Submitted Electronically

June 20, 2013

Ms. Marilyn Tavenner
Administrator & Chief Operating Officer
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-1588-P
P.O. Box 8011
Baltimore, MD 21244-1850

RE: CMS-1599-P, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2014 Rates; Proposed Rule

Dear Ms. Tavenner:

The Florida Hospital Association (FHA), on behalf of its more than 200 hospital and health system members, appreciates the opportunity to respond to the Centers for Medicare & Medicaid Services' (CMS) proposed rule to update the hospital inpatient prospective payment system (IPPS) for fiscal year (FY) 2014. FHA comments will focus on specific provisions of the proposed rule, including the documentation and coding offset, disproportionate share, and patient status.

DOCUMENTATION AND CODING OFFSET

CMS proposes a cut of 0.8 percent, or about $900 million, to IPPS payments. This would, in part, fulfill the requirement of the American Taxpayer Relief Act of 2012 (ATRA) that CMS recoup what the agency claims is the effect of documentation and coding changes from FYs 2010, 2011 and 2012 that purportedly do not reflect real changes in case mix. CMS does not address how it will complete all of the ATRA cuts, but notes that, if it implements additional cuts of 0.8 percent in each of FYs 2015, 2016 and 2017, it will have fulfilled the ATRA requirement. While we agree with CMS that this proposal helps mitigate extreme annual fluctuations in payment rates, FHA continues to believe these congressionally mandated adjustments are not warranted. CMS continues to inappropriately compare hospitals' documentation and coding practices in FY2010 to their documentation and coding practices under an entirely different system in FY2007, resulting in cuts that are expected to reduce inpatient payments to Florida hospitals by over $54 million in FY2014.

DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS

The Patient Protection and Affordable Care Act (PPACA) of 2010 mandated a reduction and redistribution in Medicare disproportionate share hospital (DSH) payments beginning in FY2014. As a result, beginning in FY2014, hospitals would receive 25 percent of the

Medicare DSH payments they would have received under the current formula - what CMS refers to as "empirically justified DSH payments" – with the remaining 75 percent paid under a different methodology. This pool will be reduced as the percentage of uninsured declines and will be distributed based on the proportion of total uncompensated care each Medicare DSH hospital provides. CMS describes the additional DSH payments made from this pool as "uncompensated care DSH payments."

CMS proposes to use inpatient days of Medicaid beneficiaries plus inpatient days of Medicare Supplemental Security Income (SSI) beneficiaries as a proxy for measuring the amount of uncompensated care each hospital provides. CMS proposes to obtain these data from hospitals' most recently available cost report. The agency would calculate the percentage of total Medicaid and Medicare SSI days among DSH hospitals that each DSH hospital accounts for. Hospitals would then receive this same percentage of what remains of the 75-percent pool as their uncompensated care DSH payment. At this time, FHA supports CMS's proposal to use data on Medicaid and Medicare SSI as a proxy for the treatment costs of uninsured patients. Currently, much work needs to be done on Worksheet S-10 of the Medicare cost report before it can be used to capture uncompensated care costs. Definitions are inconsistent with hospital practices and it is important for CMS to hold a listening session with hospitals and their representatives to clarify the S-10 instructions.

The current Medicare DSH payment formula recognizes low-income patients in proportion to the individual hospital's total patient days. However, the proposed formula would distribute 75 percent of DSH funds based on each hospital's proportion of low income patient days of all DSH-eligible hospitals in the United States. This is a significant change from existing policy and some hospitals would realize an increase in their DSH payments as a result of this change. However, many hospitals will experience significant decreases in their Medicare DSH payments which could be unmanageable in a single year and with just two months' notice**.** CMS should provide an optional transition to the new formula for those hospitals expected to experience a significant reduction from their current DSH payment.

Of great concern for many hospitals, rather than distributing these payments on the current per-discharge basis, CMS proposes to distribute these payments on a periodic interim basis. The FHA opposes this change as it would have a negative impact on cash flow for hospitals. In addition, excluding this portion of the DSH payment from the IPPS PRICER will result in confusion and underpayment from Medicare Advantage plans to both contracted and non-contracted providers. The plans frequently use the PRICER to calculate payment and, while CMS instruction for non-contracted plans states that payment is to be made at Medicare fee-for-service amounts, *including DSH*, there is no way for the plans to know what the correct rate is on a per-discharge basis. Without such clarification, Medicare Advantage payments in FY2014 may reflect an inappropriate 75 percent cut in hospitals' Medicare DSH payments.

