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WISCONSIN HOSPITAL ASSOCIATION, INC.

RECEIVED
JUN 09 2005
BY:..................

May 31, 2005

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1500-P
P.O. Box 8011
Baltimore, MD 21244-1850

Physical Address:
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1500-P
7500 Security Blvd.
Baltimore, MD 21244-1850

Dear Sir or Madam:

RE: Wage Index

In reviewing the IPPS Proposed Rule dated May 4, 2005, we have discovered a change in Computation of the Proposed FY 2006 Unadjusted Wage Index that we oppose. On page 23372 and 23373 is a description of the computation of the unadjusted wage index. Section F., Step 4 describes the formulas for allocating overhead salaries and wage related costs to excluded areas for removal from the wage index. This formula has been used for several years. However, there is a change in the formula in the Proposed Rule FY2006 that is not explained in the text:

> <u>FRVol.70, No. 85 page 23373</u>
> "Next, we computed the amounts of overhead wage-related costs to be allocated to excluded areas using three steps: (1) We determined the ratio of overhead hours (Part III, Line 13) to revised hours (Line 1 minus the sum of Lines 2, 3, 4.01, 5, 5.01, 6, 6.01, 7, **8, and 8.01**);"

The change in the formula reflects the addition of lines 8 and 8.01 to the denominator of the formula, thus lowering the denominator of the equation by the embedded subtraction from line 1, and increasing the ratio of overhead to revised hours. The higher ratio increases the amount of wage related costs removed from the wage index for excluded areas. The formula reported in the IPPS Final Rule dated August 11, 2004 reads as follows:

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UNIVERSITY OF CALIFORNIA, LOS ANGELES

UCLA

BERKELEY • DAVIS • IRVINE • LOS ANGELES • MERCED • RIVERSIDE • SAN DIEGO • SAN FRANCISCO

SANTA BARBARA • SANTA CRUZ

RECEIVED
JUN 09 2005
BY:

DEPARTMENT OF NEUROLOGY
REED NEUROLOGICAL RESEARCH CENTER
DAVID GEFFEN SCHOOL OF MEDICINE
710 WESTWOOD PLAZA
LOS ANGELES, CALIFORNIA 90095-1769

May 27, 2005

Centers for Medicare and Medicaid Services
Dept. of Health and Human Services
Attention: CMS-1500-P
PO Box 8011
Baltimore, MD 21244-1850

Dear Sirs and Madams,

I am the Director of the Stroke Center of the University of California, Los Angeles and have been a physician caring for stroke patients for over 15 years.

I am writing to request that CMS support changes to Medicare hospital inpatient reimbursement for advanced stroke treatment in FY2006. This change is crucial for improving the care and the outcomes of Americans who suffer from this devastating condition.

Stroke is the third leading cause of death and the leading cause of adult disability in the United States. Stroke costs the US healthcare system $45 billion per year. Six months after a stroke, one-third of patients have died, three-quarters are unable to return to work, and one-sixth require longterm nursing home care.

For those of us with long involvement in stroke care and research, the current era is the best of times and the worst of times.

--The best of times because we finally have a proven treatment that makes a dramatic difference for patients – reperfusion by the clot busting drug tissue plasminogen activator. Reperfusion therapy improves the outcomes of 1 in every 3 patients treated, and yields normal or near normal outcome in 1 in every 8 patients treated.

--The worst of times because so few patients receive reperfusion treatment, in large part because the Medicare hospital inpatient reimbursement structure has not yet been updated to reflect the availability of reperfusion therapy, even though the FDA approved this treatment nearly a decade ago. At academic stroke centers like ours that treat regardless of financial incentive, 5-12% of all patients receive reperfusion interventions. Unfortunately, across the country, only 1-3% of patients receive reperfusion therapy, in part because the current DRG codes encourage nontreatment. This means that of the 600,000 Americans who suffer an ischemic stroke each year in the US, 590,000 do not receive the best treatment.

Reperfusion therapy can be given at almost every hospital in the country if the hospital devotes administrative and clinical resources to stroke care. However, delivering reperfusion therapy is more expensive for hospitals, as additional infrastructure is required to assure the emergency availability of stroke-knowledgeable physicians and brain imaging studies. As a result, there is currently a financial disincentive for hospitals to establishing the necessary infrastructure and processes for providing the best available care for stroke patients.

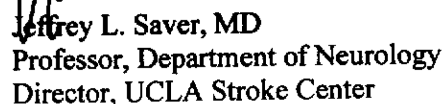
While acute care hospitals lose money when delivering reperfusion therapy, the overall US healthcare system saves money when reperfusion therapy is given, because fewer patients require longterm nursing home care. Stroke patients treated in DRGs 14/15 are the second leading contributor to Medicare post-acute care, spending totaling $2.2 billion in FY 2002. Medicare spends more on post-acute care for these patients than what it pays for acute inpatient hospital care. As a result, the changes in Medicare reimbursement that CMS is considering will not merely be cost neutral to the Federal government, but will actually save the Federal government money while simultaneously improve improving the health of stroke patients.

CMS has thoughtfully considered revising the Medicare reimbursement structure for stroke. In its Proposed Rule document this year, CMS recognized that the cost of caring for patients who receive reperfusion therapy is $10,000-16,000 higher than for other stroke patients and far exceeds the $6300 DRG payment that hospitals currently receive from Medicare for each stroke patient treated. CMS analyzed two possible cost neutral revisions in the Medicare payment structure, either of which, especially the creation of a new DRG for patients treated with reperfusion therapy, would tremendously **help hospitals deliver best care to patients by aligning reimbursements with actual costs.**

Despite recognizing the validity of the arguments for revising the Medicare payment structure, CMS did not propose actually making the revision. CMS' concern was that the number of patients currently receiving reperfusion therapy is small. However, this is a Catch-22. The proportion of patients receiving reperfusion therapy is small because the current reimbursement structure penalizes hospitals for delivering this treatment. The low proportion is actually a powerful argument for adopting the new DRG, not for tabling it. If the new DRG structure was in place, the proportion of Americans treated with the only proven beneficial therapy for stroke would increase dramatically, as has been the experience in other countries (Germany, Canada) and in US academic centers (Houston, Los Angeles, Cincinnati, etc) where financial disincentives to best care have been removed.

In closing, I would like to thank CMS for their work on behalf of Medicare beneficiaries and the special attention they have given to the needs of stroke patients. If I can provide any further information that would be helpful, please do not hesitate to contact me, by phone at 310-794-6379 or by email at jsaver@ucla.edu.

Best regards,



Jeffrey L. Saver, MD
Professor, Department of Neurology
Director, UCLA Stroke Center

52 Impact

Submitter : **Mr. Thomas F. Mullaney, Jr.**

Date: 06/07/2005

Organization : **Saint Francis Hospital & Medical Center, Hartford,**

Category : **Health Care Industry**

Issue Areas/Comments

GENERAL

GENERAL

As a director of a non-profit urban hospital, I am writing to protest this proposed rule change. If CMS continues to reduce reimbursements directly and indirectly (by this rule change) it will only hasten the day when urban hospitals such as ours will have to take draconian steps (refusal of care to the poor) inorder to stay in business. It seems to me that there are more and better ways to control the growth of governmental medical expenditures that would actually improve the overall quality of treatment and improve outcomes.

Heffter
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Craemer

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Bloomington Hospital
& Healthcare System

RECEIVED
JUN 09 2005
BY:..................

May 31, 2005

Geo. Reclass
Hosp. Reclass
Hefter
Hoi Stein
Kelly

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1500-P
P.O. Box 8011
Baltimore, MD 21244-1850

Dear Sir or Madam:

In response to the "Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2006 Rates" (70 Fed. Reg. 23306) we submit the following comment for your consideration.

Geographic Reclassifications (File Code CMS-1500-P):

42 CFR §412.230(a)(5)(iii) specifies, "An urban hospital that has been granted redesignation as rural under §412.103 cannot *receive* an additional reclassification by the MGCRB based on this acquired rural status *as long as such redesignation is in effect*." (*emphasis added*) In reviewing the August 1, 2000 final rule (65 FR 47087) implementing this regulatory provision, it appears the underlying intent is to prevent certain urban hospitals inappropriately seeking treatment as being located in a rural area for some purposes while at the same time seeking treatment as being located in an urban area for other purposes. As such, our interpretation of the regulatory provision is that an urban hospital cannot be reclassified under the MGCRB process at section 1886(d)(10) of the Act while at the same time being reclassified under 1886(d)(8)(E) of the Act.

The hospital seeks CMS clarification relative to the following question: Can a hospital apply for and be granted MGCRB reclassification for a future year if the hospital is currently designated rural under section 1886(d)(8)(E) of the Act but has also received an approved notice canceling its rural designation from the CMS Regional Office (RO)? For example, an urban hospital has been granted rural designation effective January 1, 2004. The hospital has also received notice from the RO approving its request for cancellation of rural designation effective January 1, 2006. The hospital desires to file an application for reclassification with the MGCRB by September 1, 2005, for reclassification effective October 1, 2006. Since the hospital's rural designation will cancel prior to the October 1, 2006, effective date for MGCRB reclassification, can the MGCRB approve its application assuming all other qualifying criteria are met?

Given the intent of 42 CFR §412.230(a)(5)(iii) is to prevent the simultaneous reclassification of hospitals under section 1886(d)(8)(E) and section 1886(d)(10) of the Act and the fact that the above situation avoids such simultaneous reclassification, it seems appropriate that the MGCRB could approve the hospital for reclassification assuming all other criteria have been satisfied. MGCRB verification of rural cancellation by the RO could be easily accomplished by requiring a copy of the approval notice with the MGCRB application.

The hospital notes that this situation is not far removed from a similar situation involving hospitals that receive the out-migration adjustment. In the August 1, 2004, IPPS final rule (69 FR

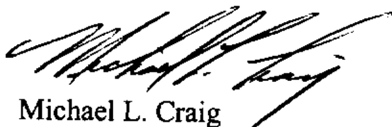
P.O. Box 1149, Bloomington, IN 47402
812-336-6821 • 800-222-9589
www.bhhs.org

49067), CMS indicated that even though hospitals are prohibited from receiving both the out-migration adjustment and MGCRB reclassification in the same year, hospitals receiving the out-migration adjustment may still apply to the MGCRB for reclassification in a subsequent year. If approved for MGCRB reclassification, the hospitals would implicitly waive the out-migration adjustment for the fiscal year effective with MGCRB reclassification. As such, hospitals can receive the benefits of the out-migration adjustment and the benefits of applying for MGCRB reclassification in the current year.

