



**Association of
American Medical Colleges**
2450 N Street, N.W., Washington, D.C. 20037-1127
T 202 828 0400 **F** 202 828 1125
www.aamc.org

VIA ELECTRONIC SUBMISSION

June 30, 2009

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

Attention: **CMS-1406-P**

Dear Ms. Frizzera:

The Association of American Medical Colleges (AAMC) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS or the Agency) proposed rule entitled "*Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment System [IPPS] and Fiscal Year 2010 Rates and to the Long-Term Care Hospital Prospective Payment System and Rate Year 2010 Rates.*" 74 Fed. Reg. 24080 (May 22, 2009). The Association's Council of Teaching Hospitals and Health Systems (COTH) comprises nearly 300 general acute nonfederal major teaching hospitals and health systems that receive Medicare payments under the IPPS. The Association also represents all 130 accredited U.S. medical schools; 94 professional and academic societies; 90,000 full-time clinical faculty; and the nation's medical students and residents.

Our comments focus on the following areas:

- capital indirect medical education (IME) payments;
- definition of a new medical residency training program;
- MS-DRG documentation and coding adjustment;
- labor-related share;
- outlier payment threshold;
- changes to the hospital market basket;
- refinement of the MS-DRG relative weight calculations;
- hospital acquired conditions;
- Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program;
- deadline for new hospitals to join GME affiliated groups;
- Modification to the Medicare DSH calculation
- EMTALA waiver regulations; and
- Medicare payments for new technologies.

CAPITAL IME PAYMENTS

The AAMC writes to express our support for the proposed regulatory changes that rescind the 50 percent reduction to capital IME payments in FY 2009. On a related point, we also write to urge strongly that CMS *not* move forward with eliminating the capital IME adjustment in FY 2010. Congress expressed its support for this vital source of funding for the nation's teaching hospitals by requiring the rescission of the 50 percent phase-out of capital IME payments for FY 2009, and by indicating in its conference report that Congress "expects the hospital community to seek a permanent fix in the annual IPPS rulemaking cycle." Moreover, 56 Senators and 220 House Members sent letters to the Administration on May 5 and May 22, respectively, urging the withdrawal of this regulation. **Specifically, the AAMC asks that CMS rescind the regulation that eliminates (effective October 1, 2009) the IME adjustment made under Medicare's capital reimbursement system.**

Implementation of the regulation will eliminate an estimated \$380 million in funding for over 1,000 teaching hospitals in all 50 states and the District of Columbia. Eliminating the capital IME adjustment threatens the financial viability of teaching hospitals, which serve a high volume of Medicare beneficiaries and provide critical services.

The capital IME adjustment is a critical source of funding for teaching hospitals, in light of the fact that the Medicare IPPS does not provide a single payment reflecting total costs (i.e., combined operating and capital costs). Additionally, teaching hospitals have inherently higher capital costs versus non-teaching hospitals. For example, they need to maintain classroom space, assure that resident training programs have access to the appropriate technologies and equipment, and sustain the sophisticated physical plants and safety systems that such technology and equipment require. As is the case under Medicare's operating PPS, the capital IME adjustment recognizes that teaching hospitals must meet the demand of treating sicker patients while simultaneously providing trauma expertise, other highly specialized patient services, and care for a disproportionately high number of uninsured patients.

CMS based its decision to eliminate capital IME payments largely on an analysis that disregarded the capital expenditure cycle that teaching hospitals use to plan and make capital investments. It also failed to examine Medicare margins across both capital and operating payment systems.

Analysis of Medicare capital margins by the AAMC demonstrates that elimination of Medicare's capital IME adjustment would lead to average capital margins of **negative 5.3%** for major teaching hospitals and **negative 6.1%** for all teaching hospitals. The margins become even more negative if the proposed documentation and coding adjustment is finalized; to **negative 9.5%** for major teaching hospitals and **negative 9.9%** percent for all teaching hospitals. It is clear that this unwarranted reduction in capital IME payments to teaching hospitals would have important negative consequences on the patients and communities they serve.

The American Hospital Association (AHA), the Federation of American Hospitals (FAH) and other provider groups at the national, state, and local levels also support the withdrawal of this policy. The AAMC urges CMS to rescind this detrimental and short-sighted regulation as part of the FY 2010 IPPS final rule.

DEFINITION OF A NEW MEDICAL RESIDENCY TRAINING PROGRAM

Teaching hospitals are subject to a cap on the number of residents that may be counted for direct graduate medical education (DGME) and a separate cap for indirect graduate medical education (IME) payments. In general, these caps are based on the number of full time equivalent (FTE) residents the hospital claimed in its most recent cost reporting period ending on or before December 31, 1996. New teaching hospitals are given three years to establish caps, based on the number of residents training in the residency programs implemented during this period.

In the proposed rule, CMS purports to “clarify” the definition of “new medical residency training program” (at 42 C.F.R. § 413.79(l)) when a new teaching hospital is attempting to establish its resident cap. The regulations define “new medical residency training program” as one “that receives initial accreditation by the appropriate accrediting body or begins training residents on or after January 1, 1995.” Following this definition, many hospitals have relied on accreditation of a new program by the appropriate accrediting body for purposes of determining whether the program’s residents could be included in the resident cap. CMS now states that the Agency will look beyond accreditation to “supporting factors” including (but not limited to) whether there are “new program directors and/or new teaching staff, and/or whether there are only new residents training in the program(s) at the different site.” 74 Fed. Reg. 24080, 24192 (May 22, 2009). CMS also proposes to consider the relationship between hospitals and the degree to which the hospital with the “original” program continues to operate its own program in the same specialty. The AAMC has several serious concerns regarding CMS’s proposal.

First, while labeled a “clarification,” CMS’s proposed rule in fact represents a significant change to long-standing agency policy. The AAMC is extremely concerned that, notwithstanding the unchanged, literal wording of the regulation, the Agency is imposing new and ambiguous criteria for a residency program attempting to qualify as a “new” program. Given that the proposed “supporting factors” were never previously published in agency guidance, a retroactive application of this new definition to hospitals that, in good faith, complied with existing regulations would be entirely inappropriate.

Second, even presuming the new criteria are properly applied (and the AAMC believes they are not), these “supporting factors” offer a hospital no reassurance that a program established today will qualify as “new” when CMS evaluates the program’s status several years from now. The AAMC notes with interest the use of the term “and/or” in CMS’s list of “supporting factors.” Under the Agency’s new formulation, a residency program with a new program director and new residents, but also with several faculty members who previously taught at what CMS views as the “original” program, for example, may or may not be considered “new”. This lack of clarity is

problematic, as a hospital may invest significant time and resources in the creation of what it believes to be a “new” program, only to find out years later that the hospital will not be reimbursed for its teaching efforts. If CMS insists on using the criteria set forth in the proposed rule as “supporting factors,” the Agency should clarify its definition and replace each use of the term “and/or” with the word “and”. A determination of whether a program is “new” cannot be based on one single factor alone (such as the presence of a single program director from an “original” program). A program that is not new should be defined as one where, at a minimum, *all* of its program directors *and* faculty, *and* residents came from an “original” program, with discretion given to the Secretary to determine that a program may still be new as a result of other circumstances.

Third, the proposal could diminish the educational quality of new programs by restricting their ability to hire experienced program directors and faculty members and of program directors and faculty members to use their skills in a residency program of their choosing. Program directors and faculty members who have become experts in their fields should be encouraged – not discouraged - to participate in the formation of new residency programs, and they must have the freedom to teach and practice where they determine their skills will be best employed. The “supporting factors” listed in the proposed rule suggest that a program director or faculty member from an existing program should not be hired by a “new” program, lest that program jeopardize its “new” status. The mere presence of a program director or faculty member who worked previously for another residency program does not make the new program identical to the program where the program director or faculty member previously worked; if the clinical setting is distinct, residents will have a different experience than they would have had in the “original” program, regardless of who directs and teaches the “new” program.

Finally, CMS’s focus on making the “new program” requirements more stringent simply does not make sense from a policy perspective. Presumably, the Agency is concerned that a hospital will shift one of its existing residency programs to another institution and use the then-open slots to count other residents (who were previously over the hospital’s cap), resulting in an aggregate increase in the number of residency positions reimbursed by the Medicare program. CMS’s proposed new definition of a “new medical residency program” does nothing to address any concerns CMS may have, however, about a nation-wide increase in the total number of reimbursed residency positions. A hospital may decide at any point to close an existing program and use those residency slots for residents previously training above its cap. Likewise, a nonteaching hospital may, at any time, decide to become a teaching hospital, start new programs, and establish a residency cap, resulting in an increase in the aggregate number of residency positions reimbursed by the Medicare program.

The AAMC encourages CMS to rescind this new and ambiguous “clarification” of the definition of a “new medical residency training program.” We believe the current regulatory definition, which allows the accrediting bodies to determine when a program is new, is appropriate and should be endorsed by CMS in the final rule. If CMS continues to believe a change is necessary, we urge the Agency to ensure that any change is clear and definitive. Establishing a new

residency program requires significant time and resources. Teaching hospitals and medical educators need assurances that if they make such an investment in the education of our future physicians, the Medicare program will pay its share of those costs by ensuring that these new residents will be included in the new teaching hospital's cap.

