MEDPAC Medicare Payment Advisory Commission

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July 9, 2004

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

Re: File Code CMS-1428-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 Systems and Fiscal Year 2005 Rates*, Federal Register Vol. 69, No. 96, page 28195-28818 (May 18, 2004). 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.

Long-term care DRGs

CMS uses long-term care diagnosis related groups (LTC-DRGs) in the prospective payment system for long-term care hospitals. The LTC-DRGs use data on patients in long-term care hospitals and are based on the DRGs used in the acute inpatient PPS. CMS therefore links the annual revisions to LTC-DRGs to the reclassification and recalibration of the acute care DRGs reported in this 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. MedPAC recommended the use of this method for the acute inpatient PPS in its June 2000 report. We support the principle of using hospital-specific relative values in establishing DRG weights and believe that CMS should explore this approach for the acute inpatient PPS.

Wage index and geographic reclassification

New definitions of geographic areas

Under current policy, CMS computes a wage index value for each metropolitan statistical area (MSA) and another value for the rest of the counties in each state, which is called the state-wide rural wage index. Based on the 2000 census data, OMB has created new definitions for MSAs and also a new designation, micropolitan statistical area (microSA). CMS proposes that counties in MSAs continue to be given the wage index calculated for their MSA. (For the 11 MSAs that are subdivided into metropolitan divisions, each division would have its own wage index.) Any county not in an MSA would be included in the state-wide rural area. This would include all of the newly defined microSAs as well as any county not in an MSA or a microSA.

CMS points out that microSAs tend to contain only one or two hospitals, which would make separate wage indexes for each microSA more volatile and directly dependent on a single hospital's data. Most microSAs (633 out of 674) were previously classified as rural and will remain in the state-wide rural area. CMS also proposes that hospitals that were in MSAs and now are not (72 hospitals in 46 counties) have the option to retain their prior MSA assignment for three years, FY 2005-7.

The Commission appreciates the difficulty of establishing labor market areas for the wage index and supports the proposal to include microSAs in the statewide rural area. However, the proposal to make an exception for those hospitals previously in an MSA and now in the state-wide rural area should be modified. The current proposal allows such hospitals to choose to retain the wage index of their former MSA for three years before having their new wage index applied. The rationale is that some of these hospitals will otherwise see a large decrease in their wage index and have difficulty transitioning. We have two comments.

Two general payment principles we follow are that hospitals should be treated equitably and large payment changes should be phased in over time. Therefore, CMS should target the exception to all hospitals that see large decreases in their wage index regardless of their previous MSA/non-MSA designation. Second, the change should be phased-in rather than just postponing a large change—for example, averaging in one third of the new value each year. Treating all hospitals the same regardless of their previous geographic designation would be more equitable, and phasing in the change would allow hospitals to transition to the new wage level. We propose that the threshold for "large" decreases be set so the cost of the exception over the transition period equals the cost of CMS's current proposal.

Occupational mix adjustment

CMS proposes to compute occupational mix adjustments for individual hospitals which are then aggregated to produce an adjusted wage index value for each labor market area. Payments in 2005 would be based 10 percent on the occupational mix adjusted wage index values and 90 percent on unadjusted wage index values. Future years might be fully adjusted.

The impetus for adjusting the wage index for occupational mix is that the wage index is intended to reflect relative differences in underlying wages across the country. Without adjustment for occupational mix, the wage index can capture differences arising from some hospitals having a more highly skilled mix of workers than others. If the higher skill mix is because the hospital has more complicated cases, the DRG assignment of the cases should reflect the extra cost. An occupational mix adjustment is intended to remove differences that result from employing higher or lower skilled workers, leaving only differences resulting from underlying wage levels.