Just as a hospital should not have to forgo the benefits of an out-migration adjustment in the current year to apply to the MGCRB for reclassification, we believe an urban hospital should not have to forgo the benefits of rural designation in the current year as long as such designation will terminate prior to the effective date of the MGCRB reclassification.

Your consideration of the above comment is greatly appreciated. Should you have any question relative to this matter, please feel free to contact me at (812) 353-5819.

Sincerely,



Michael L. Craig
Director of Reimbursement

BURDETTE TOMLIN
MEMORIAL HOSPITAL

54

RECEIVED
JUN 0 9 2005
BY:..................

Geo. Reclass.

Heffler
Hartstein
Kerry

June 3, 2005

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1500-P
Box 8011
Baltimore, Maryland 21244-1850

Re: Geographic Reclassification

To Whom It May Concern:

Burdette Tomlin Memorial Hospital appreciates the opportunity to comment on the proposed change to § 412.234(a)(3)(ii).

We view the use of Metropolitan Statistical Areas and Core Based Statistical Areas as a necessary but not perfect methodology to identify hospital wage costs and to allocate Medicare payments based upon those costs. We also view the Reclassification process as one that deals with any flaws in the methodology.

The current regulations that allow for Group Reclassifications to adjacent counties in the same Combined Statistical Area (CSA) or Consolidated Metropolitan Statistical Areas (CMSA) already eliminates Reclassifications to adjoining counties outside the CSA or CMSA. This is an issue in an all urban State such as New Jersey. The reality is that you do compete with Hospitals in adjacent counties for employees. This is confirmed by the inclusion of an Out-Migration Adjustment for Cape May County in the 2006 Proposed Rule. Elimination of the CMSA criteria will result in a further reduction in the number of Hospitals that can seek Reclassification.

Since Burdette Tomlin is not considered to be a part of the Philadelphia CSA, removal of the CMSA criteria will eliminate all possibility of Reclassification.

We must therefore request that the CMSA criteria be retained in § 412.234(a)(3)(ii).

If you have any questions, I may be reached at (609) 463-2471.

Sincerely,

Mark R. Gill
Vice President, Finance & CFO

MG/av

TWO STONE HARBOR BOULEVARD, CAPE MAY COURT HOUSE, NEW JERSEY 08210 (609) 463-2000

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Essent Healthcare, Inc.
3100 West End Ave., Suite 900
Nashville, Tennessee 37203
615 312-5100
615 312-5101 Facsimile

RECEIVED
JUN 09 2005
BY:..................

June 3, 2005

Center for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1500-P
P. O. Box 8011
Baltimore, MD 21244-1850

Re: File Code CMS-1500P
Issue Identifier - Excluded Hospitals and Units

Dear Sirs:

We are writing to comment on the proposed change to the language in §413.40(c)(4)(iii) "to clarify that the provisions of this paragraph relating to the caps on target amounts are for a specific period of time only, that is, cost reporting periods beginning on or after October 1, 1997, and before October 1, 2002." We commend the Centers for Medicare and Medicaid Services (CMS) for proposing this clarification. However, because there are multiple Fiscal Intermediaries (FI) that apply varying interpretations to the regulations, we are requesting that you provide responses to the following two (2) examples that we have encountered in the application of the rules relating to the TEFRA target rates for the cost reporting periods beginning on or after October 1, 2002. Specifically, we are seeking that you affirm our understanding of the application of the clarification of the language in §413.40(c)(4)(iii).

Example One: Psychiatric Unit established before October 1, 1997

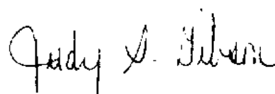
The psychiatric unit in this example was established in the cost reporting year ended July 31, 1998. Because of a change in ownership, the cost reporting period was changed to the federal fiscal year, September 30. Based on the update factors and the limitations to these factors as specified in §413.40(c)(3)(vii), the unit's hospital specific rate was $15,552.87 for the cost reporting period ended September 30, 2002 and the cap that was in effect for this unit was $10,878.94. The FI applied the update factor for FY03 of 3.5% to the capped rate of $10,878.94 and set the TEFRA rate for FY03 to $11,259.70. Based on the clarification that CMS is proposing, it is our understanding that the TEFRA rate for FY03 should have been $16,097.22 which is the hospital specific rate from FY02 increased by the FY03 update factor.

Example Two: Psychiatric Unit established on or after October 1, 1997 and before October 1, 2002

The psychiatric unit in this example was established in the cost reporting year ended September 30, 1999. Because this unit was established during the capped period, the FI has limited the unit's applicable TEFRA rate to the capped rate trended forward with the update factors as specified by CMS. Because the hospital's target amount has been higher than the capped rate, the capped rate has been applied as the TEFRA rate for the unit since its inception even for cost reporting periods beginning on or after October 1, 2002. Based on the clarification that CMS is proposing, it is our understanding that the higher hospital specific rate should be utilized as the TEFRA rate for cost reporting periods beginning on or after October 1, 2002 instead of the capped rate.

We appreciate CMS's review and careful consideration of the comments in this letter. If you have any question, please feel free to contact me at 615-312-5106.

Sincerely,



Judy S. Gibson
Vice President, Reimbursement

56-O (2)
Q Data

Hefter
Hartstein
Bidden
Krushat

Submitter : Mrs. Selina Guidry

Date: 05/25/2005

Organization : Lafayette Surgical Specialty Hospital

Category : Other Practitioner

Issue Areas/Comments

GENERAL

GENERAL

Our concern is that the 3rd and 4th qtrs of 2004 are abstracted and validated using data definitions and abstraction guidelines in place prior to complete quality measure alignment between JCAHO and CMS. There are a number of unresolved validation issues related to the incomplete alignment, e.g., vendor software, software question sequencing, CDAC abstractor reliability, etc., which have caused a hospital to fail validation - a situation which could potentially deprive the hospitals of the full market basket update if they don't pass validation.

The validation and appeals processes are still undergoing refinement to address abstractor reliability issues and vendor software issues. For this reason we believe this portion of the proposed rule appears inappropriate and premature at this time. Even though CMS has indicated to the QIO working with them on data issues that they may disregard validation failures due to these outstanding concerns it does not mean they will. This proposal will stand and be finalized if hospitals do not express their opinion.

MEMORIAL COMMUNITY HOSPITAL
313 Stoughton Road, Edgerton, Wisconsin 608-884-3441

57-0
(134)
CAH|[illegible]

Hefter
Hartstein
Collins
Mary
Smith

June 7, 2005

RECEIVED
JUN 15 2005
BY:..................

CERTIFIED MAIL
RETURN RECEIPT REQUESTED

Centers for Medicare and Medicaid Services
Department of Health & Human Services
Attention: CMS-1500-P
P.O. Box 8011
Baltimore, MD 21244-1850

Re: Proposed CMS Rule Change Dated 4/25/05 Regarding Replacement of Critical Access Hospital (CAH) Facilities

Please find the enclosed **petition signed by 134** employees of Memorial Community Hospital. I am forwarding this signed petition to you for your information.

This reflects the employees general concerns regarding the newly proposed regulations and how it will impact the community and their future.

Respectfully submitted,

Bradley Young, Human Resources Director

cc: Senator Herbert Kohl
Senator Russ Feingold
Representative Tammy Baldwin
Representative Paul Ryan
MCH Board of Trustees
Tim Size, RWHC
Steve Brenton, WHA

A PETITION
From THE EMPLOYEES of
MEMORIAL COMMUNITY HOSPITAL ASSOCIATION, Inc.
June of 2005

MCH Department: Radiology, Lab, Rehabilitation & Pharmacy

To: Centers for Medicare and Medicaid Services:

Re: Determination of the Relocation Status of a CAH

We are employees of Memorial Community Hospital in Edgerton, Wisconsin. Memorial Community Hospital was originally chartered in 1923 and has been serving the health care needs of residents of Edgerton and a number of small rural communities in our area for the past 80 years. We converted to a Critical Access Hospital in 2002.

The occupied portions of our hospital are over 40 and 50 years old, and we are desperately in need of building a new facility so we can treat our patients in the high quality environment they deserve. Our board of trustees has been planning to build a new replacement facility since 2003 and earlier this year authorized our Administration to take action to begin the process this year. We were all excited that our plans were finally becoming a reality.

We have just been notified that our hopes and dreams are now in jeopardy because of a new set of rules proposed by CMS that would effectively prevent us from building a new hospital. We were told that the new CMS rules state that we would have to have completed our building plans over a year and a half ago and only then if we planned to build on or close to our same site. We are essentially landlocked in our present location and it would be impossible to meet these new conditions.

As employees of MCH, we believe these new rules are unfair and could place our jobs in jeopardy if not withdrawn immediately or at least revised in some manner to allow us to replace our aging facility. If CMS truly has a goal of improving the quality and efficiency of healthcare in rural communities, you should be helping us to replace our antiquated buildings and facilities so we can have a decent place to deliver healthcare.

Our patients depend on us and we're depending on you to help us! We strongly oppose the new construction rules as written and implore you to repeal them and help us find a way to build a desperately needed new hospital in our community!

NAME/Signature	ADDRESS
1. Roberta C Nelson	10192 Amber Tr.
2. Thomas Clark	305 S. Richland, Oxfordville
3. David D. Dyer	4515 Oak Ct., Monona, Wis.

