



**Minnesota Hospital Association**

2550 University Ave. W., Suite 350-S  
St. Paul, MN 55114-1900  
phone: (651) 641-1121; fax: (651) 659-1477  
toll-free: (800) 462-5393; [www.mnhospitals.org](http://www.mnhospitals.org)

June 8, 2007

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

***RE: CMS-1533-P, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates; Proposed Rule (Vol. 72, No. 85), May 3, 2007***

Dear Ms. Norwalk:

On behalf of the Minnesota Hospital Association's (MHA) 131 member hospitals and health care organizations, we appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule for the fiscal year (FY) 2008 hospital inpatient prospective payment system (PPS).

While MHA supports many of the proposed rule's provisions, we oppose the proposed "behavioral offset" cuts related to the move to severity-adjusted diagnosis-related groups (DRGs) and the cuts to capital payments.

### **DRGs**

The proposed rule would replace the current 538 DRGs with 745 new Medicare-Severity DRGs (MS-DRGs), and would overhaul the complication or comorbidity list. The proposed rule also **includes 2.4 percent cuts to both operating and capital payments in both FYs 2008 and 2009, which will result in an estimated loss to Minnesota hospitals of \$396 million over five years.** In addition, the rule proposes continuing the three-year transition to cost-based relative weights, with two-thirds of the FY 2008 weight based on costs and one-third based on charges.

Payment changes alone fail to remove the inappropriate incentives created by physician self-referral to limited-service hospitals. Even with the DRG changes proposed by CMS, physicians continue to have the ability and incentive to steer financially attractive patients to facilities they own, avoid serving uninsured, Medicaid and other low-income patients, practice similar forms of selection for outpatient services and drive up utilization. We urge CMS to address the real issue of self-referral: to rigorously examine the investment structures of physician-owned, limited-service hospitals and consider our comments on CMS' interim report on the strategic plan required by the *Deficit Reduction Act of 2005*.

Leslie Norwalk, Esq.

June 8, 2007

Page 2 of 39

Minnesota hospitals support meaningful improvements to Medicare's inpatient PPS, and believe that the MS-DRGs provide a reasonable framework for patient classification. However, a transition is necessary given that the change redistributes almost \$1 billion among hospitals.

#### **CAPITAL PAYMENT UPDATE**

The proposed rule would eliminate the capital payment update for all urban hospitals (a 0.8 percent cut) and the large urban hospital capital payment add-on (an additional 3 percent cut).

**These changes would result in a payment cut of \$47 million over five years to Minnesota hospitals.**

We are opposed to these unnecessary cuts, which ignore how vital these capital payments are to the ongoing maintenance and improvement of hospitals' facilities and technology. We also oppose your consideration of possible future cuts to the indirect medical education and disproportionate share hospital adjustments under the capital system. CMS should not make any cuts or other adjustments to the capital PPS.

**CMS has far exceeded its charge by recommending arbitrary and unnecessary cuts in this proposed rule. These backdoor budget cuts will further deplete scarce resources here in Minnesota, ultimately making our hospitals' mission of caring for patients in our communities even more challenging.**

Our detailed comments are attached. If you have any questions, please feel free to contact me at (651) 603-3536 or [gredfield@mnhospitals.org](mailto:gredfield@mnhospitals.org).

Sincerely,

Gregg Redfield  
Vice President, Finance  
Minnesota Hospital Association

**Minnesota Hospital Association  
Detailed Comments on the Proposed Rule  
for the  
FY 2008 Inpatient Prospective Payment System**

**Table of Contents**

<b>DRG REFORM AND PROPOSED MS-DRGS</b> .....	4
SEVERITY OF ILLNESS .....	4
BEHAVIORAL OFFSET.....	5
REVISED CC LIST .....	8
INPATIENT PSYCHIATRIC PPS .....	8
<b>MEDICARE CODE EDITOR</b> .....	9
<b>RECALIBRATION OF DRG WEIGHTS</b> .....	9
<b>CAPITAL IPPS</b> .....	11
<b>DRGS: HOSPITAL-ACQUIRED CONDITIONS</b> .....	13
<b>HOSPITAL QUALITY DATA</b> .....	15
<b>OCCUPATIONAL MIX ADJUSTMENT</b> .....	17
<b>WAGE DATA</b> .....	17
<b>WAGE INDEX</b> .....	18
<b>RURAL FLOOR</b> .....	21
<b>PHYSICIAN OWNERSHIP IN HOSPITALS</b> .....	21
<b>PATIENT SAFETY MEASURES</b> .....	22
<b>IME ADJUSTMENT</b> .....	23
<b>REPLACED DEVICES</b> .....	24
<b>NEW TECHNOLOGY</b> .....	25
<b>ATTACHMENT I - REVISED CC LIST</b> .....	27
<b>ATTACHMENT II - RECALIBRATION OF DRG WEIGHTS</b> .....	35

**Minnesota Hospital Association  
Detailed Comments on the Proposed Rule  
for the  
FY 2008 Inpatient Prospective Payment System**

**DRG REFORM AND PROPOSED MS-DRGS**

In response to payment recommendations from the Medicare Payment Advisory Commission (MedPAC) to address the proliferation of physician-owned, limited-service hospitals, the Centers for Medicare & Medicaid Services (CMS) in fiscal year (FY) 2006 began significant efforts to reform the diagnosis-related groups (DRGs) and the calculation of the corresponding relative weights. While CMS adopted cost-based weights in FY 2007, it chose not to implement proposed adjustments to the DRG classification system to further recognize severity of illness. In FY 2008, CMS proposes continuing the transition to cost-based weights and offers a refinement to the current DRG system to better account for patient severity.

Minnesota hospitals support meaningful improvements to Medicare's inpatient prospective payment system (PPS). MHA and CMS share the common goal of refining the system to create an equitable opportunity for return across DRGs, which will provide appropriate incentives to treat all types of patients and conditions. We also believe that the system should be simple, predictable and stable over time. One of the fundamental values of a *prospective* payment system is the ability of providers to reasonably estimate payments in advance to inform their budgeting, marketing, staffing and other key management decisions.

Another core feature of the PPS is clinically cohesive and meaningful DRGs that are intuitive for providers and coders to follow, and that reflect similar resource use within DRGs. Ultimately, the inpatient PPS should foster innovation and best practice in care delivery. These are essential characteristics of a well-functioning PPS.

However, payment changes alone will not remove the inappropriate incentives created by physician self-referral to limited-service hospitals. Even with the DRG changes proposed by CMS, physicians will still have the ability and incentive to steer financially attractive patients to facilities they own, avoid serving uninsured, Medicaid and other low-income patients, practice similar forms of selection for outpatient services and drive up utilization. We urge CMS to address the real issue of self-referral: to rigorously examine the investment structures of physician-owned, limited-service hospitals and consider our comments on CMS' interim report on the strategic plan required by the *Deficit Reduction Act of 2005* (DRA).

**SEVERITY OF ILLNESS**

For FY 2008, CMS proposes to replace the current 538 DRG system with 745 Medicare-Severity DRGs (MS-DRGs). In addition, CMS has undertaken an overhaul of the complication and comorbidity (CC) list and created up to three tiers of payment for each DRG based on the presence of: a *major* complication or comorbidity (MCC), a complication or comorbidity, or *no* complication or comorbidity.

MS-DRGs represent a reasonable approach to DRG refinement. CMS should commit to this system for the near future and build in the time needed to ensure that both the agency and hospitals are adequately prepared for such a significant change.

We urge CMS to adopt the MS-DRGs over a four-year transition period. The implementation of this more extensive classification system, though budget neutral, would redistribute close to \$1 billion among hospitals nationwide. Specifically:

- In FY 2008, the emphasis should be on preparation for and testing of the new classification system. This provides CMS with adequate time to finalize data and a CC list, introduce and test software for case classification and payment, including the definitions and instructions for case classification and payment, and train its fiscal agents. It also gives hospitals, as well as vendors and state agencies, adequate time to implement and test the new system and adjust operations and staffing for predicted revenues.
- In FY 2009, DRG weights should be computed as a blend derived one-third from the MS-DRGs and two-thirds from traditional DRGs.
- In FY 2010, DRG weights should be computed as a blend derived two-thirds from MS-DRGs and one-third from traditional DRGs.
- In FY 2011, DRG weights should be derived using only the MS-DRGs.

Since there is not a perfect crosswalk from the old DRGs to the new ones, the weight used for payment in a given year would be established by blending the MS-DRG weight with a volume-weighted average of the CMS-DRG weights that feed into that particular MS-DRG. Thus, only one weight would be published in advance.

This gradual transition to the new system is easiest for CMS to implement, maintains the prospective nature of the system, is equitable across hospitals, does not require any sort of subsequent reconciliation, and does not require CMS or hospitals to run more than one GROUPER the entire year.

#### **BEHAVIORAL OFFSET**

There should be no “behavioral offset,” until MS-DRGs are fully implemented, and CMS can document and demonstrate that any increase in case-mix results from changes in coding practices rather than real changes in patient severity.

The proposed rule includes a 2.4 percent cut in both FYs 2008 and 2009 to eliminate what CMS alleges will be the effect of coding or classification changes that do not reflect real changes in case-mix. This “behavioral offset” cut is based on unsupported assumptions, and cannot be justified in advance of making the DRG changes. **MHA opposes the “behavioral offset,” which will cut payments to Minnesota hospitals by \$349 million over the next five years. This cut is unwarranted – it is a backdoor attempt at budget cuts.**

Minnesota hospitals have operated under the current DRG system for 23 years. The proposed MS-DRGs would refine the existing system; the underlying classification of patients and “rules of thumb” for coding would be the same. There is no evidence that an adjustment of 4.8 percent over two years is warranted. To the contrary, studies by RAND, cited in the preamble, looking at

claims at the beginning of the inpatient PPS, showed less than a 1 percent growth in case mix due to coding. Even moving from the original cost-based system to a new patient classification-based PPS did not generate the type of coding changes CMS contends will occur under the MS-DRGs.

**CMS should not implement a “behavioral offset” at this time.** Once the MS-DRGs are fully implemented, CMS can investigate whether payments have increased due to coding rather than the severity of patients and determine if an adjustment is necessary. CMS is not required to make a specific adjustment now. CMS can always correct for additional payments made as a result of coding changes in later years when there is sufficient evidence.

Detailed comments below explain why the examples CMS uses in its attempt to justify the coding adjustment are flawed. In addition, we also provide many reasons why we do not expect a significant increase in payment due to coding.

Maryland experience. In the rule, CMS points to the experience of Maryland hospitals moving to 3M’s All-Patient Refined DRGs (APR-DRGs) as a basis for the behavioral offset. However, MS-DRGs and APR-DRGs are two completely different ways to classify patients, and generalizing from one system to the other is misleading. The existing classification rules will change only marginally with the introduction of MS-DRGs, whereas they are very different under the APR-DRG system. Differences include:

- APR-DRGs consider multiple CCs in determining the placement of the patient and, ultimately, the payment. In fact, to be placed in the highest severity level, more than one high-severity secondary diagnosis is required.
- APR-DRGs consider interactions among primary and secondary diagnoses. Something that bumps one case type to a higher severity level might not affect another. This is not true for MS-DRGs.
- APR-DRGs consider interactions among *procedures* and diagnoses as well. MS-DRGs do not.
- APR-DRGs have four severity subclasses for *each* base DRG, while MS-DRGs have three tiers, and this is only for 152 base DRGs –106 base DRGs only have two tiers and 77 base DRGs are not split at all.
- Less than half the number of patient classifications in the MS-DRG system are dependent on the presence or absence of a CC – 410 for MS-DRGs versus 863 for APR-DRGs.