MS-DRG DOCUMENTATION AND CODING ADJUSTMENT

In FY 2008, to better recognize severity of illness in Medicare hospital payment rates, CMS began a transition from 538 "CMS DRGs" to 746 "Medicare Severity DRGs" (MS-DRGs). For FY 2008, Medicare per case payments were based on a blend comprising 50 percent of the CMS DRG relative weight and 50 percent of the MS-DRG relative weight. In FY 2009 and thereafter, the payments are based on 100 percent of the MS-DRG weights.

The proposed rule would reduce the update to the IPPS standardized amount for FY 2010 by 1.9 percentage points to account for case mix increases that occurred in FY 2008 that CMS believes are due to documentation and coding adjustments rather than increases in the severity of patients treated ("real" case mix change). Such a cut represents approximately \$23 billion over 10 years in lost revenues for all hospitals. We have concerns about the CMS analysis which derived the 1.9 percent reduction (see below). Given these concerns, and the damaging consequences of a potential 1.9 percentage point reduction to the hospital update, we urge the Agency to reduce the level of this cut.

The 1.9 percent reduction reflects CMS's estimate of the FY 2008 payment increase due to documentation and coding (2.5 percent) less the 0.6 percentage point reduction that was implemented in FY 2008 due to PL 110-90, the "TMA, Abstinence Education and QI Programs Extension Act of 2007." The purpose of the proposed reduction is to "reset" the base rate so that it does not reflect payment increases that result from what CMS believes is solely coding and documentation improvements. While CMS published an estimate of what it believes the coding adjustment is for FY 2009 (2.3 percent), the Agency chose not to further reduce the FY 2010 standardized amount and instead will wait until the FY 2011 rulemaking, when all 2009 claims are available.

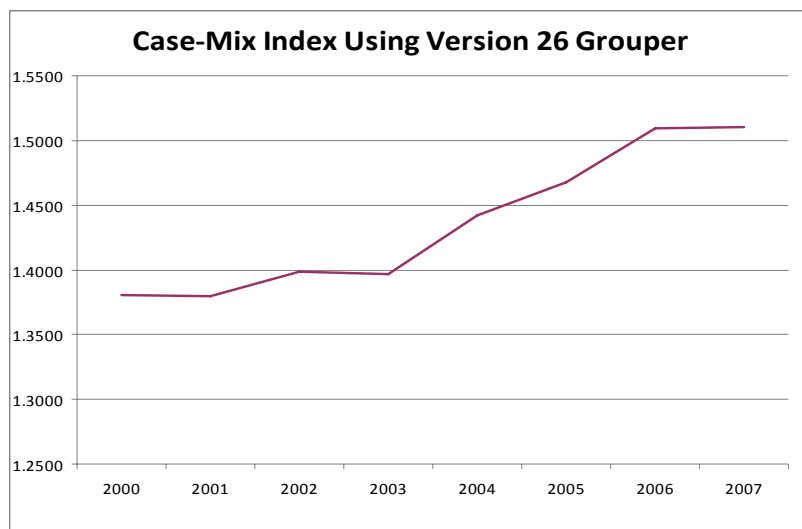
PL 110-90 also gave CMS the authority to make a further reduction to the standardized amount to "recoup" payments made in FYs 2008 and 2009 due to coding changes that were greater than the reductions contained in PL 110-90. CMS, however, chose not to propose an additional "2008 recoupment" adjustment but stated instead that the Agency would address this issue in the FY 2011 and FY 2012 rulemakings.

As teaching hospitals struggle to maintain financial stability during this economic recession, we appreciate that CMS used its discretion and did not propose to make any reductions related to FY 2009 coding changes and also chose not to seek any payment recoupments associated with FY 2008 documentation and coding changes.

However, we do have some concerns about CMS's finding that there was a decline in real case mix from FY 2007-2008 of negative 0.9 percent. Such a conclusion is at odds with an analysis conducted by The Moran Company at the request of the AAMC, along with the AHA and the FAH. Specifically, Moran ran the FY 2000 through FY 2007 claims data through the FY 2009 GROUPEX, which reflects the fully implemented MS-DRGs. This analysis provides a historical trendline for case-mix indices (CMI). Because there were limited incentives for documentation and coding changes prior to the implementation of MS-DRGs in FY 2008 and because Moran used a constant grouper, the observed CMI change should reflect real case mix only.

Moran's analysis found that from FY 2000 through FY 2007, CMI increased by about 9.3 percent, or about 1.3 percent annually. During this period there was only one notable change that might have provided hospitals with an incentive to improve documentation and coding. Specifically, in FY 2006, CMS replaced nine existing cardiac DRGs with 12 new cardiac DRGs that were based on the presence or absence of major cardiovascular conditions for cardiac patients undergoing certain procedures. It is possible that this change could have provided an incentive to improve documentation and coding. In order to account for the possibility that this change encouraged coding and documentation improvements, Moran also looked at CMI increases from FY 2000 through FY 2005 – before both the new cardiac DRGs and the new MS-DRGs were implemented – and found that CMI increased by about 6.3 percent, or about 1.2 percent annually. These changes occurred steadily over the time period – there were no jumps in any one or two years that entirely accounted for the changes. See Figure 1 for a graphic depiction of the CMI changes from FY 2000 through FY 2007.

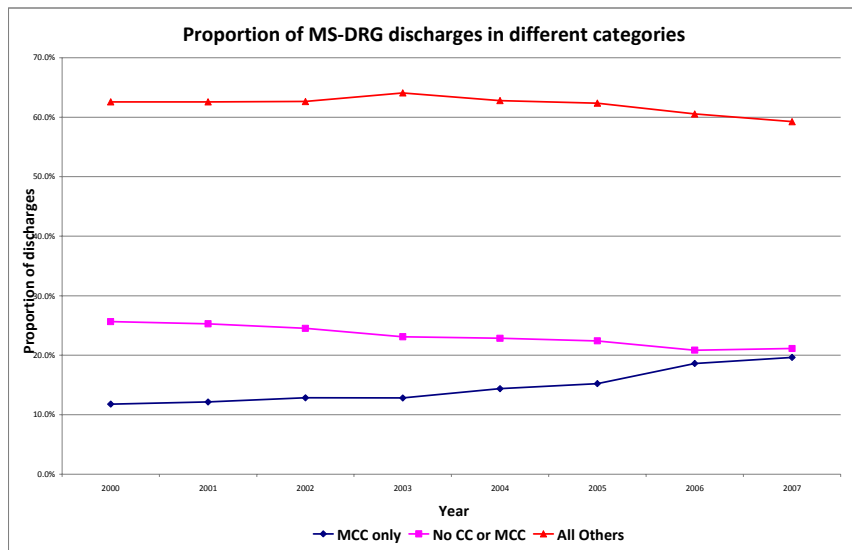
Figure 1: Case-Mix Index from FY 2000 through FY 2007 as Measured Using the Version 26 MS-DRG Grouper



We also asked Moran to look at changes in the mix of patients with and without major complications or comorbidities (MCCs) to analyze severity changes over this time period.

Moran found that the percentage of discharges for patients with MCCs increased from about 12 percent to about 20 percent from FY 2000 through FY 2007, while the percentage for patients without a CC or MCC decreased from about 26 percent to about 22 percent. These trends occurred steadily over the time period. Again, the results were similar for FY 2000 through FY 2005 – the percentage of discharges for patients with an MCC increased from about 12 percent to 15 percent and the percentage of discharges for patients without a CC or MCC decreased from about 26 percent to about 22 percent. See Figure 2 for a graphic depiction of these changes in the percentage of discharges for patients with different severity levels from FY 2000 through FY 2007.

Figure 2: Percentage of Discharges by MS-DRG Severity Level from FY 2000 through FY 2007



In order to understand the potential impact of the change in the cardiac DRGs in FY 2006 noted above, we also identified the 10 MS-DRGs with MCCs that had the largest increase in the percentage of discharges from FY 2000 through FY 2007. As noted above, in FY 2006, CMS replaced nine existing cardiac DRGs with 12 new cardiac DRGs that were based on the presence or absence of major cardiovascular conditions for cardiac patients undergoing certain procedures. It is possible that this change could have provided an incentive to improve documentation and coding. However, none of the 10 MS-DRGs referenced above were also one of the 12 new cardiac DRGs. See Table 1 for a list of the 10 MS-DRGs with MCCs that had the largest increases in the percentage of discharges from FY 2000 through FY 2007.

