MEDPAC Medicare Payment Advisory Commission

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Thomas Scully, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
Room 443-G
200 Independence Avenue, SW
Washington, DC 20201

Re: File Code CMS-1470-P

Dear Mr. Scully:

The Medicare Payment Advisory Commission (MedPAC) is pleased to submit these comments on the Centers for Medicare & Medicaid Services' proposed rule entitled *Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2004 Rates*, Federal Register Vol. 68, No. 96, page 27153-27422 (May 19, 2003). We appreciate your staff's ongoing efforts to administer and improve the inpatient prospective payment system (IPPS), particularly considering the competing demands on the agency. We have comments on several of the issues addressed in the proposed rule.

Update to the fiscal year 2004 payment rates

BIPA requires that CMS update inpatient payment rates by the rate of increase in the market basket in FY 2004. Consequently CMS proposes to update IPPS base payment rates by the forecast rate of increase in the market basket in FY 2004, currently estimated to equal 3.5 percent. The Commission recommended an update to inpatient payments equal to the rate of increase in the hospital market basket, less 0.4 percent, for FY 2004. We indicated in our March 2003 report that Medicare payments for all hospital services were adequate in FY 2003. The recommended update reflects expected changes in prices, the impact of the costs of scientific and technological advances that improve quality but increase costs, and expected improvements in productivity. The recommended update would increase payments for services covered by the IPPS by 3.1 percent in fiscal year 2004.

Long-term care hospitals

CMS uses long-term care diagnosis related groups (LTC-DRGs) in the prospective payment system for long-term care hospitals. The LTC-DRGs are based on the DRGs used in the IPPS. CMS therefore links the annual revisions to LTC-DRGs to the reclassification and recalibration of IPPS DRGs reported in the inpatient proposed rule.

CMS proposes to continue using a hospital-specific relative value method to develop LTC-DRG relative weights. This method eliminates distortions in weights due to systematic differences among hospitals in the level of costs per case and in charge mark-ups. The Commission recommended the use of this method for the inpatient PPS in its June 2000 report. We support the use of the hospital-specific relative value method for the long-term care hospital PPS and believe that CMS should explore its use with the inpatient PPS.

Add-on payments for new services and technologies

Section 533 of BIPA requires CMS to develop mechanisms to adequately incorporate and pay for new medical services and technologies under the inpatient PPS. We strongly support the methodology CMS developed for evaluating new technologies in the IPPS as articulated in the final rule published September 7, 2001. Under this policy, interested parties must apply for add-on payments for specific technologies. To qualify for add-on payments, technologies must be new and meet clinical and cost criteria. We agree with the one proposed change in the criterion for determining whether a technology would be inadequately paid under DRG payments.

The proposed rule examines the status of the one technology approved for add-on payments in FY 2003 and evaluates two applications for fiscal year 2004. In the first case, CMS proposes to continue add-on payments in FY 2004. In the second case, CMS concludes that one technology does not qualify for add-on payments because it is not new. It will analyze data from its Medicare Provider Analysis and Review (MedPAR) system to see if the other applicant technology would be inadequately paid under the DRGs based on thresholds for FY 2004 published in the FY 2003 final rule. An application for add-on payments for this technology was denied for FY 2003.

CMS notes that the small number of applications for add-on payments (five in FY 2003, two in FY 2004) may indicate that very few technologies are expensive enough to be considered. It proposes to revise the criterion it will use in FY 2005 to determine whether a technology would be inadequately paid under DRG payments. For FY 2004 it compares the standardized charges of cases involving a new technology with a threshold equal to the sum of the geometric mean and one standard deviation of standardized

charges in the DRG to which the new technology is assigned. It proposes to reduce the threshold for eligibility for add-on payments in FY 2005 from one standard deviation to 75 percent of one standard deviation beyond the geometric mean of standardized charges.

We support the proposal to require that new technologies have costs greater than the mean plus 75 percent of the standard deviation of the standardized charges in the DRG to which the new technology is assigned. The proposed threshold is reasonable and continues to tie eligibility for new technology add-on payments to the distribution of costs within each DRG. This proposal is preferable to lowering the threshold to a specific dollar amount, as proposed by some.

