MEDPAC Medicare Payment Advisory Commission

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June 23, 2005

Mark McClellan, Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Box 8011
Baltimore, Maryland 21244-1850

Re: File Code CMS-1500-P

Dear Dr. McClellan:

The Medicare Payment Advisory Commission (MedPAC) is pleased to submit these comments on CMS's proposed rule entitled *Medicare Program: Proposed Changes to the Hospital Inpatient Prospective Payment System and Fiscal Year 2006 Rates*, Federal Register Vol. 70, No. 85, pages 23305-23774 (May 4, 2005). We appreciate your staff's ongoing efforts to administer and improve the payment system for acute inpatient services, particularly considering the agency's competing demands. We have comments on several of the issues addressed in the proposed rule, and where applicable we have included the captions specified in the rule.

MedPAC recommendations on physician-owned specialty hospitals

After an extensive analysis of Medicare hospital inpatient claims and cost data, the Commission concluded that the IPPS payment rates are badly distorted, resulting in Medicare paying too much for some types of patients and too little for others. These price distortions and resulting profits send inappropriate signals to hospitals and reward or penalize individual providers based on the mix of patients they treat rather than their efficiency of treatment. We see this as an urgent issue and recommended four payment policy changes that should be implemented to substantially improve Medicare's hospital payments. We also want to be clear that the policies we recommended are not new. All four policies have been described, analyzed, and discussed for at least a decade. Our estimates suggest that adopting these policies would change Medicare inpatient payments for many hospitals. We interpret the impact of these changes as a strong indication of why payment reforms are so urgently needed.

We are pleased that CMS shares our objective of improving the accuracy of the IPPS payment rates. We are concerned, however, that CMS may not go far enough to redress the distortions that we have identified. The menu of analyses that CMS listed in its response to our recommendations is long and broad, raising the risk that some analyses might not be completed in time to support proposals for payment policy changes in fiscal year 2007. Further, CMS's

responses suggest that it did not fully understand one of our recommendations. We discuss our specific concerns below.

Refinement of diagnosis related groups (DRGs)

CMS indicates that it expects to make changes to the DRGs to better reflect differences in severity of illness among patients. It then discusses three options that are under consideration.

Comprehensive review of the comorbidities and complications (CC) list—CMS proposes to make a comprehensive review and revision of the CC list.[1] This may be a desirable improvement. However, we do not expect that even a major revision to the list would greatly improve the extent to which the IPPS payment rates capture the effects of differences in patient severity of illness.

The CC distinction is based only on the presence or absence of any CC, implicitly assuming that all CCs have equal effects on severity of illness and costs. Even if the CC review process were to correctly identify all secondary diagnoses that significantly affect hospitals' costs, our research and CMS's earlier work have shown that simply distinguishing between patients with and without CCs fails to capture large, predictable differences in costs among patients. Further differentiation is necessary to make the most effective use of information about patients' secondary diagnoses and help to minimize opportunities for hospitals to benefit financially from patient selection.

Selective review of DRGs—CMS proposes to review selected DRGs that are overpaid or those with substantial variation in charges per discharge. Focusing on DRGs in which Medicare's payment rates may be set too high would miss the large number of equally problematic DRGs in which payment rates appear to be set too low. Our analysis showed that the problem of differences in relative profitability is widespread among and within DRGs. About two-thirds of the DRGs showed relative profitability ratios that were more than 5 percent higher or lower than the average for all cases in fiscal year 2002. Differences in relative profitability among severity classes within DRGs were often substantially greater than 5 percent. Moreover, using a criterion based on the variation in charges among cases also may not help identify DRGs to revise because most DRGs have substantial variation in charges, partly reflecting unmeasured differences in illness severity among patients.