Table 1: MS-DRGs with MCCs with the Largest Increases in the Percentage of Discharges from FY 2000 through FY 2007

MS-DRG	MS-DRG Title
871	Septicemia or severe sepsis w/o MV 96+ hours w MCC
291	Heart failure and shock w MCC
682	Renal failure w MCC
314	Other circulatory system diagnoses w MCC
252	Other vascular procedures w MCC
391	Esophagitis, gastroent, and misc digest disorders w MCC
377	G.I. hemorrhage w MCC
853	Infectious & parasitic diseases w O.R. procedure w MCC
193	Simple pneumonia & pleurisy w MCC
371	Major gastrointestinal disorders & peritoneal infections w MCC

Taken together, these findings indicate that patient severity levels – indicative of real case-mix change – have steadily increased from FY 2000 through FY 2007, and that these increases are generally due to real case-mix change. CMS’s conclusion that there was a decline in real case mix is sharply at odds with historical trends suggesting real case-mix growth of 1.2 to 1.3 percent per year. In fact, CMS did not attempt to measure real case-mix change but instead derived it by comparing overall case-mix growth to its finding that documentation and coding-related increases were 2.5 percent. **An alternative approach of comparing the overall CMI growth of 1.9 percent with the historical average for real case-mix change of 1.2 – 1.3 percent would yield a much different documentation and coding effect.**

While CMS states that its observed decline in real case mix from FY 2007 to FY 2008 is due to a relative decline in above-average short-stay surgical cases that can be performed on an outpatient basis, such as certain high-volume pacemaker procedures, analysis shows that this change could not have decreased CMI by as much as CMS indicates. Moran analyzed the FY 2007 and FY 2008 volume of discharges for above-average short-stay surgical cases that can be performed on an outpatient basis, such as certain high-volume pacemaker procedures. While they found that the volume decreased substantially for some cases, at most, these decreases would have caused a 0.1 percent reduction in CMI, which does not account for the 0.9 percent decrease in CMI that CMS found.

Further, there are other policy changes that could have caused increases in real case mix, and should have mitigated any decrease due to the short-stay surgical cases. For example:

- The implementation of present-on-admission coding is leading hospitals to assess patients for a broader array of conditions. This is likely to result in additional secondary diagnoses being identified, treated and coded, which involves a real increase in resource use and, therefore, real case-mix change.
- The Recovery Audit Contractor program is encouraging hospitals to more carefully scrutinize low-acuity patients and shift care to the outpatient setting to avoid retrospective

denial of short-stay admissions. This change in practice will increase the average acuity within each base DRG of patients that remain in the inpatient setting.

- *The Medicare Prescription Drug, Improvement, and Modernization Act of 2003* (MMA) changes accelerated beneficiaries moving to Medicare Advantage. Overall, Medicare Advantage has been shown to enroll the healthier segment of the Medicare population, thereby increasing the average acuity level of the population that remains in fee-for-service Medicare.¹
- Effective in calendar year 2008, CMS made dramatic changes in the criteria for procedures that can be done in an ambulatory surgery center, thereby adding hundreds of additional procedure types. We believe that these changes are accelerating the move of lower-acuity patients to the outpatient setting, again resulting in increased acuity in the inpatient setting. The majority of ambulatory surgery centers involve physician ownership and self referral, creating a strong incentive for shifts in site of service that did not exist when physicians were deciding between the inpatient and outpatient hospital setting.

As stated above, our analysis found a historical pattern of steady annual increases of 1.2 to 1.3 percent in real case mix, which directly conflicts with CMS's conclusion that there was a decline in real case mix from FY 2007 to FY 2008. Because CMS's conclusion that real case mix declined is an inference based on its analysis of documentation and coding-related increases, we believe that the Agency's finding that there were documentation and coding-related increases of 2.5 percent in FY 2008 is incorrect. Further, the reason that CMS has set forth to explain this decline in case mix (that there was a relative decline in above-average short-stay surgical cases that can be performed on an outpatient basis) is not compelling. **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, in the final rule, CMS significantly mitigate the documentation and coding reduction**

LABOR-RELATED SHARE

The propose rule would decrease the labor-related share (used to determine the proportion of the IPPS base payment to which the area wage index is applied) from 69.7 percent to 67.1 percent due to the use of more recent data, as well as the removal of a portion of professional service labor costs from the labor-related share calculation. We have major concerns about the methodology used to remove the portion of professional service labor costs. We believe CMS must reject this methodology and continue to classify these costs in the same manner as has been calculated historically.

¹ See Medicare Payment Advisory Commission, *The Medicare Advantage Program and MedPAC Recommendations*, Testimony before the Committee on the Budget, U.S. House of Representatives, June 28, 2007.

CMS's proposal rests largely on an *ad hoc* survey of only 108 hospitals which indicated that about one-third of professional services labor costs are purchased "outside of their local labor market." 108 hospitals, which represents only three percent of total hospitals, does not constitute a representative sample and therefore the results should not be the basis of a policy change as significant as the one proposed.

CMS states that its policy motive for the proposed change is that the Agency is continuing "to look for ways to refine our market basket approach to more accurately account for the proportion of costs influenced by the local labor market." (74 Fed. Reg. at 24159). The AAMC asked The Moran Company to assess the proposed labor-related share change and its relationship to CMS's policy goal. We urge you to review their comments, which are appended to this comment letter. In brief, their view is that the proposed change is "counter-intuitive" to CMS's policy goal and would actually dampen the sensitivity of the IPPS payment methodology to area wage variations. As stated by Moran:

Academic medical centers located in large urban markets are the most likely hospitals to be in markets with substantial local competition for professional services—markets in which professional services fees are most likely to be influenced by local labor market conditions. . . . As a result, a methodology premised on the assumption that 73% of home office costs reflect national average wage patterns produces a substantial downward payment bias for teaching hospitals.

Source: "Assessing the Policy Case for CMS's Proposed Revision to the Labor-Related Share Determination Under the Hospital Inpatient Prospective Payment System. The Moran Company, June 2009.

We understand that if CMS were to only use more recent data, and hold all other aspects constant, the labor-related share would actually be increased to 72.07 percent. We urge CMS to consider this option. At a minimum, however, the current labor-related share of 69.7 percent should be retained, pending further study and analysis.

THE OUTLIER PAYMENT THRESHOLD

Under the Medicare IPPS, if the costs of a particular Medicare case exceed the relevant DRG operating and capital payment (including any DSH, IME, or new technology add-on payments) plus an outlier threshold, the hospital will receive an outlier payment. This payment equals 80 percent of the case's costs above the threshold calculation.

The outlier fixed-loss cost threshold is set at a level that is intended to result in outlier payments that are between five and six percent of total IPPS payments. Outlier payments are budget-neutral. Each year the Agency finances the outlier payment pool by reducing the inpatient standardized amount by 5.1 percent and estimating a cost threshold that should result in outlier payments that equal 5.1 percent.

The proposed rule would increase the fixed-loss cost threshold for outlier payments to be equal to a case's DRG payment plus any IME and DSH payments, and any additional payments for - new technologies, plus \$24,240, an increase of 21 percent above the FY 2009 threshold of \$20,045. The AAMC does not support the proposal to increase the outlier threshold to \$24,240 for FY 2010. Such an impact will significantly and negatively affect major teaching hospitals that have a disproportionate amount of outlier cases. These hospitals already incur losses when treating these patients, because they currently must incur \$20,045 in costs above payments before the outlier policy applies. And even under the outlier policy, these hospitals are not reimbursed for the threshold level costs and are only reimbursed for 80 percent of costs above the threshold.

To assess the outlier proposal, the AAMC, along with the AHA and FAH, asked Vaida Health Data Consultants (Vaida) to review the methodology and provide its view about how the methodology could be improved. We have appended the Vaida report to this comment letter. **We urge CMS to review the report and accept the recommendations contained therein, which would result in an outlier threshold of \$23, 305.** While this amount is still significantly higher than the current threshold, we believe it reflects a rational and well-reasoned methodology.

In its review, Vaida noted that the data used by CMS includes approximately 376,000 Medicare managed care claims. The data also reflect organ acquisition charges for organ transplant patients; given that these costs are paid separately from the IPPS system, the associated charges should not be considered when estimating outlier payments—which affects the fixed cost threshold. Removing both the managed care claims and the organ acquisition costs affects the outlier payments in opposite ways. The managed care claims tend to have fewer outliers, thus resulting in a lower fixed-loss amount than if these claims had not been included. The inclusion of organ acquisition charges, however, which tend to be higher than other hospital charges, results in an increase in the overall estimated outlier payment level. This in turn results in an overestimation of the fixed-loss amount. The combined effect of including the managed care claims and the organ acquisition charges results in an overestimation of the outlier threshold by \$130, a net \$191 million loss for all hospitals.

Vaida also makes two other recommendations regarding the outlier methodology that we believe CMS should adopt. The first is to recognize that hospitals have different fiscal year ends and, rather than project the cost-to-charge ratios (CCRs) for all hospitals for a period of one year, to base the CCRs for all hospitals over a period of two years. Such a change would acknowledge that hospitals have different fiscal year ends and would utilize their most current CCR as it becomes available. The second recommendation is to use a recent historical industry-wide average rate of change of CCRs as the projection factor rather than utilizing the relationship between actual costs and the hospital market basket and assuming that the rate of change is constant over time. More detail is provided in the attached Vaida Report. The net result of accepting these two recommendations and making the data changes due to the managed care claims and organ acquisition costs would result in an outlier threshold for FY 2010 of \$23, 305.

CHANGES TO THE HOSPITAL MARKET BASKET

The hospital market basket reflects the mix of goods and services used to provide hospital care. The change in the prices of these services forms the basis for the update that is the integral component of the update factor by which the IPPS standardized base payment amount is increased each year.

