



## Arizona Hospital and Healthcare Association

June 16, 2011

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Administrator  
Centers for Medicare & Medicaid Services  
Hubert H. Humphrey Building  
200 Independence Avenue, S.W., Room 445-G  
Washington, DC 20201

***RE: CMS-1518-P, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals, Proposed Rule (Vol. 76, No. 87), May 5, 2011***

Dear Dr. Berwick:

On behalf of our more than 104 member hospitals and other health care organizations, the Arizona Hospital and Healthcare Association (AzHHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) hospital inpatient prospective payment system (PPS) proposed rule for fiscal year (FY) 2012. While we support a number of the proposed rule's provisions, including the rural floor budget neutrality adjustment, we are concerned about other proposals, such as the documentation and coding adjustment, and the readmissions proposal. We support the comments made on this proposed rule by the American Hospital Association (AHA) in their recent comment letter to you dated June 8, 2011.

### **MS-DRG DOCUMENTATION AND CODING ADJUSTMENT**

#### **Lower Proposed Documentation and Coding Cut.**

The proposed rule includes a continuation of FY 2011's 2.9 percent recoupment cut, as well as an additional 3.15 percent permanent cut to eliminate what CMS claims is the effect of documentation and coding changes the agency says do not reflect real changes in case-mix. **This represents a total proposed coding cut of 6.05 percent to Arizona hospitals, or approximately \$156.7 million for FY 2012.** Specifically, the large cut CMS has proposed would lead to a negative net update for FY 2012. However, when the 2.9 percent FY 2012 recoupment cut is restored in FY 2013, this may lead to a large positive net update for FY 2013. One of the fundamental values of a prospective payment system is the ability of providers to reasonably estimate payments in advance to inform their budgeting, marketing, staffing and other key management decisions. CMS' proposal conflicts with this value and is a significant departure from the more transitioned approach it has used in the past to phase in documentation and coding cuts.

We urge CMS to use its policy discretion to significantly lower its proposed documentation and coding cut in order to avoid inappropriate volatility in inpatient PPS rates.

The American Hospital Association (AHA) also conducted analyses (referenced in their June 8 comment letter to you) concluding that much smaller documentation and coding adjustments are necessary than what CMS has both implemented in the past and proposed for the future. These AHA analyses indicate that much of the change CMS found is actually the continuation of historical increases in the case-mix index (CMI), not the effect of documentation and coding changes due to the implementation of the Medicare severity diagnosis-related groups (MS-DRGs). Thus, CMS' proposed cut is also excessive in light of these historical trends, and should not be implemented.

**Conduct analysis of case mix change using medical records.**

AzHHA also concurs with the detailed analysis conducted by AHA and other experts that asserts the methodology CMS used to determine the effect of documentation and coding changes on the FYs 2008 and 2009 CMIs is fundamentally flawed. We do not believe that analyzing a single year of claims is the correct methodology for determining whether there is a change in the documentation and coding practices relative to prior years. First, if claims data is used, trends should be analyzed using multiple years of data. Second, the best way to distinguish documentation and coding changes from true case mix change is actually to analyze medical records. We recommend that CMS conduct analyses to better estimate actual case-mix change by pulling a random sample of hospital medical records from different years and having coders blindly code the services using the coding standards that were in effect during the dates of service. Since the coders presumptively use one standard (the current standard) of coding during any specified year, this method holds coding practices constant and indicates the amount of real case-mix change.

**PROPOSED RURAL FLOOR BUDGET-NEUTRALITY ADJUSTMENT IN LIGHT OF COURT DECISION IN CAPE COD V. SEBELIUS**

**Provide Complete Explanation of Rural Floor Budget Neutrality Adjustment.**

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*. In its ruling, the Court of Appeals remanded the matter to CMS. In response, CMS proposed rules to increase the standardized amount by 1.1 percent and to increase the sole community (SCH) and Medicare-dependent (MDH) hospital-specific rates by 0.9 percent. We are pleased that CMS has proposed to remedy this problem in accordance with the Court of Appeals' ruling. In the interest of transparency, **AzHHA now urges CMS to release the methodologies and data necessary for hospitals to verify the calculation of the 1.1 and 0.9 percent corrections.** Hospitals need a more complete explanation of precisely

how CMS performed that calculation as well as the data sources it used. We ask CMS to explain which data are not available and describe the assumptions, extrapolations or other methods it used to assess the impact of the prior errors in rural floor budget-neutrality adjustments.