All of these differences greatly reduce the possibility that changes in coding will affect payment and make the Maryland experience an invalid comparison.

IRF PPS experience. CMS inappropriately also draws on the example of the inpatient rehabilitation facility (IRF) PPS to justify the coding adjustment. The coding changes seen under the IRF PPS resulted from a cost-based system moving to PPS, not the marginal difference the existing CMS-DRGs moving to the refined MS-DRGs.

In addition, coding under the IRF PPS is driven by the Inpatient Rehabilitation Patient Assessment Instrument (IRF-PAI). Coding for the IRF-PAI differs significantly from the long-standing coding rules that inpatient PPS hospitals have followed for three reasons:

- The IRF-PAI introduced "etiological diagnosis" into coding. The definition of this new diagnosis and the applicable coding rules are significantly different than the "principal diagnosis" used to determine the DRG. More importantly, the Official Coding Guidelines that apply to all other diagnostic coding do not apply to the selection of the ICD-9-CM etiologic diagnoses codes.
- The Official Coding Guidelines do not consistently apply to the coding of secondary diagnoses on the IRF-PAI. Several different exceptions to the guidelines have been developed by CMS for the completion of the IRF-PAI.
- The definition of what secondary diagnoses may be appropriately reported differs under the IRF-PAI from the definition used by other inpatient coders.

Greater use of codes. Most hospitals already code as carefully and accurately as possible because of other incentives in the system to do so, such as risk adjustment in various quality reporting systems. Analysis of Medicare claims from 2001 to 2005 indicates that hospitals have been coding CCs at high rates for many years. More than 70 percent of claims already include CCs, and more than 50 percent of claims have at least eight secondary diagnoses (the maximum number accepted in Medicare's DRG GROUPER). Hospitals' assumed ability to use even more CCs under MS-DRGs is very low.

According to an article in *Healthcare Financial Management*, the presence of a CC on a bill is not strongly influenced by financial gain. The proportion of surgical cases with a CC code is higher for cases where there is no CC split and, thus, no financial benefit, than on those cases where there is a CC split and a corresponding higher payment. Thus, coding is driven primarily by coding guidelines and what is in the medical record rather than by financial incentives.

In addition, many cases do not have additional CCs to be coded. For many claims, additional codes are not warranted or supported by the medical record. Therefore, there is no opportunity for a coding change to increase payment.

Order of codes. According to American Hospital Association (AHA) analysis, hospitals will not be able to "re-order" their secondary diagnoses to appear higher on the claim so that CMS will pick them up and pay them a higher rate. Most hospitals use software that automatically re-sorts the secondary diagnoses to ensure that those pertinent to payment are included in positions two through nine.

Specific codes. We examined secondary diagnosis codes and found that there were relatively few non-specific codes listed among the common secondary diagnoses of discharges without a CC/MCC. This means that hospitals cannot shift large numbers of discharges to CCs or MCCs based on putting in a more specific code to replace a non-specific code.

DRGs that do not split CCs and non-CCs. There is no opportunity for increased payment due to a change in coding for 77 base DRGs under the MS-DRGs systems, as there is only one severity class and no differentiation in payment.

Additionally, there are MS-DRGs that are now split between “w/MCC” and “w/o MCC” (a combined non-CC and CC MS-DRG) that have historically contained a single CC/non-CC split. These already required secondary diagnosis coding, thus, the codes to qualify the case as an MCC already would have been present. In these cases, it is very unlikely that the medical record would justify an MCC that is not already present. Coders are not able to interpret a case, but must code strictly based on what the physician notes in the chart. Therefore, it is highly unlikely that coding changes could move cases to the higher severity MS-DRG with MCC.

#### **REVISED CC LIST**

CMS conducted a comprehensive review of the CC list. Currently, 115 DRGs are split based on the presence or absence of a CC. For these DRGs, the presence of a CC assigns the discharge to a higher-weighted DRG.

A condition was included on the revised CC list if it could be demonstrated that the presence of the condition would lead to substantially increased hospital resource use. Compared with the existing CC list, the revised list requires a secondary diagnosis to have a consistently greater impact on hospital resources. The revised CC list is essentially comprised of significant acute diseases, acute exacerbation of significant chronic diseases, advanced or end-stage chronic diseases and chronic diseases associated with extensive debility.

We make the following overall recommendations with regards to the CC list:

- **CMS should make the final revised CC list publicly available as quickly as possible** so that hospitals may focus on understanding the impact of the revised CC list, training and educating their coders, and working with their physicians for any documentation improvements required to allow the reporting of more specific codes where applicable.
- **CMS should consider additional refinements to the revised CC list** and, in particular, address issues where the ICD-9-CM codes may need to be modified to provide the distinction between different levels of severity.
- **In situations where a new code is required, CMS should default to leaving the codes as CCs until new codes can be created.**
- **CMS should address the inconsistencies within the CC list identified by physicians and hospitals.** Where necessary, CMS should immediately obtain additional input from practicing physicians in the appropriate specialties to determine the standard of care and consequent increased hospital resource use.

**Attachment I** lists examples of many conditions that were removed from the revised CC list. We do not understand the rationale for their removal and urge CMS to maintain them on the CC list.

#### **INPATIENT PSYCHIATRIC PPS**

We urge CMS to carefully consider the implications of its proposed MS-DRG changes on the inpatient psychiatric facility PPS, specifically, the DRGs for alcohol/drug use and the changes to the CC list.

## **MEDICARE CODE EDITOR**

We applaud CMS' removal of codes from Non-Specific Principal Diagnosis Edit 7 and Non-Specific O.R. Procedures Edit 10. These two areas have been misunderstood and claims have been erroneously denied, rejected or returned as a result.

## **RECALIBRATION OF DRG WEIGHTS**

For FY 2008, CMS has not proposed any changes to the methodology adopted in FY 2007 for calculating cost-based DRG weights. The three-year transition from charge-based DRG weights to cost-based weights would continue, with two-thirds of each weight based on an estimation of costs and one-third based on charges. However, during the transition to cost-based weights, two significant issues surfaced:

- There is a mismatch between the two data sources used in establishing the cost-based weights. These differing data sources, specifically the charges from the MedPAR files and the cost-to-charge ratios (CCRs) from the hospital Medicare cost reports, can distort the resulting DRG weights. The cost report was not designed to support the estimation of costs at the DRG level.
- Hospitals mark-up different items and services within each cost center by different amounts. When the same CCR is applied to charges for these items, costs can be underestimated for items with lower mark-ups and overestimated for items with higher mark-ups. This "charge compression" can lead to the distortion of DRG weights.

AHA, Association of American Medical Colleges (AAMC) and Federation of American Hospitals (FAH) convened a workgroup made up of state association, cost report and billing experts to discuss these issues earlier this year. Their comments on the cost-based weighting methodology below are an outgrowth of this group's recommendations, which can be found in **Attachment II**.

Cost report changes. Under cost-based weights, the two sources of data that are used in establishing the DRG weights are the MedPAR files and the Medicare cost report. Charges are taken from the MedPAR files, grouped into 13 categories and reduced to cost using national CCRs calculated from the Medicare cost reports for these same 13 categories.

An examination of the cost-based weights developed for FY 2007 revealed that three problems occur by using these two different data sources together:

- First, the method used by CMS to group hospital charges for the MedPAR files differs from that used by hospitals to group Medicare charges, total charges and overall costs on the cost report.
- Second, hospitals group their Medicare charges, total charges and overall costs in different departments on their cost reports for various reasons.
- Third, hospitals across the country complete their cost reports in different ways, as allowed by CMS.

This mismatch between MedPAR charges and cost report CCRs can distort the resulting DRG weights.

CMS states that it is undertaking a comprehensive review of the Medicare cost report and plans to investigate this issue but does not propose any short-term changes to address this problem.

RTI International recommends incorporating edits to reject cost reports or require more intensive review by auditors to resolve the lack of uniformity in cost reporting. However, this will not solve the mismatch problem because the reporting is consistent with the cost reporting instructions. Currently, cost report instructions included with the CMS Form-339 allow for three methods of reporting Medicare charges. The method selected by each hospital is specific to its information systems and based on the method that most accurately aligns Medicare program charges on Cost Report Worksheet D-4 (inpatient) and/or Worksheet D, Part IV (outpatient) with the overall cost and charges reported on Worksheets A and C. Many hospitals elect to allocate some or all of the Medicare program charges from the Medicare Provider Statistical and Reimbursement data (PS&R) to various lines in the cost report based on hospital-specific financial system needs. Under this scenario, total hospital CCRs are aligned with program charges, but will not match the charge groupings used in MedPAR. This mismatching may distort the resulting DRG weights under the methodology developed by CMS. Increased edits or cost report rejections would not provide a solution to a problem that is caused by cost report instructions that allow for multiple approaches.

Instead, AHA, AAMC and FAH, along with the Healthcare Financial Management Association, are launching an educational campaign to help hospitals report costs and charges, particularly for supplies, in a way that is consistent with how MedPAR groups charges. This would allow for a consistent grouping of departments within the 13 categories identified in the August 18, 2006 final inpatient PPS rule that are currently used to create the cost-based weights, or any future expansion of the categories that may occur.

We believe that this is within the cost report instructions, but request that CMS communicate with its fiscal intermediaries (FIs) that such action is appropriate and encouraged. This will prevent FIs from unwittingly under-cutting an effort to bolster the cost-based weighting methodology. The mismatching problem is not caused by the failure of hospitals to prepare their cost reports correctly, as appears to be suggested by the RTI study. In addition, CMS should recognize that it will be more expensive and time-consuming for some hospitals to successfully implement a different approach to cost reporting. Therefore, education and training activities will take time.

Cost centers. In calculating the DRG weights, CMS currently groups charges into 13 cost centers and then applies national CCRs to convert the charges to costs. CMS is considering expanding the cost center groupings to 19 in order to separate services that have substantially different CCRs from other services currently in the same cost center. Specifically, CMS is considering the following refinements recommended by RTI:

- Separating the emergency department and blood from “other services;”
- Splitting medical supplies into devices/implants/prosthetics and other medical supplies;
- Distinguishing between CT, MRI and other radiology; and
- Splitting drugs into IV solutions and other drugs.

Using existing cost report data, changes can be made to emergency departments and blood to separate them from other services. But further breaking out supplies, radiology and pharmacy would require either changes to the structure of the cost report or the application of a regression-based adjustment. CMS’ new approach for categorizing all charges and costs into 13 specific categories may not yield the most appropriate CCR for each cost category. As a result, we support the short-term educational efforts detailed above to resolve the mismatched data and CMS’ long-term review of the cost report.

