Submitter : Dr. Mathew Stiles **Date:** 06/12/2006

Organization : Private Practice Family Physician

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS or the Agency) proposed rule entitled Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates. 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in patient care activities. The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

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To separate out CMS s newly defined patient care time from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency progr

Submitter : **Dr. Elizabeth Naumburg**

Organization : **University of Rochester**

Category : **Physician**

Date: 06/12/2006

Issue Areas/Comments

GENERAL

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In addition, I cannot conceive of how I would be able to administratively comply with this requirement. It would require documentation that would be extremely burdensome, if possible at all. To separate out CMS s newly defined patient care time from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Where am I to find the funding to pay for the staff person that would be needed to sit in on each of these didactic sessions and keep count of patient care time? The documentation requirements that this position would necessitate are unreasonable and would cause an extremely large administrative burden.

To reiterate, I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Until the government determines the best way to provide its citizens with excellence in health care, continuing to chip away at the current system is only likely to erode the system of medical education. I urge the congress to take a step back and look comprehensively about how to fulfill the goal of training excellent physicians which are an integral part of qualtiy care for all.

Sincerely,

Submitter : Dr. Joseph Blonski **Date:** 06/12/2006

Organization : St. Cloud Hospital/Mayo Family Medicine Residency

Category : Physician

Issue Areas/Comments

GME Payments

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Submitter : **Dr. Lori Carnsew** **Date: 06/12/2006**

Organization : **Dr. Lori Carnsew**

Category : **Physician**

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Sincerely,

Lori R. Carnsew, MD

Submitter : **Dr. Brian Wells** **Date: 06/12/2006**

Organization : **Dr. Brian Wells**

Category : **Physician**

Issue Areas/Comments

GME Payments

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I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs. I believe that patient care is best learned through interaction between physicians and students and didactic experience tends to be the most beneficial besides simple knowledge.

Submitter : **Dr. claudia daly** **Date: 06/12/2006**

Organization : **Dr. claudia daly**

Category : **Individual**

Issue Areas/Comments

GME Payments

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Sincerely,
(Your name here)

Submitter : **Dr. Kyle Parish** **Date: 06/12/2006**

Organization : **Dr. Kyle Parish**

Category : **Physician**

Issue Areas/Comments

GME Payments

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Submitter : Mr. Mark George **Date:** 06/12/2006

Organization : Robert Wood Johnson University Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1258-Attach-1.DOC

CMS-1488-P-1258-Attach-2.DOC

#1258-1

June 12, 2006

Centers for Medicare and Medicaid Services
Department of Health and Senior Services
Attention: CMS-1488-P
7500 Security Boulevard
Baltimore, MD 21244-1850

Subject: Comments: "Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems (IPPS) and Fiscal Year 2007 Rates." 71 Fed. Reg. 23996 (April 25, 2006).

Dear Administrator McClellan:

Robert Wood Johnson University Hospital, a premier academic health center and tertiary/quaternary referral source located in New Brunswick, NJ, respectfully submits the following comments regarding the CMS "Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates". We have outlined our concerns below for your review and consideration. Moreover, one must also keep in mind that many Medicaid and private sector payers follow Medicare's payment methodology. This ripple effect reinforces the imperative that significant changes to the Medicare system, like the DRG weighting and classification changes must be subjected to comprehensive and thorough analysis to ensure that the goals of the intended policy change are met without undue stress to the system.

CMS Proposed Rule, FY 2007

Under the proposed rule, in FY 2007, Medicare would move to a "hospital-specific relative value cost center" (HSRVcc) DRG weighting methodology. In FY 2008 ("if not earlier" according to the proposed rule) the current 526 DRGs would be replaced by 861 "consolidated severity adjusted DRGs" (CS-DRGs). According to the proposed rule press release, these two proposals represent the "first significant revision of the Inpatient Prospective Payment System (IPPS) since its implementation in 1983."

In an effort to reduce the economic incentives for physician-owned specialty hospitals and improve overall payment accuracy, CMS has proposed an overhaul of the Medicare DRG system that would reduce funding for cardiology services as much as 33% compared to FY 2006. The proposal is misguided, provides the wrong incentives for patient care, and does not accomplish CMS' goal of improving payment accuracy. In addition, because the proposal is based on questionable methods, it is impossible for hospitals to understand the

potential impact of cost-based weights until these irregularities have been thoroughly evaluated and corrected.

If implemented as proposed, the policy would **reduce** overall funding for cardiac stent DRGs by - $1.3 billion, ICD implants by - $524 million and pacemaker implants by - $225 million. As a matter of fact, the top 19 DRG losers are in MDC 5 (Diseases and Disorders of the Circulatory System), with total losses amounting to - $2.7 billion. Some of the winners include Pneumonia (+ $376 million), Septicemia (+ $376 million), Psychoses (+ $241 million or 96%), COPD (+ $236 million), and Heart Failure and Shock (+ $211 million). More detail on the proposed rule is provided in Appendix A.

Call to Action

The sweeping changes CMS proposes will have a significant impact on hospitals. Because the CMS' proposal is fundamentally flawed, any fix that is proposed should not be implemented without the benefit of a full and thorough analysis along with adequate comment period. It should also be phased in slowly to allow hospitals adequate time to plan for and adjust to proposed changes.

- The new proposed DRG weights would be based on cost data that are 3-5 years old. These data are neither current nor accurate and do not include the costs associated with many important and commonly used technologies such as drug eluting stents. There must be a way to use more current data so that new technology can be incorporated into the rate structure.
- In addition, the manner in which costs are derived from charges assumes that higher cost devices like implantable devices are marked up to the same extent as low-cost items. This is well known to not be the case.
- The hospital charges are not weighted by volume: a small hospital of 50 beds would carry as much weight as a 1,000-bed hospital. This is unprecedented.
- The technical errors and data trimming methods used, most notably the exclusion of 25% of hospital charges when deriving the cost-to-charge ratios, are indefensible and should be corrected.
- Severity adjustments have potential, but must account for both complexity and severity, not just severity. CMS is currently proposing to implement these changes in FY 2008, but has solicited comment on this aspect as well. Hospitals must be given appropriate information on the method and impact of any new severity adjustment system and be given appropriate time to evaluate and comment on future proposals. The impact of adopting cost-based methods and severity adjustment at different times should be fully understood since the changes that ensue may "whipsaw" hospitals by shifting dollars in opposite directions in succeeding years.
- The potential impact of these changes is so great, even when corrected, that they should be phased in gradually over several years.