For FY 2010, CMS proposes to “rebase” (use data from 2006 rather than 2002) and “revise” (change data sources used in the market basket methodology) the hospital operating and capital market baskets that are used as the basis for setting the standardized operating and capital payment updates.

We believe that the projected increase in the market basket for FY 2010 (which is used for FY 2010 payments) may be lower than what will ultimately be the actual increase. While we acknowledge that currently the hospital sector is experiencing a period of very low inflation now, the infusion of funds from the American Recovery and Reinvestment Act of 2009 may result in a level of price increases that are higher than currently projected. Given this period of uncertainty, and the fact that CMS is not required to revise the price proxies used in the market calculation, we urge the Agency to only rebase the data used in the calculation to reflect 2006, rather than 2002 data.

REFINEMENT OF THE MS-DRG RELATIVE WEIGHT CALCULATIONS

CMS engaged the RAND Corporation to study the MS-DRG relative weight methodology and to evaluate alternative standardization methodologies used in that methodology that can account for systematic cost differences across hospitals. Among these alternatives was an examination of the hospital-specific relative value (HSRV) standardization process, which standardizes the costs for a given discharge by the hospital’s own costliness. RAND found that “there is no clear advantage to the HSRV method or the HSRVcc method of standardizing cost compared to the current hospital payment factor standardization method . . .” (74 Fed. Reg. at 24103).

We, and others, have long opposed the HSRV standardization methodology because it unfairly disadvantages teaching hospitals that have patient care costs due to their education and research missions. We hope that RAND’s findings will bring to an end the discussions of potentially using the HSRV methodology.

RAND also opined that the current standardization method may “over-standardize” the per case costs for certain hospitals that receive payment adjustments, such as IME and disproportionate share (DSH), by removing more variability than can be empirically supported as being cost-related. However, RAND also noted that re-estimating these payment factors (such as IME and DSH) “raises important policy issues that warrant additional analyses.” (74 Fed. Reg. at 24103).

While we appreciate CMS's efforts to improve the accuracy of the MS-DRGs, modifying the IME and DSH factors, even if only for standardization purposes, raises complex and difficult issues. These payments are of critical importance to teaching and safety net hospitals and should not be altered without serious discussion of all of the potential consequences.

We also note that the changes that have been implemented to the DRG system over the past several years are the most far reaching since the IPPS was originally implemented. Hospitals are still learning and understanding these changes. In addition to these technical, yet significant changes, hospitals also are dealing with Medicare payment changes, such as the quality reporting requirements. Perhaps most importantly, however, are the serious discussions that are occurring regarding payment consequences for readmissions, and movement towards bundling of payments across providers. These types of changes will fundamentally change the Medicare IPPS system. Given all of the changes that have been implemented, as well as those being contemplated, we believe additional technical modifications to the DRG system are unwarranted, particularly at this time.

HOSPITAL ACQUIRED CONDITIONS (HACs)

The Deficit Reduction Act (DRA) required the Secretary to identify at least two conditions that are: high cost or high volume or both; result in a DRG that has a higher payment when present as a secondary diagnosis; and could have been reasonably prevented through the application of evidence based guidelines. Effective October 1, 2008, any claim submitted that includes one of the selected conditions, that is not present on admission (POA) and is the only complication condition or major complication condition (CC or MCC) listed is no longer reimbursed at the rate of the higher paying DRG.

For FY 2010, CMS is proposing to not make any additions or deletions to the current list of HACs nor make any changes to the POA reporting or payment. Instead, CMS will be conducting an evaluation of the impact of the HAC program through a joint agreement with the Centers for Disease Control (CDC) and the Agency for Healthcare Research and Quality (AHRQ). The evaluation will be based on early program data and will focus on the selection and maintenance of the HAC categories and the reporting of POA data.

We are very pleased to see that CMS will be conducting a formal evaluation of the HAC program prior to taking any further action, such as the expansion of the clinical conditions or, as proposed in an earlier rulemaking, consideration of expansion to the hospital outpatient setting. Since the implementation of the HAC program, teaching hospitals have put in place programs and processes to avoid these potential complications whenever possible. We hope that the program evaluation can help determine whether or not there has been an impact on the occurrence of these complications and/or whether or not there may be other alternatives to explore to minimize these complications and ultimately improve the quality of care for patients. We would also like to request that the results of the evaluation be made public for all stakeholders to review.

REPORTING HOSPITAL QUALITY DATA FOR ANNUAL PAYMENT UPDATE (RHQDAPU)

The Medicare Modernization Act created a Quality Reporting Program that required hospitals to submit data on a set of quality performance measures in order to receive their full payment update and imposed a penalty for those hospitals that did not participate. The Deficit Reduction Act (DRA) of 2005 increased the number of required measures for submission as well as increased the penalty for not reporting. The DRA also gave the Secretary the authority to continue to increase the number of measures reported that reflected consensus among affected parties as well as retire and/or replace those measures that were no longer relevant or scientifically current.

Measures

CMS is proposing the addition of four measures: two chart abstracted surgical care measures and two structural measures based on participation in clinical registries for the FY 2011 payment determination. This would bring the total number of measures required for the annual payment update to 46 measures.

Two of the proposed measures would require hospitals to indicate whether or not they participate in a stroke or nursing care registry. We support the use of registries, as many of our members participate in or have developed their own clinical registries. Registries allow providers to effectively manage specific patient populations and provide the ability to measure provider performance as well as patient outcomes. However, participating in a registry in of itself is not a proxy for quality care.

Public reporting of registry participation may lead to a false assumption on behalf of consumers and patients that the quality of a hospital can be judged on whether or not they participate in a particular condition specific or provider of care registry. In addition, we are concerned that these measures would implicitly encourage hospitals to participate in external registries that require a costly fee to participate.

While the four proposed measures have been endorsed by the National Quality Forum (NQF), they have not been reviewed or approved by the Hospital Quality Alliance (HQA). We strongly believe that all measures that are implemented in the quality reporting program must go through the endorsement process of both the NQF and the HQA. The NQF and HQA represent multi-stakeholder groups and are the primary organizations involved in endorsing hospital performance measures for public reporting. Both of these organizations apply specific criteria for evaluation of the measures to determine those measures that are the most salient for quality improvement and public reporting. Since these measures have not been endorsed by both of these organizations, we cannot support their implementation.

While we appreciate CMS's attention to provider burden regarding measure selection, we believe that CMS should select a measure set from the list of already approved HQA measures such as the Stroke, VTE or Infection measure sets. These sets represent evidence based guidelines to improve the quality of care of care and safety of the patient. The measure sets are also aligned with the NQF National Priorities.

Measure Harmonization

Currently, both the AHRQ and Nursing measure sets have a measure titled "Death Among Surgical Patients with Serious Treatable Complications." These measures are not different and share the same set of specifications. CMS has proposed to harmonize (which in this case is really eliminating) one of the measures, and the remaining measure would be listed under the combined topic area of AHRQ PSI and Nursing Sensitive Care. We support CMS's decision to eliminate one of the measures, as they are in fact the same measure. However, we do not support the measures being reported twice on Hospital Compare in both the Nursing and AHRQ topic areas, as this could be confusing and misleading to the consumer. We believe the organization of the measures currently by topic area points to a limitation in the display of information on the Compare website and should be revisited as part of a larger effort to revise the website.

Validation

As we stated in our FY 2009 IPPS comment letter, we support modifying the current validation program and believe the process being considered has merit. We believe that the proposed validation system minimizes the burden for many hospitals and implements a more rigorous process for validation compared to what is currently in place. However, we would like to clarify that with the new system, only those hospitals that are selected for validation would have their payment at risk, and the remaining hospitals would not be affected in any way by the results of the selected hospitals for that given year.

Since the validation program would be a new process for hospitals, there should be an initial trial period so hospitals can get accustomed to the new process without fear of penalty. In the FY 2009 IPPS rule there was discussion of conducting a test run where CMS would randomly select hospitals to participate in the validation program on a voluntary basis. We are supportive of conducting such a test for the initial year period or at least prior to the new requirements being implemented.

Electronic Health Records

As CMS begins to develop the capability and requirements for reporting of quality data through electronic health records, we encourage you to work closely with other organizations working in this area such as the NQF. The NQF has created a Health IT Expert Panel (HITEP) that has done a significant amount of work in electronic reporting of quality data and is currently working on developing a quality data set (QDS) as well as identifying dataflow changes to enable automation

of performance measures through electronic health records (EHRs) and health information exchanges. The information from the HITEP panel should be very informative as you continue to make critical decisions regarding the definition of “meaningful use” of HIT

DEADLINE FOR NEW HOSPITALS TO JOIN GME AFFILIATED GROUPS

Existing teaching hospitals that meet specified criteria may enter into Medicare GME affiliation agreements, under which they may combine their respective resident caps and redistribute them according to their agreement. In the proposed rule, CMS proposes to increase flexibility in submission deadlines for new hospitals joining Medicare GME affiliated groups.

