PREMIER TRANSFORMING HEALTHCARE TOGETHER®

December 18, 2014

U.S. House of Representatives
Committee on Ways and Means
Attention: Ms. Lisa M. Grabert, Professional Staff Member

Filed by email: HDDWAMR@mail.house.gov

Subject: Comments on discussion draft of the Hospital Improvements for Payment (HIP) Act of 2014

Dear Ms. Grabert:

On behalf of the Premier healthcare alliance serving more than 3,400 leading hospitals and health systems and nearly 110,000 other healthcare sites, we appreciate the opportunity to comment on the discussion draft of the Hospital Improvements for Payment (HIP) Act of 2014. With integrated data and analytics, collaboratives, supply chain solutions, and advisory and other services, Premier enables better care and outcomes at a lower cost. Premier, a Malcolm Baldrige National Quality Award recipient, plays a critical role in the rapidly evolving healthcare industry, collaborating with members to co-develop long-term innovations that reinvent and improve the way care is delivered to patients nationwide. The Premier healthcare alliance welcomes the opportunity to provide initial comments on the draft HIP. Our comments primarily reflect the concerns of our owner hospitals and health systems which, as service providers, have a vested interest in the effective operation of the hospital payment systems.

Premier commends the committee for developing proposals to address several issues with which the Medicare hospital prospective payment systems have struggled in recent years. We especially appreciate the committee's efforts to address problems created by the two midnight rule and medical necessity denials by Medicare's Recovery Audit Contractors (RACs) and the long appeals backlog. We are pleased that the bill would repeal the statutory condition of payment requiring critical access hospitals (CAHs) to provide an average length of stay that is less than 96 hours in duration, and we support extending the House-passed non-enforcement instruction for direct supervision for critical access hospitals for an additional year.

The bill also includes two changes advocated by Premier and others: Representative Black's amendment to establish a comprehensive, voluntary bundled payment program in Medicare and

13034 Ballantyne Corporate Place
Charlotte, NC 28277
T 704.357.0022
F 704.357.6611

444 North Capitol Street, N.W.
Suite 625, Washington, DC 20001
T 202.393.0860
F 202.393.6499

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Representatives Renacci's amendment directing the Secretary to revise the hospital readmissions quality measures to take into account socio-economic factors.

The bundling amendment would create a voluntary program through which qualified entities would provide integrated care for a broad set of applicable services. Premier believes that bundled payment is a promising approach to breaking down the existing silos of care, aligning providers' incentives and encouraging greater coordination. Because of the goal of coordinating care, bundled payments can include participation by multiple provider types across the continuum of care. We believe it is critical to include the full continuum of care across payment silos to improve patient outcomes and achieve better value.

With respect to adjustment of the readmissions measures for socio-economic factors, we encourage the committee to give the Secretary flexibility to base the adjustment on the percentage of patients who are dually eligible for Medicare and Medicaid, or on the disproportionate share percentage, or on other factors. Premier strongly supports these provisions of the bill and we would like to see them included in any subsequent versions of the bill or have them advanced as separate amendments.

Premier also encourages the committee to amend the Hospital Readmissions Reduction Program to provide a fixed target for readmission rates so that penalties would disappear if a hospital reduces its readmission rates below the target, as suggested by the Medicare Payment Advisory Commission (MedPAC) in its June 2013 Report to Congress. Such an amendment would address the issue that penalties are not correlated with hospitals' readmissions performance. Under the current program, aggregate penalties remain constant even when national readmission rates decline.

In addition, we urge the committee to amend the Hospital Readmission Reduction Program to make penalties consistent with the costs of readmissions. Given the program exacts a penalty that is four to five times greater than the revenue for each readmission case.