We do not believe that a temporary, regression-based adjustment that does not fix the underlying concerns with the cost report is appropriate. MHA is concerned that, for the sake of expediency, the use of estimates (a regression analysis approach), as opposed to efforts to collect accurate data at the appropriate cost center level, would fail the objective. In addition, the use of a regression model may be difficult to validate because as the DRG weights are modified on an annual basis. We believe that once short-term educational efforts and CMS’ long-term cost report evaluation are underway, we can have an informed discussion on which cost-report changes are needed to alleviate the issue of charge compression. We do not, however, believe that the previously recommended hospital-specific relative value methodology is needed. As clearly stated in our comments last year, we believe that the method is flawed and do not support its implementation.

## **CAPITAL IPPS**

Medicare is required to pay for the capital-related costs of inpatient hospital services. These costs include depreciation, interest, taxes, insurance and similar expenses for new facilities, renovations, expensive clinical information systems and high-tech equipment (e.g., MRIs and CAT scanners). This is done through a separate capital PPS. Under the capital inpatient PPS, capital payments are currently adjusted by the same DRGs for each case, as is done under the operating PPS. Capital PPS payments also are adjusted for indirect medical education (IME), disproportionate share hospital (DSH) and outlier payments.

For FY 2008, CMS proposes eliminating the capital update for all urban hospitals (a 0.8 percent cut) and the large urban hospital add-on (an additional 3 percent cut). However, CMS proposes to update capital payments for rural hospitals by 0.8 percent (the capital input price index). In addition, CMS is considering discontinuing the IME and DSH adjustments to capital payments.

These cuts, based solely on the discretion of the administration with no congressional direction, are unprecedented. According to MedPAC, overall Medicare margins will reach a 10-year low in 2007 at *negative* 5.4 percent. These cuts would amount to a decrease in capital payments of \$47 million over the next five years that Minnesota hospitals cannot sustain in an already under-funded system.

Capital cuts of this magnitude will disrupt hospitals' ability to meet their existing long-term financing obligations for capital improvements. Hospitals have committed to these improvements under the expectation that the capital PPS would remain a stable source of income. Reducing capital payments would create significant financial difficulties and amounts to Medicare renegeing on the full cost of caring for America's seniors and disabled. **MHA is opposed to these unnecessary cuts, which ignore how vital these capital payments are to the ongoing maintenance and improvement of hospitals' facilities and technology.**

CMS attempts to justify the cuts based on an analysis that purports to show that hospitals are experiencing substantial positive margins under the capital payment framework. The analysis, which averages hospital inpatient Medicare capital margins from 1996 to 2004, is deficient in several respects. What hospitals experienced in 1996 is irrelevant to the operating environment today. Looking at a snapshot rather than a full capital cycle of 15 to 20 years is misleading. The averaging system is meant to balance the high spending cycles of some hospitals with the low spending cycles of others over time, but isolating any given portion of the cycle may not achieve this. In addition, the regression establishing the capital PPS was based on total costs, not just capital costs, so CMS should be looking at total margins. As noted earlier, MedPAC estimates an overall hospital Medicare margin in 2007 of negative 5.4 percent. Whether or not hospitals experience a narrow positive margin for their capital payments is of small consequence to the hospital losing money, on average, every time it treats a Medicare beneficiary. Moreover, this should not be discussed in isolation from the overall payment effect in an effort to mask the fact that these are significant capital cuts.

In addition, CMS has not fully considered the ramifications of dramatic capital cuts on the use of technology and the quality of hospital infrastructure. Reduced capital payments would make buying the advanced technology and equipment that patients expect much more difficult for the nation's hospitals, and could have the effect of slowing clinical innovation. These changes disadvantage large urban and teaching hospitals, where much of the innovation and cutting-edge research is generated. These hospitals will be even more challenged to keep up with leading technology, facilities and patient care. Moreover, for many hospitals, investing in information technology would become even more challenging. Without these facility and technological improvements, *all* patients will be deprived of these advances. At a time when the administration and Congress are pushing for such investments, this proposal may have the opposite effect of slowing needed adoption of health information technology.

**MHA also opposes possible future cuts to the IME and DSH adjustments under the capital system.** CMS has no analysis of the impact of these proposed changes on the high-caliber medical education of our future physicians and the community-wide services on which hospitals often lose money providing, such as burn and neonatal units. It is irresponsible of CMS to make such changes without a clear understanding of the broader ramifications.

## **DRGS: HOSPITAL-ACQUIRED CONDITIONS**

The DRA requires CMS to identify by October 1, 2007 at least two preventable complications of care that could cause patients to be assigned to a CC DRG. 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 be reasonably preventable through the application of evidence-based guidelines. The DRA mandates 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. That is, the case would be paid as though the secondary diagnosis were not present. Finally, the DRA requires hospitals to submit the secondary diagnoses that are present on admission when reporting payment information for discharges on or after October 1, 2007. CMS recently announced that the start date for coding what is present on admission would be delayed until January 1, 2008 due to technical difficulties in software programming to accept the new information.

In the proposed rule, CMS seeks comments on how many and which conditions should be selected for implementation in FY 2009, along with justifications for these selections. CMS puts forward 13 conditions it is considering, but it recommends only six conditions for implementation at this time. The six conditions are:

- Catheter-associated urinary tract infections;
- Pressure ulcers;
- Object left in during surgery;
- Air embolism;
- Blood incompatibility; and
- Staphylococcus aureus septicemia.

This policy should be implemented starting with a small number of conditions because there are significant challenges to correctly identifying cases that meet the criteria laid out by Congress. There are further difficulties ensuring appropriate accuracy in the billing data that will enable the correct identification of the relevant cases. We ask CMS to carefully consider not only the criteria for selection set forth in the DRA, but also the ability of hospitals to accurately identify and code for these conditions. Some of the proposed conditions may not be feasible at this time.

Conditions to include for FY 2009. MHA believes that objects left in during surgery, air embolism and blood incompatibility are appropriate conditions to include for FY 2009. Because these conditions are identified by discrete ICD-9 codes, they can be coded by hospitals. More importantly, these are events that can cause great harm to patients and for which there are known methods of prevention. Minnesota's hospitals are committed to patient safety and strive to ensure that these events do not happen.

Conditions not ready for inclusion for FY 2009. The other three conditions – catheter-associated urinary tract infections, pressure ulcers and staphylococcus aureus septicemia – present serious concerns for FY 2009. The correct identification of all three of these conditions will rely on the correct identification and coding of conditions that are present on admission. CMS proposes to rely on the present-on-admission coding that it had originally planned to implement starting October 1, 2007, but which has now been pushed back to January 1, 2008 due to technical

difficulties. Implementing a present-on-admission coding indicator will be a major challenge for hospitals.

Coding accuracy can only be achieved when physicians have been educated about the need to carefully identify and record, in an easily interpretable manner, whether these conditions are present on admission. Only after reasonable reliability in physician identification and recording of the complications that are present on admission are achieved can claims be coded in such a way that CMS could accurately identify those cases that should not be classified into the higher-paying DRGs. **We urge CMS to delay implementation of the payment classification changes for cases involving pressure ulcers, catheter associated urinary tract infections and staphylococcus aureus until after it has taken the necessary steps to permit accurate identification of the relevant cases.**

In addition, these conditions are high cost or high volume, but they may not always be reasonably preventable. There is good evidence to suggest that, even when reliable science and appropriate care processes are applied in the treatment of patients, not all infections can be prevented. There is concern among infection control experts that the definitions of some of these conditions need to be reviewed and updated before they can be implemented successfully in a hospital reporting program. Additionally, we believe that hospitals face significant challenges in diagnosing these conditions accurately on admission and coding for them at that time. Our specific concerns with each of the three conditions follow.

- **Catheter-associated urinary tract infections** – Many clinicians believe that urinary tract infections may not be preventable after several days of catheter placement, and prevention guidelines are still debated by clinicians.
- **Pressure ulcers** – It is difficult to detect stage I pressure ulcers on admission, as the skin is not yet broken, even though the tissue is damaged. The National Pressure Ulcer Advisory Panel recently released revised guidelines for staging pressure ulcers and included a new definition for a suspected deep tissue injury. Although difficult to detect initially, this condition may rapidly evolve into an advanced pressure ulcer, and it is especially difficult to detect in individuals with darker skin tones. We also are concerned that the present-on-admission coding of pressure ulcers will rely solely on physicians' notes and diagnoses, per Medicare coding rules, and cannot make use of additional notes from nurses and other practitioners. Certain patients, including those at the end of life, may be exceptionally prone to developing pressure ulcers, despite receiving appropriate care. There also is evidence of an increased risk of pressure ulcer recurrence after a patient has had at least one stage IV ulcer. If CMS decides to include pressure ulcers under the hospital-acquired conditions policy, the agency should exclude patients enrolled in the Medicare hospice benefit and patients with certain diagnoses that make them more highly prone to pressure ulcers because, in these cases, the condition may not be reasonably prevented.
- **Staphylococcus aureus septicemia** – Accurately diagnosing staphylococcus aureus septicemia on admission will be a challenge. Patients may be admitted to the hospital with a staphylococcus aureus infection of a limited location, such as pneumonia or a urinary tract infection. Subsequent development of staphylococcus aureus septicemia

may be the result of the localized infection and not a hospital-acquired condition. Additionally, the proliferation of changes in coding guidelines for sepsis in recent years presents further challenges to hospital coding personnel to accurately capture present-on-admission status. Finally, there is still some debate among clinicians regarding the prevention guidelines for staphylococcus aureus septicemia.

We believe the category of staphylococcus aureus septicemia is simply too large and varied to be able to say with confidence that the infections were reasonably preventable. **We urge CMS to narrow this category to include only patients for whom it is reasonably clear that the hospital was the source of the infection and that it could have been reasonably prevented.**

With regard to the seven conditions that CMS mentions in the proposed rule but does not recommend for implementation, we agree that these conditions cannot be implemented at this time because of difficulties with coding or a lack of consensus on prevention guidelines.

Unintended consequences. Trying to accurately code for urinary tract infections that are present on admission may lead to excessive urinalysis testing for patients entering the hospital. The necessity to complete diagnostic tests before a patient is admitted to confirm present-on-admission status could lead to delayed admissions for some patients and disrupt efficient patient flow.

## **HOSPITAL QUALITY DATA**

The DRA expanded quality reporting requirements for hospitals to be eligible to receive a full market basket update. In the proposed rule, CMS puts forward five new measures – four process measures and one outcome measure – to be included for the FY 2009 annual payment determination. To receive a full market basket update, hospitals would have to pledge to submit data on these and all measures currently included in the Hospital Quality Alliance's (HQA) public reporting initiative for patients discharged on or after January 1, 2008. In addition, hospitals would have to pass data validation tests for data submitted in the first three calendar quarters of 2006.

New quality measures. We are pleased that CMS has proposed adding only measures that have been adopted by the HQA for public reporting in FY 2009. The measures proposed for FY 2009 are well-designed, represent aspects of care that are important to patients, and provide insights into the safety, efficiency, effectiveness and patient-centeredness of care.