4. [illegible signature] — 609 W. Fulton - Edgerton
5. [illegible signature] — 878 Tobacco Rd. Cambridge
6. Charlain Bartz — 890 Hain Rd. Edgerton
7. Sharon Marattk — 101 Hwy N Edgerton
8. Christine Wonder — 10743 N Bay Shore Ln Milton
9. [illegible signature] — 753 Walker Way Edgerton
10. Linda Wiedenfeld — 10603 Hillside Row Edgerton
11. [illegible signature] — 5040 Walnut Grove Rd Milton
12. [illegible signature] (Medical Staff) — 10245 Tybow Trail, Roscoe Ill 61073
13. [illegible signature] — 600 Riverside Dr. Fort Atkinson, WI 53538
14. Jackie [illegible] — 5944 N. Lilly Ln. Milton 53563
15. [illegible signature] — 305 W. Rollin St
16. Karin [illegible] — 1208-11th St
17. [illegible signature] — 706 [illegible] Dr #4 Madison WI 53714
18. [illegible signature], OTR — 802 Dandaneau Trl.
19. [illegible signature] PT — 2803 [illegible] Way, [illegible], WI [illegible]
20. [illegible signature] — 4201 Huntinghorne Dr. Janesville WI 53546
21. Gayle Rolemann, OTR — 961 W. Peck St, Whitewater, WI. 53190
22. Cindy Skaife — 56 S. Sumac Dr. Janesville, WI 53545
23. Heather Elliott — 603 W. Fulton Edgerton WI 53534
24. [illegible signature] — 5635 Newville RD Milton, WI 53563
25. [illegible] McLellan — 1835 Hammond Rd Edg 53534
26. [illegible signature] — 1121 Blaine ST - Edgerton, WI 53534

A PETITION
From THE EMPLOYEES of
MEMORIAL COMMUNITY HOSPITAL ASSOCIATION, Inc.
June of 2005

MCH Department: Finance, HIM, Billing, HR, IS & Marketing

To: Centers for Medicare and Medicaid Services:

Re: Determination of the Relocation Status of a CAH

We are employees of Memorial Community Hospital in Edgerton, Wisconsin. Memorial Community Hospital was originally chartered in 1923 and has been serving the health care needs of residents of Edgerton and a number of small rural communities in our area for the past 80 years. We converted to a Critical Access Hospital in 2002.

The occupied portions of our hospital are over 40 and 50 years old, and we are desperately in need of building a new facility so we can treat our patients in the high quality environment they deserve. Our board of trustees has been planning to build a new replacement facility since 2003 and earlier this year authorized our Administration to take action to begin the process this year. We were all excited that our plans were finally becoming a reality.

We have just been notified that our hopes and dreams are now in jeopardy because of a new set of rules proposed by CMS that would effectively prevent us from building a new hospital. We were told that the new CMS rules state that we would have to have completed our building plans over a year and a half ago and only then if we planned to build on or close to our same site. We are essentially landlocked in our present location and it would be impossible to meet these new conditions.

As employees of MCH, we believe these new rules are unfair and could place our jobs in jeopardy if not withdrawn immediately or at least revised in some manner to allow us to replace our aging facility. If CMS truly has a goal of improving the quality and efficiency of healthcare in rural communities, you should be helping us to replace our antiquated buildings and facilities so we can have a decent place to deliver healthcare.

Our patients depend on us and we're depending on you to help us! We strongly oppose the new construction rules as written and implore you to repeal them and help us find a way to build a desperately needed new hospital in our community!

NAME/Signature	ADDRESS
1. [signature]	3228 Stonecreek Dr
2. [signature] Peterson	PO Box 281 Milton, WI 53563
3. [signature] Richardson	52 Goede Rd Edgerton, WI 53534

4. Tim R Kuzynsk 1282 Butler Road

5. Cara Pryer 436 E. Delavan Dr. Janesville WI 53546

6. Lorraine Baetz 1267 Winston Dr. Apt 1 Edgerton, WI

7. Gwen Waegie 303 Marlboro Avenue Edgerton, WI

8. Brenda Hoffman 2687 Taneyton C. Stoughton, WI

9. [illegible] 715 Jewett St. Ft. Atkinson, WI

10. Van Deventer (Tanya) 6 Highland Ave Edgerton WI

11. Janet McCamey 608 Swift St Edgerton, WI 53534

12. [illegible] Olson 1371 Willow Dr. Edgerton, WI

13. Shelly L. Bladen 1214 Winston Dr., Edgerton, WI, 53534

14. Elizabeth A. Newby 417 N. Pine St, Janesville, WI 53548

15. Sue Combs 3864 Pintail Dr Janesville, WI 53546

16. Deborah Bush 1520 Canyon Dr Jvl. WI 53546

17. Rebecca Ayford 714 S. Main St., Edgerton

18. Vera Eshleman 409 S main st Edgerton

19. Sue Jaeckson 212 Swift St. Edgerton

20. Brenda Lucaro 3713 Lucey St. Janesville, WI

21. Amy McGuire 9329 Arrowhead Shores Rd. Edgerton, WI 53

22. Rhea Murwin 414 S. Parker Dr Jvl, WI 53545

23. Rick West 407 Stoughton RD Edgerton

24. Stacey Smithback 1121 Blaine St Edgerton, WI

25. Cathy Raatz 885 Arthur Dr #6 - Milton

26.

A PETITION
From THE EMPLOYEES of
MEMORIAL COMMUNITY HOSPITAL ASSOCIATION, Inc.
June of 2005

MCH Department: Dietary

To: Centers for Medicare and Medicaid Services:

Re: Determination of the Relocation Status of a CAH

We are employees of Memorial Community Hospital in Edgerton, Wisconsin. Memorial Community Hospital was originally chartered in 1923 and has been serving the health care needs of residents of Edgerton and a number of small rural communities in our area for the past 80 years. We converted to a Critical Access Hospital in 2002.

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As employees of MCH, we believe these new rules are unfair and could place our jobs in jeopardy if not withdrawn immediately or at least revised in some manner to allow us to replace our aging facility. If CMS truly has a goal of improving the quality and efficiency of healthcare in rural communities, you should be helping us to replace our antiquated buildings and facilities so we can have a decent place to deliver healthcare.

Our patients depend on us and we're depending on you to help us! We strongly oppose the new construction rules as written and implore you to repeal them and help us find a way to build a desperately needed new hospital in our community!

NAME/Signature	ADDRESS
1. Janelle Lafromboise	945 Flint Rd, Stoughton, WI 53589
2. Betty Olson	316½ W. Fulton, Edgerton WI
3. Jane Fursth	1570 Hy 73 Edgerton, Wi 53534

No.	Name	Address
4.	Lois Schroeder	811 WEST Fulton ST. EDGERTON
5.	Sara Lochner	101 Albion St. Edgerton
6.	Judy Pastorius	154 Lukas Ln. Milton
7.	Joan Arnold	3211 Cty M Milton
8.	Julie Rothins	187 N Janesville St #5 Milton Wis.
9.	Geraldine Lochner	107 Albion St Edgerton WI
10.	Kristine M. Talge	1920 Mayfair Dr. Janesville, WI 53545
11.	Michaelene A Johnson	1512 S. Crosby Ave, Janesville WI 53546
12.	Susan Swenson	500 Roy Ave, Stoughton WI 53589
13.	Mary Barrett	212 Randolph St., Edgerton, WI 53534
14.	Bernice ~~[illegible]~~	9108 Fulton Dr. Edgerton, WI 53534
15.	Jill McCamey	608 Swift St. Edgerton WI 53534
16.	Melissa Arneson	39 Edward Ave Edgerton WI 53534
17.	Deanna Wakefield	11141 Ridge Road Edgerton WI 535[illegible]
18.	Vicky Barrett	86 Craig Rd Edgerton WI 5353[illegible]
19.	Bridget Atkinson	9108 Fulton Dr Edgerton WI 53534
20.	Erika Danielson	602 Washington St Edgerton WI 5353[illegible]
21.	Katy Arneson	39 Edward Ave, Edgerton, WI, 53534
22.	Stephanie Sivier	4606 Hwy 59 W. Edgerton, WI, 53534
23.		
24.		
25.		
26.		

A PETITION
From THE EMPLOYEES of
MEMORIAL COMMUNITY HOSPITAL ASSOCIATION, Inc.
June of 2005

MCH Department: Maintenance & Housekeeping

To: Centers for Medicare and Medicaid Services:

Re: Determination of the Relocation Status of a CAH

We are employees of Memorial Community Hospital in Edgerton, Wisconsin. Memorial Community Hospital was originally chartered in 1923 and has been serving the health care needs of residents of Edgerton and a number of small rural communities in our area for the past 80 years. We converted to a Critical Access Hospital in 2002.

The occupied portions of our hospital are over 40 and 50 years old, and we are desperately in need of building a new facility so we can treat our patients in the high quality environment they deserve. Our board of trustees has been planning to build a new replacement facility since 2003 and earlier this year authorized our Administration to take action to begin the process this year. We were all excited that our plans were finally becoming a reality.

We have just been notified that our hopes and dreams are now in jeopardy because of a new set of rules proposed by CMS that would effectively prevent us from building a new hospital. We were told that the new CMS rules state that we would have to have completed our building plans over a year and a half ago and only then if we planned to build on or close to our same site. We are essentially landlocked in our present location and it would be impossible to meet these new conditions.

As employees of MCH, we believe these new rules are unfair and could place our jobs in jeopardy if not withdrawn immediately or at least revised in some manner to allow us to replace our aging facility. If CMS truly has a goal of improving the quality and efficiency of healthcare in rural communities, you should be helping us to replace our antiquated buildings and facilities so we can have a decent place to deliver healthcare.

Our patients depend on us and we're depending on you to help us! We strongly oppose the new construction rules as written and implore you to repeal them and help us find a way to build a desperately needed new hospital in our community!