The proposal rests on a CMS survey of hospitals that asked for hours of labor in specific categories and skill levels. It did not ask for the associated wages for those categories. The survey reports on 7 General Service Categories (GSCs) and the standard occupational classifications (SOCs) within them. Each GSC has 2-4 SOCs for a total of 19 SOCs. For example, the GSC *Nursing services and medical assistant services* has four SOCs: *RNs; LPNs; nursing aides, orderlies, and attendants; and medical assistants.* The 48 percent of hours represented by these categories is adjusted for skill mix relative to the national average skill mix; the 52 percent of hours not in these categories is not adjusted for skill mix.

CMS is concerned because after all adjustments are calculated, the wage index of 18 rural areas (37 percent) would decrease and 31 (63 percent) would increase. Many observers had expected that almost all rural wage indexes would increase because the nature of the services rural hospitals provide (few specialized surgeries, no ICUs, etc.) requires lesser skilled workers than urban facilities. Therefore CMS only wants to use 10 percent of the adjusted value in the wage index calculation for FY2005.

We have three comments; CMS should:

- modify the survey for the next round to include wage data,
- investigate whether a finer classification of RNs would make the adjustment more accurate, and
- analyze whether using non-hospital reported data (such as BLS or Census data) for the unadjusted hours would improve accuracy.

Collecting wage as well as hours data could make the calculation of skill mix and adjustment of hospital's average hourly wage more straightforward and accurate. For example, assigning a fixed national weight for each occupational GSC as in the proposal can lead to over- or under-adjusting—having wage data could avoid this problem. The adjustment might also be less sensitive to how workers were classified, for example as administrative rather than patient care, because the average wage in an SOC may not be as sensitive to such assignments as the hours might be.

Including all RNs in one category might obscure important differences among sub-categories of RNs. For example, surgical nurses and floor nurses may have different wages. If the mix of RNs varies substantially among hospitals and the differences in wage levels among RN subcategories are significant, the survey may have to ask for a

further breakdown of RNs to allow for a more accurate occupational mix adjustment. Therefore, CMS should investigate this issue to determine whether it is leading to inaccuracy.[1]

The issue of RN mix arises because CMS is concerned that some rural hospitals show a higher than average skill mix. This could be a result of differences in the mix of RNs. On the other hand, the data may be showing that in small rural hospitals nurses have to be capable of multitasking and cross training, because the small size of their patient loads often makes the use of lesser skilled workers (LPNs, nurses aides) impractical. This may result in a higher proportion of RNs in rural hospitals, which in turn increases their measured skill mix. Investigation of these issues seems warranted.

Using data from other sources (such as BLS or Census) to analyze the relative wages of those workers not included in the categories adjusted for skill mix (about 52 percent of hospital labor hours nationwide) might result in a better reflection of underlying wages for those workers. An ongoing concern with the wage index calculation is that some hospitals contract out their lower paid service workers, which increases their average wage because their non-patient-care contract workers are not included in the calculation. Using data that are not hospital reported would eliminate this anomaly.

Reclassification based on out-commuting

The proposed rule implements a new form of geographic reclassification enacted by the MMA which is based on the commuting patterns of hospital employees. The wage index for a county is increased if more than 10 percent of the hospital workers resident in the county commute to counties with higher wage index values. The increase is the average of the higher wage indexes, weighted by the percent of residents commuting to each of the areas. In effect the wage indexes of the subject county and the counties the workers commute to are blended. Per the law, the proposal is not budget neutral.

CMS proposes using commuting data from the 2000 census long form to determine a county's (and hence a hospital's) eligibility for this reclassification, instead of collecting the necessary data from the hospitals. The threshold is set at the minimum 10 percent for out-migration. CMS has opted not to require a minimum difference in wage index between the applicant county and a higher wage index county. No application process is required; the adjustment is automatic. Over three years, the average wages of the subject county must equal or exceed the average wages in its labor market area, and the adjustment holds for three years. CMS estimates that 224 counties will qualify with 411 hospitals.

