MEDPAC Medicare Payment Advisory Commission

601 New Jersey Avenue, N.W. • Suite 9000
Washington, DC 20001
202-220-3700 • Fax: 202-220-3759
www.medpac.gov

Glenn M. Hackbarth, J.D., Chairman
Robert D. Reischauer, Ph.D., Vice Chairman
Mark E. Miller, Ph.D., Executive Director

April 19, 2006

Mark McClellan, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Dr. McClellan:

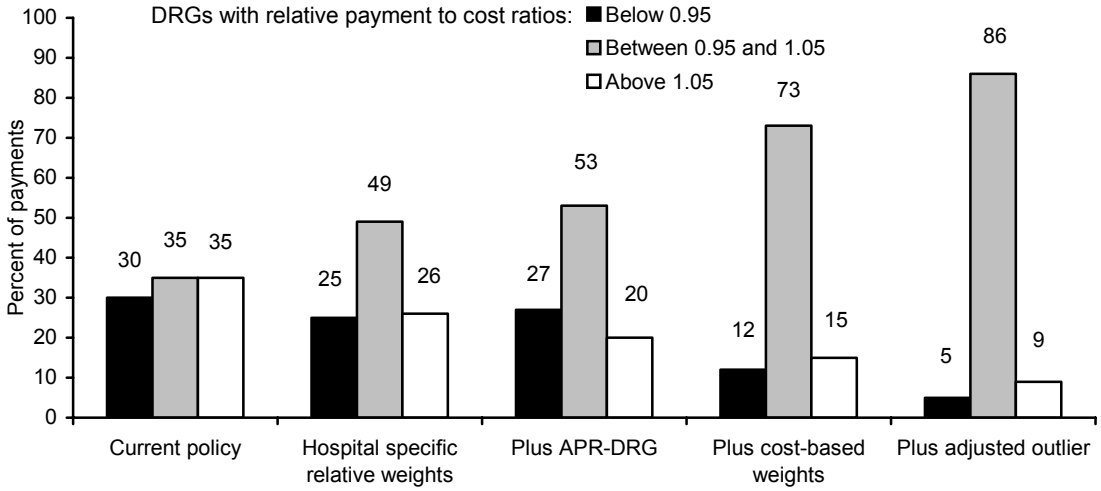
We have completed an initial review of the proposed changes in the inpatient prospective payment system. We will comment more extensively at a later date, but we wanted to provide some initial reactions. Specifically, we wanted to reiterate our strong support for improving the inpatient payment system's ability to accurately compensate providers for the type and severity of the cases they treat.

First, we are pleased that CMS has proposed three of MedPAC's four recommended changes to the inpatient PPS system. We are fully aware that undertaking these significant changes to the payment system will not be easy given CMS's workload. As you know, we recommended four changes to the prospective payment system: cost-based weights, hospital specific relative values, improved severity adjustment, and DRG specific outlier financing. Using cost-based weights and hospital specific relative values will help remove distortions caused by hospital charges that reflect a wide variance in "mark ups" from service to service. We endorse your proposal to adopt hospital specific cost-based weights in FY 2007.

We are also pleased that you have proposed an adjustment to payments for severity. As we illustrated in our 2005 specialty hospital report, the expected profitability of patients currently varies widely based on the severity of the case. For example, we found that for hip procedures (DRG 210) the payment-to-cost ratio for the least severely ill patients (APR-DRG severity level 1) was 4 percent higher than the payment-to-cost ratio for the average Medicare patient. The payment-to-cost ratio for the most severely ill patients (APR-DRG severity level 4) was 36 percent lower than the ratio for the average Medicare patient. Clearly, current payment policies benefit hospitals that focus on less severely ill patients. However, we are concerned that you are proposing to delay the severity changes until FY 2008. It is important to correct for differences in patients' severity concurrently with the corrections for charging distortions.

In fact, we believe that all four of the proposed changes to the IPPS should happen concurrently. As is shown in Figure 1 below, by implementing all four of our payment reforms, the relative profitability of treating different types of patients would become much more uniform.

Figure 1. Improving the accuracy of payments



Note: DRG (diagnosis-related group), APR–DRG (all-patient refined diagnosis-related group).