## **HOSPITAL READMISSIONS REDUCTION PROGRAM**

*The Patient Protection and Affordable Care Act (ACA)* mandates that CMS implement a program beginning in FY 2013 under which hospitals with higher than expected readmission rates would see reductions in their Medicare payments. It also mandates that reductions be based on the number of "excess" readmissions at the hospital, with a cap that would limit penalties in the first year of the program to 1 percent of the hospital's base operating Medicare payments.

Specifically, CMS proposes to use the three currently reported 30-day readmission measures for heart attack, heart failure and pneumonia. The ACA directs CMS to exclude from the measures readmissions that are unrelated to the prior discharge, such as planned readmissions and transfers. The measures proposed in the rule, however, are not a complete list—there is a very limited set of planned readmissions related only to an original heart attack admission. **CMS did not exclude any readmission measures related to heart failure and pneumonia in its proposed rule, and therefore the proposed rule does not comply with the statutory requirement.**

### **Conduct a Valid Readmissions Study to Identify Planned and Unrelated Admissions.**

As hospitals are engaged in efforts to reduce their readmission rates, they discover that there are many reasons for planned readmissions to the hospital, either related or unrelated to prior admissions. However, individual hospitals are limited in their ability to delve into this data because they only have access to records for those patients who return to their own facilities for a readmission. They cannot examine data for patients who seek further care elsewhere. CMS has access to all the hospitals' data needed to conduct a deep analysis of all Medicare readmissions. **We urge the agency to conduct a thorough study to determine the common reasons for planned readmissions for heart attack, heart failure and pneumonia patients and determine a subset of readmissions that are unrelated to a patient's initial admission for the condition.** AzHHA understands that conducting a valid readmissions study to identify planned and unrelated readmissions may not be finalized prior to FY 2013. In light of this, we suggest several interim steps that CMS could take to improve the readmission measures:

- *Always exclude certain patients from the readmission measures.* Patients with diagnoses of cancer, trauma, burns, end-stage renal disease, psychiatric disorders and substance abuse issues, as well as rehabilitation patients, should always be

excluded from the readmission measures. Such patients are highly likely to return to the hospital for a readmission due to the nature of their conditions.

- Adopt a coding modifier on hospital claims to identify planned readmissions. CMS should implement a new modifier on the hospital claims form to identify planned readmissions. Hospitals would use the modifier to indicate whether a patient's readmission was a planned hospital stay.
- Use existing classification schemes to identify related readmissions. Several existing classification schemes could be used to identify related and unrelated readmissions while CMS undertakes a more systematic study. CMS could consider related readmissions to be any readmission for which the patient's primary diagnosis falls within the same MS-DRG or major diagnostic category as the diagnosis for the initial admission.

## HOSPITAL QUALITY DATA

*The Deficit Reduction Act of 2005 (DRA)* expanded quality reporting requirements for hospitals to be eligible to receive a full market-basket update. The DRA also provided the Secretary with the discretion to add quality measures that reflect consensus among affected parties and replace existing quality measures on the basis that they are no longer appropriate. In the proposed rule, CMS includes four new measures for the FY 2014 annual payment determination and 17 measures for the FY 2015 annual payment determination. To receive a full market-basket update, hospitals would have to pledge to report data on these and all measures currently included in the hospital inpatient quality reporting (IQR) annual payment update program and pass the established data validation tests.

### **Align quality data reporting measures to reduce hospital reporting burden.**

We appreciate that CMS has articulated its principles for selecting measures for the IQR and the hospital value-based purchasing (VBP) programs. We note that the **number of quality measures on which hospitals must report to CMS is growing rapidly**, not only for the inpatient and outpatient quality reporting programs, but for the meaningful use requirements and the voluntary accountable care organization program. **We urge CMS to align the measures used for various Medicare programs whenever possible to reduce hospital reporting burden.**

### **Carefully consider any retirement of measures from public reporting.**

For FY 2014, CMS proposes retiring eight measures from the IQR program. Seven of the measures are proposed for retirement because hospitals' scores on the measures are uniformly high, or "topped out." Although these measures are uniformly high across hospitals, they may still be clinically meaningful as part of a measure set, and important

for assessing overall hospital quality and useful for consumers. Just because hospitals score very high on these measures does not make them less relevant as quality measures.