Basing DRG relative weights on estimated costs instead of charges

In its recommendations to move to a cost-based relative weight methodology, MedPAC suggested application of hospital-specific relative value units (HSRVs) to weight DRGs on estimated hospital-specific costs using individual claims data. In the proposal, however, CMS suggests this methodology is too complex and difficult to implement in a timely manner. CMS developed a modified proposal to reform the DRG system that is based on creation of 10 cost centers that are weighted by a national cost-to-charge ratio (CCR) and applied to each DRG. Each cost center is scaled across all cost centers and summed to determine the DRG relative weight.

Independent analyses of the proposed cost-based methods suggest a number of technical errors or questionable decisions in constructing the rule. For instance, in constructing the CCRs to establish the DRGs, CMS failed to adjust for hospital volume, allowing small hospitals to have as much weight as large. The statistical trimming used in calculating the CCRs also eliminated about a quarter of routine day charges (mostly large hospitals), leading to higher than expected values for this cost center. Combined with charge compression (where high cost items are marked up less than lower cost items) associated with technology-intensive procedures, these decisions uniformly bias weights downward for these procedures, leading to reduced payments.

Severity Adjusted DRGs

CMS believes accounting for severity of illness within the DRG system will more accurately align payments to costs. There are descriptions of two potential severity-adjusted DRG alternatives outlined in the proposed rule. CMS seems to favor a refinement of the all patient refined diagnosis-related group system (APR-DRG) system currently in use in Maryland. These systems are both similar to the current CMS DRG system in that they use the same ICD-9-CM diagnosis and procedure codes to determine DRG assignment. The APR-DRG system, although currently in use by many hospitals to better understand case mix, was developed for all payers, and some DRGs may not adequately account for resource use in the Medicare population. The consolidated system uses factors such as high severity of illness or base CMS DRG similarities to keep the number and mix of DRGs parsimonious.

Both severity-adjusted DRG systems have some shortcomings, particularly in accounting for complexity of care such as costly technologies.

Resultant changes to case-mix index and outlier threshold

The proposed adoption of the HSRV methodology shifts case mix to **reduce surgical payments by 5.7% and increase medical payments by 6%**, mostly due to higher costs being reported in the low CCR ancillary cost centers for surgical DRGs. CMS' proposed change to cost-based weights tends to shift payments from large urban and teaching hospitals to smaller urban and rural hospitals. The effect of adopting the consolidated severity-adjusted DRGs, however, tends to shift payments in the opposite direction based on case mix

shifts. Since CMS is only proposing to adopt cost-based weights in FY 2007, the overall impact to hospitals of the CMS proposed rule is a clear reallocation of resources from large, urban and teaching to small, rural and non-teaching hospitals. There is also a significant reallocation of payments from complex and high-tech to longer-stay cases, or from surgical to medical.

Conclusion

We appreciate the proposed rule's request for comments regarding a transition period (71 Fed. Reg. 24028).

Historically, Medicare changes of significant magnitude have included some type of transition period. For example, the move to a PPS for capital was transitioned in over a 10 year period. Other changes that were accompanied by transitions include: implementation of the operating IPPS (four years), eliminating day outliers (four years), and removing the costs of teaching physicians and residents in the calculation of the wage index (four years).

While it is unclear what an appropriately devised new DRG classification and weighting system might look like, it is obvious that such a change will still involve the redistribution of hundreds of millions of dollars. Accordingly a significant transition period must accompany any final changes.

Thank you again for the opportunity to comment on the proposed regulations.

Sincerely Yours.

Mark D. George
Director of Budget and Reimbursement

Appendix A

Proposed Payment Reductions for Coronary Stent and Related DRGs		
DRG	**Description**	**% change v. FY 2006**
555	Percutaneous Cardiovascular Procedures with MCV	- 21%
556	Bare Metal Stent without MCV	- 34.1%
557	Drug Eluting Stent with MCV	- 23.5%
558	Drug Eluting Stent without MCV	- 33.4%
518	EP Procedures without Stent	- 28.9%
Proposed Payment Reductions for ICD and Pacemaker Implant DRGs		
DRG	**Description**	**% change v. FY 2006**
515	ICD implant without Cardiac Catheterization	- 22.6%
535	ICD Implant with Cardiac Catheterization with	- 23.8%

	AMI/HF/Shock	
536	ICD implant with Cardiac Catheterization without AMI/HF/Shock	- 22.2%
551	Pacemaker implant with MCV	- 12.5%
552	Pacemaker Implant without MCV	-13.3%
Proposed Payment Reductions for CABG DRGs		
DRG	**Description**	**% change v. FY 2006**
547	CABG with Cardiac Catheterization with MCV	- 5.4%
548	CABG with Cardiac Catheterization without MCV	-8.8%
549	CABG without Cardiac Catheterization with MCV	-1.3%
550	CABG without Cardiac Catheterization without MCV	- 1.4%
Proposed Payment Reductions for Non-Coronary Vascular DRGs		
DRG	**Description**	**% change v. FY 2006**
479	Other Vascular Procedures w/out CC	- 9.2%
553	Other Vascular Procedures with CC and MCV	- 5.6%
554	Other Vascular Procedures with CC without MCV	- 3.1%
533	Extracranial Procedures with CC	- 2.6%
534	Extracranial Procedures without CC	- 2.3%

1258-2

June 12, 2006

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If implemented as proposed, the policy would **reduce** overall funding for cardiac stent DRGs by - $1.3 billion, ICD implants by - $524 million and pacemaker implants by - $225 million. As a matter of fact, the top 19 DRG losers are in MDC 5 (Diseases and Disorders of the Circulatory System), with total losses amounting to - $2.7 billion. Some of the winners include Pneumonia (+ $376 million), Septicemia (+ $376 million), Psychoses (+ $241 million or 96%), COPD (+ $236 million), and Heart Failure and Shock (+ $211 million). More detail on the proposed rule is provided in Appendix A.