Over the last few years, RAC denials of short-stay inpatient cases have spawned a litany of problems for hospitals and beneficiaries, leading to increased outpatient observation services with negative consequences for beneficiaries such as higher coinsurance payments, greater out-of-pocket drug costs, and reduced eligibility for Medicare coverage of skilled nursing facility (SNF) services. Premier supports the provisions in the bill to improve the RAC program, such as reducing the RAC look back period from four to three fiscal years; granting providers and suppliers a 30-day period to discuss reviewed claims before a denial (partial or full) is issued; requiring the Secretary of Health and Human Services (HHS) to report RAC data to the public; and creating a RAC Compare website. Although

these changes would be beneficial, we do not believe they go far enough. We urge the committee to limit the RACs' scope of work to reviewing the medical necessity of inpatient admissions only in situations where there appears to be a pattern of abuse. Absent evidence of a pattern of abuse, RACs should not be allowed to deny a medical admission ordered by a physician. Premier also recommends that the bill include a provision requiring the Secretary to evaluate RACs based on their overturn rate and to impose penalties on RACs with high overturn rates.

The increase in denials of admissions led to a dramatic increase in appeals by providers and beneficiaries, resulting in a three-year backlog of cases at the Administrative Law Judge (ALJ) level of review. Premier supports the bill's provisions offering a voluntary opportunity for providers to settle claims that are pending at the ALJ level. We are disappointed, however, that the settlement offer would apply only to denials within medical DRGs and not also to surgical DRGs. We encourage the committee to expand the scope of the settlement option to include surgical DRGs.

Several provisions of the bill would change Medicare inpatient and outpatient hospital payment systems with the goal of ameliorating the problems caused by RAC denials and greater use of outpatient observation services. Premier greatly appreciates the committee's recognition of these problems and its interest in advancing legislation, but we have very serious concerns with the proposed payment changes. We believe that RAC reform will prove sufficient to address the problems, making payment changes unnecessary.

In particular, Premier does not support establishing a new site-neutral hospital prospective payment system (HPPS). Medicare's payment systems have become increasingly complex for providers and beneficiaries, and for the Centers of Medicare & Medicaid Services (CMS) to administer, and adding a third hospital prospective payment system would add unnecessary complexity. Overlaying a totally new hospital prospective payment system on the existing payment systems would be disruptive and, as discussed below, eliminating hospital adjustments would create significant payment inequities and distort the balance and fairness of the current system.

To the extent that payment changes are sought to address issues raised by short-stay cases and overnight outpatient observation services, Premier believes that they can be made to the existing hospital inpatient and outpatient prospective payment systems. For example, separate MS-DRG weights could be established for short-stay cases in selected MS-DRGs. An inpatient discharge assigned to one of the selected MS-DRGs would be assigned one weight if it was a short-stay case and a different weight if it exceeded the short stay threshold. The MS-DRGs selected for inclusion in such a short-stay policy could be ones accounting for a high percentage of all short-stay cases, or ones with

the highest RAC denial rates, or ones chosen using other criteria. This element is similar to short-stay cases as defined in the committee bill for payment under the HPPS.

Another approach that could be considered for adoption within the existing inpatient prospective payment system (IPPS) would use the model of the post-acute care transfer adjustment. The Secretary could be directed to identify discharges with unusually short lengths of stay compared to the average length of stay in the MS-DRG. This alternative is very similar to section 102 of the bill, which would establish a per diem payment methodology for certain short-stay cases. Under either of these alternative policies for modifying the IPPS, the change must be made in a budget neutral manner.

Premier is extremely concerned about several aspects of the proposed HPPS. The HPPS would not include important hospital-specific adjustments made under the IPPS to recognize the substantially higher costs incurred by hospitals with teaching programs (indirect medical education (IME)) or hospitals serving a high percentage of low-income persons (disproportionate share (DSH)). The HPPS also would discontinue adjustments to small or rural hospitals such as sole community hospitals (SCHs), Medicare-dependent small rural hospitals (MDHs), or low-volume hospitals. Premier believes that these hospital-specific adjustments in the IPPS address factors driving the cost of care at the hospital level and that they fine-tune IPPS payment to improve equity in the payment system and create a fair payment system. Premier opposes their elimination.