NAME/Signature	ADDRESS
1. [signature]	110 Henderson STR. Edgerton WIS. 5353[illegible]
2. [signature]	712 West Rollin Edgerton WS 53534
3. [signature]	10192 Amber Tr. Edgerton, WIS. 53534

53534

4. [illegible] — 908 Robert St. Edgerton

5. [illegible] — 13 Maple Ct Edgerton 53534

6. [illegible] — 16 E Evergreen [illegible] Milton 53563

7. Ed Murphy — 7058 N.U.S. Hwy 51 Janesville, Wi 53545

8. Robert E Anderson — 923 Robert St, Edgerton Wi 53534

9. [illegible] — 905 Sweeney Rd Edgerton, Wisc 53534

10. Kelly A [illegible] — 11637 N. Circle Dr. Milton WI 53563

11. Marsha K. [illegible] — 13 Broadway, Edgerton, Wi 53534

12. [illegible] — 4327 Woodcrest Dr Janesville 53546

13. [illegible] — 703 W Fulton St Edgerton Wi 53534

14. Darcy E Connor — 1187 E Cooper Dr Edgerton, Wi 53534

15. Debbie Koerth — 923 S Arrowhead - Edgerton Wi

16. Vicki Sund — 501 Stoughton Rd Edg. Wis. 53534

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A PETITION
From THE EMPLOYEES of
MEMORIAL COMMUNITY HOSPITAL ASSOCIATION, Inc.
June of 2005

MCH Department: Hospital Nursing (Med Surg & Swing Bed)

To: Centers for Medicare and Medicaid Services:

Re: Determination of the Relocation Status of a CAH

We are employees of Memorial Community Hospital in Edgerton, Wisconsin. Memorial Community Hospital was originally chartered in 1923 and has been serving the health care needs of residents of Edgerton and a number of small rural communities in our area for the past 80 years. We converted to a Critical Access Hospital in 2002.

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NAME/Signature	ADDRESS
1. Sheri [illegible]	Janesville 53546
2. Mary Margaret Neal	213 W. Rollin St. Edgerton, Wi 53534
3. D. Sager-Miller	1141 B. Winston Dr. Edg.

No.	Name	Address
4.	Teresa Kozmer	Cambridge, WI 53523
5.	Beverly Bussey	102 Mechanic St. Edgerton.
6.	Glenn Falk	Milton Wi 53563
7.	John C Pauley	Friendship Wi 53934
8.	Katherine Snell	708 Dickinson Ave. Edgerton, Wi 53534
9.	R David Schmelzer	405 S. MADISON ST EVANSVILLE, WI 53536
10.	Shauna Radunzel	433 E. Centerway Janesville, WI 53545
11.	Rebecca Preston	Madison WI 53725
12.	Janice Seeske	451 Elm St Milton, Wi 53563
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A PETITION
From THE EMPLOYEES of
MEMORIAL COMMUNITY HOSPITAL ASSOCIATION, Inc.
June of 2005

MCH Department: Long Term Care

To: Centers for Medicare and Medicaid Services:

Re: Determination of the Relocation Status of a CAH

We are employees of Memorial Community Hospital in Edgerton, Wisconsin. Memorial Community Hospital was originally chartered in 1923 and has been serving the health care needs of residents of Edgerton and a number of small rural communities in our area for the past 80 years. We converted to a Critical Access Hospital in 2002.

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NAME/Signature	ADDRESS
1. Donna Buchman	206 High St Edgerton 53534
2. Barbara Johnson	648 W. Delavan Dr. Janesville, WI 53546
3. M. Danforth	404 So. Van Buren St Stoughton 5358

4. Cyndi Zelenka RN — 2766 Rolling View Rd, Stoughton
5. Diana Johnson CNA — 8922 N Cty F Edgerton.
6. Angie Wilderich — 619 S. Academy St, Janesville
7. Tammi Horner — 1002 N. Main St Edgerton
8. James X [illegible] — 303 Green Hill Dr. Milton Wi 53586
9. David [illegible] — 8990 N.E. Rock River Dr. Edgerton, Wi 53534
10. Colleen Yager [illegible] — 12028 Cone St, Evansville Wi 53536
11. Carrie Gustrowsky — 9308 N Fulton Edgerton
12. Annette Eckhaus CNA — 307 Comfort Cove Orfordville Wi 53576
13. Marilyn Perry — W8602 Hwy 12 Fort Atkinson Wi 53538
14. Kathy Sanderson LPN — 3205 Vold Ct #5 Janesville WI 53546
15. Leah Wilkens — 4009 Castlemoor, Janesville 53546
16. Becky Smith — 1921 Meadow Ln Janesville, WI 53546
17. MaryLynn McHarry — 863 Bingham Rd - Edgerton 53534
18. Joan Demion — 1120 Winston Dr Edg WI 53534
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A PETITION
From THE EMPLOYEES of
MEMORIAL COMMUNITY HOSPITAL ASSOCIATION, Inc.
June of 2005

MCH Department: Hospital Nursing (ER&OR)

To: Centers for Medicare and Medicaid Services:

Re: Determination of the Relocation Status of a CAH

We are employees of Memorial Community Hospital in Edgerton, Wisconsin. Memorial Community Hospital was originally chartered in 1923 and has been serving the health care needs of residents of Edgerton and a number of small rural communities in our area for the past 80 years. We converted to a Critical Access Hospital in 2002.

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Our patients depend on us and we're depending on you to help us! We strongly oppose the new construction rules as written and implore you to repeal them and help us find a way to build a desperately needed new hospital in our community!

NAME/Signature	ADDRESS
1. Michele McGuire	9329 Arrowhead Shrs.
2. [illegible]	1624 Crestview St
3. Linda Kanopf	2131 Mt. Zion Ave.

4. Brenda Jeannette 9554 Arrowhead Shores
5. Katherine Thompson 8661 N Black Oak Drive
6. Stacy Aube 203 S. Catlin St.
7. Carol Murphy 7031 N Kidder Rd
8. Joan Schuldt 5347 W. Stone Farm Rd. Edgerton, WI.
9. Tanya Worm 2912 Carrousel Lane #5 Janesville, WI
10. Margaret Murphy 115 Hickory Nut Lane
11. [illegible] 363 E. Riverdale Dr., Edgerton WI
12. [illegible] 18 Maple Court Edgerton
13. [illegible] 10728 N. Kidder Rd Edgerton
14. Susan Alwin-Popp 2323 Stonefield Lane, Janesville WI
15. Michelle Thrasher RN 2933 W Hwy 11 Janesville WI 53548
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Post Office Box 1890 • 321 Mulberry Street, S.W. • Lenoir, NC 28645-1890 • Tel. (828) 757-5100

RECEIVED
JUN 15 2005
BY:..................

WI/pd
WI/DC
AH/U

58

Heffe
Hartstein
Miller
McKenna
Ellington

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1500-P
P.O. Box 8011
Baltimore, MD 21244-1850

File Code: CMS -1500-P

Dear Centers for Medicare and Medicaid Services:

On behalf of Caldwell Memorial Hospital (Provider # 34-00041) we are pleased to comment on the proposed rule, "Medicare Program: Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2006 Rates", which appeared in the Federal Register, Volume 70, No 85, May 4, 2005. Our comments are directed to the formula used to calculate the Area Wage. As part of the CBSA 25860 there is a 6.1% decrease from our Final FFY 2005 Wage Index of 0.9510 to a Proposed FFY 2006 Wage Index of 0.8931. The overall percentage change from 2005 is -1.47%. The financial impact of this proposed Wage Index change is estimated to have a negative reimbursement impact from 2005 of $160,299 in FY IPPS Payments.

A change in how CMS calculated the AWI that affects our CBSA has been identified. The impact is between 1.0 - 1.5 percentage points on the AWI resulting in a lower AWI than what would otherwise occur. The issue involves the formula CMS uses to calculate the proportions to be used to exclude overhead dollars and hours related to excluded units. For FY 2006 this formula is

essentially the same in that it obtains the ratio of overhead hours to total hours and applies that ratio to the overhead dollars and hours to exclude overhead for excluded areas. In the past CMS applied this same ratio to wage related costs (WRC) but this year the formula has changed. For FY 2006, CMS excludes the overhead hours from total hours to calculate the ratio used to exclude WRC related to overhead. This results in a higher WRC ratio than overhead ratio for certain CBSAs and a lower AWI. Therefore, the proportion is different for calculating the proportion of dollars and hours of overhead to be excluded from the wage data then the proportion of WRC to be excluded for the same purpose.

CMS did not propose this change directly, did not discuss why or what purpose it serves or why the two proportions are different. These calculations occur after the Worksheet S-3 but before the AWI. Rather, they are calculated by CMS in formulating their AWI. So these changes are difficult to identify.

This change disproportionately affects certain CBSAs more significantly than others. For the most part there are only minor changes affecting the third and fourth decimal place of the AWI. For our area the change is more significant. We strongly urge that this change not be implemented to prevent a serious detrimental financial impact upon hospitals.

We appreciate this opportunity to submit these comments. If you should have any questions, please feel free to contact Don Gardner at 828-757-5221.

Respectfully submitted,

Don Gardner, Jr., CPA

Vice President of Finance/CFO/COO

59

RECEIVED
JUN 15 2005
BY: ____________
OFFICE OF THE ARCHBISHOP

ARCHDIOCESE OF HARTFORD
134 FARMINGTON AVENUE
HARTFORD, CONNECTICUT
06105-3784

Transfers
DRG/GEN.

June 8, 2005

The Honorable Mark B. McClellan, M.D., Ph.D.
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1500-P
P.O. Box 8011
Baltimore, Maryland 21244-1850

Re: Post-acute Care Transfers; Proposed Changes to the Hospital Inpatient Prospective Payment System and FY'06 Rates; Proposed Rule

Dear Dr. McClellan:

I appreciate this opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) draft rule on the Medicare Hospital Inpatient Prospective Payment System, as published in the May 4, 2005 *Federal Register*. We are particularly concerned about CMS' reported request to expand the number of DRGs subject to the post-acute transfer policy from the current 30 to 223.

The current Medicare transfer payment policy requires that cases assigned to one of 30 DRGs be paid as transfers when patients are discharged to psychiatric or rehabilitation hospitals or units, children's, long-term care, or cancer hospitals, and skilled nursing facilities or home health agencies. Under this policy, payment is *per diem*.

I strongly oppose expanding the transfer policy to encompass additional classes of patient cases. We believe this would fundamentally weaken the incentives inherent in the inpatient PPS. A new transfer policy covering 223 DRGs would effectively uproot an incentive-based system fueled by per-case control, to one inordinately focused on *per diem* costs.

Again, we are opposed to any expansion of the inpatient transfer policy, and believe that such a move would most assuredly not be in the best interest of patients or providers. The proposed policy would undermine clinical decision-making and penalize hospitals for providing patients with the most appropriate care in the most appropriate settings.