Call to Action

The sweeping changes CMS proposes will have a significant impact on hospitals. Because the CMS' proposal is fundamentally flawed, any fix that is proposed should not be implemented without the benefit of a full and thorough analysis along with adequate comment period. It should also be phased in slowly to allow hospitals adequate time to plan for and adjust to proposed changes.

- The new proposed DRG weights would be based on cost data that are 3-5 years old. These data are neither current nor accurate and do not include the costs associated with many important and commonly used technologies such as drug eluting stents. There must be a way to use more current data so that new technology can be incorporated into the rate structure.
- In addition, the manner in which costs are derived from charges assumes that higher cost devices like implantable devices are marked up to the same extent as low-cost items. This is well known to not be the case.
- The hospital charges are not weighted by volume: a small hospital of 50 beds would carry as much weight as a 1,000-bed hospital. This is unprecedented.
- The technical errors and data trimming methods used, most notably the exclusion of 25% of hospital charges when deriving the cost-to-charge ratios, are indefensible and should be corrected.
- Severity adjustments have potential, but must account for both complexity and severity, not just severity. CMS is currently proposing to implement these changes in FY 2008, but has solicited comment on this aspect as well. Hospitals must be given appropriate information on the method and impact of any new severity adjustment system and be given appropriate time to evaluate and comment on future proposals. The impact of adopting cost-based methods and severity adjustment at different times should be fully understood since the changes that ensue may "whipsaw" hospitals by shifting dollars in opposite directions in succeeding years.
- The potential impact of these changes is so great, even when corrected, that they should be phased in gradually over several years.

Basing DRG relative weights on estimated costs instead of charges

In its recommendations to move to a cost-based relative weight methodology, MedPAC suggested application of hospital-specific relative value units (HSRVs) to weight DRGs on estimated hospital-specific costs using individual claims data. In the proposal, however, CMS suggests this methodology is too complex and difficult to implement in a timely manner. CMS developed a modified proposal to reform the DRG system that is based on creation of 10 cost centers that are weighted by a national cost-to-charge ratio (CCR) and applied to each DRG. Each cost center is scaled across all cost centers and summed to determine the DRG relative weight.

Independent analyses of the proposed cost-based methods suggest a number of technical errors or questionable decisions in constructing the rule. For instance, in constructing the CCRs to establish the DRGs, CMS failed to adjust for hospital volume, allowing small hospitals to have as much weight as large. The statistical trimming used in calculating the CCRs also eliminated about a quarter of routine day charges (mostly large hospitals), leading to higher than expected values for this cost center. Combined with charge compression (where high cost items are marked up less than lower cost items) associated with technology-intensive procedures, these decisions uniformly bias weights downward for these procedures, leading to reduced payments.

Severity Adjusted DRGs

CMS believes accounting for severity of illness within the DRG system will more accurately align payments to costs. There are descriptions of two potential severity-adjusted DRG alternatives outlined in the proposed rule. CMS seems to favor a refinement of the all patient refined diagnosis-related group system (APR-DRG) system currently in use in Maryland. These systems are both similar to the current CMS DRG system in that they use the same ICD-9-CM diagnosis and procedure codes to determine DRG assignment. The APR-DRG system, although currently in use by many hospitals to better understand case mix, was developed for all payers, and some DRGs may not adequately account for resource use in the Medicare population. The consolidated system uses factors such as high severity of illness or base CMS DRG similarities to keep the number and mix of DRGs parsimonious.

Both severity-adjusted DRG systems have some shortcomings, particularly in accounting for complexity of care such as costly technologies.

Resultant changes to case-mix index and outlier threshold

The proposed adoption of the HSRV methodology shifts case mix to **reduce surgical payments by 5.7% and increase medical payments by 6%**, mostly due to higher costs being reported in the low CCR ancillary cost centers for surgical DRGs. CMS' proposed change to cost-based weights tends to shift payments from large urban and teaching hospitals to smaller urban and rural hospitals. The effect of adopting the consolidated severity-adjusted DRGs, however, tends to shift payments in the opposite direction based on case mix

shifts. Since CMS is only proposing to adopt cost-based weights in FY 2007, the overall impact to hospitals of the CMS proposed rule is a clear reallocation of resources from large, urban and teaching to small, rural and non-teaching hospitals. There is also a significant reallocation of payments from complex and high-tech to longer-stay cases, or from surgical to medical.

Conclusion

We appreciate the proposed rule's request for comments regarding a transition period (71 Fed. Reg. 24028).

Historically, Medicare changes of significant magnitude have included some type of transition period. For example, the move to a PPS for capital was transitioned in over a 10 year period. Other changes that were accompanied by transitions include: implementation of the operating IPPS (four years), eliminating day outliers (four years), and removing the costs of teaching physicians and residents in the calculation of the wage index (four years).

While it is unclear what an appropriately devised new DRG classification and weighting system might look like, it is obvious that such a change will still involve the redistribution of hundreds of millions of dollars. Accordingly a significant transition period must accompany any final changes.

Thank you again for the opportunity to comment on the proposed regulations.

Sincerely Yours.

Mark D. George
Director of Budget and Reimbursement

Appendix A

Proposed Payment Reductions for Coronary Stent and Related DRGs		
DRG	**Description**	**% change v. FY 2006**
555	Percutaneous Cardiovascular Procedures with MCV	- 21%
556	Bare Metal Stent without MCV	- 34.1%
557	Drug Eluting Stent with MCV	- 23.5%
558	Drug Eluting Stent without MCV	- 33.4%
518	EP Procedures without Stent	- 28.9%
Proposed Payment Reductions for ICD and Pacemaker Implant DRGs		
DRG	**Description**	**% change v. FY 2006**
515	ICD implant without Cardiac Catheterization	- 22.6%
535	ICD Implant with Cardiac Catheterization with	- 23.8%