CMS's proposal leaves unclear how the adjustment will be made in subsequent years. In year two, 224 counties will have higher wage indexes as a result of the out-commuting adjustment. When the calculation for the adjustment is made in year two, will those higher values be used when making the adjustment for the counties that adjoin and

[1] Additional burden from collecting detailed RN subcategory data might be offset by collecting data on fewer GSCs because some of them account for very few hours and our analysis shows that the total skill mix adjustment is very closely correlated to the Nursing Services GSC adjustment.

commute to those 224 counties? If so, the effect of the out-commuting adjustment could ripple out each year to more counties. CMS should investigate the impact of this ripple effect and also whether it would be possible to update its commuting data using data from the Census Bureau's American Community Survey rather than using data from the 2000 census for ten years.

Single and dominant hospital wage index areas

A related issue is what to do with wage index areas with only one or with a dominant hospital (using the new area definitions, there are now 49 such areas). Dominant and single hospitals are concerned that they cannot reclassify because they cannot exceed 108 percent of the average wage in their area, which is a criterion for reclassification. This is a problem, they argue, if neighboring MSAs have higher wage indexes and compete for the same workers, or if in the case of dominant hospitals the smaller hospitals are pulling down the average. Part of the problem is that even though these hospitals essentially set their own wage index value, they may have difficulty catching up to neighboring MSAs' wage levels due to the four year lag between when hospital wage data are collected and used in calculating the wage index.

CMS asked for comments on whether the automatic out-commuting adjustment would solve the problem. It is a promising approach. Because of blending, the value of reclassification based on out-commuting would generally be lower than that of traditional reclassification, which might be appropriate given that single and dominant hospitals have an above-average degree of influence over their own wage index value.

Post-acute care transfer policy

The post-acute transfer policy applies to cases discharged to hospitals or hospital units not subject to the acute inpatient PPS, skilled nursing facilities, and services furnished by a home health agency if the services relate to the condition or diagnosis of the inpatient stay. Transfer cases are paid a per diem rate for each day of the stay, up to the full DRG amount.

The post-acute transfer policy initially applied to 10 DRGs in FY 1999. In FY 2004, CMS expanded the policy to cover 29 DRGs. In expanding the policy CMS defined a set of criteria for DRGs, one of which requires that the DRG have at least 14,000 post-acute transfer cases. In order for a DRG to remain under the transfer policy, CMS also requires that it continue to have at least 14,000 post-acute transfer cases.

CMS is proposing to eliminate DRG 483 (tracheotomy with mechanical ventilation except for head and neck diagnoses), which is currently subject to the post acute transfer policy and split it into two new DRGs (541 and 542). However, each of the two new DRGs would have fewer than 14,000 post-acute transfer cases, and thus would not qualify for the transfer policy under existing criteria. CMS therefore is proposing a second set of criteria that could be used to identify eligible DRGs. The alternative criteria include a lower transfer volume threshold of 5,000 cases, which would allow DRG 541 and 542 to be covered.

CMS should establish the principle that once a DRG is covered under the post-acute transfer policy it will remain under the policy —even if the DRG is split or if the number of post-acute transfers in the DRG falls below the current volume standard. Allowing DRGs to come off the transfer policy would make the payment system less stable and result in inconsistent incentives over time. A drop in the number of transfers to post-acute settings is to be expected after the transfer policy is applied to a DRG, but the frequency of transfers may well rise again if the DRG is removed from the policy. If CMS adopts this principle, then it should consider bringing DRGs 263 and 264 (which were dropped last year due to their volume of transfers falling below 14,000) back under the post-acute transfer policy.

Crossover patients in facilities changing payment system classification

Crossover patients are Medicare beneficiaries that are in a hospital at the time the hospital converts to another payment system classification. Currently providers receive two separate payments for crossover patients—one under each payment system that was in effect while the patient was in the hospital. Crossover patients most commonly occur when a hospital converts from being covered by the acute inpatient PPS to a long-term care hospital (LTCH).

CMS is proposing to make only one payment for crossover patients in hospitals that covert from an acute inpatient PPS hospital to a long-term care hospital, basing such payment on the LTCH PPS. The length of stay for these patients (which governs whether the cases are short stay outliers) would include the days from both the acute care and LTCH portions of the stay.