Adoption by the HQA is only one of three criteria that we believe all new measures included in the pay-for-reporting program should fulfill. In addition to HQA adoption, all measures should be endorsed by the National Quality Forum (NQF) through its consensus review process. We appreciate CMS' statement that, should any of the measures proposed for FY 2009 not receive NQF endorsement by the time of publication of the final rule, they will not be adopted for FY 2009. Finally, prior to inclusion in the pay-for-reporting program, all measures should undergo a field test to observe for any operational issues and assess the degree to which the measures can be implemented successfully by hospitals and data vendors.

Leslie Norwalk, Esq.

June 8, 2007

Page 16 of 39

Because we believe that all measures for public reporting should be adopted by the HQA, endorsed by the NQF and tested in the field before implementation, we have concerns with some measures listed by CMS for possible implementation for FY 2009 or subsequent years because they do not fulfill these criteria. Measures should be evidence-based, contribute to the comprehensiveness of performance measurement, be under a hospital's control and account for potential unintended consequences. We urge CMS only to propose and select measures that meet all of these conditions. **CMS should only choose measures that have been NQF endorsed and HQA adopted.**

The NQF currently is developing national quality goals. The HQA has agreed that the NQF's national goals should provide a foundation for its future work. **CMS should indicate its intent to follow the national goals as well.**

Measure maintenance. MHA believes it is critical that the measures included in the pay-for-reporting program represent best clinical practice. Therefore, we are pleased that CMS recognizes that there may be a need to retire, replace or revamp reporting measures. Currently, CMS and the Joint Commission have a process for reviewing measures and identifying modifications that should be made as a result of changes in scientific evidence. **As a process is developed to retire or replace measures for the pay-for-reporting program, we urge them to include hospitals, data vendors and other stakeholders.** When amending measures, CMS and the Joint Commission should take into account the ability of hospitals, the data warehouse and data vendors to successfully and quickly implement changes in reporting measures. In particular, to understand the effects that reporting changes have on hospitals, CMS should seek input from hospital data collection personnel as a part of the measure review process.

Data resubmission, validation and appeals. The proposed rule does not address the issue of data resubmission when the hospital or its vendor become aware of an error in the data that was sent to Q-Net exchange for posting on Hospital Compare. **MHA urges immediate adoption of an effective mechanism for allowing 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.

Recently, many hospitals have had difficulties with their data submission. These problems commonly have been due to errors in the software at the data warehouse, and have caused an undue administrative burden for hospitals. They have focused staff attention on data collection and reporting and away from quality improvement initiatives to provide better care to patients. **CMS needs to address these data issues in an expedited manner.** Specifically, the data specifications need to be articulated well in advance of the start of data collection so that both the vendors that assist hospitals in collecting and formatting data for submission and the data warehouse have an appropriate amount of time to adjust their software and test it to ensure it functions properly.

In addition, improvements must be made to the current validation process. Many hospitals have been notified that there have been problems validating the data they submitted. In several instances, these validation problems have been due to inconsistencies in the definitions of some variables used by CMS' contractors who are reabstracting patient-level data and comparing it to the data submitted by the hospitals. While the reabstraction of five charts per quarter for each

hospital may have been a sufficient validation strategy when only 10 measures were being collected and reported, it is insufficient to ensure the reliability of the data as we continue to expand the number of measures and the number of patients on whom data are being collected. A more resilient and less resource intensive method of validation is needed. We are working with a well known research and data enterprise to explore alternatives and will share their recommendations about more effective, less cumbersome validation processes with CMS in the next few weeks.

Regardless, the data submitted by a hospital may be called into question and that hospital should have the opportunity to file an appeal indicating why its data were correct. The appeals process should be straightforward, transparent and timely. Hospitals should have clear guidance on how to submit their appeals, and CMS should provide timely appeals decisions. For payments in FY 2007, approximately 130 hospitals across the nation filed appeals, and were told to expect a response within a few weeks. They did not get a response for several months, well into the payment year. This caused unnecessary cash flow problems. **CMS should use the experience in FY 2007 to construct a process for adjudicating appeals in a timely fashion and should clearly lay out that process prior to publication of the final rule.**

## **OCCUPATIONAL MIX ADJUSTMENT**

By law, CMS must collect data every three years on the occupational mix of employees from hospitals subject to the inpatient PPS in order to construct an occupational mix adjustment to the wage index to control for the effect of hospitals' employment choices – such as greater use of registered nurses (RNs) versus licensed practical nurses or certified nurse aides – rather than geographic differences in the costs of labor.

Hospitals collected the hours and wages of employees from January 1 through June 30, 2006. CMS proposes to use these data in adjusting the FY 2008 area wage index. CMS also requested comments on what occupational mix adjustments to use for hospitals that did not turn in the data and whether to penalize such hospitals in the future.

For FY 2008, we believe that CMS' proposal to use the area's average adjustment for non-responsive hospitals and the national average adjustment for non-responsive counties is reasonable. For FY 2009 and beyond, because data from all hospitals is needed to construct an accurate national average hourly wage, full participation is critical. **We urge CMS to construct an application of the occupational mix adjustment that encourages hospitals to report but does not unfairly penalize neighboring hospitals. We also encourage CMS to establish some sort of appeal process for hospitals with extenuating circumstances (e.g., hospitals affected by natural disasters).**

## **WAGE DATA**

CMS expanded its collection of contract labor with cost reporting periods beginning on or after October 1, 2003 to include administrative and general (A&G), housekeeping, dietary and management and administrative services. The FY 2008 wage index, based on FY 2004 cost report data, marks the first year CMS can determine what the impact would be if it included such

costs in the wage index. CMS contends that the data are reasonable and accurate and that the vast majority of hospitals would not be affected by the change. Thus, CMS proposes to include such contract labor costs in the wage index for FY 2008.

However, we believe that the impact is greater than suggested by CMS due to an error in the calculation. We agree that lines 22.01 (Contract A&G Services), 26.01 (Contract Housekeeping Services) and 27.01 (Contract Dietary Services) are and should be included in Step 4. The purpose of Step 4 is to allocate a portion of overhead wages and wage-related costs to the excluded areas, and then to subtract a commensurate amount from wages and wage-related costs included in the wage index. However, while line 9.03 (Contract Management and Administrative) was included in the total wages in Step 2, lines 22.01, 26.01 and 27.01 were not. This results in a double negative effect. First, the contract labor for those three lines was never included. And second, a portion of those same costs are being subtracted from the wages and wage-related costs included in the wage index.

**CMS should fix the calculation and then reassess the impact on hospitals. While MHA supports the inclusion of contract labor, a transition should be considered if the impact on any individual hospital is great.**

## **WAGE INDEX**

In FY 2009, CMS is required to consider changes to the area wage index. The following are some of the fundamental concerns our members have with the wage index, as well as with MedPAC's recommendation for CMS' deliberation over the next year. A workgroup, comprised of state, regional and metropolitan hospital association executives as well as other national hospital associations, ranked their concerns as follows:

1. Volatility of wage index year to year.
2. Self-perpetuating – hospitals with low wage indices are unable to increase wages to become competitive in the labor market.
3. Unrealistic geographic boundaries.
4. Geographic boundaries create “cliffs” where adjacent areas have very different indices.
5. Inaccurate measure of actual labor costs.
6. Fiscal intermediaries are inconsistent in their interpretations.
7. Hospitals can be penalized for erroneous data submitted by other hospitals in the same geographic area.
8. Exclusion of some personnel from the wage index calculation – outsourcing of low-wage workers raises an area's wage index.

Regarding MedPAC's recommendation, which will be released in its June report, our members had the following concerns.

Data source. MedPAC considered the use of Bureau of Labor Statistics (BLS) data rather than the hospital-reported data collected on CMS' Medicare cost reports. While this approach may be significantly less burdensome for hospitals, there are critical differences between the two data sets that must be carefully evaluated. The new data source is the cornerstone of the MedPAC approach and represents a fundamental change. Many of the other aspects of the draft proposal possibly could be applied using hospital wage data as it is currently collected. Key differences between the CMS and BLS methodologies include:

- **Inclusion of non-hospital employers** – The BLS wage data for a particular occupation are collected from *all employers*, not just short-term, acute-care hospitals participating in Medicare. Wage rates, however, vary depending on the type of employer (hospital, nursing home, physician office, insurance company, university, etc.), and the mix of employers varies by market. Thus, wage rates will be influenced by the specific mix of hospital vs. non-hospital employers of the same occupations. Consequently, the BLS data may not be an accurate reflection of labor costs experienced by hospitals in communities with a higher proportion of other types of health care organizations.

In addition, section 1886(d)(3)(E) of the *Social Security Act* specifies that the wage index must be based on data from “subsection (d) hospitals.” The BLS data set would need to be altered to remove the wages and hours for non-inpatient PPS providers to satisfy this requirement, or the law would have to be changed to accommodate the use of BLS data.

- **Different treatment of certain types of personnel in wage data collection** – Wages paid by companies that offer temporary employees to health care providers are included in the BLS sample. Thus, contract workers are included. However, their wages reflect the lower rate that the employees are paid *by* the agency as opposed to what the hospitals pay *to* the agency for the contract workers. This may understate labor costs in shortage areas with high use of registry nurses.

In addition, there are employee wages included in the current CMS data that are not included in the BLS data, such as Part A physicians' time unrelated to medical education. This may materially affect wage estimates in areas with a high penetration of teaching hospitals, particularly those that have provider-based clinics where employed physicians provide care not associated with teaching residents.

- **Process to review/verify data** – Unlike CMS' public process for review and correction of wage data at the hospital level, BLS has a strict confidentiality policy that would preclude hospitals from verifying the accuracy of the data.

**Not designed to capture differences in wage growth between geographic areas** – Every six months, BLS surveys 200,000 establishments (“a panel”), building the full sample of 1.2 million unique establishments over a three-year period. BLS's methodology relies on a “single national estimate” of wage growth for broad occupational divisions, called the *Employment Cost Index*. This approach fails to account

for any differences in wage growth between markets over the three-year period. As BLS notes, *“This procedure assumes that there are no major differences [in wage growth] by geography, industry, or detailed occupation.”*

- **Pay-period rather than full-year data** – While CMS collects wage data for a 12-month period, the BLS survey captures only two payroll periods per year, one in May and the other in November.
- **BLS excludes the cost of benefits** – According to an AHA Annual Survey, benefits represent over 25 percent of hospitals’ labor costs nationally. Looking across states, this percentage varies from a low of 18 percent to a high of 31 percent. Therefore, any adjustments made to include benefit costs would have to be market-specific. If benefits information is to be added, it would have to be collected on CMS’ Medicare cost report in order to adjust the BLS data. This would negate the potential benefit of eliminating the collection of hospital-specific wage data.
- **BLS excludes pay counted by CMS** – The BLS data excludes shift differentials, overtime pay and jury duty – all of which CMS includes. Overtime pay can be a cost associated with local labor shortages and shift differentials can vary as well, depending on local labor market conditions.
- **Full-time and part-time employees are equally weighted** – While CMS collects both wages and hours, BLS collects a count of workers within a series of wage ranges. The survey makes no distinction between full-time and part-time workers in estimating wage rates from the data collected. To the extent that the use of part-time versus full-time workers varies by market or type of employer, this could distort the wage calculation if part-time hourly wages are lower than full-time wages.
- **Data subject to sampling error** – Estimates using a sampling methodology like the BLS approach are going to be less reliable than using the entire universe of PPS hospitals, as is done by CMS. Both surveys would be subject to non-sampling error (e.g., errors from respondents providing incorrect data). However, the CMS process allows for extensive public scrutiny of the data while the BLS approach does not.