	AMI/HF/Shock	
536	ICD implant with Cardiac Catheterization without AMI/HF/Shock	- 22.2%
551	Pacemaker implant with MCV	- 12.5%
552	Pacemaker Implant without MCV	-13.3%
Proposed Payment Reductions for CABG DRGs		
DRG	**Description**	**% change v. FY 2006**
547	CABG with Cardiac Catheterization with MCV	- 5.4%
548	CABG with Cardiac Catheterization without MCV	-8.8%
549	CABG without Cardiac Catheterization with MCV	-1.3%
550	CABG without Cardiac Catheterization without MCV	- 1.4%
Proposed Payment Reductions for Non-Coronary Vascular DRGs		
DRG	**Description**	**% change v. FY 2006**
479	Other Vascular Procedures w/out CC	- 9.2%
553	Other Vascular Procedures with CC and MCV	- 5.6%
554	Other Vascular Procedures with CC without MCV	- 3.1%
533	Extracranial Procedures with CC	- 2.6%
534	Extracranial Procedures without CC	- 2.3%

Submitter : Mrs. Sara Roughton **Date:** 06/12/2006

Organization : Sentara Healthcare

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

I am writing in regards to the proposed changes to implement APRDRG's this year. There are several factors with this change that will be a large burden to facilities. First, the time frame for this implementation is a major concern. First, we will have to train ourselves to understand the changes and then teach our 70+ coders in our 7 hospital system. Our IT department already has schedule projects ongoing and this change and this will disrupt their procedures as they will need to reschedule and organize this large task. We feel we need another year to get prepared for this major change and hope this letter will help entice you to do so, thank you

Submitter : Mr. Harry Kotlarz **Date:** 06/12/2006

Organization : DePuy Orthopaedics Inc., a Johsnon & Johnson compa

Category : Device Industry

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1488-P-1260-Attach-1.DOC

#1260

June 8, 2006

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1427-FC
P.O. Box 8010
Baltimore, MD 21244-8018

Re: Proposed changes to orthopaedic DRGs 544 and 545 - "Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates; Proposed Rule" April 25, 2006 [CMS–1488–P]

DePuy Orthopaedics, Inc., a Johnson & Johnson company, is a driver of transformational change in orthopaedic care, with a focused commitment to help surgeons achieve excellence in surgical practice. DePuy Orthopaedics is committed to the development of innovative therapies and treatments to enhance patient care.

In response to the Centers for Medicare and Medicaid Services' (CMS) proposal to a) change the current charge-based method used to develop the annual DRG weighting factors to a hospital-specific, relative-value (HSRV), cost-based system and, b) modify the DRG system to "consolidated severity adjusted DRGs," DePuy Orthopaedics respectfully submits the following comments.

Deletion of DRG 209 and Creation of DRGs 544 and 545. In the FY 2006 final rule (70 FR 47303), CMS deleted DRG 209 (Major Joint and Limb Reattachment Procedures of Lower Extremity) and created new DRGs 544 (Major Joint Replacement or Reattachment of Lower Extremity) and 545 (Revision of Hip or Knee Replacement). The establishment of two new DRGs was intended to more appropriately compensate hospitals that perform revisions of joint replacements since the revision procedures are more resource intensive than original replacement procedure. While this change represented a major modification to the reimbursement methodology for these procedures, we applaud CMS for taking the initiative to adjust the payment discrepancies that may have existed under DRG 209.

Reduction in Reimbursement for DRGs 544 and 545. We are greatly concerned by the two proposals put forth in the proposed rule which will result in a reduction in reimbursement for DRGs 544 and 545, a mere seven months after the initiation of the new DRGs. The new HSRVcc and consolidated severity adjusted DRGs would result in an overall decrease in reimbursement to hospitals for DRGs 544 and 545. The analysis contained in the rule projects a payment reduction of 13.0% for DRG 545 (Revision of Hip or Knee Replacement).[1]

[1] CMS-1488-P (Display Copy) "Table I.--Payment Impact from HSRVcc and Consolidated Severity-Adjusted DRGs by Selected High Volume DRGs." Pgs 99-100.
2. Bozic K, Katz P, Cisternas M, Ono L, Ries M, Showstack J. Hospital resource utilization for primary and revision

Payment Impact from HSRVcc and Consolidated Severity-Adjusted DRGs by Selected High Volume DRGs

CMS DRG V23.0	CMS DRG Description	Number of Cases	Percent Change in Relative Weight Due to HSRVcc	Percent Change in Discharge Weighted Average Weight Due to Consolidated Severity-Adjusted DRGs	Total Impact All Changes
544	REATTACHMENT OF LOWER EXTREMITY	407,310	-4.0%	-1.0%	-5.0%
545	REVISION OF HIP OR KNEE REPLACEMENT	41,021	-3.0%	-10.0%	-13.0%

Creation of DRG 545 was intended as stated in the FY05 IPPS final rule, (page 47305) to "replace payment issues for hospitals that perform the more difficult revisions of joint replacements." We feel it is premature to propose a payment reduction within less than a year of implementation and that claims data are insufficient to understand the true financial impact to hospitals.

Data Submission by Massachusetts General Hospital, the Mayo Clinic and the University of California at San Francisco. This group of researchers completed two studies on hospital resource utilization in total joint arthroplasty (TJA). A pilot study compared detailed resource utilization (using activity-based costing methodology) between primary and all types of revision total hip arthroplasty (THA) procedures at UCSF.[2] The second, a multi-center study involving more than 10,000 patient clinical and financial records from all three institutions, compared relative resource utilization among primary, single component and both component revision THA and total knee arthroplasty (TKA).[3]

The findings were consistent with those of previous investigators [4-6] who demonstrated significant differences in operative time, length of stay, complication rates and overall resource utilization between primary and different types of revision TJA procedures.

The April 25 2005 Federal Register contained an announcement from CMS splitting DRG 209 into two separate DRGs: DRG 544 (Primary Hip and Knee Replacement) and DRG 545 (Revision Hip and Knee Replacement). In explaining its decision, CMS cited the importance of the input from the American Academy of Orthopaedic Surgeons (AAOS) and orthopaedic surgeons, stating, "We agree with the commenters and the AAOS that the creation of a new DRG for revisions of hip and knee replacements should resolve payment issues for hospitals that perform the more difficult revisions of joint replacements."

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total hip arthroplasty. *J Bone Joint Surg Am.* 2005;87(3):570-576.

3. Bozic K, Durbhakhala S, Berry D, et al. Differences in Patient Characteristics, Procedures Characteristics, and Hospital Resource Utilization in Primary and Revision TJA. *J Arthroplasty* (Accepted for Publication, March. 2005).

4. Iorio R, Healy W, Richards J. Comparison of the hospital cost of primary and revision total hip arthroplasty after cost containment. *Orthopedics* 1999;22(2):195-199.