In addition, distributing these payments on a periodic interim basis would arbitrarily impose payment cuts on certain sole community hospitals (SCHs). Specifically, CMS proposes that the additional uncompensated care DSH payments would not be accounted for in determining whether SCHs' federal PPS amount or their hospital-specific amount is higher because the agency proposes to make the payments on a periodic interim, rather than per-discharge, basis. This will result in the federal PPS amount being lower than it otherwise would have been. In turn, certain SCHs will be paid under their hospital-specific rate when they otherwise would have been paid a higher federal PPS amount.

FHA is also concerned about the uncompensated DSH cost settlement process. As proposed, the only aspect of the uncompensated care DSH payment that CMS would settle is whether or not a hospital was eligible for DSH at all. If the hospital received uncompensated care DSH payments but was later deemed to be ineligible based on actual data, CMS would recoup the entire payment when ineligibility is determined, but would not make a payment to a hospital if upon audit they were determined DSH-eligible and had not received an initial DSH payment. Under this proposal, CMS may pay out a total amount of uncompensated care DSH payments that are less than the actual size of the 75 percent pool. FHA urges CMS to modify its proposal to include an annual reconciliation to ensure that the total amount of uncompensated care DSH is actually distributed.

Finally, FHA asks CMS to reconsider the amount of money it proposes removing from the Medicare DSH program in FY2014. Reducing overall Medicare DSH payments more than $1 billion, as proposed, is predicated on the Congressional Budget Office (CBO) assumption of a two percent reduction in the number of uninsured Americans for all of FY2014, but this projection appears to be overly optimistic. While the Medicare DSH cuts will take effect on October 1, 2013, not a single new person will become insured that day either through Medicaid expansion or insurance acquired through a health insurance exchange. In fact, neither Medicaid expansion – in states that have chosen to expand – nor the health insurance exchanges will be operational until at least January 1, 2014, so there will be no immediate decrease in the number of uninsured Americans at all. Further, it is implausible to expect everyone eligible for new health insurance will pursue that insurance on the first day it is available to them. Instead, obtaining health insurance will be an incremental process that will play out over months and, possibly, even years.

While we recognize that CMS is required to use the CBO estimate to measure the projected increase in the rate of people with health insurance, we believe CMS should recognize that the CBO estimate is based on a calendar year but Medicare DSH funding is addressed on a federal fiscal year basis. The best way to adjust for this, we believe, is to normalize the CBO estimate by using a weighted average to blend the estimates for the parts of the two separate calendar years that are part of FY2014.

INPATIENT ADMISSIONS CRITERIA FOR MEDICARE PART A

The proposed rule includes new definitions for inpatient status. FHA is concerned that CMS has proposed to prospectively cut inpatient payments by 0.2 percent to offset the estimated $220 million in additional inpatient PPS expenditures it claims will be associated with this proposed policy. While we appreciate CMS's effort to clarify what is required for payment of inpatient hospital services under Medicare Part A, CMS's proposed time-based presumption of medical necessity is not reflective of the way hospitals function today and therefore is likely to generate more problems than solutions.

Physician Orders: CMS proposes to clarify the rules governing physician orders of hospital, including critical access hospital (CAH), inpatient admissions. Specifically, CMS proposes that an individual becomes an inpatient of a hospital if a physician (or other qualified practitioner, as provided in the regulations) orders an inpatient admission in accordance with the hospital Conditions of Participation (CoPs). CMS also proposes that Medicare payment is dependent on appropriate documentation in the medical record, including physician admission and progress notes. A patient's treating physician must make a reasonable *prospective* determination as to

whether inpatient admission is required. Accordingly, any evaluation of a physician's medical judgment must consider the medical facts available at the time of the decision. In CMS's own words and in accordance with its guidelines, when making inpatient admission determinations, treating physicians should consider the "medical predictability of something adverse happening to the patient" (Medicare Benefit Policy Manual, CMS Pub. 100-02, Ch.1, §10). FHA continues to believe that the current rule allowing the physician to use his clinical judgment of the placement needs of the patient to prevail in determining patient status should not be changed, but rather should be enforced and strengthened with the Medicare contractors. We must move from the "20/20 hindsight" review of records and base patient status on the information known to the physician at the time of the admission order.