Thank you for this opportunity to comment on the proposed inpatient PPS rule.

Sincerely,

+ Henry J. Mansell

Most Reverend Henry J. Mansell
Archbishop of Hartford
Chairman, Saint Francis Hospital and Medical Center

(860) 541-6491/FAX (860) 541-6293

60

Hospital and Medical Center

Luis F. Diez, MD
System Medical Director, Ambulatory Services
Chief, Section of General Internal Medicine

Associate Professor of Clinical Medicine
University of Connecticut School of Medicine

114 Woodland Street
Hartford, Connecticut
06105-1299

860 714-4897

RECEIVED
JUN 15 2005
BY:..................

June 7, 2005

The Honorable Mark B. McClellan, MD, PhD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1500-P
P.O. Box 8011
Baltimore, MD 21244-1850

RE: CMS Draft : Changes in Post-acute Care Transfer Rules

It is with great respect that I write you to express my thoughts on the new proposal that would result in a drastic increase in the number of DRGs, thereby placing them in subjection to the post-acute transfer policy.

The proposal calls for raising the current number of 30 DRG's to 223, thereby eliminating the current DRG per case reimbursement system.

I oppose this transfer policy change based on my perception that incentives would significantly be weakened by placing the emphasis on per-diem costs rather than positive medical outcomes by continuing the per-case control method. I have no doubt this will ultimately have a negative effect on the quality of patient care by emphasizing cost over medical rationale.

I oppose this measure on behalf of both patients and medical providers. I sincerely hope that you will weigh these factors.

I thank you for your time reading my comments.

Sincerely,

Luis F. Diez, MD
System Medical Director, Ambulatory Services
Saint Francis Hospital & Medical Center

Associate Professor of Clinic Medicine
University of Connecticut School of Medicine

LFD/mm

G:/lfd/ltr/DRGchangeMcClellan060705.doc

61

Corporate Office
333 Irving Avenue
Bridgeton, New Jersey 08302
(856) 575-4505

RECEIVED
JUN 15 2005
BY:------------------

Glo. Reclass.
Heller
Hartstein
Kealy

June 2, 2005

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1500-P
Box 8011
Baltimore, Maryland 21244-1850

Re: Geographic Reclassification

Gentlemen:

South Jersey Hospital appreciates the opportunity to comment on the proposed change to § 412.234(a)(3)(ii).

We view the use of Metropolitan Statistical Areas and Core Based Statistical Areas as a necessary but not perfect methodology to identify hospital wage costs and to allocate Medicare payments based upon those costs. We also view the Reclassification process as one that deals with any flows in the methodology.

The current regulations that allows for Group Reclassifications to adjacent counties in the same Combined Statistical Area (CSA) or Consolidated Metropolitan Statistical Areas (CMSA) already eliminates Reclassifications to adjoining counties outside the CSA or CMSA. This is an issue in an all urban State such as New Jersey. The reality is that you do compete with Hospitals in adjacent counties for employees. This is confirmed by the inclusion of an Out-Migration Adjustment for Cumberland County in the 2006 Proposed Rule. Elimination of the CMSA criteria would result in a further reduction in the number of Hospitals who could seek Reclassification.

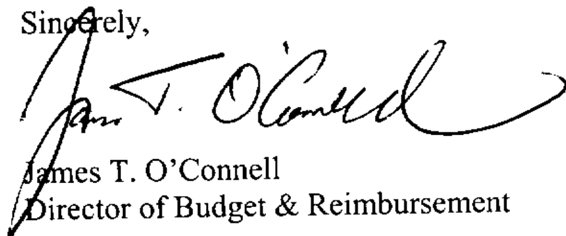
South Jersey Hospital is part of the Philadelphia CSA and borders on four Core Based Statistical Areas of which two are not part of the Philadelphia CSA, removal of the CMSA criteria would limit the possibilities of South Jersey Hospital seeking Reclassification.

We must therefore request that the CMSA criteria be retained in § 412.234(a)(3)(ii).

Centers for Medicare and Medicaid Services
Page Two
June 2, 2005

If you have any questions, I may be reached at (856) 575-4777.

Sincerely,



James T. O'Connell
Director of Budget & Reimbursement

JTO/dr

SHORE MEMORIAL
HOSPITAL

RECEIVED
JUN 1 5 2005
BY:..................

62
Geo. Reclass

June 9, 2005

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1500-P
Box 8011
Baltimore, Maryland 21244-1850

Re: Geographic Reclassification

Gentlemen:

Shore Memorial Hospital appreciates the opportunity to comment on the proposed change to § 412.234(a)(3)(ii).

We view the use of Metropolitan Statistical Areas and Core Based Statistical Areas as a necessary but not perfect methodology to identify hospital wage costs and to allocate Medicare payments based upon those costs. We also view the Reclassification process as one that deals with any flows in the methodology.

The current regulations that allows for Group Reclassifications to adjacent counties in the same Combined Statistical Area (CSA) or Consolidated Metropolitan Statistical Areas (CMSA) already eliminates Reclassifications to adjoining counties outside the CSA or CMSA. This is an issue in an all urban State such as New Jersey. The reality is that we do compete with Hospitals solely in our own county and adjacent counties for employees. Elimination of the CMSA criteria would result in a further reduction in the number of Hospitals who could seek Reclassification.

Atlantic County is part of the Philadelphia CMSA and is currently prohibited from Reclassifying to adjoining Ocean County which is part of the New York CMSA. In addition, Atlantic County is not considered to be a part of the Philadelphia CSA or any other CSA, so removal of the CMSA criteria would eliminate all possibility of Reclassification.

We must therefore request that the CMSA criteria be retained in § 412.234(a)(3)(ii).

If you have any questions, you may contact Mr. George Limberes at (609) 653-3256.

Yours truly,

James T. Foley
Vice President of Finance/CFO

63

Cleveland Regional Medical Center
Carolinas HealthCare System

RECEIVED
JUN 1 5 2005
BY:

May 27, 2005

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1500-P
P. O. Box 8011
Baltimore, MD 21244-1850

To whom it may concern:

I am writing to voice concerns about the current process for CDAC data validation. Many data abstractors utilize tools for data collection which employs "skip logic". This functionality helps the abstractor maneuver through the data collection process without having to memorize the JCAHO methodologies and exclusionary criteria for each quality indicator (outlined in the flow chart section of the Specifications Manual for Core Measures). Therefore, the "skip logic" helps the abstractor in avoiding unnecessary data collection for elements that are not pertinent due to clinically coherent exclusions.

Under the current CDAC validation rules, any data element abstracted incorrectly and tied to other elements by skip logic will result in a string of data errors. The CDAC will count the first invalid entry and each subsequently skipped response as individual errors. Cleveland Regional Medical Center failed CDAC validation in 2Q04 for this very reason. We ask that this methodology be modified. Consideration should be made with regard to overall data validity rate in this instance. An invalid response and any subsequent skipped responses regarding the same topic should be counted as one error. We respectfully request timely resolution to this as this data validation is tied to 2006 APU update eligibility in the coming months.

Sincerely,

Nicky Howell RN, BSN

Nicky Howell, RN, BSN
Clinical Performance Improvement Coordinator

64

ARCHDIOCESE OF HARTFORD
THE CHANCERY
134 FARMINGTON AVENUE
HARTFORD, CONNECTICUT 06105-3784

RECEIVED
JUN 15 2005
BY:..................

June 8, 2005

The Honorable Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS -1500 –P
P.O. Box 8011
Baltimore, MD 21244-1850

RE: *Post-acute Care Transfers; Proposed Changes to the Hospital Inpatient Prospective Payment System and FY'06 Rates; Proposed Rule*

Dear Administrator McClellan:

I appreciate this opportunity to comment on the Centers for Medicare and Medicaid Services (MDS) draft rule on the Medicare Hospital Inpatient Prospective Payment System, as published in the May 4, 2005 *Federal Register*. We are particularly concerned about CMS' reported request to expand the number of DRGs subject to the post-acute transfer policy from the current 30 to 223.

The current Medicare transfer payment policy requires that cases assigned to one of 30 DRGs be paid as *transfers* when patients are discharged to psychiatric or rehabilitation hospitals or units, children's, long-term care, or cancer hospitals, and skilled nursing facilities or home health agencies. Under this policy, payment is *per diem*.

I strongly oppose expanding the transfer policy to encompass additional classes of patient cases. We believe this would fundamentally weaken the incentives inherent in the inpatient PPS. A new transfer policy covering 223 DRGs would effectively uproot an incentive-based system fueled by per-case control, to one inordinately focused on per diem costs.

Again, we are opposed to any expansion of the inpatient transfer policy, and believe that such a move would most assuredly not be in the best interests of patients or providers. The proposed policy would undermine clinical decision-making and penalize hospitals for providing patients with the most appropriate care in the most appropriate settings.

Thank you for this opportunity to comment on the proposed inpatient PPS rule.

Sincerely,

Sister Mary Kelly, C.S.J.

Sister Mary Kelly, C.S.J.
St. Francis Hospital and Medical Center, Hartford, CT
Board Member

(860) 541-6491 / FAX (860) 541-6309

Pennock
HEALTH SERVICES
1009 West Green St., Hastings, MI 49058 • 269-945-3451 • www.pennockhealth.com

65-0
Geo. Reclass. (5)

Hefter, Hartstein, Kenley, Jones

RECEIVED
JUN 15 2005
BY:..................

June 10, 2005

Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attn: CMS-1500-P
PO Box 8011
Baltimore, MD 21244-1850

Dear Sirs:

We ask you to consider Geographic Reclassification for Pennock Hospital from the Grand Rapids MSA to the Kalamazoo-Battle Creek MSA.

On April 18, 2005, Representatives of Pennock Hospital, met with Marc Harstein and Margo Blige Holloway in the office of Representative Vernon Ehlers, together with staff from offices of Senators Carl Levin and Debbie Stabenow to request CMS administratively reclassify Pennock Hospital and prevent the potential severe loss of $1,000,000 Medicare reimbursement.

