MCHC

Metropolitan Chicago Healthcare Council

The Trusted Voice and Resource for Healthcare

222 S. Riverside Plaza, Chicago IL 60606
mchc.org T 312.906.6000 F 312.506.4900

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January 12, 2015

The Honorable Kevin Brady
Chair, Subcommittee on Health
Committee on Ways and Means
1102 Longworth House Office Building
Washington D.C. 20515

Dear Chairman Brady:

On behalf of the Metropolitan Chicago Healthcare Council (MCHC), which represents more than 150 member hospitals and health care organizations, we appreciate this opportunity to provide comments on the Hospital Improvements for Payment (HIP) Act of 2014 discussion draft. While there are many provisions that will effectively address a number of hospitals' concerns with Medicare payment policies and intensive audit activity, the recommendations for a hospital short-stay payment policy as outlined in the Hospital Prospective Payment System (HPPS) provisions would require significant additional review and consideration due to their complexity and administrative burden both for hospitals and the Centers for Medicare & Medicaid Services (CMS), which would administer the program.

MCHC and its members support the legislation's provisions that repeal the 0.2 percent two-midnight payment reduction, extend the Recovery Audit Contractor (RAC) audit moratorium on patient status reviews for six months, and improve the operations of the RAC program. We also welcome the steps outlined in the Establishing Beneficiary Equity in the Hospital Readmission Program Act, which would create a more fair and effective program by taking into account patient socio-economic factors.

We are not convinced, however, that a completely separate and entirely new payment system is required so that hospitals can be appropriately reimbursed for short-stay inpatient cases and overnight outpatient care requiring observation services, and we have serious concerns with the HPPS as proposed. We support the short-stay payment policy principles developed by the American Hospital Association and articulated in its own response to you on HIP. As discussions continue on the proposed HPPS and the development of a new policy for short hospital stays, we urge you to rely on AHA's principles and to take into consideration the following comments:

- Medical Education and Low-Income Patients – MCHC strongly opposes a short-stay payment mechanism that does not distribute add-on payments, including indirect medical education (IME) and disproportionate share hospital (DSH) payment adjustments, to the hospitals that currently receive them under the inpatient prospective payment system. These long-standing, policy-driven payments were developed to ensure access to care and to recognize the unique costs and complex care demands incurred by teaching hospitals and those serving large low-income populations. Under the HPPS proposal, IME and DSH payment adjustments associated with inpatient short-term hospital services would be aggregated and spread among all hospitals regardless of whether they engage in graduate medical education, provide continuous specialized services, or treat a disproportionate share of low-income patients. As proposed, the IME and DSH payments would eventually be eliminated entirely, which runs completely counter to the purpose of these add-on payments, jeopardizing access to care for many low-income Medicare patients.

- Wage Index – We also strongly oppose the HPPS provisions that would create a new area wage index (AWI) using a Bureau of Labor Statistics (BLS) computed wage index and that would eliminate the opportunity for Medicare geographic reclassification for hospitals competing with contiguous labor markets offering higher wages. The proposal to use a BLS wage index for short-stay Medicare

payment is not appropriate public policy as the lack of transparency of BLS data would severely restrict both CMS and hospitals from identifying aberrant data and verifying the accuracy of the wage index. In addition, there are concerns with the database itself since BLS does not have a single database that includes both wages and fringe benefits, there is no distinction in how part-time and full-time employees are treated (i.e., employees working a 20-hour or 40-hour week are equally weighted), and data on contract labor are included where individuals are employed, not where their contracted work was actually performed. As to Medicare geographic reclassifications, there is no rationale on why these wage index adjustments would be appropriate for longer-staying hospital inpatients but not for those with shorter stays.

- RAC Reviews – During any transition period to a new short-stay payment system, we support the extension of a moratorium on RAC patient-status or short-stay reviews through the duration of the transition. In addition, we support legislative solutions for a less administratively burdensome and more effective program. We, however, do not support the use of RACs to validate dual coding to build a new short-stay payment policy and the contingency fees that would reward the RACs for identifying complex dual coding errors while reducing payments to hospitals for medically necessary care.

- ICD-10 Coding – We fully support the upcoming October 1, 2015 implementation date for ICD-10 coding and are very concerned with the administrative burden of the dual ICD-10/HCPCS coding suggested in the proposed HPPS. At a time when hospitals are just implementing ICD-10, it is unrealistic to expect them to take on any new or additional coding requirements. Even with encoders, dual-coding would be a manual process. The references to the development of a HCPCS to ICD-10 crosswalk, and vice versa, also give us pause since the fundamental designs of these two systems do not lend themselves to such a tool.

In addition, we believe the HIP legislation should include a change to the current three-day hospital inpatient qualifying stay for post-acute skilled nursing facilities (SNF) coverage to be more in line with current medical practice. SNF payment should be based on clinical criteria on whether this is the right level of care for the patient, who may need those services immediately, not on whether the patient has been a hospital inpatient for at least three days, a criteria that has remained unchanged since the inception of the Medicare program despite improvements in clinical protocols and significant reductions in hospital lengths of stay. For example, many hip replacement patients may currently have no coverage for SNF services, although they may medically require these services, because the patients are able to leave the hospital after the second day.

We appreciate your consideration of our comments and look forward to legislation that incorporates our suggestions. If you have any questions, please feel free to contact me directly or my colleague Susan Melczer, Director, Patient Financial Services, at 312-906-6007 or smelczer@mchc.com.

Sincerely,

Dennis O'Sullivan
Senior Director, Government and Public Relations
T: 312-906-6080
E: dosulliv@mchc.com