Under current instruction and law, Medicare covers and reimburses inpatient hospital admissions where a physician certifies the need for medical treatment (42 C.F.R. §424.13(a)). The decision to admit a patient as an inpatient is up to the discretion of the physician responsible for a patient's care at the hospital (Medicare Benefit Policy Manual, Pub. 100-2, Ch. 1, §10). FHA believes the decision on the appropriate setting of care can best be made by the patient's physician based on the patient medical history, co-morbidities, severity of signs and symptoms, current medical need and the risk of an adverse event and do not incorporate any time-based criteria. However, an admission order should not be a condition for payment unless the order makes the admission presumptively reasonable and medically necessary.

Time-based Admission Benchmark: CMS proposes new admission guidance for hospitals and CAHs. Specifically, it proposes that physicians or other practitioners should admit a beneficiary if:

- they expect that the beneficiary will remain in the hospital for more than one Medicare utilization day, which CMS defines as an admission that crosses two midnights; or
- the beneficiary requires a procedure that is specified as inpatient-only.

CMS proposes that patients who are not expected to remain in the hospital over two midnights, and the procedure is not specified as inpatient-only, should not receive payment under Medicare Part A, but rather be considered an outpatient and paid under Part B. CMS also proposes that the judgment of the physician and the physician's order should be based on complex medical factors, such as patient history and co-morbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event. As is currently required, the physician must clearly and completely document the clinical facts supporting the requirement for inpatient hospital admission. CMS indicates this documentation would justify the medical necessity of the admission, regardless of the actual duration of the hospital stay and whether it crosses two midnights. If it was reasonable for the physician to expect the beneficiary to require a stay lasting two midnights, even though that did not transpire, payment would be made under Medicare Part A if the documentation in the medical record reflected such complex medical factors (and the physician's order and certification requirements also are met).

Current guidance states that "a patient is considered an inpatient if formally admitted as an inpatient with the expectation that he or she will remain at least overnight and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight" (Medicare Benefit Policy Manual, Pub. 100-2, Ch. 1, §10). The Medicare Benefit Policy Manual further specifies that coverage for medically necessary inpatient admissions does not depend "solely on the basis of the length of time the

patient actually spends in the hospital;" rather, a physician's decision whether to admit a patient as an inpatient is a complex medical judgment, made after considering a number of factors, including:

- The patient's medical history and current medical needs;
- The types of facilities available to inpatients and to outpatients and the relative appropriateness of treatment in each setting;
- The severity of the signs and symptoms exhibited by the patient;
- The medical predictability of something adverse happening to the patient;
- The need for diagnostic studies to assist in assessing whether the patient should be admitted; and
- The availability of diagnostic procedures at the time and at the location when such testing is needed.

FHA does not believe that a retrospective review of patient status based on hours of care is appropriate. Individual patients respond differently to the care provided. In addition, is there really a difference in a patient admitted at 11:59 p.m. from the patient with the same condition admitted at 12:01 a.m.? From the physician perspective, supporting two midnights will be significantly different for these two patients with the same condition. The determination to admit in the emergency room could be a few or several hours after the patient initially presents. If this time is not included in the calculation of "time span" then the total care provided to the patient would not be considered.

Finally, CMS proposes that the starting point for the time-based instruction would be "when the beneficiary is moved from any outpatient area to a bed in the hospital in which additional hospital services will be provided." Such a proposal is not consistent with the way many hospitals are configured and the actual delivery of care. Many hospitals do not move patients from an observation bed to an inpatient bed when status changes. At the same time, in certain areas of the country and at certain times of the year, patients are "housed" in outpatient areas such as the Emergency Department as there is a shortage of inpatients beds – an inpatient bed rate is charged, however, as there is a physician order for inpatient status and that is the level of care provided. Such action is detailed as appropriate in the Provider Reimbursement Manual, § 2205. The proposal from CMS to start the clock based on patient placement rather than the time of the physician order would significantly impact the current delivery of care. The FHA believes that the trigger to start the "clock" for the time-based presumption for an inpatient admission should begin at the earlier of when the physician writes the admission order or when the beneficiary is treated in the emergency department or placed in a bed for observation. This practice would be consistent with Medicare's three-day payment window policy, which bundles admission-related services furnished to beneficiaries during the three days preceding their admission into Medicare's payment for that admission.