Pennock Hospital is an 88 bed hospital located in Barry County, Michigan. It was a "Lugar Hospital"and was assigned to the Kalamazoo-Battle Creek wage index for many years. In February 2005, the proposed regulations assigned Pennock Hospital to the Grand Rapids wage index.

In the same proposed regulations, the following Grand Rapids MSA hospitals were reclassified under Section 508 to the Kalamazoo-Battle Creek MSA: Metropolitan Hospital, Saint Mary's Mercy Medical Center, Spectrum Health, Gerber Memorial Hospital, Holland Community Hospital, Hackley Hospital , Zeeland Community Hospital , Munson Medical Center, Mercy General Health Partners and North Ottawa Community Hospital.

Pennock Hospital, closest to Kalamazoo, was not eligible to participate in the Section 508 reclassification, since at that date it was a Lugar hospital and already receiving the Kalamazoo-Battle Creek wage index.

The Grand Rapids wage index is 11.9% less than the Kalamazoo wage index and this reclassification scenario will cause Pennock Hospital to lose approximately $1,000,000 in federal fiscal year 2006 and corresponding to Pennock Hospital's fiscal year.

Please consider that Pennock Hospital is the closest hospital to Kalamazoo, is the only hospital in Barry County and furnishes annual health care services to over 70,000 residents. Outpatient Services exceed 170,000 patient visits, including 28,000 Emergency Department visits and 3,300 inpatient admissions. Pennock Hospital is a full service healthcare provider with diverse Physician Specialities in Obstetrics, General Surgery, Orthopedics, Urology, Ophthalmology, Internal Medicine, Radiology, Pathology, Podiatry, Cardiology, Oncology, Neurology and Family Practice.

Pennock Hospital must incur the <u>same significantly large equipment expenses</u> as surrounding healthcare providers to maintain technologically up to date patient services that our patients expect.

Pennock Hospital's wage and benefit expenses are 59% of total operating expenses. The Hospital must <u>offer equally competitive wage scales</u> for scarce healthcare professional in the areas of Pharmacy, Physical Therapy, Registered Nursing , Radiology and Laboratory Technicians. We must directly compete with the surrounding Section 508 hospitals for these professionals and now are at a severe disadvantage by this reclassification.

It will be extremely difficult, if not impossible for Pennock Hospital to attract these necessary professionals and provide continued quality patient services , in consideration of $1,000,000 lower Medicare reimbursement due to the inequitable classification in the Grand Rapids MSA and resultant significantly lower wage index..

We ask that the Department of Health and Human Services administratively reclassify Pennock Hospital to the Kalamazoo-Battle Creek MSA so that we will be reimbursed on the same equal basis as all other surrounding Grand Rapids-Battle Creek MSA hospitals.

Sincerely,

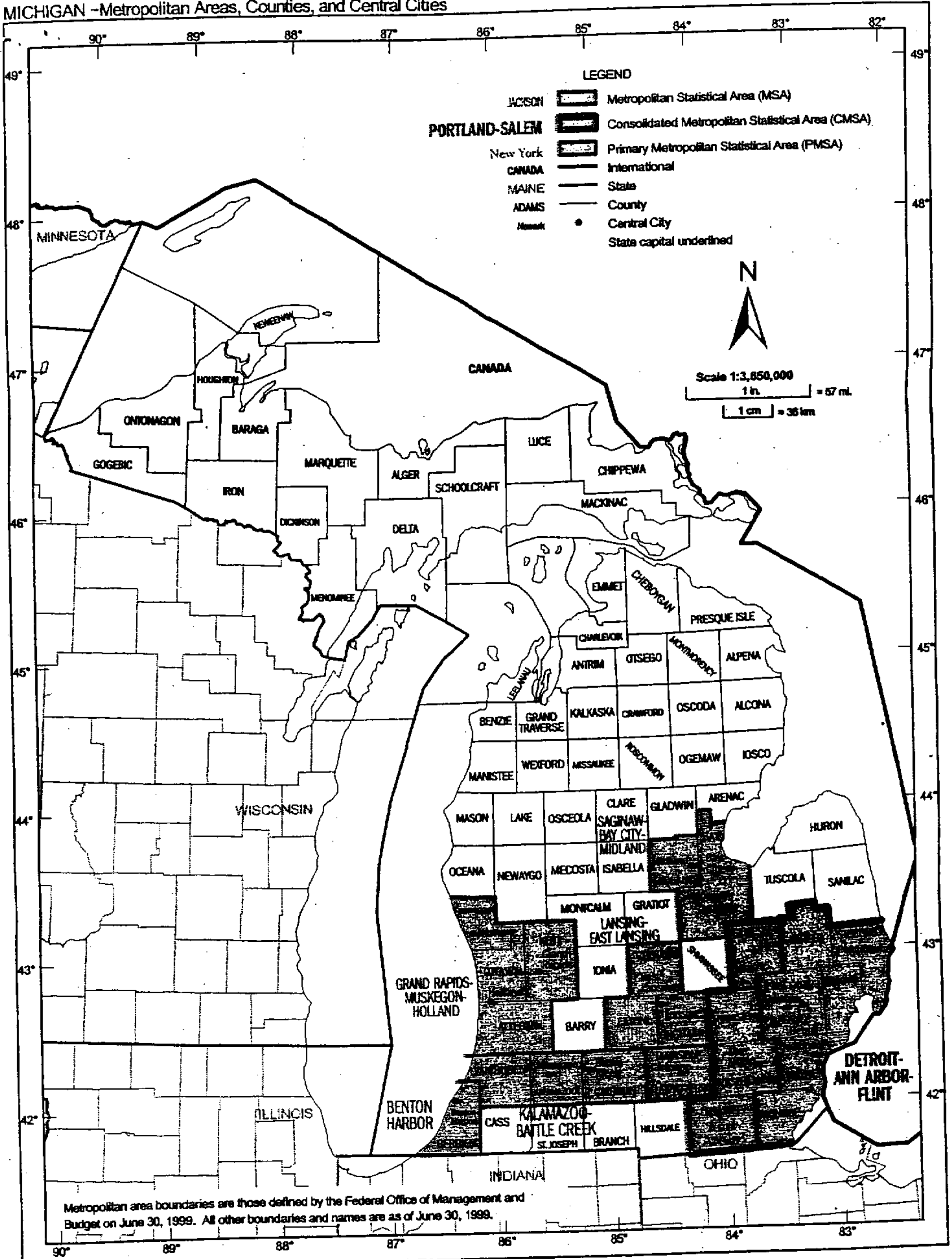
Harry L. Doele
Chief Executive Officer

Wade W. Nitz
Chief Financial Officer

Enclosure: We have attached a Michigan Map showing the locations of Pennock Hospital and the Section 508 reclassified Hospitals.

cc. Representative Vernon Ehlers
Senator Carl Levin
Senator Debbie Stabenow

MICHIGAN -Metropolitan Areas, Counties, and Central Cities



U.S. DEPARTMENT OF COMMERCE Economics and Statistics Administration Bureau of the Census

1000 MINERAL POINT AVE.
P.O. BOX 5003
JANESVILLE, WI 53547-5003
608•756•6000

A System for Life

RECEIVED
JUN 15 2005
BY:

66

WI/Bd

HHa
Harsteen
Miller

June 9, 2005

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1500-P
P.O. Box 8011
Baltimore, MD 21244-1850

RE: Wage Index

Dear Sir or Madam,

The IPPS Proposed Rule dated May 04, 2005, includes a change in Computation of the Proposed FY 2006 Unadjusted Wage Index. I wish to express my opposition to this change. Pages 23372 and 23373 describe the computation of the unadjusted wage index. In Step 4 (Section F), the rule describes the formulas for allocating overhead salaries and wage related costs to excluded areas, then removed from the wage index. This formula has been used for several years, but the proposed rule changes this formula and is not explained in the text:

> FRVol.70, No. 85 page 23373
> "Next, we computed the amounts of overhead wage-related costs to be allocated to excluded areas using three steps: (1) We determined the ratio of overhead hours (Part III, Line 13) to revised hours (Line 1 minus the sum of Lines 2, 3, 4.01, 5, 5.01, 6, 6.01, 7, **8, and 8.01**);"

The change in the formula reflects the addition of lines 8 and 8.01 to the denominator of the formula, thus lowering the denominator of the equation by the embedded subtraction from line 1, and increasing the ratio of overhead to revised hours. The higher ratio increases the amount of wage related costs removed from the wage index for excluded areas. The formula reported in the IPPS Final Rule dated August 11, 2004 reads as follows:

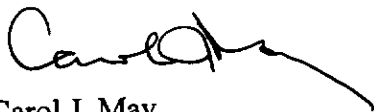
> FRVol.69, No. 154 page 49050
> "Next, we computed the amounts of overhead wage-related costs to be allocated to excluded areas using three steps: (1) We determined the ratio of overhead hours (Part III, Line 13) to revised hours (Line 1 minus the sum of Lines 2, 3, 4.01, 5, 5.01, 6, 6.01, and 7)"

Thus, lines 8 and 8.01 do not appear in the denominator of the equation in the IPPS Final Rule for FY2005.

I could not find an explanation for this change in the text of the Proposed Rule for FY2006. Nor am I aware of any impact study being performed for the proposed change, which will particularly affect hospitals that have a large component of excluded area salaries, such as Mercy Health System.

I oppose the change in the Computation of the Proposed FY2006 Unadjusted Wage Index because it was not explained in the text of the Proposed Rule, it has a negative impact on Mercy Health System as well as other facilities in the State of Wisconsin, and it is inconsistent with the formula used in prior years.

Sincerely,



Carol J. May
Corporate Controller

RECEIVED
JUN 15 2005
BY:

May 24, 2005

The Honorable Mark B. McClellan M.D., Ph.D, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS -1500-P
P.O. Box 8011
Baltimore, MD 21244-1850

Re: Post-acute Care Transfers; Proposed changes to the hospital inpatient prospective payment systems and FY '06 rates; proposed rule

Dear Administrator McClellan:

On behalf of Mississippi Baptist Health System, we appreciate this opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) proposed rule on the Medicare Hospital Inpatient Prospective Payment System, as published in the May 4, 2005 *Federal Register*. We are particularly concerned about CMS' reported proposal to expand the number of DRGs subject to the post-acute transfer policy from the current 30 to 223.