CMS' proposal will not materially lessen the reporting burden to providers because hospitals will still be required to report on other detail measures within in the measure sets containing those measures proposed for retirement. Each measure within a set has only a few unique data elements associated with it. Therefore, even with the retirement of some measures, the bulk of data collection will continue to be required for those topic areas.

We agree that there are appropriate circumstances in which measures should be retired, such as when continued use of the measure may have unintended, negative consequences. However, we believe that universally high scores among providers on a particular measure is not by itself a valid justification to cease public reporting of a measure. **As an intermediate step, we recommend CMS eliminate topped out measures from the hospital Value-Based Purchasing (VBP) program to reduce the scoring compression, but for the time being continue tracking those high-scoring measures in the IQR program and *Hospital Compare*.** CMS should take steps to assess what impact the retirement of a measure may have on care delivery, hospital reporting burden, and public use of quality information.

#### **Refine Healthcare-Associated Infection Measures Further Before Including Them In the IQR.**

CMS proposes to add three measures of healthcare-associated infection, all collected through the NHSN system, to the IQR program for the FY 2015 annual payment update determination. These measures include methicillin-resistant staphylococcus aureus (MRSA) bacteremia rates, Clostridium difficile standardized infection ratio, and health care personnel influenza vaccination rates. AzHHA recommends that CMS further refine these measures before including them in the IQR. Hospitals currently use testing mechanisms of varying sensitivity, which could unfairly portray hospitals that choose the more sensitive testing technology as having more positive cases.

#### **Delay Transition to EHR-Based Data Collection for the IQR.**

In the proposed rule, CMS seeks comment on when hospitals will be ready to transition to EHR-based data collection and submission and suggests that 2015 may be an appropriate year. **However, we do not believe that enough progress will be made in this regard to expect universal data collection through EHRs by 2015 for the IQR program.** Hospitals share CMS' goal of ultimately collecting and submitting quality measures information through EHRs and such a transition should allow for more information to flow with less data collection burden. However, hospitals have informed us that the collection and submission of the clinical quality measures have been one of the most challenging aspects of meeting the stage I meaningful use criteria.

**Shorten the Data Submission Timeframe by Two Weeks, Instead of Four.**

CMS proposes reducing the quality data submission time period to allow for a to-be-determined data correction period. Rather than 135 days, the data submission period would be 104 days. Likewise, the time allotted for hospitals to submit their population and sample size information would be reduced from four months to three months, and the HCAHPS data submission time period would be reduced from about 14 weeks to about 13 weeks. **We suggest as an intermediate step CMS shorten the data submission timeline by two weeks, instead of four. This would build in time for a data correction period while ensuring that hospitals are not overwhelmed by a drastically shortened data collection period.** In addition, this would align the IQR data submission timeline with The Joint Commission's data submission timeline.

**DRGs: HOSPITAL-ACQUIRED CONDITIONS**

**Eliminate the Proposed Addition of Contrast-Induced Kidney Injury as a HAC.**

CMS proposes to add one new condition, contrast-induced acute kidney injury, and five new ICD-9 codes to three of the current HAC categories. We agree that the addition of the five new ICD-9 codes to the existing HAC categories is appropriate. However, **we oppose CMS' proposal to add contrast-induced acute kidney injury as a HAC.** CMS' definition would mean that any patient discharged under a code for acute kidney failure (584.9) who received any kind of kidney scan or other contrast will be assumed to have contrast-induced acute kidney injury. However, this cannot be determined simply from the presence of these codes on a claim. Just because a patient has had a procedure with contrast does not mean that there is an automatic linkage that the contrast is the cause of the kidney problem. Further, our understanding is that acute kidney injury may be a temporary condition, and could be due to many different causes including dehydration, urinary tract obstruction (including benign prostatic hypertrophy) and low blood volume, among other reasons.

**HOSPITAL VALUE-BASED PURCHASING PROGRAM**

**Propose a Performance Period for the VBP Program That Is Consistent With Statutory Requirements.**

The ACA mandates that measures selected for the VBP program be included on the *Hospital Compare* website for at least one year prior to the beginning of the performance period for the fiscal year for which the measure is being added. CMS proposes that the FY 2014 performance period for the efficiency measure would begin on May 15, 2012. Therefore, in order to fulfill its statutory obligations, CMS would have to have posted hospitals' performance on this measure on *Hospital Compare* by May 15, 2011. We are unaware of any such posted information. Therefore, CMS cannot finalize its proposed performance period. **We urge CMS to propose a new performance period that is consistent with statutory requirements.**

In addition, in the VBP final rule, CMS established that the performance period for the eight HAC measures will begin on March 3, 2012, which CMS states is one year after the measures were first displayed on *Hospital Compare*. However, the measures were not displayed on March 3, 2011, they were first displayed on the CMS website on March 31, 2011 and on *Hospital Compare* on April 21, 2011. We urge CMS to correct this error and change the start of the HAC performance period to April 21, 2012.