#### Geographic boundaries.

- **Current geographic boundaries** – The current wage index methodology, with the exception of some commuting pattern adjustments, assumes that there is no inter-relationship between areas. By simply being on opposite sides of a geographic boundary, two hospitals can have very different reimbursement, even though they are competing for the same workforce. More refined areas – as in MedPAC’s proposal to vary wage indices by county – may be more realistic and less arbitrary. On the other hand, the “smoothing” approach, whereby wage index values or wages of neighboring areas are artificially constrained to allow only a 10 percent difference in wage indices, may mask actual variation in wages between areas. For example, there may be real, greater differences between outlying counties and an urban core.

In addition, MedPAC plans to use the decennial Census to determine variation between the counties. So, for 2008, MedPAC would use the 2000 Census data to establish the relationship between counties within a metropolitan statistical area until the 2010 Census is available. Using data this old may create differences in wage indices that are inconsistent with the actual difference experienced in wages.

- **Single rural area wage index** – While a single wage index for all rural areas of a state may be reasonable for some states, it may not adequately reflect wage variation in large states. While varying the wage indices within rural areas may make sense, we question whether the decennial census data – now seven years old – produces accurate estimates of current area wage differences.
- **Year-to-year volatility** – Volatility in wage indices from one year to the next makes it difficult for hospitals to estimate Medicare payments for budgeting purposes. While the three-year rolling average employed by BLS may reduce volatility, alternative approaches should be examined, including those that do not rely on BLS data.

We look forward to a full discussion of possible changes to the wage index in the FY 2009 rulemaking process and appreciate CMS' consideration of the issues raised in the meantime.

## **RURAL FLOOR**

CMS proposes applying the budget-neutrality adjustment associated with the rural floor to the wage index rather than the standardized amount in FY 2008. While it considered both an iterative process and a uniform reduction, the agency said the uniform reduction is operationally easier and results in the same wage indices.

MHA supports this move assuming that it removes the compounding affect of applying the budget-neutrality adjustment for the rural floor to the standardized amount annually since 1998. We believe that it was an unintended error to repeatedly apply the rural floor budget-neutrality adjustment without first reversing the prior year's adjustment as is done with the outlier calculation each year. We also suggest that CMS remove the effects of the adjustments made from 1999 through 2006 by increasing the positive budget-neutrality adjustment proposed to the standardized amount intended to just reverse the 2007 adjustment.

## **PHYSICIAN OWNERSHIP IN HOSPITALS**

The proposed rule would require that that all physician-owned hospitals at the beginning of an admission or outpatient visit disclose to patients that physicians have an ownership interest or investment in the hospital and offer to make a list of physician investors available on request. The beginning of an admission or outpatient visit is defined to include pre-admission testing or to require registration. Such hospitals also would have to require, as a condition for medical staff privileges, that physician investors disclose to their patients that they have an ownership interest when they refer patients to the hospital for services. **Although Minnesota does not have a physician-owned hospital, MHA supports implementation of a physician-ownership disclosure requirement.**

There are several specific aspects of the proposal that deserve comment:

- **Locus of requirement** – CMS asked whether the requirement should be located in the provider agreement or conditions of participation. **We recommend that the ownership disclosure requirement be incorporated into provider agreements** because the conditions of participation should be focused on care delivery standards.
- **Scope of requirement** – CMS asked whether the definition of a “physician-owned hospital” should exclude physician ownership or investment interests based on the nature of the interest, the relative size of the investment, or the type of investment (e.g., publicly-traded securities and mutual funds). **We recommend that the only exception to the definition of a “physician-owned hospital” be when physician ownership is limited to holding publicly-traded securities or mutual funds that satisfy the requirements for the exception under §411.356(a),(b). We oppose any exception based on the size of investment.** It is important for patients to know whenever there is a duality of interest on the part of their physician that could cause a conflict of interest in making decisions about their care. The size of that interest is immaterial to the fact that the conflict may exist.
- **Definition of the beginning of an admission or outpatient visit** – The “beginning of an inpatient admission or outpatient visit” specifically includes pre-admission testing and registration. **We recommend that the definition be clarified to include scheduling as well as pre-admission testing and registration.** Patients should receive these disclosures at the earliest opportunity so that they have an ability to act on the information if they choose.
- **Provision of list of physician investors** – The proposal would require that physician-owned hospitals offer to provide patients with a list of the physician investors on request, but does not establish any time frame for doing so. **We recommend that the list be provided to patients at the time the request is made.** We believe providers should be able to provide the list immediately upon inquiry, so that patients would get the information in time to consider it.

## **PATIENT SAFETY MEASURES**

As part of the DRA-required report to Congress, CMS also raised the issue of the safety of patients in physician-owned specialty hospitals. Recent events and media coverage of safety concerns also have highlighted problems. The proposed rule would address these issues in several ways:

- Require a written disclosure to patients of how emergencies are handled when the hospital does not have a physician available on the premises 24 hours a day, 7 days a week; and
- Seek comment on whether current requirements for emergency service capabilities in hospitals both with and without emergency departments (EDs) should be strengthened in certain areas, including required staffing competencies, certain equipment availability, and required 24-hour-a-day, 7-day-a-week ED availability.

While these requirements may sound reasonable, we believe they miss the mark on the real issue to be addressed: safety concerns in physician-owned specialty hospitals.

It makes sense to apply special requirements like these to physician-owned specialty hospitals, but not to all hospitals. The safety concerns that have been raised with physician-owned specialty hospitals occur because these facilities operate outside the traditional network of care delivery in this country. They are free-standing facilities, are generally not part of a larger system of care, most often have no transfer agreements with other hospitals or providers of care in a community, and tend to specialize in one type of care delivery, challenging their ability to treat the unexpected event or emergency.

This is not the case with full-service community hospitals. Full-service community hospitals are part of a network of care in their community, involving referrals from local physician practices, reliance on local trauma support networks, participation in local emergency medical transport systems and transfer agreements among facilities. Even small and rural hospitals located in more remote areas are part of a planned network of care and patient triage. Small and rural hospitals often stabilize and transport patients to other facilities, but that transport is communicated, the receiving hospital is alerted and the patient's clinical information collected at one hospital goes with the patient to the next hospital. Small and rural hospitals also are often connected to a system of care through telemedicine, which allows for access in more remote areas to specialists and other clinical expertise available at larger, more urban hospitals. **Applying additional requirements for this group of community hospitals is unnecessary and costly.**

## **IME ADJUSTMENT**

In the FY 2007 final rule, CMS finalized a policy to exclude residents' time spent in non-patient care activities from the resident count for purposes of IME (in all settings) and direct graduate medical education (in non-hospital settings) payments. Since that time, the agency has received questions about the treatment of vacation or sick leave and orientations. While recognizing that this time is neither devoted to patient care nor non-patient care, but rather a third category, the proposed rule would treat vacation and sick time differently than it would treat orientation time. Orientation time would continue to be included as part of the full-time equivalent (FTE) count, as it always has.

Under the proposed rule, vacation and sick time would be removed from the total time considered to constitute an FTE resident. Thus, it would be removed from both the numerator and denominator of the FTE calculation. CMS acknowledges that this would result in lower FTE counts for some hospitals and higher counts for other hospitals, solely because of this regulatory change.

MHA believes CMS' proposal is operationally impractical. Hospitals would not only have to keep track of the leave for each resident, but then somehow apportion the leave to each of the hospitals the residents' rotate through. **We recommend that CMS treat sick and vacation leave similarly to how it proposes to treat orientation time as part of the FTE count.** We do not believe that it is necessary for CMS to parse each hour of residents' time. The vast majority

of time counted in the FTEs is related to patient care, and any further changes would have minor affects, nationally speaking, while having major implications at the individual hospital level.

## REPLACED DEVICES

In the calendar year 2007 outpatient PPS final rule, CMS adopted a policy that requires a reduced payment to a hospital or ambulatory surgical center when a device is provided to them at no cost. Similarly, CMS believes that payment of the full inpatient PPS DRG in cases in which the device was replaced for free or at a reduced cost effectively results in Medicare payment for a non-covered item.

Unlike the current outpatient PPS policy (which applies only when a device is provided at no cost), CMS proposes to reduce the amount of the Medicare inpatient PPS payment when a full or partial credit towards a replacement device is made or the device is replaced without cost to the hospital or with full credit for the removed device. However, CMS proposes to apply the policy only to those DRGs under the inpatient PPS where the implantation of the device determines the base DRG assignment (22 DRGs), and situations where the hospital receives a credit equal to 20 percent or more of the cost of the device.

CMS also proposes to use new condition codes to report the use of such devices to trigger manual processing by the FIs. The hospital would be required to provide paper invoices or other information to the FI (or Medicare Administrative Contractor) indicating the hospital's normal cost of the device and the amount of the credit received. In cases where the device is provided without cost, CMS proposes that the normal cost of the device will be subtracted from the DRG payment. In cases where the hospital receives a full or partial credit, the amount credited will be subtracted from the DRG payment.

CMS justifies this change by noting that "in recent years, there have been several field actions and recalls with regard to failure of implantable cardiac defibrillators and pacemakers." Although MHA does not dispute this fact, we believe it ignores the underlying concept of the DRG payment system.

DRG payments are fundamentally based on averages of historical costs and charges. To reduce the payment for cases involving replacement of a medical device assumes that either these types of cases have not occurred in the past or are occurring at such a dramatic increase as to materially skew the averages used to develop the DRG weights. In fact, CMS notes that "we believe that incidental device failures that are covered by manufacturers' warranties occur routinely." This statement acknowledges that incidental device failure has occurred in the past and was likely covered by the manufacturer warranty. If so, this practice is part of the historical cost and charge data used to develop the current DRG weights for cases involving implantation. Reducing payment for certain cases involving a re-implantation would ignore the average DRG weight for those cases that already implicitly include this reduction. **Therefore, we ask CMS to reconsider implementing this proposal. However, if CMS implements this policy, we agree that it should limit the number of DRGs to which the policy applies. In addition, we agree that insignificant credits or refunds should not trigger this policy. However, CMS should consider raising the proposed threshold from 20 percent to greater than 50 percent or the majority of the cost of the device.**

Given the administrative burden of manually processing these claims, it is not worth the burden on the hospitals' or FIs' part if only a nominal portion of the cost of the device is at issue. In addition, inpatient PPS payments are often less than costs. **If CMS implements this policy, estimated costs should be calculated from the charges on the claims and only reduce the DRG payment by the device cost if the payment is greater than the cost of the case less the cost of the device.**

## NEW TECHNOLOGY

Section 503 of the *Medicare Modernization Act* (MMA) provided new funding for add-on payments for new medical services and technologies and relaxed the approval criteria under the inpatient PPS to ensure that the inpatient PPS would better account for expensive new drugs, devices and services. However, CMS continues to resist approval of new technologies and considers only a few technologies a year for add-on payments. **MHA also is disappointed that CMS has not increased the marginal payment rate to 80 percent rather than 50 percent, consistent with the outlier payment methodology, as we previously requested.**

Moreover, we are concerned about CMS' ability to implement add-on payments for new services and technologies in the near future. Recognizing new technology in a payment system requires that a unique procedure code be created and assigned to recognize this technology. The ICD-9-CM classification system is close to exhausting codes to identify new health technology and is in critical need of upgrading.