Current regulations require each hospital in a GME affiliated group to submit its Medicare GME affiliation agreement to its intermediary or Medicare Administrative Contractor (MAC) and the CMS Central Office no later than July 1 of the residency program year during which the agreement would be in effect. This deadline precludes new hospitals opening after July 1 from immediately entering into GME affiliation agreements. CMS’s proposal permits a new hospital that opens after July 1 of a given year to submit a GME affiliation agreement at any time prior to the end of its first cost reporting period to participate in an existing affiliated group. The AAMC appreciates CMS’s attention to this issue and supports this proposal as a logical remedy for the technical problem new hospitals currently face in immediately joining affiliated groups.

MODIFICATION TO THE MEDICARE DSH CALCULATION

Under the Social Security Act, hospitals that serve a disproportionate number of low-income patients may qualify for a Medicare DSH adjustment. Under the most common method for qualifying for the DSH adjustment, a hospital’s DSH payments are based in part on the level of the hospital’s disproportionate patient percentage (DPP). The DPP is the sum of what is referred to as the “Medicare fraction” (the number of inpatient days furnished to patients entitled both to Medicare Part A and SSI benefits divided by the total number of inpatient days furnished to patients entitled to Medicare Part A benefits) and the “Medicaid fraction” (the number of inpatient days furnished to patients eligible for Medicaid but not entitled to benefits under Medicare Part A, divided by the total number of inpatient days).

CMS proposes to offer hospitals additional options regarding the methodology used to report days in the numerator of the DPP Medicaid fraction. The Agency states that its current policy requires hospitals to report Medicaid inpatient days in the cost reporting period in which a patient is discharged, but the Agency acknowledges that hospitals currently may be using other methods. Under the proposed rule, hospitals would be able to report Medicaid inpatient days in the cost reporting period in which the patient was discharged *or* admitted *or* based on dates of service.

During the May 6, 2009, Hospital Open Door Forum teleconference, CMS stated that a hospital must notify the Agency if it intends to use a methodology other than date of discharge for

reporting Medicaid-eligible days. The proposed rule preamble language and the proposed regulations at 42 C.F.R. § 412.106(b)(4)(iv), however, indicate that the hospital must notify CMS only if it is seeking to make a “change” to its methodology, while acknowledging that hospitals currently may be using other methods of counting Medicaid-eligible days other than date of discharge. 74 Fed. Reg. at 24188. The AAMC urges CMS to clarify in the final rule precisely under what circumstances hospitals must submit a notification to CMS.

EMTALA WAIVER REGULATIONS

The Emergency Medical Treatment and Labor Act (EMTALA), also commonly referred to as the patient “anti-dumping” statute, imposes certain obligations on Medicare-participating hospitals regarding the examination and treatment of individuals who come to a hospital emergency department for examination or treatment of a medical condition. EMTALA also permits the temporary waiver of several of the Act’s requirements in emergency areas during emergency periods. In the FY 2010 IPPS Proposed Rule, CMS proposes to align the statutory requirements with those of the EMTALA regulations.

The AAMC supports CMS’s efforts to ensure that the regulations more accurately reflect the EMTALA statutory language. One of CMS’s proposed changes to the EMTALA regulations should, however, be clarified. In the proposed rule, CMS proposes to amend the EMTALA regulations at 42 C.F.R. § 489.24(a)(2)(i) to permit waiver of EMTALA sanctions only if the “inappropriate transfer” “arises out of the circumstances of the emergency.” The AAMC believes this proposed language lacks clarity and may be subject to various interpretations. The AAMC agrees with the AHA’s comments that the proposed regulatory language for inappropriate transfers should more closely mirror the language in the Social Security Act and read as follows: “(a) If relating to an inappropriate transfer, the transfer is necessitated by the circumstances of the declared emergency.”

MEDICARE PAYMENTS FOR NEW TECHNOLOGIES

Pursuant to the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), CMS established a methodology in a September 7, 2001 final rule (66 Fed. Reg. 46902) that would provide additional payments to hospitals for new technologies that they use and that are not yet reflected in the DRG payment system. To qualify for the additional payments, a technology must meet three criteria under the DRG system, one being that the technology must be “new.” In addition, in the FY 2006 IPPS final rule, CMS established certain conditions that would allow new technology add-on payments for the new use of an existing technology. Specifically, the new use of the existing technology cannot be substantially similar to the use of the existing technology. The final rule included two factors to consider in determining whether the two technologies are “substantially similar”: (1) whether the product uses the same or a similar mechanism of action to achieve a therapeutic outcome; and (2) whether the product is assigned to the same or a different MS-DRG.

As a result of an application the Agency received regarding the CLOLAR® (clofarabine)

Charlene Frizzera
June 30, 2009
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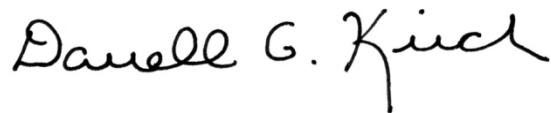
Injection, CMS is proposing to take into consideration for “substantial similarity” determinations whether an existing service or technology has a new indication. Under this proposal, CMS would add the following factor to the two factors (discussed above) the Agency already uses to make its determination of “substantial similarity”: whether the new use of the technology involves the treatment of the same or similar type of disease and the same or similar patient population. Because, in the CLOLAR example, the device would be used to treat a different patient population than the pediatric population for which it was originally approved, CMS believes that the new indication is not substantially similar to the previous indication and that the device would therefore be eligible for new technology add-on payments.

The AAMC agrees with CMS and supports the proposal that treatment of a different type of disease or different patient population should be taken into consideration when determining whether a new indication is substantially similar to a previous indication, and consequently eligible for the new technology add-on payment.

CONCLUSION

Thank you for the opportunity to present our views. We would be happy to work with CMS on any of the issues discussed above or other topics that involve the academic health center community. If you have questions regarding our comments, please feel free to contact Karen Fisher, J.D., at 202-862-6140 or at kfisher@aamc.org.

Sincerely,

A handwritten signature in black ink that reads "Darrell G. Kirch". The signature is written in a cursive style with a large, prominent 'K'.

Darrell M. Kirch, M.D.

cc: Joanne Conroy, M.D., AAMC
Karen Fisher, AAMC

**Assessing the Policy
Case for CMS's
Proposed Revisions to
the Labor-Related
Share Determination
Under the Hospital
Inpatient Prospective
Payment System**

June, 2009

THE MORAN COMPANY

Assessing the Policy Case for CMS’s Proposed Revisions to the Labor-Related Share Determination Under the Hospital Inpatient Prospective Payment System

On May 1, 2009, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule for the Medicare Inpatient Prospective Payment System (IPPS) changes that will be implemented on October 1, 2009.² As part of that proposed rule, CMS proposes to “rebase” and “revise” the market basket used to measure hospital input cost inflation.³ The proposed revisions will, among other effects, change the “labor-related share” used to determine what portion of payments to a hospital under the IPPS should be adjusted to reflect local variations in labor costs.⁴ The revisions CMS has made have the effect of lowering the labor-related share from the 69.731% value implemented in Fiscal Year (FY) 2009 to 67.062% in 2010.

The Moran Company was engaged by the Association of American Medical Colleges to evaluate the policy rationale underlying this proposed change, and assess what this methodology change implies for payment accuracy from the perspective of academic medical centers. Our findings are as follows:

- While CMS is statutorily required to “rebase” the IPPS market basket for FY 2010, it faces no comparable requirement to “revise” the data concepts underlying the labor-related share calculation.
- The specific changes CMS proposes to make are material; if they are not made, the labor-related share calculation would support a valuation in excess of 72.000%.
- CMS advances no explicit policy case for the adjustments other than a general appeal to more accurate accounting of such costs.
- The implicit rationale behind the proposal—that a substantial share of labor-related costs in professional and managerial services is not “local”—does not mean that such costs do not vary from locality to locality based on labor market conditions.
- The policy, as proposed, would differentially affect hospitals—including most academic medical centers in the United States—that operate in markets with above-average labor costs.
- Given the stated intent of the policy, this result is counter-intuitive—since hospitals in large metropolitan areas are in fact most likely to be in markets where the labor costs associated with professional and home office services are determined by local labor market conditions.

Our rationale for these findings is presented in the balance of this report.

² *Medicare Program, Proposed Changes to the Hospital Inpatient Prospective Payment System for Acute Care Hospitals and Fiscal Year 2010*. Display copy CMS-1406-P.

³ CMS-1406-P, p. 282ff.

⁴ CMS-1406-P, pp. 383-310.

The CMS Proposal

In the preamble to the proposed rule, CMS notes that while it is required to “rebase” the hospital market to later data at least every four years, its mandate to “revise” the underlying data concepts for the labor-related share says it must do so “from time to time.”⁵ Thus the CMS proposal represents a discretionary decision to make the proposed change in FY 2010.

The question CMS is addressing turns on the treatment of the costs of outside professional and managerial services used by hospitals. The policy addresses both specified professional services contracted by the hospital (legal, accounting, engineering and management consultant services), and the costs associated with operations and management services incurred by hospital systems to which the hospital may belong—which are provided outside the labor market in which the hospital is located. Through FY 2009, the market basket concept used to establish both the annual update and the labor-related share determination have been based on the assumption that the labor portion of those costs should be adjusted to reflect wage variation across labor markets.