Evaluation of alternative DRG systems—CMS proposes to examine alternative DRG systems, such as the all patient refined DRGs (APR-DRGs), to better capture severity. However, CMS notes two concerns with making extensive changes in the DRGs. First, adopting an alternative system might improve payment accuracy, but it also could substantially alter the distribution of payments among hospitals. As we stated earlier, we interpret the potential redistribution of payments among hospitals as strong evidence that the current payment system is distorted and

[1] The CC list identifies secondary diagnoses that qualify as comorbidities (coexisting conditions present at hospital admission) or complications (conditions that develop during the stay) that, when present, affect patient severity of illness and are expected to significantly increase the cost of care.

that is why our payment recommendations should be adopted quickly. Maintaining the status quo—especially in the face of evidence that some hospitals benefit from distorted payment rates while others are disadvantaged—should not be an objective.

The Commission recognizes that such payment changes can be disruptive to hospitals. Thus, we recommended that the Congress and the Secretary implement our payment policy recommendations through a transitional period so that hospitals do not face abrupt changes in Medicare payments.

CMS's second concern is that significantly expanding the number of DRGs could lead to changes in hospitals' case-mix reporting that may cause inappropriate increases in Medicare payments. We recognized in our report that major DRG refinements will affect hospitals' reporting and coding behavior in ways that could increase Medicare payments. Under the law, the Secretary has discretion to make a prospective adjustment to the national base payment amounts to offset expected increases in payments resulting from changes in hospitals' case-mix reporting. The Secretary also has the means to carry out this policy by using data from reabstracted medical records that are collected in Medicare's quality assurance program. CMS also has other tools to address this problem, such as:

- Excluding from any refined DRG secondary diagnoses (for example, history of cancer) that might be too easily used to overstate a patient's severity of illness and obtain higher payment,

- Issuing guidance to remind hospitals that diagnoses should be reported on the claim only if they materially affect the course of the patient's inpatient care, and

- Monitoring case-mix changes for individual hospitals and using the measured changes to select hospitals for review and audit of medical records and claims.

We will continue to work with CMS as it considers these and other options for mitigating inappropriate increases in payments resulting from changes in hospitals' case-mix reporting.

Changing the way CMS sets DRG relative weights

CMS raises concerns about each of MedPAC's recommendations for improving the accuracy of the DRG relative weights—using estimated costs instead of charges, calculating weights based on the national average of hospital-specific relative values (HSRV), and adjusting the relative weights for differences in the prevalence of outlier payments across DRGs. While we agree that no method of setting relative weights will be perfect, the current method is far from perfect and must be improved.

Using estimated costs—CMS notes that cost estimates for services must be derived by applying a hospital's average departmental or other cost-to-charge ratios to the associated service charges it reports on its Medicare claims. Cost measurement errors may occur because hospitals report their costs for departments that include many services with potentially different markups and

hospitals differ in the level of departmental detail in their cost reports. As a result, cost estimates may be biased in certain circumstances.

Both charge-based and cost-based relative weights will contain some error because of hospitals' charge-setting practices and the limitations of available data on accounting costs. We conclude, however, that cost-based weights would better track the true relative costliness of DRGs than charge-based weights because one large, systematic source of errors would be removed.

It is clear that hospitals' charges contain substantial error—as a basis for estimating the relative costliness of services or different types of cases—because hospitals' charge markups are highly varied both among and within hospitals.[2] In our survey of hospitals' charge-setting practices, hospitals told us that they often did not look at costs when they were setting charges.[3] Our analysis of hospitals' claims and cost reports shows that average markup levels differ substantially among hospitals. Further, charge markups show a strong pattern among hospital departments, with relatively low markups for routine and intensive care services and high markups for ancillary departments, such as radiology, operating room, laboratories, and supplies. These differences in markup levels will result in varying amounts of distortion in charge-based relative weights at the DRG level, depending on the mix of services typically used in treatment for patients in each DRG.

The available evidence also suggests that hospitals' markups often differ among services within departments. CMS correctly points out that these differences would introduce errors in cost estimates for individual services because hospitals' departmental average cost-to-charge ratios are too high for some services and too low for others. But mark-ups differing among individual services causes the same problem with charge-based weights. The difference is that in the cost-based weights, substantial differences in markup levels across departments are removed, while in the charge-based weights, they are included.