We agree that hospitals should not receive two payments for crossover patients, and CMS's proposal to pay for just one patient stay under the LTCH PPS appears reasonable. CMS should consider applying this policy to all conversions, including acute care to rehabilitation, rehabilitation to long term care, and long term care to rehabilitation. Payment rules consistent with those proposed for acute care to LTCH conversions could be established, with payment based either on the payment rate for the final discharge setting or on the highest of the two rates.

Reporting of hospital quality data for annual payment update

In the MMA, Congress determined that hospitals covered by the acute inpatient PPS should only receive a full update if they report information on the quality of inpatient care to Medicare.

MedPAC supports the concept of the Medicare program obtaining more information on quality from providers, including hospitals. Such focus should encourage hospitals to measure care in important clinical areas and become accustomed to providing these data to the program. Public reporting of information on quality should encourage low performers to improve care and recognize the efforts of those who deliver high quality care. Further, we recommended in June 2003 that CMS explore the possibility of tying payment to quality performance. This type of reporting helps build the infrastructure to implement such a program for hospitals.

While the Commission supports tying payment to performance, we do not believe that Medicare should 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 on behalf of Medicare beneficiaries, that information on the quality of care be provided to beneficiaries and the program.

Nonetheless, any system for reporting quality data must ensure that the measures evolve to ensure that Medicare is able to obtain the best and most useful information possible on hospital quality. Currently, the statute requires hospitals to report on the measures that were a part of the National Voluntary Hospital Reporting initiative as of November 2003. To be credible with hospitals and to ensure that payment is tied to reporting on measures that reflect appropriate medical practice, the Secretary should have the authority to revise the measures on an ongoing basis. This could mean adding or retiring measures as clinical guidelines change or when providers reach high levels of performance in certain areas.

New technology add-on payments

The acute inpatient PPS includes add-on payments for new technologies that meet specific newness, cost, and clinical improvement criteria. The rule notes that due to provisions in the MMA, the add-on payments will no longer be administered in a budget-neutral manner. In addition, the MMA lowered the threshold for the cost criterion.

In the proposed rule, CMS evaluates 2 technologies that currently receive add-on payments, 1 technology denied add-on payments in FY 2004 and 10 new technologies. Evaluating each technology poses a challenge to CMS by presenting unique circumstances. For several reasons, we urge CMS to be conservative in its evaluation of technologies for add-on payments, ensuring that technologies are significantly different from predecessor technologies, costly, and with clinical benefit. First, add-on payments can be seen as an unbundling of the DRG system, which relies on a per-case payment to provide incentives for hospitals to be efficient and weigh the benefits of new technologies against their costs. In addition, the MMA changed the cost criteria in a way that will increase the number of technologies potentially eligible. Finally, the add-on payments now represent new expenditures under the payment system.

One of the technologies under consideration—cardiac resynchronization therapy with defibrillation—raises a question of what to do when a new technology is already in widespread use. The proposed rule states that these devices have only been on the market since May 2002. Nevertheless, they were reported as being used in 22 percent of all cases in two relevant DRGs (514 and 515). Given that representation in the data is one element of newness, does this technology still meet the criteria for add-on payments? If the technology is likely to diffuse further and represent an even greater share of the cases, it may. However, it is clear that the costs of this technology are already reflected in the data used to set payment rates.

One way to deal with this problem would be to exclude cases where the technology has been used from the calculation of mean charges for the DRG during recalibration of the relative weights. This would avoid overpaying for the technology by including its costs in

the base payment while also providing an add-on payment. This approach should be used for all cases where the new technology can be tracked.

Low-volume adjustment

The MMA provides for an adjustment to Medicare's inpatient payment rates for hospitals that are located at least 25 road miles from a like hospital and have fewer than 800 total discharges. The statute requires CMS to develop an empirically justifiable adjustment formula based on the relationship between hospitals' costs per discharge and volume of discharges. CMS proposes an adjustment formula nearly identical to the one that MedPAC modeled in its June 2001 *Report to the Congress: Medicare in Rural America.* The formula establishes a maximum adjustment of 25 percent, with the percentage add-on declining as volume increases and phasing out at 500 discharges. CMS's own analysis supports the conclusion that 500 discharges is the appropriate cutoff point, and we support this proposal.