For FY 2010, CMS is proposing two changes.

First, it proposes to reduce the share of professional services labor costs counted as “local.” Based on data from an *ad hoc* survey CMS conducted in late 2008, it proposes to revise these allocations based on a determination that approximately a third of these costs are purchased “outside of their local labor market,” and hence are not “local.”⁶

Second, it proposes to reduce the share of costs in NAICS 55 “Management of Companies & Enterprises” to reflect findings, from a separate analysis of data from its Home Office Medicare Records (HOMER) database suggesting that only 27% of these costs should be classified as “local” and adjusted for area wage variation.

The combined effect of these two adjustments is material. In the published rule, CMS noted that the effect would be to lower the labor-related share from 69.731% in FY 2009 to 67.062%. The actual effect of these adjustments, however, is much larger. According to an analysis prepared by the CMS Office of the Actuary, in the absence of these changes, rebasing to the 2006 data would have resulted, holding all other aspects of the rebasing constant, in a labor-related share of 72.074%⁷. Virtually all of the change, according to this analysis, is due to the reclassification of NAICS 55 costs as national: the reclassification of the professional services costs reduced the labor-related share by 0.8%, while the NAICS classification lowered it by 4.2%.

The Policy Rationale for the CMS Proposal

In presenting its proposal, CMS indicates that the policy motive for these revisions is that, “We continue to look for ways to refine our market basket approach to more accurately account for the proportion of costs influenced by the local labor market.”

⁵ CMS-1406-P, p. 285.

⁶ CMS-1406-P, pp 303-305.

⁷ Supplemental information provided by the Office of the Actuary in response to a written request.

In the absence of definitive evidence regarding the cost structure of hospitals related to these services, it is not possible to determine whether the adjustments CMS is proposing will actually improve payment accuracy. Yet given the specific approach CMS has taken to these adjustments, there is reason for some concern that the decision to lower the labor-related share may actually retard payment accuracy.

This concern flows from the fact that, under the CMS market basket methodology, all labor costs are partitioned into two baskets: those that are “local,” and hence subject to adjustment for local labor market variations, and those that are “non-local”, and hence are not adjusted at all for area wage variations. Even if CMS is correct in its conclusion that a substantial share of labor-related costs is “non-local,” it does not necessarily follow that such costs do not vary based on local labor market conditions. While the CMS methodology implicitly assumes that the labor costs associated with these “non-local” services more closely reflect the national average than labor market conditions in the local area of the hospital receiving the services, there are a number of reasons to question this conclusion in the absence of more definitive data.

The Market for Hospital Professional Services

In the market for professional services provided to hospitals, our experience suggests that the participants can be partitioned into the following categories:

- Truly local firms whose clientele is comprised of the hospitals in a specific geographic area, e.g., the management consulting subsidiary of a municipal hospital association;
- Local offices of regional or national firms that will staff local assignments with some mix of local and non-local professionals;
- Firms that are “regional,” in the sense of serving multiple geographic markets from a centralized location, e.g., a state capital; and
- Truly national firms, that operate nationwide from a single headquarters office, and who serve local hospitals without assistance from locally-based practitioners.

The CMS methodology is premised on the assumption that a bright line can be drawn between these categories, with the implicit assumption that any firm that does not fall into the first category would experience labor costs indistinguishable from those that fall in the last category. Yet in reality all such firms compete against each other in each local market. To the extent that the bids of local competitors (in either local, regional or national firms) are shaped by the local market for professional labor, outside competitors have to be willing to at least match those bids if they want the business.⁸ Hence local labor market conditions drive the prices local hospitals will pay for professional services even if those services wind up being rendered by professionals from out of town.

The implication that there is a national market for the labor costs underlying these services is not borne out by the available facts. There is, in fact, substantial regional variation in salaries paid to entry-level and early-career professionals who represent the lion’s share of the cost that will be

⁸ In fact, firms with no local presence face competitive disadvantages due to the costs of maintaining non-local personnel on site during the conduct of engagements.

billed to hospitals. In 2008, entry-level associate salaries in New York law firms fell in the range of \$145,000-\$160,000 annually, while the range in Kansas City was \$75,000-\$105,000.⁹ Even within States, variation can be significant: legal salaries in the Washington DC suburbs in Virginia are more than 14% higher than they are 90 miles down the road in Richmond.¹⁰ Similar variation can be seen in other fields. Starting accounting salaries are 18 percent higher in Boston than they are in Dallas,¹¹ while industrial engineers in Boston have median earnings 33% higher than in Little Rock.¹²

Putting these pictures of the market for professional services to hospitals together, it is clear that a payment methodology premised on the notion of a national professional services market with uniform prices fails to reflect the reality of what hospitals pay for professional services. In fact, it seems likely that the volume of services being rendered to local hospitals by national firms without local or regional offices may be *de minimus*.¹³ Since CMS did not disclose, in either its Federal Register notice or the proposed rule, the content of the survey instrument that was used to gather the data used in this analysis, it is impossible to tell how professional services firms were identified as being “national firms.”¹⁴ As the foregoing suggests, determining the “localness” of a contract based on the mailing address of the contractor could materially understate the volume of services rendered by national or regional firms with a local presence, who would be fully subject to local labor market conditions.

Home Office Expenses

The application of a “non-local equals national” dichotomy to home office cost allocations is potentially equally problematic. Even supposing that only 27% of all home office costs are incurred in the same geographic market as the local hospital to whom those costs are allocated, it does not necessarily follow that the remainder of these costs is normally distributed across the U.S. labor market as a whole. There are two reasons to be concerned about this implicit assumption.

First, it is generally understood that there is a significant degree of correlation between the location of a multi-hospital system, and the geographic locations of its member hospitals. All systems except the limited number of truly national hospital chains tend to be clustered in sub-areas of the country. Therefore, an assumption that 73% of home office labor costs more closely resemble national versus regional wage patterns is not necessarily supported by the methodology CMS is proposing.¹⁵

⁹ www.infirmation.com/shared/search/payscale-compare. June 9, 2009.

¹⁰ www.valawyersweekly.com/specialfeatures/summer-associates-salary-survey/. June 9, 2009.

¹¹ www.payscale.com/research/US/job=accountant/. June 9, 2009.

¹² www.bls.gov/oes/oes-data.htm. June 9, 2009.

¹³ Even if the prevalence of services rendered by such firms was significant, such firms would be likely to be headquartered in urban areas, and hence have wage structures materially above the national average.

¹⁴ CMS-1406-P, p. 305.

¹⁵ The HOMER data CMS indicates it used to reach this conclusion would, in fact, support analysis of whether the distribution of home office costs across U.S. labor markets in fact reflects the national average. There is no evidence, however, that CMS conducted this analysis.

Second, it is generally the case that home office operations of multi-hospital systems and chains tend to be located in urban areas, even if the hospitals in the system or chain are ex-urban or rural. This implies that average wage costs in these system headquarters may be systematically higher than the national average wage cost, making a national pricing proxy suspect in this case as well.

Impact of the Proposed Policy

If implemented as proposed, the practical effect of this policy would be to dampen the sensitivity of the IPPS payment methodology to area wage variations. This results directly from the fact that the policy makes the labor-related share percentage materially smaller than it would be in the absence of this methodology change. Hospitals in the lowest-wage areas would receive higher payments; hospitals in the highest-wage areas—which include a large share of the nation’s academic medical centers—would receive lower payments.

The magnitude of these payment variations will be large. As noted earlier, the two proposed methodology changes, holding all other elements of the rebasing constant, lower the labor-related share of operating payments by five percentage points. A California medical center with an area wage index of 1.5000 would have its operating payments reduced by 2.5% solely by reason of this change.

Given the stated intent of the policy, this result is counter-intuitive. Academic medical centers located in large urban markets are the most likely hospitals to be in markets with substantial local competition for professional services—markets in which professional services fees are most likely to be influenced by local labor market conditions. Similarly, to the extent that academic medical centers are associated with multi-hospital systems, the headquarters costs for such systems are substantially more likely to be located in the same MSA as the academic medical center.¹⁶ As a result, a methodology premised on the assumption that 73% of home office costs reflect national average wage patterns produces a substantial downward payment bias for teaching hospitals.

Given the limited amount of information CMS has presented about the distribution of these costs across hospitals, it is impossible to reach a conclusion about whether this change increases or decreases payment accuracy in the aggregate. From the perspective of academic medical centers, however, it seems highly likely that the proposed changes would adversely affect payment accuracy as CMS has proposed to define it.

¹⁶ As noted, CMS’s HOMER data would permit analysis of this question.

Addendum 2

VAIDA HEALTH DATA CONSULTANTS

3209 Curlew Street Davis, California 95616-7517 (530) 758-0493
E-mail: vaida@dcn.davis.ca.us

June 15, 2009

MODELING FFY 2010 OUTLIER PAYMENTS

DATA SOURCES.