CMS also correctly notes that cost data are not as timely as charges from claims. Thus, estimated cost weights may trail changes in relative costliness more than would charge-based weights. We suggested in our report a method for recalibrating the relative weights that would mitigate the timeliness problem, and reduce the burden of annually re-estimating costs. Under that method, CMS would recalibrate the weights using cost estimates only periodically (for example, every third or fifth year). In each such year, CMS would also calculate charge-based weights and the relationships between the cost-based weights and the charge-based ones. In the intervening years, CMS would use charge-based weights, but adjust them to account for the latest available estimates of the relationship between cost and charge weights.

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[2] See, for example, "California Hospitals Open Books, Showing Huge Price Differences", Wall Street Journal, December 27, 2004, available at http://online.wsj.com/article/0,,SB110410465492809649,00.html

[3] See Worzala, C. and J. Ashby. 2004. Survey of hospital charge-setting practices. Presentation to Medicare Payment Advisory Commission meeting, September 10, Washington, DC. http://www.medpac.gov.

Calculating weights using the national average of hospital-specific relative values—In the hospital-specific relative value (HSRV) method, relative weights are based on the national average of relative values calculated within each hospital. CMS notes that a 1993 RAND study showed some evidence that charge-based weights calculated by the HSRV method were compressed—undervaluing high-cost DRGs and overvaluing low-cost DRGs. The compression observed in this study, however, may not hold today. The RAND study used sample claims data for fiscal years 1985 through 1989. If we are correctly interpreting the results, the inferred compression in the HSRV weights was not caused by the method itself, but primarily by the pattern of cross-subsidies in charge mark-ups by hospitals that performed the majority of major cardiac surgeries. Charge markups, however, were much smaller 15 years ago than they are today and cardiac surgeries were performed by a narrower group of hospitals. Thus, the same results may not hold with current data or with weights based on the HSRV method applied to estimated costs.

We view the HSRV method as an important adjunct to using estimated costs as the basis for the relative weights. Using estimated costs removes distortions in the relative weights caused by differences in hospitals' markups across departments. But the level of costs still differs, sometimes dramatically, among hospitals. The HSRV method removes distortions that arise because certain kinds of cases (sophisticated surgical DRGs, for example) are treated primarily in high-cost hospitals. The HSRV method addresses this problem by removing the effects on the relative weights of differences in the level of charges or costs across hospitals regardless of their source.

Another way to look at it is that the HSRV method is a more effective way (than the current method CMS uses) of removing the effects on the weights of differences in the level of costs or charges among hospitals. CMS's method—standardizing hospitals' charges—accounts for differences in charges that are presumed to be associated with certain payment factors included in the IPPS:

- Market input price levels as measured by the wage index and cost of living adjustment (applied in Alaska and Hawaii);

- Teaching activity as measured by the indirect medical education (IME) adjustment; and,

- Service to low-income patients as measured by the disproportionate share hospital (DSH) adjustment.

Given the known limitations of these factors (particularly that the IME and DSH adjustments are poorly related to the cost impact of teaching and treating low-income patients), standardized charges or costs are likely to be at least somewhat distorted. But even if this method worked perfectly, standardized charges or costs would still differ substantially across hospitals because of differences in hospital costliness.

Adjusting the DRG weights for differences in the prevalence of outlier payments—CMS's discussion of this recommendation suggests some misunderstanding of our proposal. The

Commission recommended that CMS reduce the relative weight for each refined DRG to reflect the estimated prevalence of outlier payments in that category.[4] This policy would replace the current policy of reducing the national base payment amounts by the estimated national average prevalence of outlier payments (5.2 percent), thereby making relative profitability more uniform across DRGs. We determined that removing the current outlier adjustment to the national base payment amounts would require legislation because this adjustment is specifically required in current law.