5. Lavernia C, Drakeford M, Tsao A, Gittelsohn A, Krackow K, Hungerford D. Revision and primary hip and knee arthroplasty. A cost analysis. *Clin Orthop* 1995 Feb;(311):136-141.

6. Barrack RL, Sawhney J, Hsu J, Cofield RH. Cost analysis of revision total hip arthroplasty. A 5-year followup study. *Clin Orthop* 1999 Dec;(369):175-178.

CMS also noted that the data they received on differences in resource utilization in primary and revision TJA were most convincing. "The commenters reported on a recently completed study comparing detailed hospital resource utilization and clinical characteristics in over 10,000 primary and revision hip and knee replacement procedures at three high-volume institutions: the Massachusetts General Hospital, the Mayo Clinic, and the University of California at San Francisco."

CMS credited the importance of input and collaboration with members of the AAOS and AAHKS in helping it understand the issues related to coding deficiencies and reimbursement discrepancies related to TJA procedures.

Consolidated Severity-Adjusted DRGs by Selected High Volume DRGs

It is documented that the creation of DRG 545 last year took into account the financial burden to hospitals for this procedure and was the result of detailed claims and cost reporting analysis. Such an immediate reduction in reimbursement would place hospitals performing revision procedures at a further financial disadvantage. In addition, we are concerned that the hospitals currently performing the complex, resource intensive revision procedures may choose to limit access to this procedure, due to the reductions in payment. Consolidating the severity-adjusted DRGs would undo this change, and assign revisions together with initial replacements. Essentially CMS is undoing the payment adjustment made in 2006 to reflect the greater resource utilization seen with revision hip and knee surgeries.

We suggest that the relative weight of DRG 545 be maintained at the FY 2006 level until a sufficient amount of claims data is available to determine the true financial impact to hospitals.

Several health care groups including the American Hospital Association and the Heart Rhythm Society (HRS) support at least a one-year delay of CMS's proposed changes to the Inpatient Prospective Payment System.

We appreciate your consideration of the above comments. Please contact the undersigned if you have any questions.

Best Regards,

DePuy Orthopaedics, Inc.
a Johnson & Johnson company

Harry J. Kotlarz, MBA
Director, Health Economics and Reimbursement
700 Orthopaedic Drive
Warsaw, IN 46581-0988
406-542-9300 phone
406-542-9302 fax
612-590-9446 cell
hkotlar@dpyus.jnj.com

Submitter : Mr. Charles Cataline **Date:** 06/12/2006

Organization : The Ohio Hospital Association

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1261-Attach-1.RTF

#1261

OHIO HOSPITAL ASSOCIATION

June 12, 2006

Mark McClellan, MD, PhD
Administrator
Centers for Medicare & Medicaid Services
ATTN: CMS-1488-P
P.O. Box 8010
Baltimore MD, 21244-1850

Dear Dr. McClellan:

On behalf of its 170+ hospital and health system members, the Ohio Hospital Association is commenting on CMS' proposed rule on the *PPS for Inpatient Hospital Services Proposed Rule for 2007 Fiscal Year,* published in the April 25, 2006, *Federal Register.*

The proposed rule would establish inpatient hospital payments rates for federal fiscal year 2007 and includes two significant proposed changes, first to shift the methodology for calculating Medicare Inpatient Hospital Prospective Payment System (IHPPS) diagnosis-related group (DRG) relative weights from hospital charges to costs, and second, to refine IHPPS DRGs so CMS can more specifically base inpatient hospital Medicare payments on each patient's severity of illness or injury.

OHA joins the American Hospital Association (AHA) in its support of improvements to the Medicare IHPPS that create an equal opportunity for return across DRGs and provides an equal incentive for hospitals to treat all types of patients and conditions, and OHA applauds CMS for its attempts to answer industry concerns with such far-reaching policy and payment initiatives.

However, OHA is very concerned about the payment implications of an implementation of either of the two major IHPPS payment methodology revisions as early as October 2006. OHA recommends that if they are ultimately adopted as conceived, it be done in tandem, no earlier than October 2007, with an at least three-year transition.

OHA recommends the delayed, dual implementation and transition based on projections of the wide-ranging effect on Medicare payments from hospital to hospital, and on the need for some hospitals to budget for payment decreases, and determine whether they can continue to provide services most impacted by the hospital-specific relative value (HSRV) cost-based DRG weighting methodology and severity-adjusted DRGs.

155 East Broad Street, Floor 15 Columbus, Ohio 43215-3620 www.ohanet.org 614.221.7614 614.221.4771 fax

Specifically, OHA supports:

- **A Simultaneous Adoption of Any Changes to Weights and Classifications**

  CMS is moving forward with its policy and payment changes to answer industry and Congressional criticism that the current IHPPS system easily permits some hospitals to focus on specialized conditions and DRGs in order to maximize Medicare reimbursement.

  Many hospitals that do not specialize face the unintended consequence of payment cuts so large they will be pushed into financial crises that could force them to reconsider which services they can deliver to their communities. This uncertainty about Medicare reimbursement will be made worse if CMS adopts a two-step implementation.

  However well analyzed—and most industry experts agree CMS' research and policy recommendations need additional work—the updates redistribute a great deal of Medicare reimbursement in a very short timeframe. Most hospitals are not financially prepared to weather the swings in Medicare payments two major payment policy start-ups would cause. **As such, CMS should combine the two policy changes to provide better predictability and to eliminate as much as possible any swings in reimbursement from one year to the next.**

- **An at least one-year delay in the implementation of any major payment policy change**

  As outlined above, CMS is poised to move too aggressively on a pair of major policy shifts that require additional study. Because of the enormous amount of money the policies redistribute, hospitals need additional time to absorb the financial impact and provide the necessary staff education and training.

  OHA is concerned that the potential for wide swings in Medicare payment will be made worse by the as-yet unknown effects of the implementation of the 100% occupational mix adjustment, scheduled by court order for Oct. 1, 2006.

  In addition, OHA is aware of serious concerns on the part of the AHA and other major industry experts on the methodologies CMS has employed to arrive at its proposals.

OHA joins the AHA in its support of the move to cost-based DRG weights but believes CMS' proposed method is flawed. More work is needed to determine the best way to create cost-based weights.