CMS plans to base the low-volume adjustment on data from a one-year period as reported in each hospital's most recently submitted cost report, which generally covers a period two years previous to the payment year. We have two comments on this approach. First, although the MMA appears to require a one-year calculation, a volume measure based on a three-year moving average number of discharges would better track hospitals' underlying patient volume. Demand for inpatient care often varies substantially from year to year in small hospitals.

Second, CMS might consider basing the adjustment rate on the number of discharges in the current year, rather than relying on two-year old cost report data. Then reconciliation to actual volume can be accomplished less than a year from the end of the hospital's fiscal year. CMS's proposed approach, in contrast, would delay adjustment to the hospital's actual volume for as much as three years—potentially resulting in payments that are much too high or low in the meantime.

While predictable payments are important, we believe that an interim adjustment based on past volume trends can provide sufficient predictability, since it is not difficult for hospitals to monitor their discharge volume to gauge whether the interim rate will result in over- or under-payment. Although basing the adjustment on current data will necessitate a settlement process, the impact on CMS's processing should be modest since only one additional line on the cost report will be needed and the number of hospitals receiving the adjustment is expected to be small. We note that CMS already uses the approach we are suggesting for both IME and DSH payments.

Outlier payments

CMS makes outlier payments for extremely costly patients. An outlier payment is made when the cost of a case exceeds the sum of DRG payments (including new technology, IME and DSH add-ons) plus a fixed loss amount. The cost of a case is estimated by

applying a cost-to-charge ratio (from the hospital's most recent tentatively settled cost report) to the Medicare charges the hospital reported on its claim. In 2003 CMS found that some hospitals had been increasing charges very rapidly, which led to an inappropriate increase in outlier payments at these hospitals. In June 2003 CMS promulgated a revised outlier payment policy to address this problem.

Each year CMS sets a fixed loss amount that is intended to make total operating outlier payments equal 5.1 percent of operating DRG payments. CMS proposes an unusually high loss threshold of $35,085 for FY 2005, largely because it assumes that hospitals' charges will increase from 2003 to 2005 at the same rate they increased from 2001 to 2003—the period before the new outlier policy went into effect. CMS suggests that the proposed threshold may be higher than needed to meet the 5.1 percent target, given that it will be using more up-to-date and generally lower cost-to-charge ratios to determine whether cases qualify for outlier payments.

We are concerned that the proposed loss threshold will lead to outlier payments that are too low in FY 2005.[2] As we argued in comments when CMS proposed its new outlier policy, CMS should reduce the fixed loss amount to reflect its anticipation of lower growth in charges. Failing to adjust the loss threshold would inappropriately deny additional payments to hospitals that have extraordinarily costly cases. CMS should identify methods and data that permit it to estimate charge growth reflective of current trends. For example, it could inflate charges from 2003 to 2005 using the rate of change between the nine months after the June 9, 2003 change in outlier policy and the same period the preceding year.

Graduate medical education

Medicare makes prospectively-determined payments that are intended to cover its share of hospitals' direct costs of running approved resident training programs, including resident salaries, physician supervisory costs, and associated program overhead expenses. These direct graduate medical education (GME) payments, which are separate from Medicare's payment rates for inpatient and outpatient care, are based on hospital-specific costs per resident from a 1984 base year, updated for inflation and multiplied by a weighted count of residents.

The BBRA established a national average per resident amount governing payment for certain providers and also established caps on the number of residents hospitals may count. The MMA provides for a redistribution of the resident caps, lowering the caps for hospitals that are currently training fewer than their allotted number of residents and redistributing the vacant positions to other hospitals.