1. The MEDPAR 2008 computer file obtained from CMS. The file contains 13,122,134 records, each corresponding to a Medicare hospital discharge occurring in FFY 2008.
2. CMS FFY 2010 Impact File (Proposed Rule Version). This file produced by CMS shows the estimated level of FFY 2010 outlier payments by hospital (as percentages). It also shows the hospital-specific parameters used for calculating PPS payments, such as DSH and IME adjustment factors, cost to charge ratios (CCRs), wage indexes, etc.
3. The March 2009 update of the Provider Specific File (PSF)¹⁷. The file consists of data used by Fiscal Intermediaries to determine IPPS payments.

REPLICATION OF THE CMS ESTIMATED 2010 OUTLIER PAYMENT LEVELS (IPPS 2010 PROPOSED RULE).

The regular and outlier FFY 2010 payments were estimated for 11,003,513 discharges in the MEDPAR database subject to IPPS. These are the same discharges used by CMS to generate the 2010 Proposed Rule Impact File¹⁸. It is noteworthy that 3.4 percent of these discharges are attributable to Medicare Advantage (MA) managed care patients identified in the MEDPAR file as “Paid by HMO”. The overwhelming majority of these claims are “no payment” claims. Hospitals are required to submit such claims for determining the disproportionate share and indirect medical education adjustments. Since hospital services to MA managed care patients are not paid under IPPS, claims attributable to these patients should not be included in estimating the impact of the Proposed Rule and the proposed 2010 outlier fixed loss amount¹⁹. Since some of the models discussed here attempt to match the CMS calculations to the greatest extent possible, the MA managed care discharges were included unless stated otherwise. The exclusion of MA managed care claims will be discussed in a separate section.

¹⁷ The PSF version used for the Proposed Rule was the December 31, 2008 update. The March 2009 update available at the time of this writing incorporates all the earlier PSF data.

¹⁸ These are discharges subject to IPPS and with non-zero covered days and charges. The number of these discharges is the same as the number of “Bills” for virtually all the hospitals in the Impact File.

¹⁹ In the Proposed Rule CMS stated explicitly that MA claims were excluded from the calculation of the proposed 2010 MS-DRG weights. It is my understanding that others have found that may not have been the case.

Regular payments were calculated based on the proposed DRG weight, the patient discharge destination (for identifying transfers), the applicable proposed standardized amounts and the other hospital-specific parameters determining PPS payments. The latter are the wage index, the non-labor cost of living adjustment, and the DSH and IME adjustment factors. Each of these parameters has different values applicable to operating and capital payments. The parameters were obtained from the CMS Impact File.

Outlier payments were calculated inflating 2008 charges by 15.11 percent and projecting Impact File cost to charge ratios to 2010 (using the charge inflation factor and the CCR projection factors from the 2010 Proposed Rule). The inflated charges were reduced to costs using the projected cost to charge ratios and compared to the proposed FFY 2010 fixed loss amount of \$24,240. The latter was adjusted as appropriate on a hospital-specific basis.

Following CMS' approach, the 2010 outlier payment projections incorporated a 1.6 percent projected case mix growth factor. CMS anticipates the shift of some cases currently in lower paying DRGs to higher paying DRGs because of assumed coding improvement. This would lead to lower outlier payments for these cases as the DRG payment increases. Since it is not possible to model individual DRG shifts, the proposed 2010 DRG standardized amounts and capital rates were increased by 1.6 percent²⁰. If outlier payments were modeled without the case mix growth factor the proposed 2010 outlier fixed loss amount would be higher.

With these assumptions the FFY 2010 operating and capital outlier payments were estimated at 5.05 and 5.49 percent of the respective total payments, net of DSH and IME amounts. The estimates are in reasonably good agreement with the CMS figures of 5.10 percent for operating and 5.46 percent for capital payments. The dollar amount of FFY 2010 outlier payments at the 5.05/5.49 percent levels was estimated at \$5,052B.

ESTIMATE OF THE FFY 2010 FIXED LOSS AMOUNT CHANGING THE PROJECTION PERIOD FOR THE COST TO CHARGE RATIOS.

Starting in FFY 2007 CMS recognized the need to account for the change over time in the cost to charge ratios. In the 2010 Proposed Rule CMS states that it is appropriate to project all CCRs for a period of one year. The cost to charge ratios were obtained from the December 31, 2008 update of the Provider Specific File. For many hospitals these CCRs need to be projected over periods of time other than one year in order to reflect the FFY 2010 CCRs more realistically. Assuming CCRs are updated nine months after the end of the hospitals' fiscal periods, hospitals with fiscal periods ending in January will be paid during October 2009 using their 2008 CCR (i.e., the CCR for the fiscal period ending January 31, 2008). Starting in November 2009, the 2009 CCR should be available and used through the remaining eleven months of FFY 2010. The December 31, 2008 Provider Specific File contains, at least in principle, the 2008 CCRs of

²⁰ This is equivalent to increasing the proposed 2010 DRG weights by 1.6 percent.

hospitals with fiscal periods ending in January. This actual CCR would be used for one month of the FFY 2010, i.e., October, while the projected value (simulating the CCR update on November 1, 2008) will be used for only eleven months of FFY 2010, not twelve as assumed by CMS. Similarly, the projected CCRs for hospitals with fiscal periods ending in February and March should be used only for ten and nine months of FFY 2010, respectively.

The situation is different for hospitals with fiscal periods ending in April through December. For hospitals with fiscal periods ending in April, the December 31, 2008 PSF update contains their 2007 CCRs (which became available on January 31, 2008, nine months after the end of the fiscal period). The 2007 CCRs will be updated to 2008 on January 31, 2009 and be in effect from October 1, 2009 to January 31, 2010. On the latter date the 2008 CCRs will be updated to 2009 and be in effect for the remaining eight months of FFY 2010. Therefore, for hospitals with fiscal periods ending in April the CCRs should be projected over a period of one year for the first four months of FFY 2010 and projected over a period of two years for the remaining eight months of FFY 2010. Similarly, hospitals with fiscal periods ending in May should have their CCRs projected over a period of one year for five months and over a period of two years for seven months; hospitals with fiscal periods ending in June should have their CCRs projected over a period of one year for six months and over a period of two years for six months; and so on. For hospitals with fiscal periods ending in December the CCRs should be projected over a period of twelve months for the full FFY 2010.

Since the public version of MEDPAR does not show the month of discharge it is not possible to assign different CCRs based on dates. Instead, a weighted average “effective” CCR was calculated for each hospital. For example the effective CCR for hospitals with fiscal periods ending in March was calculated as (3/12) times the PSF CCR plus (9/12) times the PSF CCR projected over a period of one year; the effective CCR for hospitals with fiscal periods ending in April was calculated as (4/12) times the PSF CCR projected over a period of one year plus (8/12) the PSF CCR projected over a period of two years.

Using this approach to projecting CCRs the FY 2010 fixed loss amount was estimated at **\$23,960**.

ESTIMATE OF THE FFY 2010 FIXED LOSS AMOUNT USING HISTORICAL VALUES TO PROJECT THE COST TO CHARGE RATIOS.

CMS estimated the rate of change in CCRs by assuming the relationship between actual costs and the hospital market basket stays constant over time. The ratio of the rate of change in the cost per discharge to the rate of change in the market basket was calculated for three different years (2005-2007). The ratios were averaged and the result multiplied by the rate of change in the 2008 market basket to estimate the 2008 cost inflation. The estimated 2008 cost inflation was divided by the 2008 charge inflation in order to estimate the annual rates of change at -1.60 percent for operating CCRs and -2.52 percent for capital CCRs.

An alternative approach to estimating the rate of change in CCRs is to use a recent historical industry-wide average rate of change as the projection factor. This is exactly the approach CMS uses to project charge inflation. The December 31, 2008 update of the PSF shows the effective dates of changes in the file. This allows comparing the CCRs in effect at different points in time. The two most recent points in time separated by a whole year for which sufficient data were available were October 1, 2007 and October 1, 2008. Data were available for 3,262 out of the 3,513 hospitals used for outlier projections. These hospitals account for approximately 93 percent of all MEDPAR cases subject to IPPS. The average operating CCR (weighted by the number of Medicare IPPS cases) was 0.326928 on October 1, 2007 and 0.319650 on October 1, 2008, resulting in yearly rate of change of -2.23 percent. For the capital CCRs the respective averages were 0.026497 and 0.026012 resulting in a rate of change of -1.83 percent. It should be noted the 2008 fixed loss amount was set by CMS using **projected** 2007-2008 rates of change of +0.27 percent for operating CCRs and -2.56 for capital CCRs²¹.

Using the CCR 2007-2008 rates of change as annual projection factors but otherwise maintaining the same assumptions and methodology as CMS, the 2010 fixed loss amount is estimated at **\$23,805**. If the CCR projection methodology is modified as described above to take into account hospitals' fiscal periods, the 2010 fixed loss amount is estimated at **\$23,430**.

ESTIMATE OF THE FFY 2010 FIXED LOSS AMOUNT WITHOUT MANAGED CARE DISCHARGES AND REMOVING ORGAN ACQUISITION CHARGES

As discussed above, the CMS Impact File estimates appear to include approximately 376,000 MA managed care discharges. This assertion is based on the fact that the number of "Bills" shown in the Impact File for each hospital can be matched only by including the managed care discharges.