In addition, the HPPS would base the area wage adjustment on data surveys of pay localities for the Employment Cost Index (wages and salaries of private industry workers) published quarterly by the Bureau of Labor Statistics rather than on wage and hour data reported by hospitals on Medicare cost reports. The bill also would prohibit the Secretary from establishing a wage index floor or granting geographic reclassifications. Premier believes that a wage index based on hospital-reported data from the cost report more accurately represents the variation in actual labor costs across hospitals. We oppose adopting a new wage index based on the ECI data and the substantial and unjustified redistribution that such a change would cause.

Premier also is very concerned about the transitional payment system proposed for inpatient short-stay cases in fiscal years 2016-2019. The bill establishes a payment pool from which payments for short-stay cases would be made during these four years. The bill provides that the amount in the inpatient short-term payment pool for FY 2016 is a percentage of the payments made for all IPPS discharges in FY 2014. The percent is specified to be the level that would achieve a reduction in payments under section 1886 equivalent to "Z" percent; the actual level of factor "Z" is not included in the draft bill.

The bill directs the Secretary to set the level of payment rates for inpatient short-term hospital discharges during the transitional period so that total payments for these discharges will equal the total amount in the pool.

Premier opposes this methodology for setting the transitional payment rates. We strongly believe that the bill should not reduce Medicare payments to hospitals. We are concerned that the value of "Z" could be set at whatever level is necessary to make the overall bill budget neutral; or to make only Title I budget neutral; or possibly to help finance other Medicare amendments such as changes to the SGR reform. Hospitals continue to face large cuts from the Affordable Care Act as well as from more recent legislation such as the Pathway to SGR Reform Act of 2013; the American Taxpayer Relief Act of 2012 (ATRA); Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA); and the American Jobs and Closing Tax Loopholes Act of 2010 (AJCTLA). Hospital payment cuts have consequences. The cumulative effect of the reductions imposed by recent legislation is having an adverse effect on hospitals. Additional payment cuts would threaten hospitals' ability to maintain their current level of service to patients and communities.

We also note that in specifying a reduction of "Z" percent, the bill refers to payments under section 1886, rather than payments under section 1886(d). Besides the IPPS, section 1886 includes many other hospital payment provisions in establishing the size of the reduction, leading to a larger reduction. These other provisions include IPPS capital; rehabilitation, psychiatric, and long-term care hospitals or units; direct graduate medical education; and DSH uncompensated care payments (section 1886(r)).

For short-term hospital stays in a subsection (d) hospital during FY 2016, the bill requires hospitals to submit information necessary to process a claim as both an inpatient hospital discharge under subsection (d) and as hospital outpatient department services under section 1833(t). Premier is concerned about the burden that dual claims submission will place on both hospitals and Medicare contractors. We also have difficulty interpreting the bill language concerning whether these cases will be paid according to their site of service (inpatient or outpatient) or whether all short-stay cases will be paid as inpatient cases in view of the proposed new §1886(u)(4)(A)(iii). Finally, we oppose the role of the RACs in auditing hospitals' compliance with the dual claims submission requirement and with the proposed 10 percent reduction in payment for failure to submit the claims as required. We believe this new role for the RACs is unnecessary and could lead to further RAC issues. CMS can monitor compliance through claims matching and edits.

We also would like to take this opportunity to express our concerns and opposition to repealing the moratorium on physicians-owned hospitals and allowing full building and bed expansion of physician-owned hospitals.

In closing, the Premier healthcare alliance appreciates the opportunity to review the committee's draft bill and to submit these comments for your consideration. Please do not hesitate to contact Duanne Pearson, director of federal affairs, at 202.879.8008 or duanne_pearson@premierinc.com if you would like to discuss these issues further.

Sincerely,

Blair Childs
Senior vice president, Public Affairs