



June 30, 2009

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

RE: CMS-1406-P, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment System for Acute Care Hospitals and Fiscal Year 2010 Rates and to the Long-Term Care Hospital Prospective Payment System and Rate Year 2010 Rates; Proposed Rule (Vol. 74, No. 98), May 22, 2009

Dear Ms. Frizzera:

The New Hampshire Hospital Association (NHHA), on behalf of our 26 member hospitals, appreciates this opportunity to comment on the proposed rule for FFY 2010 for the Inpatient Prospective Payment System (IPPS). Our comments are focused on the inpatient prospective payment system rule and not on the long term care hospital prospective payment system.

While we support a number of the proposed rule's provisions, including on hospital-acquired conditions and diagnosis-related group reclassifications, we have concerns about the documentation and coding adjustment and market basket revision, as well as payment cuts related to the wage index rural floor, capital payments, Medicare-dependent hospitals and critical access hospitals. We are in agreement with comments submitted on the rule by the American Hospital Association.

MS-DRG DOCUMENTATION AND CODING ADJUSTMENT

The proposed rule includes a 1.9 percent cut to both operating and capital payments in FY 2010 and beyond – \$63 million over 10 years impact to New Hampshire hospitals – to correct the base rate for payments made in FY 2008 that CMS claims are the effect of documentation and coding changes that do not reflect real changes in case mix. In combination with other policy changes, this cut results in all hospitals in the country being paid \$1 billion less in FY 2010 than in FY 2009. **In its analysis of documentation and coding changes, CMS concludes that from FY 2007 to FY 2008, there was a decline in real case mix; in contrast, our analysis found that there is a historical pattern of steady annual increases of 1.2 to 1.3 percent in real case mix and we are concerned that CMS' conclusion is incorrect.** Further, because CMS' conclusion that real case mix declined is an inference based on its analysis of documentation and coding-related increases, we are concerned that the 1.9 percent proposed cut also is inaccurate and overstated. We recognize that CMS could have taken action to reduce payments more than proposed in this rule.

We appreciate that CMS did not propose cuts for documentation and coding changes in FY 2009 or cuts to recoup the estimated documentation and coding overpayments in FY 2008. However, given the severity of the 1.9 percent proposed cut, and in light of the fact that our

analysis shows real increases in patient severity, we ask that the agency significantly mitigate its proposed documentation and coding cut.

HOSPITAL MARKET BASKET

As required by law, CMS proposes to rebase the market basket from FY 2002 to FY 2006 and revise certain categories and price proxies. However, the projected increase in the market basket could be extremely volatile this year. While the country has recently experienced a period of very low inflation, funds from the *American Recovery and Reinvestment Act of 2009* are beginning to work their way into the economy and we are beginning to see signs of a recovery. We do not know the effect this will have, but a period of inflation could substantially affect the market basket estimate. In addition, the predictability of hospitals' payments has been, and will continue to be, extremely volatile. CMS is required to revise the weights used in the hospital market basket every four years to reflect the most current data available, but the agency is not required to modify the price proxies used in the market basket calculation. Accordingly, **we urge CMS only to rebase the data and weights used in the market basket calculation, and not to revise the price proxies used in the calculation.** Doing so will result in a more stable estimate of the increase in the market basket and demonstrate forbearance given the economic volatility that has occurred and may be yet to come.

OTHER PROPOSALS

We also strongly oppose the following direct payment cuts:

- Applying budget neutrality for the rural floor and imputed rural floor on a statewide basis. In our comment letter on the FY 2009 inpatient PPS proposed rule, we outlined our opposition to this policy. Although CMS went forward with its proposal, NHHA continues to oppose applying budget neutrality on a statewide basis. We continue to content that applying budget neutrality on a nationwide basis minimizes the policy's impact on payments and results in all hospitals in the nation funding a national policy. New Hampshire is one of a few states already impacted by this policy and the effect has been detrimental to our impacted hospitals. Accordingly, **we urge CMS to withdraw this policy and again apply rural floor budget-neutrality adjustments on a nationwide basis.**
- Not making a positive budget-neutrality adjustment to reverse the FYs 1999 through 2006 standardized amount budget-neutrality adjustments for the rural floor, which have negatively impacted New Hampshire hospitals in their payments significantly through 2009. Therefore, **NHHA urges CMS to remove the compounding effect of applying the rural floor and budget-neutrality adjustment to the standardized amount annually in years past and restore these funds to the hospitals.**
- Eliminating the indirect medical education adjustment to capital payments. Eliminating the IME adjustment will threaten the financial viability of teaching hospitals in New Hampshire, and will impose a threat on future physician supply creating access problems for Medicare beneficiaries. This proposal directly impacts New Hampshire hospitals and results in payment cuts to teaching hospitals in New Hampshire by over \$2.3 million in FY 2010 and \$11.9 million over five years. **NHHA urges CMS to remove this proposal and to continue to provide IME adjustments related to capital payments in order to ensure that teaching hospitals are able to provide residents with access to training using the latest high-tech equipment and technology.**
- Applying a cumulative retroactive budget-neutrality adjustment to the FY 2002-based Medicare-dependent hospital and the FY 2006-based sole community hospital hospital-

