ACP
American College of Physicians
INTERNAL MEDICINE | Doctors for Adults

June 13, 2008

Kerry N. Weems
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Attention: CMS-1390-P

Dear Acting Administrator Weems:

The American College of Physicians (ACP) representing over 125,000 internists and medical student members, appreciates the opportunity to comment on: *Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2009 Rates; Proposed Changes to Disclosure of Physicians Ownership in Hospitals and Physicians Self-Referral Rules, Proposed Collection of Information Regarding Financial Relationships Between Hospitals and Physicians; 73 Fed. Reg. 23,528 (April 30, 2008).* Our comments are specifically focused on the following areas:

- Hospital Acquired Conditions—Expansion of Included Conditions
- Hospital Acquired Conditions—Present on Admission (POA) Indicator Reporting
- Hospital Acquired Conditions—Implementation of International Classification of Diseases -10 (ICD-10)
- Hospital Acquired Conditions—Application of Nonpayment for Hospital Acquired Conditions to Other Settings
- Physician Self-Referral Provisions—Gainsharing Arrangements
- Avoidable Readmissions

Hospital Acquired Conditions—Expansion of Included Conditions

The 2008 Hospital Inpatient Prospective Payment System final rule carried out provisions set by the Deficit Reduction Act of 2005 (DRA), stating that beginning October 1, 2008, the Centers for Medicare and Medicaid Services (CMS) can no longer assign an inpatient hospital discharge to a higher diagnosis-related group (DRG) if a certain hospital acquired condition (HAC), pre-selected by CMS, was not present on admission. The criteria for pre-selection required the condition to be of (a) high cost or high volume or both; (b) result in the assignment of the case to

a DRG that has a higher payment when present as a secondary diagnosis; and (c) could reasonably have been prevented through the application of evidence-based guidelines. The 2008 rule further defined eight conditions that reportedly met these criteria to be included on this HAC list:

- Serious Preventable Event—Object Left in Surgery
- Serious Preventable Event—Air Embolism
- Serious Preventable Event—Blood incompatibility
- Catheter-Associated Urinary Tract Infections
- Pressure Ulcers (Decubitus Ulcers)
- Vascular Catheter—Associated Infection
- Surgical Site Infection—Mediastinitis after Coronary Artery Bypass Graft (CABG) Surgery
- Hospital-Acquired Injuries—Fractures, Dislocations, Intracranial injury, Crushing Injury, Burn, and Other Unspecified Effects of External Causes

The ACP agrees that the three serious preventable conditions defined in the 2008 rule could reasonably be avoided through the application of evidence-based guidelines, and that the implementation of this new policy for those conditions could effectively improve both healthcare quality and value. Regarding the other defined conditions, the College agrees with the Medicare Payment Advisory Commission (MedPAC) analysis that these may not be totally preventable even if appropriate guidelines are followed in patients of a given severity or complexity of illness. (MedPAC's June 11, 2007 Comment Letter to CMS on the 2008 Inpatient Hospital Prospective Payment System proposed rule**)**. The MedPAC recommendation that CMS develop and use a severity-adjustment methodology to address this concern is appropriate.

Based on its statutory authority, CMS is now seeking to expand this list of defined HACs through this proposed rule. ACP believes that the medical evidence does not support the contention that many of these new additions to the HAC list can reasonably be avoided for all patients through the application of evidence-based guidelines. Specifically, the College has concerns regarding the following conditions:

- Surgical Site Infections Following Specific Elective Procedures
- Staphylococcus aureus Septicemia
- Clostridium Difficile-Associated Disease
- Ventilator-Associated Pneumonia
- Deep Vein Thrombosis/Pulmonary Embolism
- Legionnaires' Disease
- Delirium

ACP concurs with the American Medical Association (AMA) analysis pertaining to the above conditions and refers the agency to their comment letter in response to this proposed rule that explains why it is unreasonable to expect these conditions to be totally avoidable.

The College supports the intent of this rule to reduce the incidence of HACs, but believes that the inclusion of the above conditions on the HAC list—with the related payment implications—is unrealistic unless changes are made to the policy. **For these conditions, the College recommends that CMS consider two possible alternative approaches:**

- **Develop a methodology that determines how to significantly reduce (since complete elimination is untenable) each HAC through the application of evidence-based guidelines, in which payment denial occurs only if evidence-based guidelines were not implemented and followed.**
- **Establish a payment methodology based on the development of a pre-established "baseline" that would measure the amount of times that each HAC is likely to occur in an individual hospital when there is compliance with all appropriate evidence-based guidelines. Payment adjustments would be made if the inpatient hospital's HACs exceed this baseline.**

Hospital Acquired Conditions—Present on Admission (POA) Indicator Reporting

CMS proposes to require the collection of POA indicator information both to identify which conditions were acquired during hospitalization in order to both carry-out the HAC payment provision and for other broader public health uses**. The ACP urges CMS to consider the following general issues with respect to the POA indicator reporting process:**

- **Is POA discovery feasible in all cases and, if not, how is this to be addressed in the process?**
- **To what extent does this process have the potential to promote the provision of additional services to clearly determine whether a condition is present on admission and consequently add (unnecessarily) to overall cost of care?**

Hospital Acquired Conditions—Implementation of ICD-10

CMS has requested public comment concerning the adoption of ICD-10 to facilitate more precise identification of HACs. ACP suggests that CMS consider the implications on physicians, particularly for those in small outpatient practices, of switching to ICD-10. While such a change may or may not make the identification of HACs more accurate and precise, it would surely have the more fear-reaching implication of imposing a significant administrative burden for the hundreds of thousands of physicians in the country.