Under current policy, a single percentage—5.2 percent—is withheld from each DRG payment to form the outlier pool. The policy also calls for a national "fixed-loss" threshold—the amount of loss that any case must exceed to qualify for outlier payments. DRGs with high DRG weights and payment rates tend to have greater variation in costs, making them more likely to meet the threshold and trigger outlier payments. This can lead to differences in profitability across DRGs because DRGs with high weights get more outlier payments than were withheld for them in the outlier pool. DRGs with low weights get lower outlier payments than were withheld.

A related problem is that the high standardized charges for the cases paid as outliers are included in calculating the relative weight for each DRG. Including these very high charges tends to overstate the true relative costliness of typical cases in DRGs that have lots of outlier cases. The overstatement is greatest in DRGs with high weights.

Together, the current policies for financing outlier payments and calculating relative weights create differences in relative profitability among DRGs. These differences in relative profitability, in turn, create opportunities and financial incentives for patient selection and payment inequities among hospitals. Under our recommendation, outlier payments in each DRG would be financed out of the aggregate payments in the DRG. This would reduce the distortion in the relative weights that comes from including the outlier cases in the calculation of the weight and it would correct the differences in profitability that stem from using a uniform outlier offset for all cases. Thus, our recommendation would help to make relative profitability more uniform across DRGs.

Revising the IPPS through a transitional period

As we mentioned above, the estimated impact of our recommendations suggested to us the need for a transition period to cushion the impact for some hospitals that would face substantial changes in Medicare patient revenues. We also recognize that a transition from one DRG payment system to another might be complicated. We will continue to work with CMS to develop ways to mitigate the complexity and burden of a transition mechanism.

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[4] Prevalence of outlier payments is measured by the proportion that outlier payments represent of DRG payments: outlier payments divided by the sum of regular DRG payments plus outlier payment (excluding IME and DSH payments).

Critical access hospitals

On the issue of allowing critical access hospitals (CAHs) to relocate, the rule should provide CAHs with the flexibility to build a new facility within the same community when rebuilding is the most economical option.

The proposed rule states that a CAH will lose its necessary provider status (and cost-based reimbursement) if it relocates to a new location (defined as being more than 250 yards from its current site) unless the new building fulfills all of the following criteria:

- meets the same necessary provider criteria that were in place when the hospital became a CAH;
- serves the same service area;
- improves access to care; and
- was in the process of being developed prior to December 8, 2003.

The last of the four criteria will prevent virtually all CAH relocations that were not underway in 2003. Due to these criteria, a CAH may choose to remodel an aging facility even when building a new facility would be less expensive—just to retain cost-based reimbursement. In addition, the criteria for serving the same service area and improving access appear somewhat vague and cumbersome to administer.

We suggest that CMS adopt alternative criteria for relocations—that the new CAH building must be located:

- within 2 miles of the current location; or
- within 5 miles of the current location provided that the nearest hospital is more than 15 miles away.

These two alternative criteria would require the CAH to continue serving the same community and prevent it from moving significantly closer to another hospital's core market area. The criteria would be much simpler to administer and yet would provide enough flexibility so that hospital boards can find a suitable site for a new facility when new construction is more economical than renovation.

Low-volume hospital payment adjustment

By applying the same percentage adjustment to all hospitals qualifying as low-volume providers, CMS's low-volume adjustment may pay hospitals treating similar numbers of patients quite differently. We believe that a continuous adjustment (that is, one with an adjustment rate that declines as volume increases) would work better, but because few PPS hospitals are receiving

this payment adjustment, we acknowledge that developing a new payment formula will not be CMS's highest priority in the coming year.

The MMA requires CMS to develop an empirically justifiable adjustment formula based on the relationship between hospitals' costs per discharge and volume of discharges. Based on the results of a multivariate analysis, CMS last year adopted a 25 percent adjustment for all hospitals with fewer than 200 all-payer discharges. This year CMS updated its analysis of the effect of discharge volume on Medicare costs per case and also estimated the impact of volume on Medicare inpatient margins. Based on these analyses, the agency proposes to continue the formula adopted last year and to again reevaluate the adjustment based on updated data next year.