The current Medicare transfer payment policy requires that cases assigned to one of 30 DRGs be paid as *transfers* when patients are discharged to psychiatric or rehabilitation hospitals or units, children's, long-term care, or cancer hospitals, and skilled nursing facilities or home heath agencies. Under this policy, payment is *per diem*.

Mississippi Baptist Health System strongly opposes expanding the transfer policy to encompass additional classes of patient cases. We believe this would fundamentally weaken the incentives inherent in the inpatient PPS. A new transfer policy covering 223 DRGs would effectively uproot an incentive-based system fueled by per-case cost control, to one inordinately focused on per-diem costs.

Again, we are opposed to any expansion of the inpatient transfer policy, and believe that such a move would most assuredly *not* be in the best interests of patients or providers. The proposed policy would undermine clinical decision-making and penalize hospitals for providing patients with the most appropriate care in the most appropriate settings.

Thank you for this opportunity to comment on the proposed inpatient PPS rule.

Sincerely,

MISSISSIPPI BAPTIST HEALTH SYSTEM

Kurt W. Metzner
President/CEO

KWM/ld
cc: Senator Trent Lott
Senator Thad Cockran
Representative Bennie Thompson
Representative Chip Pickering
Premier, Inc.

1225 North State Street Jackson, Mississippi 39202 1-601-968-1000 www.mbhs.org

CMS-1500-P-16 **Changes to the Hospital Inpatient Prospective Payment Systems and FY 2006 Rates**

Submitter : **Dr. Lesley Maloney**

Date & Time: **04/29/2005**

Organization : **ASHP**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1500-P-16-Attach-1.DOC

68-0
Nurs/AH/Pharm (12)

Attachment #16
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

April 29, 2005

Hefter
Hartstein
Truong
Lefkowitz
Ruiz

Re: CMS-1500-P
Funding for Pharmacy Residency Programs

Dear CMS:

My name is Lesley Maloney, and I am currently in a specialty residency with the American Society of Health-System Pharmacists. I am writing to urge CMS to restore funding for second-year, specialized pharmacy residency programs.

Funding for these programs is critical to ensure an adequate supply of pharmacy practitioners who have specialized training and knowledge in therapeutic areas such as oncology, critical care, and infectious diseases as well as nontherapeutic areas of management and patient safety. This issue is of great importance as the pharmacy profession begins preparation to implement medication therapy management programs as part of the new Medicare drug benefit. Without proper funding, Medicare beneficiaries will have little to no access to the expertise of clinical pharmacy specialists or the skills gained through other non-therapeutic management programs, leading to unnecessary increases in Medicare spending.

My specialty residency, the ASHP Executive Residency in Association Management and Leadership, is a postgraduate training program conducted at ASHP headquarters and assists in training pharmacists for association staff positions in national, regional, state and local professional pharmacy or other health-related organizations. Throughout my residency, I have worked on issues such as health disparities and the need for better patient access to pharmacy services. The ASHP residency has also increased my awareness of the importance of patient and medication safety, the value of pharmacy expertise in the management of the medication supply chain, and the need for continual dialogue with outside groups such as IOM and CMS on practice issues and regulations to provide optimal patient outcomes.

Without funding of specialized residencies, such as the ASHP executive residency, the vital role of pharmacists in patient care and medication safety issues will be greatly diminished. Pharmacists continue to be the medication-use experts, and research has shown that their involvement in patient care is critical. Specialized residencies are the best place for pharmacists to obtain high quality, specific patient care skills and training in order to provide the best outcomes for public health.

ASHP submitted survey data to CMS in a timely manner in 2004 and 2005 to show that most hospitals require or prefer to employ clinical pharmacy specialists who have completed second-year specialty residency programs. In closing, I once again urge CMS to restore funding for second-year, specialized pharmacy residency programs in order to provide better patient outcomes and to reduce overall health care costs for society.

Sincerely,

Lesley Maloney, Pharm.D.
Executive Resident in Association Management and Leadership

WI/Gen/Update
Impact

CMS-1500-P-111 **Changes to the Hospital Inpatient Prospective Payment Systems and FY 2006 Rates**

Hefter
Harnstein
Miller
Kraemer

Submitter : **Mr. Michael White** **Date & Time:** **05/27/2005**

Organization : **Mercy Medical Center - North Iowa**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

The formula for the calculation of the wage index has changed, but no reason or impact was given.

CMS-1500-P-111-Attach-1.DOC

70

NT

CMS-1500-P-116 **Changes to the Hospital Inpatient Prospective Payment Systems and FY 2006 Rates**

Hefter
Hartstein
Treitel
Walz

Submitter : **Dr. William Jaffe** **Date & Time:** **05/28/2005**

Organization : **New York University**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Dear Dr. Mark McClellan:
Attached is a copy of the letter posted to you last week regarding the New Technology Add On Payment issue relating to ceramic bearings for hip arthroplasty. Thank you for your consideration.
Sincerely yours,
Dr. Bill Jaffe

CMS-1500-P-116-Attach-1.DOC

~~35-0~~ SAME AS Attachment to 1/C
RECEIVED JUN 02 2005 BY:................ 70

NYUHJD
NYU-Hospital for Joint Diseases
Department of Orthopaedic Surgery

William L. Jaffe, M.D.
Clinical Professor and Vice Chairman

SCHOOL OF MEDICINE
NEW YORK UNIVERSITY

May 24, 2005

Mark McClellan M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1500-P
P.O. Box 8011
Baltimore, MD 21244-1850

Dear Dr. McClellan:

I would like to commend CMS for approving a new ICD-9 Code for improved bearing surfaces for hip arthroplasty that will allow orthopedic surgeons to track and confirm the superior performance of these devices. It is our hope and expectation that this will eventually lead to a higher reimbursement DRG that will allow hospitals to make these components available to Medicare and Medicaid patients affording them longer survivorship for their implants. This will not only avoid the danger, pain, and suffering associated with premature revision of standard components, but would also avoid the enormous expense of readmission and revision surgery.

Ceramic-ceramic bearings appear to meet your criteria for new technology as outlined in Section 412.87(b)(1) of your current regulations in that they represent an advance in technology that substantially improves performance of a hip arthroplasty using standard bearing materials. The virtual elimination of particulate debris, the benign nature of the minimal debris created, and the absence of wear and osteolysis is in stark contrast to previous experiences with hip arthroplasty. Current and continuing peer-review data confirm and extend our enthusiasm for these devices.

I respectfully request CMS to approve as new technology add on payment ceramic-ceramic bearings to make these devices available to appropriate patients with confidence that it would be both a medically and fiscally responsible decision.

Sincerely yours,

William L. Jaffe, M.D.
Clinical Professor and Vice-Chairman
New York University School of Medicine

WLJ/mg

Hospital for Joint Diseases 301 East 17th Street, New York, NY 10003 Phone 212.598.6796 Fax 212.598.6581

Mount Sinai-NYU
Medical Center and Health System

Attachment to #116

NYUHJD
NYU-Hospital for Joint Diseases
Department of Orthopaedic Surgery

William L. Jaffe, M.D.
Clinical Professor and Vice Chairman

May 24, 2005

Mark McClellan M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1500-P
P.O. Box 8011
Baltimore, MD 21244-1850

Dear Dr. McClellan:

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I respectfully request CMS to approve as new technology add on payment ceramic-ceramic bearings to make these devices available to appropriate patients with confidence that it would be both a medically and fiscally responsible decision.

Sincerely yours,

William L. Jaffe, M.D.
Clinical Professor and Vice-Chairman
New York University School of Medicine

WLJ/mg

Hospital for Joint Diseases 301 East 17th Street, New York, NY 10003 Phone 212.598.6796 Fax 212.598.6581

Mount Sinai-NYU
Medical Center and Health System

University of Alabama, School of Medicine

Stacy A. Voils
Critical Care Specialty Resident
Virginia Commonwealth University/
Medical College of Virginia Campus
Smith Building, Room 351
410 North 12th Street
P.O. Box 980533
Richmond, VA 23298-0533
(804)828-0215

71

Submitter : Dr. Clay Dunagan

Organization : BJC HealthCare

Category : Hospital

Date: 05/31/2005

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1500-P-127-Attach-1.DOC

& Data 7/

Hetter
Hartstein
Budden
Kurashat

CMS Validation Problems

Attachment #127
Comments on Accuracy of Validation

1) Software algorithm differences between CMS and JCAHO data collection tools cause many of the "mismatches". Examples:
   a. CMS tool contains data elements that JCAHO tool does not. These CMS data elements are counted as mismatches since they are "missing" from the JCAHO abstraction.
   b. CMS data elements have different names than JCAHO data elements. These CMS data elements are counted as mismatches since they are "missing" from the JCAHO abstraction.
   c. JCAHO tool does not require collection of data elements for patients that are excluded from certain measure(s). CMS tool does not have this capability and requires collection on all data elements. These CMS data elements are counted as mismatches since they are "missing" from the JCAHO abstraction even though we cannot physically abstract them using the JCAHO tool.

2) Prior to 2005 discharges, the CMS and JCAHO abstraction guidelines do NOT match for all data elements. BJC hospitals have had mismatches counted against them even though the JCAHO abstraction guidelines and/or instructions sent directly from JCAHO ORYX project contacts were followed. This is concerning since the 2006 Marketbasket adjustment will be based on Q3/Q4 2004 validation.

3) The validation process does not currently match the intended outcome. If the intention is to validate that the publicly reported performance numbers are accurate, then the validation process should reflect that intention. Currently, the process is simply a data element by data element validation of data abstraction. Examples:
   a. In order for a patient to be included in the numerator for the Discharge Instructions measure in CHF, the instructions must address six different items. If the CMS abstractor says that 4/6 items were addressed and an individual hospital's abstractor says 5/6 items were addressed, the performance matches for that patient because not all six items were addressed with the patient. However, CMS will still count one mismatch even thought the performance would not change based on that one mismatch.
   b. If the hospital's abstractor mistakenly says that a patient does not have LVSD, then there will be a mismatch counted for that data element and also for ACE-I Clinical Trial Status, ACE-I Contraindication, and ACE-I Prescribed at Discharge. Four data element mismatches will be counted due to one error.