Medical Review: CMS also proposes that this new two-midnight benchmark be used for the purpose of medical review of hospital inpatient admissions. CMS proposes, for beneficiaries who require an inpatient stay that spans two midnights, that its external review contractors, such as the Medicare Administrative Contractors (MACs) and Recovery Audit Contractors (RACs), would *presume* that hospital inpatient status is reasonable and necessary. There is no guarantee, however, that the RACs or MACs would follow this guidance. Also, while CMS notes that one day stays have been the largest proportion of RAC denials, it should be noted that a vast majority of these are reversed upon appeal, indicating that the care in the inpatient setting for 24 hours or less was appropriate and should be paid under Part A.

HOSPITAL-ACQUIRED CONDITIONS (HACs)

Beginning in FY2015, PPACA requires CMS to impose a one percent reduction in Medicare payments for all MS-DRGs for hospitals in the top quartile of risk-adjusted national HAC rates. FHA supports the overall approach to linking payment incentives to specific potentially preventable hospital safety issues as described in the HAC reduction program for FY2015. While the current model incorporates adjustments for age, gender, and comorbidity, we believe additional adjustments for diagnostic and procedural case mix should also be included to better capture the patients that are being treated. These factors are currently included in the detailed specifications for the Agency for Healthcare Research & Quality (AHRQ) and Centers for Disease Control and Prevention (CDC) measures but are not explicitly discussed in the proposed rule. FHA requests that CMS confirm that the case mix adjustment factors listed in the detailed technical specifications for the measures will be used in the proposed payment program.

FHA believes the six patient safety indicators (PSIs) included in Domain 1 should be weighted individually versus weighted as a single composite. Many of the measures proposed are primarily surgical and do not reflect care provided to medical patients at a hospital. We are concerned that this imbalance may not reflect the full spectrum of care provided by a hospital.

In addition, we are concerned that all measures in the HAC program be reviewed by the Measures Applications Partnership (MAP) and endorsed by the National Quality Forum (NQF). Any measures that do not meet these two criteria should not be included.

READMISSIONS

CMS proposes to use claims data from the July 1, 2009 through June 30, 2012 period to calculate hospital readmission rates. In addition, in the FY2014 program, CMS proposes to exclude planned readmissions from the three readmissions measures – acute myocardial infarction (AMI), heart failure (HF) and pneumonia (PN). While the FHA is appreciative of the proposed exclusion for planned readmissions, we are disappointed that CMS has not yet excluded readmissions unrelated to the initial reason for admission, as required by PPACA**.**

It is unclear whether CMS has excluded admissions denied by the RAC from either the numerator or the denominator of the readmissions calculator. The hospital has already had the payment for these admissions taken back by the CMS contractor. They should not be included anywhere in the readmissions calculation. Otherwise the hospital is being penalized twice, once for the RAC denial and again for the readmission rate.

HOSPITAL VALUE BASED PURCHASING PROGRAM

As proposed, the basic structure of the hospital VBP program will continue in FY2014, as it has in FY2013. For 2014, one new clinical process measure and three new mortality measures (30-day AMI, CHP, and pneumonia) are being added. For FY2016, CMS proposes two infection measures – Catheter-Associated UTI and Surgical Site Infection. FHA objects to the inclusion of CAUTI and SSI as they are already included in the HAC measures proposed for FY2015 forward. It is inappropriate to include measures in multiple places; this is double jeopardy for hospitals.

In FY2016, CMS proposes to change the process weighting to 10 percent and efficiency to 25 percent. FHA recommends that these be weighted at 15 percent for process and 20 percent for efficiency. It is more appropriate to calculate a hospital's VBP performance on activity within its

control than to put an additional five percent into the efficiency domain – where many decisions about services received by the beneficiary are determined by a physician or the patient, rather than the hospital.

The FHA appreciates the opportunity to provide these comments for consideration in finalizing the IPPS rule for FY2014. If there are any questions, please do not hesitate to contact me at kathyr@fha.org.

Sincerely,

Kathy Reep
Vice President/Financial Services