Source: MedPAC analysis of Medicare hospital inpatient claims and cost reports from CMS, fiscal year 2000–2002

Some have characterized the increases in payments to certain hospitals and decreases to others resulting from the changed payment rates as "unintended". In fact, the redistribution of payments among hospitals is the intended, necessary consequence of correcting the current distortions in the IPPS payment rates. The hospitals that treat cases that are now relatively underpaid should receive an increase in payments while hospitals treating cases that are currently overpaid should receive a decrease in payments. Payment redistributions should not be permitted to forestall needed payment reforms; they reflect the fact that the current system is inaccurate and therefore, unfair to some hospitals.

As Table 1 shows, implementing all four of our policy recommendations in a budget-neutral manner would entail a small (1 to 2 percent) change in payments for most categories of hospitals. The one exception would be physician-owned specialty hospitals.

These hospitals have specialized in types of patients for which Medicare tends to overpay and should receive a significant reduction in their inpatient payments. Within each of the categories of full-service hospitals shown in the table, there would be both winners and losers, reflecting hospitals' unfavorable or favorable mix of patients in light of current payment distortions.

Table 1: Distributional effects of more accurate inpatient payments

Category of hospital	Percent change in payments	Percent of hospitals losing 5% or more	Percent of hospitals gaining 5% or more
Urban	-0.2%	7%	21%
Rural	0.9	6	18
Physician-owned heart hospitals	-9.6	88	0
Physician-owned Orthopedic hospitals	-8.2	77	0
Major teaching	-1.9	15	10
Other teaching	-0.4	8	15
Non-teaching	1.2	6	22

Source: MedPAC analysis of Medicare hospital inpatient claims and cost reports from CMS, fiscal year 2000–2002

It is also important to understand that examining impacts by the traditional category of hospital masks the underlying impacts. Urban hospitals as a group experience a very small reduction (-0.2 percent) in payments, but most urban hospitals would gain. Our analysis suggested that major teaching hospitals' payments overall would decrease by 1.9 percent under our policy recommendations. But 10 percent of major teaching hospitals would experience a 5 percent or more increase in payments while 15 percent would face a 5 percent or more downward adjustment.

The problem of over- and under-payments and the resulting distortions in providers' financial incentives can affect both specialty hospital and community hospital behavior. Our reforms are needed to remove the opportunity for specialty hospitals to profit simply from DRG and patient selection. But, changing payments to specialized hospitals is not enough. Reforms are also needed to correct distortions in the payment systems that affect all hospitals.

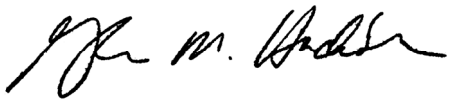
We want to again stress the importance of adopting all four of our recommended policy changes concurrently. Each of our recommendations targets a specific source of distortion in the current payment rates. Failure to adopt any of them would leave some payment distortions in place, thereby continuing to favor some kinds of patients over others. Consequently, we reiterate our previous recommendation that Congress grant the Secretary the authority to address the limitations of the current outlier financing policy. Adopting all of the policies we recommended would create the most accurate payments and prevent hospitals from facing unjustified shifts in their payments that may occur under partial adoption of the payment reforms. Concerns about giving hospitals time to adapt to the changes may be better managed by implementing all four changes in 2007 and then giving hospitals a transition period**.** In the absence of congressional action on outlier legislation, we urge you to move ahead immediately with the changes that can be accomplished through regulation.

We are pleased that you are considering requiring hospitals to report secondary diagnosis present at admission as part of your implementation of Section 5001(c) of the DRA. Identifying secondary diagnoses present at admission is important to ensure that hospitals do not receive additional payment for the specified preventable conditions that develop during the stay. Collecting data on all conditions present on admission for all DRGs is critical to enable Medicare to develop and apply payment adjustments based on the quality of care more broadly. This is important for accuracy of payment and as one component of paying for performance. MedPAC previously (March 2005) recommended that secondary diagnosis present at admission be collected for all Medicare admissions, and we would urge you to include such a requirement in your final rule.

Finally, we want to support your efforts in developing a plan to move forward on hospital pay for performance. As you know, we have recommended a legislative change to allow redistributing a portion of inpatient payments among hospitals that achieve a high level of quality or improve the quality of their care. We believe a sufficient number of accepted quality indicators are available to move ahead quickly on hospital pay for performance.

Thank you for considering our comments.

Sincerely,



Glenn M. Hackbarth, J.D.
Chairman