Although the MMA requires that CMS use the resident count from the most recent year's settled cost report for determining whether a hospital will lose residency positions, we

[2] CMS latest estimate is that outlier payments will also be too low in FY 2004—4.4 percent of total DRG payments.

believe hospitals should be allowed to use the highest resident count from the past three years. A hospital's number of residents can vary from one year to the next due to difficulties in matching residents in some years or to unforseen events such as residents on maternity leave. Basing the reference resident level on the highest count reported from the past three years would ensure that hospitals are not unfairly penalized in determining the reductions to their resident cap. We doubt that this change would have much effect on overall GME and IME spending, but it likely would result in slightly fewer resident positions being reallocated.

Long-term care hospitals within hospitals

MedPAC recognizes and has documented the rapid growth in long-term care hospitals (LTCHs), particularly LTCHs within hospitals. For example, the rate of growth in the number of LTCHs within hospitals is almost three times the rate of growth in all LTCHs—35 percent versus 12 percent per year from 1993 through 2003. In addition, the pace of growth has accelerated recently—the same number of LTCHs opened in the first half of fiscal year 2004 as in all of fiscal 2003. There are also rapid increases in LTCH cases and Medicare spending—for instance, the number of LTCH cases increased 24 percent from 2001 to 2002 and spending quintupled from $398 million in 1993 to $1.9 billion in 2001.

In our research on long-term care hospitals, we found that supply of LTCHs, especially LTCHs within hospitals, matters. Controlling for severity of illness and other factors, we found that being discharged from an acute care hospital with a colocated LTCH quadrupled the probability that a patient would use LTCH care. Nevertheless, both freestanding LTCHs and LTCHs within hospitals have strong relationships with acute care hospitals—freestanding facilities receive 42 percent of cases from their primary referring hospital and LTCHs within hospitals receive 61 percent of patients from their host hospital.

Long-term care hospital policies cannot be considered in isolation. Shortcomings in the acute care hospital and skilled nursing facility (SNF) payment systems may contribute to the growth in LTCHs and refinements to the payment policies for SNFs and acute care hospitals may be needed.

CMS has proposed limiting the share of patients from the host hospital admitted to LTCHs within hospitals. We see some risks to CMS's approach. First, the proposed 25 percent rule may be inequitable: It only applies to LTCHs within hospitals and not to freestanding LTCHs. Second, it does not ensure that patients go to the most appropriate post-acute setting. Third, this approach may be circumvented by hospitals building freestanding LTCHs instead of LTCHs within hospitals.

We share CMS's concern that the LTCH payment system creates an incentive for unbundling of the IPPS, in addition to overpayment for the care provided by LTCHs. Like CMS, we are concerned that the unbundling risk may be particularly great in the case of LTCHs within hospitals. In the Commission's deliberations, we considered a moratorium on LTCHs within hospitals, but did not adopt it. Instead, we reserved judgment pending further analysis of the risks posed by LTCHs within hospitals.

Similarly, we reserve judgment on CMS's proposal on LTCHs within hospitals until we see more empirical evidence demonstrating the unique risk posed by them.

Critical access hospital psychiatric units

Critical access hospitals (CAHs) receive cost-based Medicare payments for inpatient and outpatient services. Under previous policy, CAHs were limited to 15 acute inpatient beds and were prohibited from having distinct-part psychiatric units. But under the MMA they will be allowed to have 25 general-acute beds plus 10 psychiatric beds in a distinct-part unit. CAHs will receive prospective payment for services provided in the distinct-part unit and must meet the conditions of participation for such units in hospitals covered by the acute inpatient PPS.

One rule of participation is that psychiatric services must be under the direction of a board certified psychiatrist. The hospital must also have an "adequate" number of doctors with appropriate qualifications "to provide essential psychiatric services." Our concern is that due to the small size of CAHs and the limited number of psychiatrists in rural areas, CAHs may attempt to hire psychiatrists that spend only a small portion of their time at the CAH, possibly splitting their time among several CAHs or other hospitals. CMS might consider requiring clinical directors to devote a specified minimum amount of time to each psychiatric unit they serve.

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