specific rates, which will reduce payments in FY 2010. NHHA supports AHA comments on the calculation of the hospital-specific rates. Based on the AHA analysis, eventually over time, the retroactive budget-neutrality factors will total 100 percent. When this occurs, their applications to the hospital-specific rates will yield rates of \$0. This further demonstrates that applying a cumulative retroactive budget-neutrality adjustment is not correct and cannot be consistent with what Congress intended when rebasing the hospital-specific rates.

- Continuing the transition to stricter reclassification criteria, which increases the threshold for hospitals to qualify for reclassification to another labor market area; As a result, this will impede a hospital's ability to offer competitive salaries to qualified individuals and, furthermore, provide the highest quality care and adequate access to beneficiaries. **NHHA urges CMS not to proceed with the final year of transition for the reclassification criteria, which would increase the threshold to 88% for urban hospitals and group reclassifications and 86% for rural hospital reclassifications. NHHA urges CMS to continue to study wage index to make future changes that create a more equitable system.**
- Reducing payments for outpatient services to certain critical access hospitals from 101 percent of costs to 100 percent of costs, which will cut payments to New Hampshire Critical Access Hospitals by almost \$1 million in FY 2010. NHHA agrees completely with the AHA's position whereas this provision to reduce reimbursement for the Optional Payment Method goes directly against the intent of Congress. Therefore, **NHHA urges CMS to withdraw its proposal to reduce payment from 101% to 100% of reasonable costs under the Optional Payment Method.**

HOSPITAL QUALITY DATA

NHHA is in agreement with comments submitted by AHA regarding hospital quality data and encourage CMS to look to the Partners' goals as a framework for the types of measures that should be included in the pay-for-reporting program. The goal of the national priorities is to engage all stakeholders in a shared effort to make quality improvements in the most important areas of patient care. The Hospital Quality Alliance (HQA) has agreed that the Partners' national goals should provide a foundation for its future work, and it would be beneficial for CMS to follow these national goals as well. **We believe that measures added to the pay-for-reporting program must first go through the rigorous, consensus-based assessment processes of both the NQF and HQA.**

Public reporting of a small and actionable set of measures on *Hospital Compare* leads to a significant investment of provider resources in collecting data and improving performance. Therefore, the measures chosen for public reporting should be important measures that accurately and reliably assess meaningful aspects of care. It is incumbent on CMS to choose the best possible measures for this purpose. To do this, CMS should follow a clear set of criteria to determine which measures are most scientifically sound. We suggest that CMS look to criteria

Although they have been endorsed by the NQF, because they have not been adopted by the HQA, **we do not support the inclusion of the two proposed surgical care measures – postoperative urinary catheter removal on postoperative day 1 or 2 and perioperative temperature management – into the pay-for-reporting program.**

With regard to the two structural measures of clinical registry participation – participation in a systematic clinical database registry for stroke care and participation in a systematic clinical database registry for nursing sensitive care – these measures should not be included in the pay-for-reporting program because they are not tightly linked to improving quality and patient care, nor have they been endorsed by the NQF or adopted by the HQA. For many of the pay-for-reporting measures, such as providing beta-blockers upon discharge to heart attack patients, there is a great deal of scientific evidence that providing that particular process of care can improve patient outcomes. The structural clinical registry participation measures fail to meet that standard. There is no established connection between whether a hospital answers “yes” or “no” to the registry participation measures and the quality of the care that hospital provides.