To permit hospitals sufficient time to plan and to allow CMS and the industry additional time to fine tune the policies and supporting data, **CMS should not adopt either of the proposals to reweigh or refine the IHPPS DRGs until federal fiscal year 2008, at the earliest.**

- **Three-year Transition**

At no time since the inception of the IHPPS, has CMS implemented a major change in payment policy without an at least-three year transition from the old to the new payment rates. **Given the magnitude of payment redistribution across DRGs and hospitals' need to budget for it, any changes CMS implements should be transitioned over no less than three years.**

- **Expansion of Hospital Quality Data Indicators**

The proposed rule states that to qualify for the full 3.4 percent market basket update, hospitals would have to pledge to submit data on discharges back to January 1, 2006, on 21 quality measures, not all of which are currently included in the data set reported to the Quality Improvement Organization Clinical Warehouse. Hospitals that don't report the full set of data by August 15 would receive an inpatient update equal to the market basket minus two percentage points.

All Ohio hospitals support the reporting of quality data but the proposed rule would force them to re-abstract discharges, renegotiate agreements with the vendors that assist collecting and processing the required information, and resubmitting data to the warehouse. **OHA recommends CMS require hospitals that want a full market basket update to pledge to submit the data for all 21 quality measures starting with discharges on or after July 1.**

- **Resident Time in Patient Activities**

CMS proposes to clarify the rule to exclude the medical resident time spent in didactic activities from the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

The stated rationale is they not related to patient care. The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all indirect medical education payments (regardless of setting), and for direct graduate medical education payments when the activities occur in a non-hospital setting, such as a physician's office or affiliated medical school.

The proposed clarification is inappropriate, in that the activities cited are an integral component of the patient care activities engaged in by residents during their residency programs, and it reverses long-standing CMS opinion that patient care activities should be interpreted broadly to include scholarly activities, such as educational seminars, classroom lectures, and presentation of papers and research results to fellow residents, medical students, and faculty. **OHA recommends CMS rescind the clarification that excludes medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education and indirect medical education payments**

- **Availability of the DRG Grouper**

The proprietary nature of the proposed CS-DRG Grouper is of great concern to OHA. The current DRG Grouper logic has been in the public domain since the start of the PPS, and without the new Grouper logic, it is virtually impossible for anyone to analyze the proposed PPS changes and comment on the patient classifications and Medicare payments that result. In addition, potentially high price to purchase new software from a vendor with a monopoly on its distribution will add significantly to the administrative cost of implementing the proposed changes. **OHA recommends CMS make any new DRG classification system widely available to the public**.

OHA appreciates the opportunity to comment. You may feel free to contact me at any time if you have any questions or concerns at 614.221.7614 or electronically at charlesc@ohanet.org.

Sincerely,

Charles Cataline
Senior Director, Health Policy
cc/

Submitter : Dr. Susan Bidigare **Date:** 06/12/2006

Organization : Dr. Susan Bidigare

Category : Individual

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS or the Agency) proposed rule entitled Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates. 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in patient care activities. The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

Background
The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a nonhospital setting, such as a physician s office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not related to patient care .

This position reverses the Agency s position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty. [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency s 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs.

Residency Program Activities and Patient Care
I firmly believe that with the possible exception of extended time for bench research, there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician s educational development into an autonomous practitioner.

To separate out CMS s newly defined patient care time from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,

Submitter : **Dr. James Kroeze** **Date: 06/12/2006**

Organization : **Southwestern Medical Clinic**

Category : **Physician**

Issue Areas/Comments

GME Payments

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Sincerely,

Dr. Kroeze

Submitter : Dr. Lee Radosh **Date:** 06/12/2006

Organization : The Reading Hospital and Medical Center

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

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I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,

Lee Radosh, MD

Submitter : **Date: 06/12/2006**

Organization :

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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Background
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Residency Program Activities and Patient Care
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To separate out CMS s newly defined patient care time from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Submitter : Dr. Kevin Piggott **Date:** 06/12/2006

Organization : MGH Family Medicine Residency

Category : Individual

Issue Areas/Comments

GME Payments

GME Payments

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I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,

Kevin L. Piggott, MD FAAFP
Assistant Director, MGH Family Medicine Residency

Submitter : **Dr. Donald Quest** **Date: 06/12/2006**

Organization : **American Association of Neurological Surgeons**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

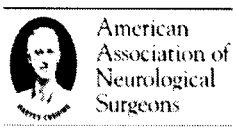
Please see attached comments from the American Association of Neurological Surgeons and the Congress of Neurological Surgeons

CMS-1488-P-1267-Attach-1.PDF

#1267

AMERICAN ASSOCIATION OF
NEUROLOGICAL SURGEONS
THOMAS A. MARSHALL, *Executive Director*
5550 Meadowbrook Drive
Rolling Meadows, IL 60008
Phone: 888-566-AANS
Fax: 847-378-0600
info@aans.org

President
DONALD O. QUEST, MD
Columbia University
New York, New York



CONGRESS OF
NEUROLOGICAL SURGEONS
LAURIE BEHNCKE, *Executive Director*
10 North Martingale Road, Suite 190
Schaumburg, IL 60173
Phone: 877-517-1CNS
FAX: 847-240-0804
info@1CNS.org

President
RICHARD G. ELLENBOGEN, MD
University of Washington
Seattle, Washington

June 12, 2006

Mark B. McClellan, MD, PhD
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1488-P
P.O. Box 8011
Baltimore, Maryland 21244-1850

RE: Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates; CMS-1488-P

Dear Dr. McClellan:

The American Association of Neurological Surgeons (AANS) and the Congress of Neurological Surgeons (CNS), representing over 4,000 neurosurgeons in the United States, appreciate the opportunity to comment on the above referenced Notice of Proposed Rulemaking (NPRM) published in the *Federal Register* on April 25, 2006.

The subjects on which we are commenting include:

- **Changes to the DRG Methodology**. The AANS and the CNS recommend that CMS delay the implementation of the new DGR payment methodology for at least one-year to give the agency additional time to correct some serious methodological flaws and allow hospitals, physicians and other providers affected by the changes a better opportunity to work with CMS to implement an improved hospital payment system.