Since the early 1990s, there have been many discussions regarding the inadequacy of ICD-9-CM diagnoses and inpatient procedure classification systems. ICD-10-CM and ICD-10-PCS (collectively referred to as ICD-10) were developed as replacement classification systems.

The National Committee on Vital and Health Statistics (NCVHS) and Congress, in committee language for the MMA, recommended that the Secretary undertake the regulatory process to upgrade ICD-9-CM to ICD-10-CM and ICD-10-PCS. Congress' call for action recognized that procedure classification codes serve to identify and support research and potential reimbursement policies for inpatient services, including new health technology, as required under the *Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000*.

To date, despite these recommendations, as well as the recommendations of several federal health care agencies and offices and health care trade and professional associations, the Department of Health and Human Services (HHS) has not yet moved forward to adopt the ICD-10 classification upgrades. Absent a switch to ICD-10 soon, hospitals will experience significant coding problems that will affect the efficiency of the current coding process, adding significant operational costs. In addition, failure to recognize this looming problem will only impede efforts to speed the adoption of electronic health records.

At the April 2005 ICD-9-CM Coordination and Maintenance (C&M) committee meeting, many expressed the need to start limiting the creation of new procedure codes in order to allow the classification system to last at least two more years. ICD-9-CM procedure code categories 00 and 17 were created to capture a diverse group of procedures and interventions affecting all body systems. The establishment of these code categories represented a deviation from the normal

Leslie Norwalk, Esq.

June 8, 2007

Page 26 of 39

structure of ICD-9-CM and a stopgap measure to accommodate new technology when no other slots in the corresponding body system chapters (e.g., musculoskeletal system, circulatory system, etc.) were available. The plan was to use codes in chapter 00 first and then begin populating chapter 17.

Category 00 is now full, and the C&M committee is entertaining proposals for codes in category 17. At the April 2005 C&M meeting, a proposal was presented that would, in effect, leave only 80 codes available in this category. In order to conserve codes, this proposal was rejected and replaced instead with three codes that did not provide information as to what part of the body the surgery was performed on. Many of the specific body system chapters are already filled (e.g., cardiac and orthopedic procedures). In recent years, as many as 50 new procedure codes have been created in a single year. This means that it is possible for ICD-9-CM to completely run out of space in less than a year. We concur with the NCVHS recommendation to issue a proposed rule for adoption of ICD-10. We also would support an implementation period of at least two years.

**We strongly recommend that the Secretary expeditiously undertake the regulatory process to replace ICD-9-CM with ICD-10-CM and ICD-10-PCS.** HHS should take the necessary steps to avoid being unable to create new diagnosis or procedure codes to reflect evolving medical practice and new technology. It is easier to plan for this migration than to respond to the significant problems that will likely result in unreasonable implementation time frames. It is imperative that the rulemaking process start immediately.

ATTACHMENT I – Revised CC List

**SPECIFIC COMMENTS ON THE  
COMPLICATION AND COMORBIDITY (CC) LIST**

The following list represents conditions currently proposed for removal from the CC list. **These conditions should be reinstated as CCs.**

Category 250.xx Diabetic manifestations.

Currently, all diabetes mellitus codes in category 250 are considered CCs except for those with a fifth-digit sub-classification of 0 (diabetes type II or unspecified type, not stated as uncontrolled). We agree that there may not be significant additional hospital resources required for a long-standing diabetic patient who is clinically stable and consistently under diet, oral or insulin control and without diabetic manifestations affecting major organ systems. However, we fail to understand why the CCs for diabetic manifestations are being removed. Patients whose diabetes has advanced to renal manifestations (250.4x), ophthalmic manifestations (250.5x), neurological manifestations (250.6x), peripheral circulatory disorders (250.7x) or other specified manifestations, including hypoglycemia shock (250.8x), require additional care and monitoring.

For example, a patient with diabetic nephropathy may require additional blood tests to monitor renal function, careful coordination of medications so as not to further compromise renal function and possibly even dialysis if the disease has progressed to stage V chronic kidney disease or end-stage renal disease. Diabetic manifestations can significantly increase the length of stay of patients suffering from infections, trauma, myocardial infarction or any other serious illness. The fact that diabetes is present may even result in patients who otherwise might be managed on an outpatient basis requiring admission. For example: patients with infections, who have undergone outpatient surgery or chemotherapy; or may require rapid initiation of rigorous control of the diabetes to improve outcome; or the primary medical problem or the therapeutic intervention can cause a major deterioration in diabetes control; or if there is acute onset of retinal, renal, neurological or cardiovascular complications of diabetes.

More importantly, chronic, stable diabetic patients may develop uncontrolled diabetes (codes 250.x2 and 250.x3), which would require close monitoring of the patient to determine the etiology of the control problem and subsequent modification of therapy. Frequent monitoring of blood sugars and medication adjustments may be required until the patient is stabilized.

Code 276.6, Fluid overload.

Patients with fluid overload require intravenous diuresis and/or renal dialysis, depending on the etiology of the fluid overload. These patients require increased nursing care through repeated assessment of signs and symptoms of congestion and changes in body weight. Monitoring of daily weight, intake and output is recommended to assess clinical efficacy of diuretic therapy. In addition, they require careful physical and symptom assessment and monitoring of vital signs, body weight and laboratory results to optimize fluid status. They also require careful observation for development of a variety of side effects, including renal dysfunction, electrolyte abnormalities and symptomatic hypotension, especially when diuretics are used at high doses and in combination. Patients need to undergo routine laboratory studies and clinical examination, as dictated by their clinical response. Serum potassium and magnesium levels need to be monitored at least daily and maintained in the normal range. More frequent monitoring may be necessary when diuresis is rapid.

Overly rapid diuresis may be associated with severe muscle cramps, which should be treated with potassium replacement, if indicated. Patients treated with diuretics need to be monitored carefully for excessive urine output, development of hypotension and reductions in serum potassium, magnesium and renal function. Serial determinations of creatinine and blood urea nitrogen (BUN) are particularly important when these side effects are present or anticipated. Diuretic therapy must be highly individualized based on the degree of fluid overload present and the degree of volume loss produced to minimize these side effects.

All this points to increased monitoring and hospital resources, and we believe this condition should remain a CC.

Code 276.51, Dehydration.

Dehydration is a condition in which the body contains an insufficient volume of water for normal functioning. It can be caused by a wide range of diseases and states that impair water homeostasis in the body. Causes can include infectious diseases and malnutrition, as well as other external or stress-related causes. Vomiting and diarrhea are common causes. Dehydration can be classified as mild, moderate or severe based on how much of the body's fluid is lost or not replenished. Severe dehydration is a life-threatening emergency. Treatment of moderate-to-severe dehydration may require hospitalization and intravenous fluids with replacement of electrolytes and continuing assessment of electrolyte status.

We do not understand why dehydration (code 276.51) is being removed from the CC list. If the intent is to exclude cases of mild dehydration that may not require significant additional resources, the ICD-9-CM codes currently do not distinguish levels of severity. A revision to the ICD-9-CM codes to provide further specificity on the level of severity would be required to recognize the significant additional resources required to treat moderate and severe dehydration.

Code 276.52, Hypovolemia.

Hypovolemia is a state of decreased blood volume; more specifically, a decrease in volume of blood plasma. Common causes of hypovolemia can be dehydration, bleeding and severe burns. Drugs such as diuretics or vasodilators are typically used to treat hypertensive individuals. Treatment is dependent on the underlying cause. If the hypovolemia is due to bleeding or severe burns, these patients may require blood transfusions, which are costly and require more intensive nursing monitoring.

Code 276.9, Electrolyte and fluid disorders.

Patients with electrolyte and fluid disorders are treated with intravenous fluids and require more frequent monitoring of electrolyte levels.

Code 282.69, Other sickle-cell disease with crisis.

We believe that code 282.69, Other sickle-cell disease with crisis, should be a major complication or comorbidity (MCC), consistent with the other sickle-cell disease with crisis codes (282.42, 282.62, and 282.64). The main symptoms are crisis or sudden pain in joints or organs. The affected joints or organs vary from patient to patient. The most common areas are the chest, back and torso, leading to difficulty breathing during the crisis. A crisis may last from only a few hours to weeks. We believe that the fact that this code includes "crisis" indicates of

an acute flare up of the disease and could require antibiotics, pain management, intravenous fluids, blood transfusion, surgery and psychosocial support. These patients also are best managed in a comprehensive multi-disciplinary program of care, indicating increased hospital resource use.

Code 284.8, Aplastic anemias, NEC.

This code includes aplastic anemia due to chronic systemic disease, drugs, infection, radiation, aplasia of bone marrow, red cells, panhematopenia, panhemocytopenia, acquired bone marrow failure, toxic aplastic anemia or other specified type not elsewhere classified (NEC). Treating aplastic anemia involves suppression of the immune system, which may be achieved by daily medicine intake or, in more severe cases, a bone marrow transplant or platelet transfusions. Medical therapy of aplastic anemia often includes a short course of anti-thymocyte globulin (ATG) or anti-lymphocyte globulin and several months of treatment with cyclosporin to modulate the immune system. Mild chemotherapy with agents such as cyclophosphamide and vincristine also may be effective. Antibodies therapy such as ATG targets T-cells, which are believed to attack the bone marrow. Medical treatment also requires evaluation of renal and liver functions often by measuring BUN, serum creatinine, serum bilirubin and liver enzymes. All of these therapies represent significant additional hospital resources. In addition, increased patient monitoring is required to determine a patient's response to treatment and to prevent any possible complications.

Code 285.1, Acute posthemorrhagic anemia.

This code is assigned when a physician documents acute posthemorrhagic anemia. It also includes acute postoperative anemia if the physician documents significant amount of blood loss resulting in anemia but does not label it as a postoperative complication. Treatment is dependent on the source of bleeding. If the source of bleeding is not identified, significant resources may be devoted to determining and controlling the source of bleeding. Even if the source of the bleeding is known and controlled, blood transfusions may be necessary. Blood transfusions represent additional resources in terms of the cost of blood storage and processing, blood administration and the significant monitoring required of these patients.

Codes 287.30, 287.39, 287.4, 287.5, Thrombocytopenia.

Thrombocytopenia is a serious medical problem involving low platelets. It may be caused by a number of different factors such as chemotherapy, medications, infection or immune problems. Treatment depends on the cause of the condition. In some cases, a transfusion of platelets may be required to stop or prevent bleeding. As previously stated, we believe that transfusions of blood and blood products represent a significant increase in hospital resources.