The low-volume adjustment should be based on the empirically established relationship between the number of all-payer discharges and Medicare cost per discharge. Reliance on margins analysis appears to have caused CMS to structure the adjustment such that all hospitals below the size threshold receive the same 25 percent adjustment while those above the threshold receive no adjustment. This payment "cliff" would create highly inequitable payment for a hospital with just over 200 discharges compared with one with just under that number, as well as extreme payment changes from one year to the next for a hospital whose discharge volume averages in the neighborhood of 200 discharges. We strongly suggest that CMS adopt a simple linear formula that starts with a 25 percent adjustment at the hypothetical level of one discharge and phases out at some point beyond 200 discharges. This structure, however, should not increase the aggregate level of spending CMS proposes in its NPRM.

It is not necessary to update the analysis and the formula for the low-volume adjustment every year. Measurements of the effect of volume differences on unit costs are sensitive to changes in sample size, and the number of hospitals available for analysis has been dropping steadily due to conversions to the critical access hospital program. The adjustment should reflect the long-term relationship between volume and costs, which should not change significantly from year to year.

Wage index

CMS computes a hospital wage index to adjust Medicare payments for differences in underlying wage levels across the country. A value is computed for each metropolitan statistical area (MSA) in the country and another value for all counties not in MSAs in each state. For 2006, CMS proposes few major changes from 2005 policy. We comment on two policies below.

Occupational mix adjustment

CMS proposes continuing policy from 2005, which uses a blended wage index—10 percent adjusted for occupational mix and 90 percent unadjusted. It also states that ". . . for future data collections, we would revise the occupational mix survey to **allow** hospitals to provide both wage and hours data for each of the employment categories. . ." We support collecting wage as well as hours data—doing so could make the calculation of skill mix and adjustment of hospitals' average hourly wages more straightforward and accurate, as we observed last year.

Therefore, we suggest that CMS require—not allow—hospitals to provide both wage and hours data.

Exclusion of critical access hospital wage data

CMS does not now collect wage data from critical access hospitals (CAHs), and excludes historical data for hospitals now classified as CAHs from wage index calculations. We continue to believe that CAHs should be included in the wage index.

The wage index should ideally reflect the market labor compensation rates faced by all providers offering similar services and employing similar occupations as hospitals covered by Medicare's inpatient and outpatient PPSs. CAHs are similar in these respects to other small rural hospitals, and in many cases they are located close enough to hospitals remaining under prospective payment to compete for the same workers. With five hundred hospitals converting to CAH status in just the last three years, CAHs now dominate the rural labor market in a number of states. In these cases, data from CAHs may become critical to obtaining an accurate representation of rural wage levels, and it is important to remember that this representation determines payments for several other types of providers (skilled nursing facilities, home health health agencies, ambulatory surgical centers, inpatient rehabilitation facilities, and long-term hospitals) in addition to acute care hospitals. Because there is a long lag between when wage and hours data are collected and when they can be reflected in the wage index, CMS should begin to collect the required data from CAHs this year.

Hospital market basket

Section 404 of the MMA requires CMS to revise the market basket weights and the labor share in the market basket to reflect the most current data available more frequently than once every five years. CMS's past practice has been to monitor the appropriateness of the market basket every year and to rebase and revise the index when necessary. CMS's analysis shows that updating the weights more frequently than every five years would make only small differences in its market basket forecasts, and some of the data used (specifically, data from the Bureau of Economic Analysis) are only available on a five-year cycle. Consequently, the Commission concludes that updating the weights more often than once every five years is unnecessary and potentially counterproductive.

Rebasing the market basket requires CMS to devote a significant amount of resources. Given how stable the market basket numbers remain under different base year weights, it seems unproductive for CMS to rebase more often than every five years. In fact, the four-year rebasing schedule CMS proposes could make the market basket weights even more out of date due to the timing of the BEA data. For example, rebasing in a given year could dictate use of old data for the weights that will apply for the next four years, while waiting one more year to rebase would allow much newer data to be used for three of those four years.