Another apparent problem is related to the organ acquisition charges for organ transplant patients. Organ acquisition costs are paid separately from IPPS, therefore the associated charges should not be considered when estimating outlier payments²². The Impact File estimates and, by inference, the FY 2010 proposed fixed loss amount appear to include organ acquisition charges for organ transplant patients. This assertion is based on the significantly better agreement with the Impact File outlier estimates if the organ acquisition charges are not excluded. The inclusion of organ acquisition charges affects the FY 2010 outlier payment estimates of 215 Impact File

²¹ Federal Register, / Vol. 72, No. 162 / Wednesday, August 22, 2007, page 47418.

²² A similar problem may have occurred with hemophilia patients receiving blood clotting factors. Blood clotting factors are also paid separately from IPPS. There are 282 patients in the MEDPAR file assigned to MS-DRG 813 (Coagulation Disorders) with pharmacy charges ranging from \$100,000 to \$5,700,000. These pharmacy charges are included in the covered charges used to estimate 2010 outlier payments. However, blood clotting factor charges cannot be separated from other possible pharmacy charges.

hospitals that had at least one case for which the inclusion resulted in total charges exceeding the outlier threshold. Modeling outlier payments for these hospitals with the organ acquisition charges left in yields an average outlier payment level difference from the Impact File of 0.7 percent. If the organ acquisition charges are removed the difference becomes -4.38 percent.

The exclusion of MA managed care claims and the removal of organ acquisition charges affect the estimated level of 2010 outlier payments in opposite ways. The exclusion of MA claims slightly increases the level of outlier payments, as the excluded managed care patients are less likely to exceed the outlier threshold compared to the fee for service patients. By definition, the removal of organ acquisition charges decreases the outlier payment level. Combining the exclusion of managed care patients and the removal of organ acquisition charges results in an overall estimated 2010 outlier payment level of 5.02 percent (operating) and 5.46 percent (capital). As described above, modeling 2010 outlier payments without these two changes resulted in payment levels of 5.05 and 5.49 percent, respectively. In terms of absolute dollars FY 2010 outlier payments were overestimated by approximately \$191M if managed care claims were included and organ acquisition charges were not removed.

Making the two changes described above but otherwise using the CMS assumptions detailed in the Proposed Rule resulted in an estimated 2010 fixed loss amount of **\$24,110**. Using the alternative models for projecting CCRs the estimated 2010 fixed loss amount was estimated at **\$23,835** with Proposed Rule CCR projection factors but taking into account hospitals' fiscal periods; at **\$23,675** using historical rates of change to project CCRs over a one-year period; and at **\$23,305** using historical rates of change to project CCRs over periods determined by the hospitals' fiscal period ending month.

ESTIMATE OF THE FFY 2009 OUTLIER PAYMENTS

FFY 2009 outlier payments can be estimated by using the FY 2009 payment rules and MS-DRG weights, and inflating MEDPAR 2008 charges to 2009. CMS assumes no continued improvement in documentation and coding in FY 2009, but estimates that the use of the FY 2009 relative weights will result in an additional 0.7 percent case mix growth. Since the estimate of FFY 2009 outlier payments uses the FY 2009 weights, the 0.7 percent effect is built-in and no additional case mix growth factor is needed. The one-year charge inflation was set at 7.29 percent, the same value used by CMS. Using the CCRs from the Impact File the 2009 outlier payment level was estimated at 5.33 percent, in reasonably good agreement with the CMS figure of 5.4 percent. (The Impact File CCRs were not projected forward in time, consistent with the one-year projection period used by CMS for the FFY 2010 estimates.)

The actual CCRs used to make the fourth quarter 2008 and first quarter 2009 payments are now available from the March 2009 update of the Provider Specific File. The fourth quarter 2008 and first quarter 2009 payments were estimated using these CCRs and the assumptions above. Occasionally CCRs change during the quarter. In these instances an "effective" CCR for the quarter was calculated based on the number of days each actual CCR was in use. The CCRs for

the remaining two quarters of FFY 2009 were estimated using the historical rates of change in CCRs and taking into account the hospitals' fiscal periods. The result is virtually the same: the FFY 2009 outlier payment level was estimated in this model at 5.32 percent.

Two factors appear to account for the apparent lack of sensitivity to the use of projected versus Impact File CCRs. The first is that, because of the availability of actual CCRs for the first two quarters of FFY 2009, only CCRs of hospitals with fiscal periods ending in July through November needed to be projected forward in time. Only 24 percent of all hospitals used for the outlier estimates meet this condition. In addition the projection periods are relatively short ranging from five months (July fiscal period ends) to one month (November fiscal period ends). The second factor is that, while the actual first and second FFY 2009 CCRs in the March 2009 Provider Specific File are different from the Impact File for 28 percent of the hospitals, the average change in total CCRs -operating plus capital- weighted by the number of MEDPAR discharges is small (0.2 percent).

CALCULATION OF THE FFY 2008 FIXED LOSS AMOUNT RESULTING IN OUTLIER PAYMENTS OF 5.1 PERCENT

Outlier payments actually made in 2008 for specific patients can be determined directly from the 2008 MEDPAR data. The operating outlier payment, if any, is explicitly shown for each Medicare discharge. In principle regular DRG operating payments can also be easily determined from data in the file. Specifically, the operating payment net of indirect medical education and disproportionate share adjustments is the DRG PRICE less BLOOD DEDUCTIBLE, CAPITAL, DSH and IME payments. The amounts shown in capitals are all fields in the MEDPAR records. However in some cases involving payments by other payers or the use of coinsurance/lifetime days the formula above does not hold up. To avoid this difficulty regular DRG operating payments were calculated based on the DRG weight and the applicable wage index and cost of living adjustment. Since these are the only parameters necessary for determining the regular DRG operating payment net of indirect medical education and disproportionate share adjustments, the calculation should be quite accurate. Medicare Advantage (MA) managed care discharges were excluded. Total 2008 outlier payments determined directly from the 2008 MEDPAR file amounted to 3.849B, or 4.57 percent of total Medicare IPPS payments net of indirect medical and disproportionate share adjustments. This translates into a shortfall of \$467M relative to the 5.1 percent target. The Proposed Rule states that 2008 outlier payments were at the 4.8 percent level.

The outlier amounts that should have been paid could be calculated from the MEDPAR data if the cost to charge ratios actually used were available. The CCRs can be obtained from the March 2009 update of the Provider Specific File. However, they can be applied accurately only if they did not change during a given quarter, as the public version of MEDPAR shows only the quarter of the patients' dates of discharge. If the CCRs did change during the quarter, "effective"

CCRs were calculated based on the number of days each actual CCR was in use. Using this approach the 2008 fixed loss amount that would have resulted in operating outlier payments at the 5.1 percent level was estimated at **\$20,100**.

FFY 2010 ESTIMATED FIXED LOSS AMOUNTS AND UNDERLYING ASSUMPTIONS

METHODOLOGY	Charge Inflation (Proposed Rule, Rate of Change from Jul-Dec 2007 to Jul-Dec 2008	Coding Improvement Factor	Change in Operating Cost to Charge Ratios	ESTIMATED FFY 2010 FIXED LOSS AMOUNT (\$)
	(Per Year)	(2007-2009)	(Per Year)	
Charges Projected From FFY 2008 to FFY 2010; CCRs Projected Forward One Year	7.29%	1.6%	-1.6% (CMS)	24,240
Charges Projected From FFY 2008 to FFY 2010; CCRs Projected According to FPE	7.29%	1.6%	-1.6% (CMS)	23,960
Charges Projected From FFY 2008 to FFY 2010; CCRs Projected Forward One Year	7.29%	1.6%	-2.23% (VHDC)	23,805
Charges Projected From FFY 2008 to FFY 2010; CCRs Projected According to FPE	7.29%	1.6%	-2.23% (VHDC)	23,430

FFY 2010 ESTIMATED FIXED LOSS AMOUNTS EXCLUDING MANAGED CARE CLAIMS AND REMOVING ORGAN ACQUISITION CHARGES

METHODOLOGY	Charge Inflation (Proposed Rule, Rate of Change from Jul-Dec 2007 to Jul-Dec 2008	Coding Improvement Factor	Change in Operating Cost to Charge Ratios	ESTIMATED FFY 2010 FIXED LOSS AMOUNT (\$)
	(Per Year)	(2007-2009)	(Per Year)	
Charges Projected From FFY 2008 to FFY 2010; CCRs Projected Forward One Year	7.29%	1.6%	-1.6% (CMS)	24,110
Charges Projected From FFY 2008 to FFY 2010; CCRs Projected According to FPE	7.29%	1.6%	-1.6% (CMS)	23,835
Charges Projected From FFY 2008 to FFY 2010; CCRs Projected Forward One Year	7.29%	1.6%	-2.23% (VHDC)	23,675
Charges Projected From FFY 2008 to FFY 2010; CCRs Projected According to FPE	7.29%	1.6%	-2.23% (VHDC)	23,305