the HACs, with other policies that tie Medicare payment to the HAC measures.

CMS proposes to add questions to the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey in three areas: care transitions, admission through the emergency department, and mental health status. While CHA supports collecting information on these topics in principles, we believe CMS should provide additional information before including the proposed questions.

Care transitions are a critical part of patient care, and an appropriate topic for the HCAHPS survey. However, before adopting these specific questions we request the CMS release additional information on their relationship to patient outcomes. Adjusting properly for patient mix is very important to ensuring that the HCAHPS survey results represent meaningful comparisons of patient experience of care across hospitals, and we are particularly concerned that admission through the emergency room be included in the patient mix adjustors, since this is a factor that has been associated with meaningful differences in HCAHPS results. However, collecting this information through a patient survey is not ideal, and we ask that CMS provide details in the final rule regarding the testing and validity of the proposed emergency room question. The proposed addition of a question on mental health status, if properly designed and validated, could be beneficial for use in adjusting for patient mix given evidence that patients with depression symptoms appear to correlate with lower HCAHPS scores. Before including this topic in HCACPS however, CHA requests that CMS provide evidence that the question proposed answers the intended question and is systematically related to scores.

Several measures have been proposed for addition to the IQR program beginning with the FY 2015 payment determination. Three rely on the same risk adjustment system that is used for the current readmission measures for heart attack, heart failure, and pneumonia. These are the measures of complications for elective total arthroplasty of the hip or knee, readmissions for

elective total arthroplasty of the hip or knee, and hospital-wide readmissions. As noted earlier, CHA is concerned that the current risk adjustment methodology is inadequate and does not take into account patient characteristics and socioeconomic factors that increase readmission rates for hospitals serving a high percentage of low-income patients. In addition, the two readmission measures do not differentiate between related and unrelated admissions and the hip or knee readmission measure does not exclude planned admissions. We appreciate CMS' efforts to remove some planned readmissions from the hospital-wide measure and urge them to take a similar approach with all readmission measures. **For these reasons, CHA does not support the addition of the three proposed new risk-adjusted claims based measures until the risk adjustment methodology is improved. We do support addition of the proposed measure of elective delivery prior to 39 weeks gestation, which reflects a broad consensus regarding a standard of care to improve birth outcomes.**

With respect to the VBP Program, CHA opposes the addition of the Medicare spending per beneficiary measure to the program in FY 2015. This measure has not been endorsed by the National Quality Forum or recommended by the MAP for inclusion in the VBP, and the statute provides CMS with flexibility as to the timing of the addition of such a measure. Substantively, we continue to be concerned that the assessment period from 3 days prior to admission through 90 days post discharge is too long as a measure of hospital efficiency. While it is appropriate to hold hospitals accountable for care transitions, not all spending during this lengthy period is under the control of the hospital. Moreover, we believe that all outcomes measures should be adjusted for appropriate demographic and socioeconomic factors, including age, sex, race and severity of illness. This measure does not meet that test. Again, this measure should not be included in the VBP Program until all these issues are addressed.

CHA does not support the domain weights proposed for the VBP Program in FY 2015. First, we do not support the addition of the Medicare spending per beneficiary measure as noted above. As we have commented in the past, we believe that a patient experience of care domain weight of 30% is too high given evidence that patients who are sicker, with longer stays, and those with depression symptoms correlate with lower HCAHPS scores. While we agree that improving patient outcomes is the ultimate goal of quality improvement efforts like the VBP Program, the limited measures proposed for inclusion in in the outcome domain for FY 2015 do not justify the proposed 30% weighting factor. The value of the clinical process of care measures should not be understated in light of the limitations of the outcome measures at this early stage of the VBP Program. We also urge CMS to reduce the weight given to the outcomes domain because we believe the baseline and performance periods for the mortality measure are too short. CMS should revise the measure for future years and at the least assign the measure a lower weight. **Therefore, we recommend that the final rule exclude the efficiency domain for FY 2015, reduce the weights for the HCAHPS 20%, reduce the weight for the outcomes domain to 15% and give a weight of 65% to the clinical process of care domain.**

For FY 2016, CMS proposes to reconfigure the VBP Program domains from four domains (Clinical Process of Care, Patient Experience of Care, Outcomes, and Efficiency) to six domains

that follow the National Quality Strategy: (NQS) Clinical Care; Person- and Caregiver-Centered Experience and Outcomes; Safety; Efficiency and Cost Reduction; Care Coordination and Community/Population Health. CHA supports the NQS and appreciates the value of constructing VBP Program domains that parallel system-wide quality improvement goals. In particular, we believe that hospitals have an important role to play in promoting improvements to community and population health. However, it is still early in the development of the VBP Program and the proposal would re-shuffle existing VBP Program measures into different domains, which would lead to unpredictable VBP scores even if the performance of all hospitals on all measures was unchanged. At the same time, there are insufficient measures available to support the six-domain construction. The population health domain would be empty, and the efficiency and patient domains would have only one and two measures, respectively**. We recommend that CMS postpone consideration of the alternative six-domain structure for a future year after hospitals have experience with the VBP Program and a more comprehensive set of measures has been adopted.**

CHA supports an increase in the minimum cases needed for a hospital to receive a score on the mortality measures from 10 to a number between 25 and 50, based on the analysis summarized in the proposed rule. While hospitals should not be unnecessarily excluded from the VBP Program, the case minimums need to be high enough to assure that scores reliably displaying differences in performance among hospitals on the quality measures. While ideally hospitals should have sufficient cases to have scores on all domains, the proposal to set a two-domain minimum for hospitals to receive a total score under the VBP Program for FY 2015 is acceptable. We suggest, however, that CMS monitor how many hospitals would be excluded from the program if an all-domain minimum were established and include this information in future rulemaking so that the appropriate minimum number of domains can be reconsidered based on program experience.

CMS proposes to use a subregulatory process for two separate purposes in the IQR and VBP Programs. In one case, a subregulatory process would be used to update measure specifications when they are changed by the NQF during its update process. If the NQF made substantial changes to the nature of the measure, these would be considered through the rulemaking process. In the second case, CMS proposes to use a subregulatory process to update performance periods and performance standards under the VBP Program, using methods finalized during rulemaking.

CHA appreciates the constraints imposed on CMS by relying on the annual Medicare inpatient hospital notice and comment rulemaking process and the potential benefits to hospitals for having measure updates and performance periods adjusted in a timely fashion. **However, we have concerns about the proposed use of subregulatory processes, which by their nature lack the transparency and opportunity for industry input provided under rulemaking.** CHA can support a sub-regulatory process with respect to truly minor NQF-related updates if CMS ensures a transparent process with adequate warning to hospitals and monitors for any resulting arbitrary effects on hospitals total performance scores. Significant measure changes

should continue to be made through notice and comment rulemaking, and guidance given on how CMS will determine a change to be minor or significant.

With respect to the proposed use of a subregulatory process for establishing performance periods for VBP Program measures, we believe that this is a significant element of the VBP program that should be determined under rulemaking procedures to ensure public input, especially given that the program is just being implemented for the first time. If the timing of the annual inpatient hospital rulemaking cycle is the impediment, perhaps CMS should consider whether there are other options for accomplishing rulemaking on these elements.

Thank you for the opportunity to share these comments in regard to the proposed FY 2013 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,

Michael Rodgers
Senior Vice President
Public Policy and Advocacy