In the Commission's view, CMS should rebase the hospital market basket in years that new BEA data become available, combining these data with the most recent Medicare cost report data

available at that time. This essentially means that market baskets would be rebased every five years, unless CMS found some other compelling reason to either revise or rebase the market basket sooner. The Secretary should propose legislation to repeal Section 404 of the MMA requiring the more frequent updating of the market basket.

Hospital quality data

In the MMA, the Congress directed CMS to reduce hospitals' update for services covered by the acute inpatient PPS by 0.4 percent if they fail to report information on the quality of patient care provided to Medicare beneficiaries. MedPAC supports the concept of the Medicare program obtaining more information on quality of care from providers, including hospitals. In our March Report to the Congress this year, we recommended that the Congress establish a quality incentive payment policy for hospitals, and this type of reporting helps build the infrastructure to implement such a program. However, Medicare should not have to financially reward or penalize providers based on whether they report data. It is reasonable for Medicare to expect, as a condition for receiving payments, that information on the quality of care be provided to beneficiaries and the program.

Nonetheless, any system for reporting quality data must ensure that Medicare is able to obtain the best and most useful information possible on hospital quality. Pursuant to that goal, we comment on CMS's proposal for ensuring the reliability of the quality data hospitals report and we suggest that this rule provides an opportunity to require hospitals to report additional data on the hospital claim form that are needed to support quality improvement initiatives.

Ensuring the reliability of quality data

For fiscal year 2005, the first year of mandated reporting, CMS required only that hospitals submit data for the 10 specified quality indicators covering the first quarter of calendar year 2004 by no later than August 1, 2004. For fiscal year 2006, CMS is proposing that hospitals must continuously submit data for the 10 measures on a quarterly basis, achieve an 80 percent reliability score on a chart-audit process, and have at least two consecutive quarters of data published.

We support CMS's efforts to review the data submitted through a chart audit process and to impose stringent standards for data accuracy. Data meeting high standards of completeness and accuracy will be essential to their use in a pay for performance system. We are concerned that a sample of five charts for each hospital may be insufficient to accurately establish the reliability of the data individual hospitals submit. But we plan to wait until the Government Accountability Office completes its analysis of the reliability of the quality data submitted to date before we consider the need for more specific comments on CMS's procedures.

Improving quality data

This rule provides an opportunity for CMS to implement another Commission recommendation that would greatly expand Medicare's ability to measure the safety of hospital care using

administrative data. In our March 2005 Report to Congress, we recommended that CMS require hospitals to identify which secondary diagnoses were present on admission on the inpatient payment claims.[5] The National Uniform Billing Committee has included a field on the UB04 to accommodate this information, and two states already require that hospitals report the information.

Adding information to the claim on secondary diagnoses present at admission would make important data available for a far wider range of quality improvement applications. For example, it would enable a quality measure to distinguish between a patient population that has a high rate of infections when they enter the hospital from a population that frequently acquires infections during their hospital stay.

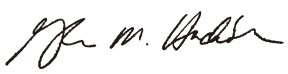
We believe that either the proposed rule on conditions of participation (70 Federal Register 15266, March 25, 2005) or this rule on payment policy could provide an opportunity for CMS to implement this recommendation, and we have suggested it in both contexts.

Conclusion

MedPAC appreciates the opportunity to comment on the important policy problems and proposals crafted by the Secretary and CMS. The Commission also values the willingness of CMS's staff to provide relevant data and to consult with us concerning technical policy issues. We look forward to continuing this productive relationship.

If you have any questions, or require clarification of our comments, please feel free to contact Mark Miller, MedPAC's Executive Director.

Sincerely,



Glenn M. Hackbarth, J.D.
Chairman

[5] On page 4 of this letter, we suggest that as one strategy for dealing with changes in case-mix reporting that inappropriately increase payments after the number of DRGs is expanded, CMS could exclude from any refined DRG secondary diagnoses (for example, history of cancer) that might be too easily used to overstate a patient's severity of illness and obtain higher payment. That approach involves CMS's use of secondary diagnoses in defining DRGs; it would not affect how hospitals report secondary diagnoses on the claims as discussed here.