In addition, we are concerned that these measures contain an implicit encouragement by the Medicare program for hospitals to participate in clinical data registries designed and run by external organizations. Many clinical registries require hospitals to pay a costly fee to participate. **We urge CMS not to adopt the quality measures assessing participation in clinical data registries.**

The NQF endorsed and the HQA adopted several other measures that CMS did not propose to include for FY 2011. In particular, the NQF endorsed and the HQA adopted two measures of infection rates: surgical site infection and central line catheter-associated blood stream infection. The HQA believes that these measures are ready for public reporting. They have been thoroughly specified, are currently used in other reporting initiatives, are salient to consumers and hold important information that hospitals can use for their quality improvement programs. CMS lists the central line catheter-associated blood stream infection rate measure as a possible measure for FY 2012 or beyond; the surgical site infection rate measure is not listed in the proposed rule. **We urge CMS to reconsider implementing these measures of infection rates as soon as possible.**

Data Resubmission, Validation and Appeals. The proposed rule does not address the issue of data resubmission when a hospital or its vendor becomes aware of an error in the data that was sent for posting on *Hospital Compare*. **NHHA urges immediate adoption of an effective mechanism that allows hospitals and their vendors to resubmit quality measure data if they discover an error.** The point of public reporting is to put accurate and useful information into the hands of the public, and this is facilitated by allowing known mistakes to be corrected.

In the rule, CMS proposes a new process for validating hospitals' quality data beginning in FY 2012. Unlike the current process, which involves the review of a small number of medical charts from all hospitals, the proposed process would audit a larger number of charts from a randomly selected sample of hospitals. For the FY 2012 payment determination, CMS proposes to review 12 medical charts each quarter from 800 hospitals randomly selected each year from among all hospitals with at least 100 eligible patient cases. The review would assess the accuracy of the hospital's measure rate, as opposed to the accuracy of the individual data elements.

CMS' proposed process holds promise as a reasonable approach to ensure the accuracy of the quality data and improve upon the deficiencies in the current validation process.

DRGs: HOSPITAL-ACQUIRED CONDITIONS

The DRA required CMS to identify by October 1, 2007 at least two preventable complications of care that could cause patients to be assigned to an MS-DRG with a CC or MCC. The conditions must be either high-cost or high-volume or both, result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis, and are reasonably preventable through the application of evidence-based guidelines. The DRA mandated that for discharges occurring on or after October 1, 2008, the presence of one or more of these preventable conditions would not lead to the patient being assigned to a higher-paying DRG. In the FY 2008 PPS final rule, CMS adopted eight conditions for which it would no longer pay a higher DRG rate if the conditions were not present on admission. In the FY 2009 rule, CMS selected two additional conditions and expanded one of the original categories.

This year, CMS does not propose to add or remove any hospital-acquired conditions. Rather, the agency focuses on evaluating the impact to date of the hospital-acquired conditions policy. We support CMS' evaluation of the policy and believe that a robust program evaluation should be conducted before CMS considers adding any more hospital-acquired conditions. Improving care for patients should be the end goal of this policy. **We urge CMS to use any information learned from the evaluation to examine ways that care can be improved.**

Payment Changes Based on Present-on-Admission Coding. The payment changes for hospital-acquired conditions apply only when the selected conditions are the only CCs or MCCs present on the claim that cause the patient to be assigned to a higher MS-DRG. Under this policy, CMS does not make higher payments for the selected conditions if they are coded as not present on admission or if the medical record documentation is insufficient to determine whether the condition was present on admission. In other words, CMS does not make a higher payment if the condition is coded on the claim with an "N" (not present on admission) or a "U" (medical record documentation is insufficient). CMS stated that it will not pay a higher payment amount when the medical record documentation is insufficient because it believes this will foster better medical record documentation. However, the reporting of present-on-admission indicators is still new, and hospitals continue to learn how to apply them, as well as educate their physicians on the required documentation without which present-on-admission reporting is impossible. **We urge CMS to reverse its position and pay for hospital-acquired conditions coded with the "U" indicator.**

NHHA appreciates having the opportunity to comment on the proposed rule. If you have any questions, please contact me or Paula Minnehan, VP, Finance and Rural Hospitals, at 603-225-0900 or pminnehan@nhha.org

Sincerely,



Steve Ahnen
President