For the sake of consistency, we believe that the following codes should remain as CCs:

- 287.30 Primary thrombocytopenia, unspecified;
- 287.4 Secondary thrombocytopenia; and
- 287.5 Thrombocytopenia, unspecified.

This would be consistent with the other specific thrombocytopenia codes that have remained as CCs:

- 287.31 Immune thrombocytopenic purpura;
- 287.32 Evans' syndrome; and
- 287.33 Congenital and hereditary thrombocytopenia purpura.

303.00-303.02, Acute alcohol intoxication.

Acute alcohol intoxication has the potential to adversely affect almost every organ system. However, cardiovascular, gastrointestinal and neurologic problems are of particular concern. Alcoholic intoxication also may affect morbidity and mortality through the development of cardiac arrhythmias and tachyarrhythmias, particularly idiopathic atrial fibrillation. Ventricular tachyarrhythmias also may be provoked, and heavy drinking may increase the risk of sudden cardiac death from fatal arrhythmias. Patients with acute alcohol intoxication require additional monitoring, even if the more serious potential complications do not materialize. Airway assessment and protection also are crucial because of the suppressed protective reflexes that can result from intoxication and the increased potential for vomiting secondary to gastric irritation. Therapeutic intervention priorities include hydration with intravenous fluids, symptomatic control of nausea and vomiting, and correction of electrolyte imbalances such as hypomagnesemia. In severe cases – those of severe stupor and coma – the patient may even need intubation to support respirations (which may stop spontaneously) and to protect the lungs from filling with vomit. Acute alcohol ingestion is particularly likely to complicate the management of trauma patients. Agitated patients must be protected from themselves and require more intensive nursing supervision and care. Evaluation of an acutely intoxicated patient may require repetitive examinations and a quantitative assessment of intoxication. There also may be a need for social service interventions including counseling, treatment or shelter referrals.

Codes 402.xx, Hypertensive heart disease.

We believe combination codes within a category should be handled consistently. For example, codes 402.00, 402.01, 402.11 and 402.91 are considered CCs. This range of codes includes hypertensive heart disease without heart failure (402.00), as well as those with heart failure (402.01, 402.11 and 402.91). Based on the ICD-9-CM classification, code 402.x1 is assigned when there is hypertensive cardiomegaly, cardiopathy, cardiovascular disease or heart disease **with** heart failure (including congestive heart failure 428.0). However, independently, neither benign or unspecified hypertension (401.1 or 401.9), nor congestive heart failure (428.0) are CCs. We are unable to determine whether the inclusion of 402.00 or the omission of 428.0 was an oversight. We recommend that code 402.00 be removed from the CC list and code 428.0 be reinstated as a CC.

Codes 403.90 and 403.91.

We believe combination codes within a category should be handled consistently. Codes 403.00, 403.01 and 403.11, representing the malignant and benign forms of hypertension associated with chronic kidney disease (CKD), have remained on the revised CC list, while codes 403.90 and 403.91, representing unspecified hypertension, have been removed. Most physicians fail to specify hypertension as benign and often will assume the hypertension to be benign when not specifically documented as “malignant.” The hospital resources utilized in addressing patients with benign or unspecified hypertensive CKD are the same. However, ICD-9-CM rules require that these cases be coded to the “unspecified” form of the code. We believe that the original intent was to recognize the additional resources involved in the treatment of patients with Stage

IV CKD (585.4), Stage V CKD (585.5) or end-stage renal disease (585.6). Additional increased monitoring and resources for these patients includes renal dialysis and possibly care of any dialysis-related arteriovenous fistulae. Codes 585.4 and 585.5 are considered CCs, while code 585.6 is considered an MCC in the current proposed CC revision.

An additional coding problem is that the current fifth digits for category 403, Hypertensive chronic kidney disease, are divided as:

- “0” with chronic kidney disease stage I through stage IV, or unspecified; and
- “1” with chronic kidney disease stage V or end-stage renal disease.

The proposed CC revision list has grouped the chronic kidney disease codes as follows:

- 585.4 CKD, stage IV (severe) – CC;
- 585.5 CKD, stage V – CC; and
- 585.6 End-stage renal disease – MCC.

The breakdown of the fifth digit “0” for category 403 makes it difficult to split these conditions in a consistent manner since CMS could be including the less-severe stages of CKD in 403.x0 in an effort to also recognize CKD stage IV. There also is a problem in determining whether 403.x1 should be a CC or an MCC since the fifth-digit of “1” includes CKD stage V (a CC), as well as end-stage renal disease (an MCC).

Until a change to the ICD-9-CM classification is made, we recommend that code 403.90 be considered a CC and code 403.91 an MCC.

#### Code 413.9, Angina pectoris.

Angina requires medical treatment with beta-blockers, nitroglycerin, calcium channel blockers, vasodilators, ACE inhibitors or statins. Patients with this condition require evaluation and monitoring to ensure that they do not progress to more significant cardiovascular problems.

#### Code 426, Conduction disorders.

We have found some inconsistencies in whether heart blocks are considered as CCs. It is unclear whether this is for clinical reasons or whether this was an accidental oversight. We recommend that CMS seek input from the appropriate clinical specialties as to the current treatment of heart blocks. For example, some heart blocks have remained as CCs (namely 426.0, Atrioventricular block, complete; 426.12, Mobitz (type) II atrioventricular type; and 426.89, Other specified conduction disorders), while other similar heart blocks, including complete heart blocks, have been removed, such as:

- 426.13, Other second degree atrioventricular block;
- 426.53, Other bilateral bundle branch (this is considered a complete heart block);
- 426.54, Trifascicular block (this also is a form of complete heart block);
- 426.6, Other heart block (includes intraventricular block, sinoatrial block, sinoauricular block); and
- 426.9, Conduction disorder, unspecified.

Code 427.31, Atrial fibrillation.

Atrial fibrillation (AF) is a significant medical condition that requires treatment to prevent stroke. The American Heart Association recommends aggressive treatment of this heart arrhythmia. Anticoagulant and antiplatelet medications thin the blood and make it less prone to clotting. Warfarin is the anticoagulant now used for this purpose, and aspirin is the antiplatelet drug most often used. Long-term use of warfarin in patients with AF and other stroke risk factors can reduce stroke by 68 percent. Medications are used to slow down rapid heart rate associated with AF. These treatments may include drugs such as digoxin, beta-blockers (atenolol, metoprolol, propranolol), amiodarone, disopyramide, calcium antagonists (verapamil, diltiazam), sotalol, flecainide, procainamide, quinidine, propafenone, etc. Electrical cardioversion may be used to restore normal heart rhythm with an electric shock when medication does not improve symptoms. Drugs (such as ibutilide) can sometimes restore the heart's normal rhythm. These drugs are given under medical supervision and are delivered through an IV tube into a vein, usually in the patient's arm. These patients also require repeated blood tests and additional nursing care.

Patients with atrial fibrillation require more intensive resources, including admission to the intensive care unit if symptoms do not abate. In more severe situations, radiofrequency ablation or atrial pacemaker insertion may be required when medical treatment is unsuccessful.

Code 428.0, Congestive heart failure, unspecified.

Currently, ICD-9-CM codes do not distinguish between acute, chronic or acute exacerbation of chronic congestive heart failure (CHF). All forms of this condition are assigned to code 428.0. Medical record documentation may not typically include information on whether the CHF is systolic or diastolic (acute versions of heart failure with this specificity are considered MCCs).

**We request that 428.0 be added as an MCC until a new code can be created to identify acute exacerbation of CHF.**

Based on advice published in *Coding Clinic for ICD-9-CM*, Fourth Quarter 2002, pp. 52-53, and confirmed in Fourth Quarter 2004, p. 140, even if the information available specifies systolic or diastolic heart failure, code 428.0 is assigned as an additional code to identify the fact that this is a "congestive" episode. CHF is not an inherent component of either systolic or diastolic heart failure. When the diagnostic statement lists CHF along with either systolic or diastolic heart failure, two codes are required.

The fact that there is "congestion" is medically more problematic and more resource intensive than either systolic or diastolic dysfunction. Uncompensated CHF leads to pulmonary edema, which may necessitate care in the intensive care unit and a prolonged hospital stay. Coding guidelines necessitate that acute pulmonary edema of cardiac origin be assigned code 428.0, Congestive heart failure, unspecified.

Category 451, Thrombophlebitis.

We fail to understand why certain codes for thrombophlebitis have remained as CCs (e.g., 451.19, 451.81, 451.83 and 451.89), while the similar codes listed below have not:

- 451.0, Thrombophlebitis of superficial vessels of lower extremities;
- 451.11, Thrombophlebitis of femoral vein (deep) (superficial); and
- 451.2, Thrombophlebitis of lower extremities, unspecified.

Treatment of thrombophlebitis includes medicines to ease pain and inflammation and anticoagulants to break up clots and keep new clots from forming. Blood tests and dosage adjustments are required at least daily. Depending on the severity of the condition, and the patient's response to treatment, care also may involve removal of the thrombus and application of compression bandage. Additional nursing care also is required to keep the leg elevated. Additional testing such as echocardiograms may be required to ascertain the extent and location of the thrombophlebitis.

459.0, Hemorrhage, unspecified.

Generally, this code would only be reported when there is insufficient information to report a more specific code to identify the source of bleeding. Nevertheless, the presence of this code could reflect that significant workup was conducted to identify the source of bleeding but none was found.

Category 630-677, Complications of pregnancy, childbirth and puerperium.

We are concerned about the number and wide breadth of codes from Chapter 11 of the ICD-9-CM, Complications of pregnancy, childbirth and puerperium (categories 630-677), that are being removed from the CC list. According to CMS, due to the low volume in the Medicare population, diagnoses related to newborns, maternity and congenital anomalies were classified using All-Patient Refined DRGs (APR-DRGs). According to this methodology, APR-DRG default severity 1 (minor) diagnoses were classified as non-CCs. We are concerned about the lack of public comment and widespread clinical validation of whether these conditions are assigned to the appropriate severity level. Of special concern are conditions such as infections, acute renal failure, air and pulmonary embolism, cardiac arrest, shock, etc. that are CCs or MCCs and would be coded as such if not for the fact that the ICD-9-CM classification considers problems associated with pregnancy, childbirth and the puerperium to be so clinically significant that they require special combination codes. The combination codes are intended to identify that the presence of the pregnancy complicates the condition. For example, code 415.19, Other pulmonary embolism and infarction is an MCC, while code 673.20, Obstetrical blood-clot embolism, unspecified, is not even a CC.

We recommend that codes in Chapter 11 be carefully evaluated and validated with clinical experts, similar to the process to which the codes in other chapters were submitted. Combination codes should be treated consistently. If the condition is considered a CC or MCC in a non-pregnant patient, the corresponding pregnancy-related combination code also should be a CC or MCC.

Category 765.0, Extreme immaturity.