As ACP has stated in numerous other forums, the benefit of moving from ICD-9 to ICD-10 has not been demonstrated in the outpatient setting. The costs associated with such a switch, however, would be high considering the number of documents that must be edited, software that must be updated, and policies that must be redrafted. **ACP urges CMS to consider the full implications of any such broad change prior to any implementation decision. The College's position is that the current projected benefits of a change from ICD-9 to ICD-10 do not outweigh the related person-power and financial costs.**

Hospital Acquired Conditions--Application of Nonpayment for HACs to Other Settings

CMS has asked for comments related to the potential future implementation of a payment methodology similar to the current HAC approach to other settings; including to physician practices. **ACP recommends that CMS conduct an analysis of the current HAC policy, in consultation with technical experts, physician organizations, hospitals and other impacted providers, before moving forward to expand the proposed HAC methodology to other settings.** ACP appreciates the acknowledgement that such an approach would vary by setting and contends that an agency assessment of the effect of the HAC policy on quality, cost, and other factors is essential before an attempt to apply the concept to physician practices, which are larger in number and more diverse than hospitals.

Physician Self-Referral Provisions—Gainsharing Arrangements

ACP remains significantly concerned about the continued rise in health care costs and believes that efforts to slow growth while improving or at least maintaining quality should be attempted. The College concurs with recent MedPAC comments that the judicious expansion of gainsharing arrangements has the potential to increase both healthcare quality and efficiency (MedPAC March 2005 Report to Congress). The development of these relationships between hospitals and physicians also helps breakdown the artificial silos produced from different payments sources for Medicare Part A and B. The College has frequently made reference to how these Medicare silos do not recognize how improved outpatient care can reduce avoidable hospitalizations and save money within the Medicare system. In fact, the current payment approach actually penalizes these efforts to the extent that additional, less costly outpatient services are provided to avoid a hospitalization because of the way that the flawed Sustainable Growth Rate (SGR) formula system compares outpatient expenditures to a national target.

The College recognizes that these gainsharing arrangements must be appropriately crafted to allow for transparency to patients and all other parties involved, as well as ensure that appropriate access to high quality care is maintained. The College applauds recent Medicare efforts to experiment with the use of gainsharing through the Medicare Hospital Gainsharing and the Medicare Acute Care Episode Demonstration. **ACP urges CMS to continue to explore the development of physician and hospital gainsharing arrangements.**

Avoidable Readmissions

CMS requested public comments on considerations and options for applying incentives to reduce avoidable hospital readmissions. The College supports this effort recognizing that approximately 18 % of hospitalized Medicare patients are rehospitalized within 30 days, that an estimated 76 percent of these readmissions are “potentially preventable” and Medicare spending for these “potentially preventable” readmissions is estimated at $12 billion (MedPAC, June 2007 Report to Congress).

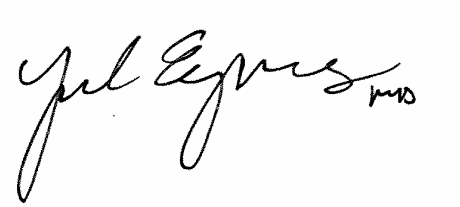
The College is pleased that CMS recognizes the significant complexity of this hospital readmission issue. Specifically, CMS recognizes in the proposed rule the need for: routine,

valid, and reliable measurement of hospital-specific rates of readmissions; accurate methods to assign accountability and the development of valid risk-adjustment techniques to account for patient-specific factors that influence the likelihood of readmission, e.g. age, disease severity and co-morbidities. CMS also recognizes the possibility of unintended adverse effects (e.g. decreased access to necessary hospital care) if the issue is not correctly addressed.

The College encourages CMS to continue to actively address the issue of avoiding unnecessary hospital admissions. We also request that any suggested approaches to decrease readmission that employ increased out-patient services address the fact that current SGR methodology does not accurately attribute these savings and can potentially financially penalize outpatient physicians through the SGR methodology.

The ACP applauds CMS' efforts to improve the quality and efficiency of hospital care as reflected by the provisions included in this proposed rule. We trust you will seriously consider the ACP recommendations contained in this letter. Please contact Neil Kirschner, Ph.D. at 202 261-4535 or nkirschner@acponline.org if you have any specific questions regarding these comments.

Sincerely,



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