Treatment of rural health centers, Federally qualified health centers, and critical access hospitals in the hospital wage index

We recognize that the hospital wage index is used in the prospective payment systems for inpatient, outpatient, skilled nursing facility, home health, ambulatory surgical center, inpatient rehabilitation, and long-term care hospital services. The wage index should reflect the market labor compensation rates faced by providers offering the same services and employing the same occupations as hospitals. In principle, the index should reflect the level of market labor prices free, as much as possible, of the effects of differences in occupational mix and skill mix.

CMS proposes to exclude wage data for rural health centers (RHCs) and Federally qualified health centers (FQHCs) from the calculation of the FY 2004 wage index. These facilities offer ambulatory care services similar to those of hospital outpatient departments and are likely to draw from the same labor market as hospitals covered by the IPPS. They employ many of the same occupations as acute care hospitals' inpatient and outpatient units. Unless RHCs and FQHCs employ a distinct skill mix within these occupations, it is not clear why CMS should exclude their wage data from the calculation of the FY 2004 wage index.

CMS includes wage data for facilities that used to be IPPS hospitals in the wage index even if they are now critical access hospitals (CAHs). It requests comments on whether it should exclude wage data from such hospitals from the wage index calculation. CAHs offer many of the same services and employ similar occupations as other rural hospitals. To the extent that they pay lower average wages, exclusion of their wage data would increase the wage index value for their market area. CAHs may pay lower average wages because they employ a less complex skill mix than other hospitals. Alternatively, they may have lower market wages because of their location further away from urban areas. It is premature at this time to drop these providers without evidence that the resulting wage index would more accurately capture prevailing market wages.

Expansion of the post-acute transfer policy

Under the inpatient PPS, Medicare treats cases discharged from the hospital to another PPS hospital with shorter than average stays as partial cases, paying a per diem amount for each day, up to the full DRG payment amount. Starting in 1999, the transfer policy was extended to include cases in 10 DRGs that are discharged to post-acute care settings after shorter than average stays.

The transfer payment policy helps to link acute and post-acute payment systems by adjusting inpatient payments when a portion of care is shifted to another setting where Medicare also pays for the beneficiaries' care. This policy also improves hospitals financial incentives to provide quality care. By matching payments more closely to the incremental costs of each day of care, the transfer policy helps to diminish the influence of financial considerations on hospitals' clinical decision-making. This would better allow payments to follow patients and prevent hospitals that do not have access to appropriate post-acute care resources from being disadvantaged.

In its March 2003 report, the Commission recommended expanding the post-acute transfer policy to 13 additional DRGs in the coming fiscal year. CMS proposes to expand the post-acute transfer policy to DRGs meeting three criteria. It proposes to include DRGs where at least 10 percent of cases were transferred to post-acute care prior to reaching the geometric mean length of stay, with a decline in length of stay of at least 7 percent from 1998 to 2003, and with a geometric mean length of stay of at least 3 days. CMS includes both members of paired DRGs that differ in the presence or absence of a complication or comorbidity if at least one DRG meets the criteria. It proposes to expand the transfer policy to 19 additional DRGs. The Commission finds the criteria reasonable and commends CMS for going forward with the next step in expansion of the post-acute transfer policy. CMS should evaluate the results of this change and then consider expansion to all DRGs.

Outliers

CMS announces the proposed value of the fixed loss outlier threshold for FY 2004 based on proposed FY 2004 rules and FY 2002 MedPAR data. The proposed threshold does not reflect changes in outlier payment rules. At the time of publication of the IPPS proposed rule, the proposed rule on outlier payment policies had been published (March 5) but not finalized. The IPPS proposed rule estimates a FY 2004 outlier threshold of $50,645. The IPPS final rule will determine the final outlier threshold for FY 2004 based on the policies adopted in the outlier final rule published on June 9. In estimating the FY 2004 threshold, to the extent feasible CMS should base cost-to-charge ratios on the most recent tentative settled cost reports.

As stated in the Commission's submitted comments on the proposed outlier rule, we concur with CMS's analysis of problems with Medicare's outlier payment methods under the IPPS and generally support CMS's proposed solutions. We commented that CMS should revise the fixed loss outlier threshold for the remainder of FY 2003 in the outlier final rule. CMS noted in the final outlier rule that its current estimate suggested that a revised FY 2003 threshold would be greater than the current threshold and did not revise it.

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 the CMS 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