Codes in category 765.0, Extreme immaturity, represent infants with a birthweight of less than 1000 gm. Common problems with very low birthweight babies are low oxygen levels at birth; inability to maintain body temperature; difficulty feeding and gaining weight; infection; breathing problems, such as respiratory distress syndrome; neurological problems, such as intraventricular hemorrhage; gastrointestinal problems, such as necrotizing enterocolitis; and sudden infant death syndrome (SIDS). While some of these problems have unique ICD-9-CM codes that could be reported, not all of them do (e.g., inability to maintain body temperature). Nearly all very low birthweight babies need specialized care in the neonatal intensive care unit until they can gain weight and are well enough to go home. Care for very low birthweight babies

Leslie Norwalk, Esq.

June 8, 2007

Page 34 of 39

often includes temperature-controlled beds, special feedings – sometimes with a tube into the stomach if a baby cannot suck – as well as other treatments for complications. These codes would always be secondary diagnoses in newborn cases. The survival of these newborns is directly related to their weight at birth. Even after discharge from the hospital, the risks for long-term complications and disability are increased for babies with very low birthweight. Generally, the lower the birthweight, the greater the chances for developing intellectual and neurological problems, which affect the child's care.

#### V45.1, Renal dialysis status.

We believe that patients on renal dialysis should be recognized for the additional resources required to provide dialysis and to care for the arteriovenous fistula.

#### Diagnoses associated with patient mortality.

In the proposed rule, CMS noted that diagnoses that were closely associated with patient mortality were assigned different CC subclasses, depending on whether the patient lived or died. These diagnoses are:

- 427.41, Ventricular fibrillation;
- 427.5, Cardiac arrest;
- 785.51, Cardiogenic shock;
- 785.59, Other shock without mention of trauma; and
- 799.1, Respiratory arrest.

We agree that these diagnoses should be considered MCCs for patients who are discharged alive. However, we disagree with CMS' proposal to make these diagnoses non-CCs when a patient dies. We urge CMS to consider the patient's length of stay. We agree that a patient who expires soon after admission may not have significant resources associated with these conditions, but we believe that this is not true when a patient has been hospitalized at least a week.

## **ATTACHMENT II – Recalibration of DRG Weights**

### **COST REPORT CHANGES TO IMPROVE THE ACCURACY OF “COST-BASED” WEIGHTS**

#### **Recommendations of the Cost Report Workgroup**

**April 2007**

#### **BACKGROUND**

On August 18, 2006, the Centers for Medicare & Medicaid Services (CMS) published the final rule for the inpatient Medicare prospective payment system (PPS) implementing a change in how diagnosis-related group (DRG) weights would be developed. CMS modified the previous system, which relied solely upon hospital charge data, and developed an approach that would establish weights based on hospital “cost” data. CMS suggested that this type of revision would lead to the creation of DRG weights that more accurately reflect the relative resource use by DRG. Recognizing the financial impact of changes to the weights on some hospitals, and the possible need for further refinements, the final rule allowed for a three-year transition using a blend of the “charge-based” system and the “cost-based” system.

Under the cost-based system, the two sources of data that are utilized in establishing the DRG weights are the Medicare Provider and Review (MedPAR) files (an accumulation of claims filed by each hospital) and the Medicare cost report (MCR). Charges are taken from the MedPAR files, grouped into 13 categories and reduced to cost from cost-to-charge ratios (CCR) calculated from the MCRs for these same 13 categories.

An examination of the cost-based weights developed for fiscal year 2007 revealed that some significant problems occur by combing these two data sources:

- First, the method used by CMS to group hospital charges for the MedPAR files differs from how hospitals group Medicare charges, total charges and overall costs on the cost report.
- Second, hospitals group their Medicare charges, total charges and overall costs in different departments on their cost reports for various reasons.
- Third, hospitals across the country complete their cost reports in different ways, as allowed by CMS.
- Fourth, CMS’ new approach for categorizing all charges and costs into 13 specific categories may not yield the most appropriate CCR for each cost category.

This mismatch between MedPAR charges and cost report CCRs can distort the resulting DRG weights. It is important to note that the cost report was not designed to support the estimation of costs at the DRG level.

As a result, American Hospital Association, Association of American Medical Colleges and the Federation of American Hospitals convened a workgroup of hospital experts to evaluate the current MCR and other elements that provide input into the cost report – such as the Uniform

Billing form and related codes, Medicare paid claims summaries (PS&Rs), and hospital accounting structures and reports – to discuss how they affect the above issues. The group's charge was to identify what changes might be made to the MCR and/or other related inputs to ensure CMS' approach yields more accurate weights. Workgroup participants are listed at the end of this section.

## **WORKGROUP RECOMMENDATIONS**

- **In order to achieve more accurate DRG cost-based weights, all hospitals should prepare their MCRs so that Medicare charges, total charges and overall costs are aligned with each other and with the categories currently utilized in the MedPAR file.** This allows for a consistent grouping of departments within the 13 categories identified in the August 18, 2006 final inpatient PPS rule that are used to create the cost-based weights. The workgroup recommends that the medical supplies category be the primary area of focus.

The workgroup recognizes that hospitals will need to consider how MCRs are used by Medicare and other payers as they look at how best to make these changes.

- **The workgroup recommends that this approach be supported by educational materials to be developed and disseminated by the national, state, regional and metropolitan hospital associations in collaboration with the Healthcare Financial Management Association.** The recommended approach will augment the current cost report instructions, but still follow existing cost reporting requirements. The workgroup recognizes that some hospitals will be better situated to adopt these changes; as a result, it will be more expensive and time-consuming for some hospitals to successfully implement this recommendation. However, the workgroup believes that the investment is worth the effort in order to lessen distortions in cost-based DRG weights that affect all PPS hospitals' Medicare reimbursement.
- **The workgroup suggests that the national associations inform CMS of the group's recommendations to ensure fiscal intermediary (FI) cooperation.** While many hospitals will be able to accomplish the recommended changes to the cost report from general ledger data, other hospitals will have to use cost estimation techniques. Without assurance from CMS that it will instruct the FIs to accept these computations, some hospitals may be unwilling to make these changes.
- The workgroup considered changes to the Uniform Bill, MCR, revenue codes and MedPAR, but determined that these changes would require a multi-year process with involvement beyond the hospital field. However, the recommendations outlined above do not fix all of the problems identified by the workgroup. **The workgroup recommends that the hospital field work with CMS to identify whether changes should be made to the cost report and other inputs to address other areas of potential distortion.**

## **RECOMMENDED APPROACH FOR MODIFYING COST REPORTS TO ACHIEVE CONSISTENT REPORTING**

The approach outlined below addresses two problems identified by the workgroup:

- First, hospitals do not always consistently categorize their Medicare charges, total charges and total costs into departments on the cost reports, causing a mismatch within the CCR and/or a mismatch between the CCR and the Medicare charges. Medicare charges, total charges and total costs should be reported consistently.
- Second, a significant number of hospitals do not categorize their Medicare charges, total charges and total costs on the cost report in the same manner as CMS categorizes Medicare charges on the MedPAR file. This creates a mismatch of MedPAR and cost report data that may distort cost-based DRG weights.

The workgroup recommends that hospitals evaluate their reporting of charge and cost data in their cost reports to ensure that they consistently categorize overall hospital costs, charges and Medicare charges.

Currently, cost report instructions included with the CMS Form-339 allow for three methods of reporting Medicare charges. The method selected by each hospital is specific to its information systems and based on the method that most accurately aligns Medicare program charges on Cost Report Worksheet D-4 with the overall cost and charges reported on Worksheets A and C. Many hospitals elect to allocate some or all of the Medicare program charges from the Medicare PS&R to various lines in the cost report based on hospital-specific financial system needs. Under this scenario, total hospital CCRs are aligned with program charges but will not match the charge groupings used in MedPAR. This mismatching may distort the resulting DRG weights under the methodology developed by CMS.

The workgroup has identified the reporting of medical supplies costs and charges on the cost report as the most significant problem area because of two issues:

- First, many hospitals include medical supply charges in different ancillary departments (e.g., the operating room (OR), the emergency department (ED), etc.) These charges are billed on the UB92 bill using the 27X revenue code series for medical supplies. Ultimately, the medical supply charges for the Medicare program are either mapped to line 55 (the Medical Supply Cost Center) in the cost report or allocated to various other departments. If the 27X charges on the Medicare PS&R are allocated to various departments on the MCR, and not all of the total charges and total costs have been reclassified to the same departments on Worksheets A and C, the CCR for medical supplies will be misstated (generally understated), which will distort the “cost-based” weights for DRGs containing significant medical supply charges. Inconsistencies in reporting can cause this type of distortion.
- Second, problems can occur when hospitals choose (as allowed by CMS) to allocate the MCR total charges and costs for some medical supplies to the departments where the supplies are used. Supply costs and charges might be allocated to the OR and the ED in

Leslie Norwalk, Esq.

June 8, 2007

Page 38 of 39

addition to the Medical Supply Cost Center. Many of these hospitals achieve consistency in their cost reports by allocating the Medicare charges on the PS&R to the OR, ED and Medical Supply Cost Center. This practice is allowed by cost report instructions but will result in charge groupings that do not match the way charges are grouped in the MedPAR file. MedPAR groups ALL medical supplies on line 55 of the cost report. Since the MedPAR groupings are used to establish the 13 categories used to set the cost-based DRG weights, the practice described above will result in CCRs that do not match the charges to which they are applied.

Therefore, we are urging hospitals to examine how they complete their cost reports and adopt the approach of classifying all **billable** medical supply costs and charges to line 55 of the cost report and mapping the 27X Revenue Summary codes from the PS&R only to line 55. While it is preferable to accomplish this within the hospital's accounting systems, it can be accomplished through a reclassification on Worksheet A-6 of the cost report. It is our understanding that most, if not all, hospital revenue accounting systems have the ability to report charges by Revenue Summary code by department. Charges containing the 27X Revenue Summary codes would be reclassified to line 55 from any department mapped to lines other than 55. In addition, the cost of the **billable** medical supplies also should be reclassified to line 55 from any department mapped to lines other than line 55.

## Cost Report Workgroup Participants

### Facilitator

#### **Steve Clark**

Clark, Koortbojian and Associates

### Sponsoring Organizations

#### **American Hospital Association**

Danielle Lloyd

Don May

Caroline Steinberg

#### **Association of American Medical Colleges**

Karen Fisher

#### **Federation of American Hospitals**

Steve Speil

### Participants

#### **Pat Andersen**

Oklahoma Hospital Association

#### **George Arges**

American Hospital Association/National  
Uniform Billing Committee

#### **Norman Belcher**

HCA

#### **Susan Friedman**

Montefiore Medical Center

#### **Bob Halinski**

Universal Health Services Inc.

#### **Steve Harwell**

Healthcare Association of New York  
State

#### **Karen Heller**

Greater New York Hospital  
Association

#### **Clara Kridle/Jose Robles**

Price Waterhouse Coopers

#### **Todd Nelson**

Grinnell Regional Medical Center

#### **Kathy Reep**

Florida Hospital Association

#### **Trisha Schirmers**

Allina Health System

#### **Mike Smith**

Catholic Healthcare West

#### **Cecil Terry**

BJC Healthcare

#### **Tim Wolters**

BKD, LLP