- **DRG Severity Adjustments.** The AANS and CNS support delaying the implementation of severity adjusted DRGs until at least FY 2008. Additionally, if CMS moves to a severity adjusted payment system, we support implementing the cost-based payment system and the severity adjusted DRGs at the same time.

- **Neurosurgical Procedures**. The AANS and CNS are concerned about reductions in hospital payments for several neurosurgical procedures, including acute ischemic stroke, spine fusion, deep brain stimulation and carotid stents and urge CMS to carefully review these procedures to ensure adequate hospital reimbursement so Medicare patients continue to have access to these vital services.

WASHINGTON OFFICE
KATIE O. ORRICO, *Director*
725 Fifteenth Street, NW, Suite 800 Washington, DC 20005
Phone: 202-628-2072 Fax: 202-628-5264 E-mail: korrico@neurosurgery.org

- **EMTALA.** The AANS and CNS support the recommendations of the EMTALA Technical Advisory Group (TAG) regarding emergency care provided by specialty hospitals, and we commend CMS for including these in the proposed regulation.

- **Graduate Medical Education.** The AANS and CNS support the recommendation of the American Association of Medical Colleges (AAMC) asking CMS to maintain its 1999 definition of patient care for purposes of the GME payment calculations.

CHANGES TO THE DRG METHODOLOGY

The AANS and CNS certainly support the basic goal of accurate payment for hospital care. However, given the breadth and complexity of the proposed changes to the hospital payment system, we urge CMS to delay implementation of the new methodology for at least one-year. Although we realize that the agency is under enormous pressure to move to a system whereby the Diagnosis Related Groups (DRGs) are based on hospital specific costs, rather than hospital charges, we are concerned about the ramifications that such sweeping changes may have on patient care. The proposal is the most significant revision of the DRG system since the inception of the Inpatient Prospective Payment System (IPPS) in 1983 and therefore requires CMS and healthcare providers enough time to more thoroughly examine the proposal. The 60-day comment period, followed by only a few months for CMS to consider all the comments and recommendations before implementing this new payment system on October 1, 2006, is simply not an adequate timeframe to conduct this review.

We understand that several health policy experts have identified significant flaws in the methodology used by CMS to determine the cost based DRG system. First, in "trimming" the data for the calculation of the cost-based DRG weights, CMS has excluded 260 large hospitals with high costs from the cost center calculations. By omitting this data, the results of the proposed changes are significantly different than if these hospitals were included. Secondly, the use of hospital weighting rather than discharge weighting of the cost to charge ratios has led to a bias against larger facilities that provide more intense and expensive care. We urge CMS to correct these fundamental methodological flaws before the new payment system is implemented.

DRG SEVERITY ADJUSTMENTS

CMS has proposed delaying implementation of severity adjustments until FY 2008, "if not sooner", noting that it will replace the current 526 DRGs with either 861 consolidated severity-adjusted DRGs or an alternative severity adjusted DRG system. The agency notes that it is delaying implementation of the severity-adjusted DRGs because it is concerned about the impact such changes would have if implemented concurrently with the changes resulting from the move to a cost-based system.

If CMS moves forward with a severity-adjusted DRG payment system, the AANS and CNS concur that it should not be implemented for at least another year. Based on initial considerations of the impact of the new system neurosurgical patients, we urge CMS to delay implementation of severity adjusted DRGs until a thorough analysis of the impact has been conducted and presented to the public in a clear and understandable manner in order for meaningful comments to be developed.

WASHINGTON OFFICE
KATIE O. ORRICO, *Director*
725 Fifteenth Street, NW, Suite 800 Washington, DC 20005
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We also agree with MedPAC's recommendation that CMS implement the severity changes concurrently with the new hospital specific cost-based weights. Implementing these two major changes to the hospital payment system separately will only cause greater confusion and angst among hospitals and other healthcare providers.

NEUROSURGICAL PROCEDURES.

The AANS and CNS are concerned about reductions in hospital payments for several neurosurgical procedures, including acute ischemic stroke, spine fusion, deep brain stimulation and carotid stents and urge CMS to carefully review these procedures to ensure adequate hospital reimbursement so Medicare patients continue to have access to these vital services.

1. Acute Ischemic Stroke. The AANS and CNS agree with the concept that DRGs should reflect patient severity of illness. However, we are concerned about the unintended impact the severity adjustments may have on DRGs that were recently established. In the Medicare Hospital IPPS Final Rule published on August 12, 2005, CMS created the new DRG 559 *Acute ischemic stroke with the use of thrombolytic agent*, to reflect the higher inpatient costs associated with the administration of the reperfusion drug, tissue plasminogen activator (tPA). This change was a result of several years of discussions with CMS and organizations supporting stroke patients and the professionals who care for them.

   However, based on initial calculations by the American Stroke Association using the 3-M algorithm website provided by CMS in the NPRM, we understand that the proposed severity adjustment system would eliminate DRG 559 and place stroke cases in one of the three ischemic stroke DRGs in the consolidated APR-DRG system (DRGs 56-58). The DRGs described are all weighted less than the current weight for DGR 559, and therefore, do not adequately compensate hospitals for the higher costs associated with stroke patients who receive a reperfusion agent. In addition, the majority of cases using tPA would be assigned to the lowest of the three proposed new DRGs for ischemic stroke, further compounding the difference between the current DRG 559 and the proposed new system. While we appreciate CMS making available the 3-M algorithm, we believe that more scrutiny of the consequences of the changes is warranted and we support modification of the APR-DRGs that would include a DRG to specifically describe the use of tPA in the treatment of stroke.

2. Spine Fusion. We are particularly concerned about initial analyses showing that under the new cost-based system there is a significant decrease in the payment for DRGs for Spinal Fusion. Some estimates show that the proposed repricing methodology results in reductions of as much as 8.07% for DRG 497 *Spinal Fusion with Complication or Comorbidity (CC)* and up to 9.8% reductions in DRG 498 *Spinal Fusion without (CC)*. All together, the impact on surgical DRGs could be a reduction of almost 7%. In addition, DRG 546 *Spinal Fusion except Cervical with Curvature of the Spine or Malignancy* may not sufficiently address clinical severity and resource difference among spinal fusion cases that involve fusing multiple levels of the spine.