Comments on Process

1) It is difficult to reconstruct the percent of agreement based on the provided case detail and summary reports. The method that is used to construct the numerator and denominator on the summary report is unclear. The case detail report does not seem to reflect the denominator provided in the summary report, that is, we are unable to determine which data fields are counted in the denominator. In addition, the case detail report does not always reflect the numerator provided in the summary report. The case detail report does not contain all the mismatches that are counted against the hospitals. Examples:

for determining whether a hospital meets the threshold of acceptability, then what is the rationale for performing a full-scale assessment of reliability based on all fields?

CMS Validation Problems

4) As mentioned previously, the method that is used to construct the numerator and denominator on the validation summary report is unclear. Up to this point, the proposed 95% confidence interval has not been provided to the hospitals. Therefore, we cannot effectively try to reproduce the calculation and decision. If the numerator and denominator inclusion criteria are clearly specified, it would be straightforward to calculate the CI of interest based on a single stage cluster sample.

Submitter : Mr. John Wohler

Date: 06/01/2005

Organization : St. Agnes Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1500-P-133-Attach-1.DOC

72

WI/Bd Impact

Hefker, Hartstein, Miller, Kraemer

Attachment #133
June 1, 2005

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1500-P
P.O. Box 8011
Baltimore, MD 21244-1850

Physical Address:
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1500-P
7500 Security Blvd.
Baltimore, MD 21244-1850

Dear Sir or Madam:

RE: Wage Index

It has come to my attention that the IPPS Proposed Rule dated May 4, 2005, contains a change in the computation of the Proposed FY 2006 Unadjusted Wage Index. On page 23372 and 23373 is a description of the computation of the unadjusted wage index. Section F., Step 4 describes the formulas for allocating overhead salaries and wage related costs to excluded areas for removal from the wage index. This formula has been used for several years. However, there is a change in the formula in the Proposed Rule FY2006 that is not explained in the text:

> FR Vol.70, No. 85 page 23373
> "Next, we computed the amounts of overhead wage-related costs to be allocated to excluded areas using three steps: (1) We determined the ratio of overhead hours (Part III, Line 13) to revised hours (Line 1 minus the sum of Lines 2, 3, 4.01, 5, 5.01, 6, 6.01, 7, **8, and 8.01**);"

The change in the formula reflects the addition of lines 8 and 8.01 to the denominator of the formula, thus lowering the denominator of the equation by the embedded subtraction from line 1, and increasing the ratio of overhead to revised hours. The higher ratio increases the amount of wage related costs removed from the wage index for excluded areas. The formula reported in the IPPS Final Rule dated August 11, 2004 reads as follows:

> FRVol.69, No. 154 page 49050
> "Next, we computed the amounts of overhead wage-related costs to be allocated to excluded areas using three steps: (1) We determined the ratio

of overhead hours (Part III, Line 13) to revised hours (Line 1 minus the sum of Lines 2, 3, 4.01, 5, 5.01, 6, 6.01, and 7)"

Thus, lines 8 and 8.01 do not appear in the denominator of the equation in the IPPS Final Rule for FY2005.

This change is not explained in the text of the IPPS Proposed Rule for FY2006. No impact study has been performed for the proposed change, which will particularly affect CBSA's with hospitals that have a large component of excluded area salaries. The change has a negative 2.77 percent impact on the wage index for our hospital.

I am opposed to the change in the Computation of the Proposed FY2006 Unadjusted Wage Index on the grounds that it was unexplained in the text of the Proposed Rule, it has a negative impact on our hospital and the majority of CBSA's in our State, and it is inconsistent with the formula as it was applied in prior years.

Sincerely,

John Wohler
Reimbursement Analyst
St. Agnes Hospital

CMS-1500-P-165

Submitter : Mr. Jerry Stringham

Date: 06/06/2005

Organization : Medical Technology Partners, Inc.

Category : Health Care Industry

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1500-P-165-Attach-1.PDF

Attachment #165
73

DLG/CC

Hefter, Hartstein, Brooks, Gruber, Kelly, Hug

June 6, 2005

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1500-P
PO Box 8011
Baltimore, MD 21244

Re: Inpatient Proposed Rule - CC List Comment

Dear Sir or Madam:

Medical Technology Partners (MTP) is submitting this comment in response to the notice in the 2006 Inpatient Prospective Payment System Proposed Rule, which indicated that CMS will perform a comprehensive review of the CC List for fiscal year 2007. We are extremely pleased to hear that there will now be a formal review of the CC List. Since first communicating with you in March 2003, we have been able to review this issue in far greater depth. We are convinced that a substantial change to the CC List will improve its simplicity and fairness and provide more appropriate incentives to make cost-effective and quality care a reality for Medicare beneficiaries.

MTP has had longstanding concern that the current CC list provides financial rewards for hospitals when preventable nosocomial infections occur. Hospitals should never be paid extra funds for a nosocomial infection. They should be paid enough, on aggregate, to manage nosocomial infections without payment being tied to the infection itself.

At a minimum, CMS needs to dramatically reduce the conditions eligible for higher payment under this system. Our comment includes suggested criteria for inclusion of complicating conditions.

Complications and Comorbidities

The IPPS has long recognized that patients with complications or comorbidities are likely to result in higher costs to hospitals and, therefore, pay hospitals more when complications occur. The IPPS DRG system pays hospitals differently even when identical patients receive similar care but are separated by complicating or comorbid conditions. While this represents an effort to create fairness in the system, it has the disadvantage of creating economic disincentives to programs and technologies that improve the quality of care that Medicare patients receive.

The need to reduce urinary tract infections is high – UTIs are an example of where the CC system needs to be changed

With the current CC system, CMS provides hospitals with additional payment when hospital-acquired urinary tract infections are coded and submitted with claims under IPPS, which differentiates between claims with complications and comorbidities (CCs) and those without CCs. Urinary tract infections (UTIs) (ICD-9 diagnosis codes 599.0 or 996.64) are a common complication of hospitalizations and are particularly associated with the use of indwelling urinary

15200 Shady Grove Road, Suite 350, Rockville, Maryland 20850 • 301-296-4334 • (f) 443-583-2476

catheters, often called Foley catheters. According to MTP's analysis of the 2003 MedPAR dataset (2003), MTP determined there were over 1.4 million claims with a diagnosis of UTI. Over 1.1 million of these claims were secondary diagnoses, which is a very large number of Medicare beneficiaries. [MTP has written an extensive analysis paper that studies this issue and can provide this paper to CMS, if desired.]

UTIs are common but frequently preventable through better hospital practices and the use of improved technology. Many new techniques have emerged to reduce the rate of hospital-acquired infections. Some techniques are as simple as proper hand washing or avoiding inappropriate use of certain devices while others require new technologies. Given the current system, hospitals are financially penalized for investing in this program, as some patients are no longer eligible for the higher payment associated with the complication.

The current CC system rewards hospitals with higher payments for other common complicating conditions, such as ventilator-associated pneumonia and septicemia, conditions that can be potentially prevented with investment in programs and products. MTP's position is that hospitals should not be rewarded with higher payments for lower quality care.

Medicare reimbursement under the current CC system discourages adoption of quality enhancing practices

The DRG system frequently provides hospitals with additional payment if the patient acquires a complication during the admission. This occurs when the primary diagnosis is assigned to a DRG pair where one DRG is with complication or comorbidity (CC) and the associated DRG is without CC. For example, two patients with BPH receive a TURP. If the patient acquires a UTI, which qualifies as a CC, the hospital receives substantially more money than if the UTI is prevented.

This scenario is against the spirit of the DRG system. Hospital payment for identical patients receiving an identical procedure should be the same. Hospitals can then base technology acquisition and quality improvement programs solely on the cost-averting analysis rather than factoring in lost revenue. Only by dramatically changing the CC system can this disincentive be removed.

Providing hospitals with incremental payment for a nosocomial infection, particularly when the infection might be preventable, is not good policy. This is true for UTIs, ventilator-associated pneumonia, sepsis, and many other complications. Hospitals should have every financial incentive to improve patient safety and care by making every possible effort to reduce the incidence of hospital-acquired infections.

Should the CC List be changed or should the CC system be removed?

Given the huge financial disincentives, homogenizing all DRG pairs to one DRG may be justified. Hospitals will still receive the same total amount of money for the same patients but with more financial incentive to improve quality.

However, MTP is concerned that some patients with a truly comorbid condition, such as diabetes, may have trouble finding hospitals willing to take them. If higher risk patients face access problems, a CC system would be warranted. It could be that instead of a CC system, it should evolve to just a C system (comorbid conditions only).

The current CC system is an opt-in system that excludes specific diagnosis that are normally related to the admitting diagnosis. The use of the CC system should be as rare as possible and only diagnoses that are specifically included should be used. Before inclusion as a CC condition, a diagnosis should meet the following criteria:

1. The patient group should represent a higher cost in that DRG than those without the comorbid condition.
2. The condition can be prevented, in any possible way, by superior care in the hospital.
3. The condition should not be related to the primary diagnosis.
4. There is at least some indication that the patient would face inadequate options for finding appropriate medical care without a more appropriate payment.

Our reading of the current system indicates that only criteria 1 and 3 are used in the current system.

Changing the system will reward quality care

CMS' recent efforts to pay hospitals more when they produce better quality is a good direction for beneficiaries. The current CC system provides an enormous effort against CMS' quality initiatives. With the existing CC system, CMS currently pays hospitals more when the quality is worse. An important step to paying more for better quality is to stop paying more for worse quality. Certainly a hospital should not receive additional payment for a complication that was preventable. This is the case with nosocomial infections, for which there is widespread concern that not enough is being done to prevent them.

MTP thanks CMS for its efforts to readdress the CC system. MTP hopes that there will be an open hearing to discuss the optimal structure for ideal incentives for quality care. Thank you for the opportunity to comment. If you have any questions or if you would like additional information about our analysis, please do not hesitate to call me at 301-296-4334 or email me at jstringham@medicaltechpartners.com.

Sincerely,

Jerry Stringham
President