## WAGE INDEX

CMS proposes to revise its policy for determining pension costs for Medicare wage-index purposes. Specifically, it proposes to generally maintain the current requirement that pension costs must be funded to be reportable and that all hospitals must report actual pension contributions funded during the reporting period on a cash basis. CMS also proposes to include in the wage index pension costs equal to the hospital's average actual cash contributions to the defined-benefit pension plan over a three-year period. This three-year average would then be utilized as the hospital's includable pension cost for purposes of determining the wage index in FY 2013 and beyond. Under this proposal, hospitals would not be treated consistently. Certain hospitals may have overfunded or "pre-funded" pension plans as of the start of the three-year rolling average contribution methodology, while other hospitals are underfunded. The proposed methodology does not include such prefunded amounts in the wage index calculations. Thus, hospitals with pre-funded pension plans would have individual hospital wage indices that were, and would continue to be, understated over the life of the plan. In contrast, hospitals that have underfunded pension plans as of the start of the proposed methodology would have individual hospital wage indices that were, and would continue to be, overstated over the life of the plan.

**Convene a Technical Advisory Group to Recommend Allowable Pension Cost for the Medicare Wage Index.** CMS should take the time to ensure that the changes are appropriate and fair to all hospitals. **We recommend that CMS create a Medicare Technical Advisory Group (MTAG) charged with making recommendations on the most appropriate way to determine the pension costs that should be included in the wage index.** Doing so would allow CMS to obtain extremely important input from the hospital field on a very technical issue. After consultation with the MTAG, the agency should propose a methodology that accurately reflects the total resources hospitals expend over the life of their defined-benefit pension plans and recognizes those costs fully in the wage index. After this policy has been set, CMS should propose a cost-finding methodology that compliments the wage-index methodology. For example, it is possible that CMS will, after seeking input from an MTAG group, recommend that hospitals recognize Generally Accepted Accounting Principles (GAAP) as the appropriate methodology for determining pension costs for Medicare wage-index

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purposes. In that case, for cost-finding purposes, it might be more appropriate to include GAAP pension expenses if funded during the year, or within a 12-month period after year end, and consider any needed modifiers that might be caused by either underfunded or overfunded plans coming into the cost-finding policy.

**Proposed FY 2012 Wage Index Adjustment Based on Commuting Patterns of Hospital Employees.** CMS proposes that, for the FY 2012 wage index, it will calculate the outmigration adjustment using the same formula described in the FY 2005 inpatient PPS final rule, with the addition of using the post-reclassified wage indices. While we do not have concerns about this proposal, we have a concern about its application. If CMS uses the hospital's rural-floor wage index, rather than its post-reclassified wage index, to determine eligibility for the outmigration adjustment it sets up a circular pattern whereas if the hospital is eligible for the outmigration adjustment and accepts it, it then causes its wage index to set the rural floor for the state, which then causes the hospital to not be eligible for the outmigration adjustment anymore. Thus, the hospital loses the outmigration adjustment because it accepted it in the first place. This is not appropriate and causes undue volatility in PPS rates.

**Review Statutory Language Around Lugar Designations.**

CMS' proposal does not solve the Lugar redesignation problem for all hospitals. A minority of Lugar hospitals is not eligible for the outmigration adjustment, and thus, still would not have the ability to waive their Lugar urban status. It defies common sense that hospitals physically located in rural areas have no choice but to be considered urban for Medicare purposes. If a hospital that is physically located in a rural area would like to waive its Lugar urban status in order to be considered rural, which is its true geographic status, it only seems fair to allow that. **Thus, we respectfully request that CMS review the statutory language around Lugar redesignations and reconsider whether the agency has the authority to allow any and all Lugar hospitals to waive their Lugar status for all purposes under the inpatient PPS.**

Thank you for the opportunity to comment on the proposed rule.

Sincerely,



James F. Haynes

Senior Vice President and Chief Financial Officer