

NATIONAL ASSOCIATION OF URBAN HOSPITALS

Private Safety-Net Hospitals Caring for Needy Communities

March 21, 2006

The Honorable Charles E. Grassley
Chairman
Senate Finance Committee
Washington, D.C. 20510

The Honorable Max Baucus
Ranking Member
Senate Finance Committee
Washington, D.C. 20510

Dear Senators Grassley and Baucus:

I am writing on behalf of the National Association of Urban Hospitals (NAUH) to express our enthusiastic support for your February 9 letter urging the Centers for Medicare & Medicaid Services (CMS) to move forward “with significant refinements to the hospital inpatient prospective payment system for fiscal year 2007.” For more than a decade, NAUH has been calling on CMS to improve the accuracy of its Medicare payment system through the implementation of a severity-based DRG system, and we are most grateful that MedPAC has endorsed such a system and that you have reinforced your support for MedPAC’s recommendation through your letter to Dr. McClellan.

While NAUH supports the implementation of a severity-based DRG system and the unprecedented payment accuracy it would bring, we disagree with some of the nuances of the path recommended by MedPAC as described in your letter of February 9, and we would like to take this opportunity to share these concerns with you.

In particular, the third paragraph of your letter addresses four specific recommendations. We agree wholeheartedly with the first recommendation: “refining the current DRGs to more fully capture differences in the severity of illness among patients.” We also understand the rationale underlying the second recommendation: “basing the DRG relative weights on the estimated cost of providing care rather than on charges.” These changes alone represent major steps toward a more accurate Medicare payment system.

On the other hand, NAUH disagrees strongly with the third recommendation: “basing the DRG relative weights on the national average of hospitals’ relative values in each DRG.” One of the fundamental strengths underlying the entire concept of a DRG system is that basing such a system on nation-wide data gives rate-setters a statistically valid sampling of data upon which to base rates. The current system does this by basing the relative weights on the average of every case nation-wide within each DRG. NAUH believes that the proposed approach departs significantly, and inappropriately, from this basic concept and would have a dramatic and undesirable effect on the entire Medicare DRG system. Specifically, it would completely skew the DRG relative weights, which are the key to a more accurate payment system. Currently, those relative weights are based on true national averages. Under the proposed approach, they would be based on what would amount to an average of the averages of all individual hospitals. This means that the averages of hospitals that treat just a few cases – a statistically inadequate sampling – would carry the same weight as those of hospitals that treat large numbers of cases. The resulting average would be less accurate, not more accurate, than the current methodology. NAUH believes that the current methodology for calculating relative weights is far more accurate than the proposed methodology and should therefore be retained. Another approach that would achieve the same end would be to base the DRG relative weights on estimated costs rather than hospital charges.

We also have misgivings about the fourth recommendation: “adjusting the DRG relative weights to account for differences in the prevalence of high-cost outlier cases.” The sole purpose of this proposed change appears to be to reduce the relative values within selected DRGs in which outliers are common for the purpose of funding the statutorily mandated pool of funds required to pay those outlier cases. This would have the unfortunate and, we believe, inappropriate effect of requiring only the hospitals that provide the kinds of care that result in outliers to pay for all of that care and absorb all of the financial losses associated with it themselves instead of spreading those costs and those losses among all hospitals.

It is important to keep in mind, in considering this issue, that outlier payments are essentially insurance, or stop-loss protection, for hospitals against the unexpected and potentially enormous costs they may sometimes incur treating just a single medical case, or only a few cases. NAUH recognizes that a more precise, severity-based DRG system should reduce the number of outliers by capturing more of those cases within the new DRGs – and also reduce the problem of hospitals seeking to take only the simplest, lower-cost, most profitable cases – but the remaining outlier cases can prove devastating to the financial health of an institution. The concept of outlier payments is to spread the impact of such cases among all providers and the public sector and not force individual hospitals to bear them alone.

Consider the following example of how this proposal would undermine this concept. A region has five hospitals, all of which provide some level of care to burn patients but one of which has special expertise in delivering such care. Within the region, the most difficult cases are treated by the hospital that specializes in burn care. Some of the cases that the other four hospitals send to the hospital with the special expertise will end up as outliers, but many will be patients who truly need that specialized care but who do not rise to the level of outliers. Within their specific DRG, these will be the most expensive patients to treat, yet because the relative weights have been reduced to pay for the outlier pool, the hospital that specializes in treating the most complex patients will see its regular reimbursement reduced to pay for outliers. Under the current system, all five hospitals help absorb the cost of this expensive but essential care; with the proposed changes in the relative weights, the hospital that has invested the most money in this type of care, and has developed the most expertise, would pay for the outliers itself while all of the hospitals would benefit from its willingness to invest in the resources to be the burn center for the entire community. In addition to being unfair, this could discourage more hospitals from developing special expertise in response to clear community needs (even now, relatively few hospitals cultivate such special capabilities because the financial price they pay for doing so is so great) while also encouraging hospitals that have already done so to abandon it because it has become too costly. For these reasons, NAUH opposes this proposal to adjust the DRG relative weights to account for differences in the prevalence of high-cost outlier cases.

In your letter to Dr. McClellan, you wrote that “Medicare payments should reflect what it actually costs hospitals to provide care to beneficiaries.” We wholeheartedly agree. You also wrote that “Specialty hospitals have been able to cherry pick the most profitable patients, leaving community hospitals to treat the less profitable, the poor and the uninsured. This patient selection is inappropriate. Any incentives in the payment system to systematically choose one patient over another must be removed.” While we agree, we also recognize that this type of behavior is not limited to specialty hospitals and is not always a cynical attempt to make more money or avoid serving uninsured or poorly insured patients. Every day, ordinary community hospitals – most of them exceptionally well-qualified to care for the vast majority of medical problems – refer some of their most complex cases to other hospitals that are better equipped to treat those problems. For more than 20 years, those other hospitals have provided high-level care that requires more resources to treat than average cases in exchange for reimbursement based on nation-wide averages, and they have suffered financially as a result. The type of severity-based DRG system that NAUH has advocated for more than a decade, and that MedPAC has now endorsed, should rectify this unfortunate shortcoming in the Medicare reimbursement system by making that system’s payments much more accurate and appropriate. As pointed out in your letter, CMS took initial steps in the 2006 inpatient PPS final rule “to revise the cardiovascular surgery DRGs to better recognize the patient severity of illness.” We join you in encouraging CMS to finish the job it started last year – ideally, in time for the 2007 inpatient PPS final rule – but also hope

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you will consider the points we have raised about two of the four specific recommendations cited in your letter.

Once again, we commend and thank you for the strong, clear message you have sent to CMS that the Senate Finance Committee wants a better, more accurate Medicare payment system. We also appreciate your consideration of our views, invite any questions you may have about the policy basis underlying them, and welcome an opportunity to work with you and your staff to achieve what would certainly be a major improvement in how the public sector reimburses hospitals for the care they provide to our nation's elderly citizens.

Sincerely,

Ellen Kugler, Esq.
Executive Director