3. Implantation of Intracranial Neurostimulator System for Deep Brain Stimulation (DBS). The AANS and CNS understand that Medtronic has expressed concerns that if CMS assigns its Kinetra implantable dual array neurostimulator pulse generator to DRG 1 *Craniotomy Age > 17 with CC* or DRG 2 *Craniotomy Age > 17 without CC* that the device will be inadequately reimbursed. Medtronic has recommended that the device be assigned to DRG 543

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Craniotomy with Implant of Chemo Agent or Acute Complex CNS Principal Diagnosis. In the proposed rule, CMS concludes that the issue will be better addresses when CMS has finalized its consolidated severity-adjusted DRGs. The AANS and CNS urge you to carefully review this matter to ensure adequate reimbursement under the new payment system.

4. Carotid Artery Stents. CMS states that it has been contacted by manufacturer representatives who have suggested that all carotid artery stenting cases be assigned to DRG 533 *Extracranial Procedures with CC* rather than the lower paying DRG 534 *Extracranial Procedures without CC.* CMS concluded that carotid artery cases would be better addressed in the consolidated severity-adjusted DRG system than through a change in the current DRG assignment. This is a perfect example of why CMS should develop a single system -- cost-based, severity adjusted DRGs -- all at once (and no earlier than 2008) to ensure that hospital reimbursement is accurate. The AANS and CNS urge you to carefully review this matter to ensure adequate reimbursement under the new payment system.

EMTALA

Based on advice from the Emergency Medical Treatment and Labor Act (EMTALA) Technical Advisory Group (TAG), CMS does not currently intend to require that all hospitals have an emergency department as a condition of Medicare participation. In addition, CMS is not proposing regulatory changes regarding on-call requirements. However, the agency is proposing to require that all Medicare-participating hospitals (including specialty hospitals) with specialized capabilities must accept appropriate transfers of unstable individuals, regardless of whether the hospital with specialized capabilities has an emergency department. CMS has stated that it expects that this clarification of current policy may result in an increase in the number of specialty hospitals accepting transfers of emergency patients on nights and weekends.

The AANS and CNS support the recommendations of the EMTALA Technical Advisory Group (TAG). There is nothing in EMTALA that requires hospitals to have an emergency department, so CMS is correct not to place such a requirement on Medicare-participating hospitals. Furthermore, it is entirely appropriate for specialty hospitals that have the capability and capacity to accept patients in transfer if they have specialized capabilities that the transferring hospitals lack. We commend CMS for including adopting the EMTALA TAG recommendations, which have gone through a very thorough review process.

GRADUATE MEDICAL EDUCATION

The AANS and CNS share the concern of the Association of American Medical Colleges (AAMC) and others regarding the CMS proposal to exclude medical resident time spent in didactic activities in the calculation of Medicare direct GME (DGME) and indirect medical education (IME) payments. This "clarification" contradicts a policy stated in a September 1999 letter from Tzvi Hefter, Director, Division of Acute Care, which stated that patient care activities should be interpreted broadly and include "scholarly activities, such as educational seminars, classroom lectures. . . and presentation of papers and research results to fellow residents, medical students, and faculty." These activities cited are an integral part of the patient care activities of residents and we urge CMS to withdraw its "clarification" and reaffirm the position stated in 1999.

WASHINGTON OFFICE
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CONCLUSION

The AANS and CNS are concerned that the enormity of proposed changes in the NPRM requires more time and accurate data to fully assess the impact on hospital operations and patient care. The limited time to review and adjust to such monumental changes by October 2006 could have a far reaching negative impact on patients, hospitals, physicians, and their communities. We urge CMS to delay implementation of the DRG recalculations until the flaws in the proposal are corrected and all stakeholders have had ample opportunity to assess the expected results. In addition, we ask that CMS provide at least a 3-year transition period when it does implement this new payment system.

Thank you for the opportunity to comment on these important issues.

Sincerely,

Donald O. Quest, MD, President
American Association of Neurological Surgeons

Richard G. Ellenbogen, MD, President
Congress of Neurological Surgeons

Staff Contact
Catherine Jeakle Hill
Senior Manager of Regulatory Affairs
AANS/CNS Washington Office
725 15th Street, NW
Suite 800
Washington, DC 20005
Office: 202-628-2072
Fax: 202-628-5264
Email: chill@neurosurgery.org

Submitter : **Dr. Kenneth Stillman** **Date: 06/12/2006**

Organization : **Dr. Kenneth Stillman**

Category : **Individual**

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS or the Agency) proposed rule entitled Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates. 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in patient care activities. The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

Background
The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a nonhospital setting, such as a physician s office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not related to patient care .

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I firmly believe that with the possible exception of extended time for bench research, there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician s educational development into an autonomous practitioner.

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Sincerely,

Ken Stillman, MD

Submitter : Dr. Sean McCloy **Date:** 06/12/2006

Organization : Maine Integrative Wellness

Category : Individual

Issue Areas/Comments

GME Payments

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Sincerely,

Sean McCloy, MD MPH

Submitter : Dr. Kathleen Macken **Date:** 06/12/2006

Organization : United Family Medicine Residency Program

Category : Individual

Issue Areas/Comments

GME Payments

GME Payments

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Sincerely,
Dr. Kathleen Macken
Program Director
United Family Medicine Residency PRogram
545 W. 7th St.
ST. Paul, MN 55102
651-241-1002

Submitter : Dr. Cherolee Trembath **Date:** 06/12/2006

Organization : Providence Hospital

Category : Association

Issue Areas/Comments

GME Payments

GME Payments

I appreciate the oppportunity to comment on theCMS rule 71 Fed. Reg. 23996 (April 25, 2006.)Department of Family Medicine at Providence Hospital in Southfield, MI. I have participated in training residents for 25 years. Much is being said about physician shortage in general and Primary Care physicians specifically. By trimming the payments for time spent in didactic activities under this rule, we will severely handicap our educational system. In fact, it is often difficult to distinguish didactics from patient care as they happen together in a seamless fashion most frequently. Also all resident didactics contribute to increased quality of care as seen in the generally significant higher quality measurements seen at teaching institutions. I stongly urge CMS to rescind this clarification of the proposed rule, relating to the counting of didactic time for purposes of DGME and IME payments. We need to recognize the integral and vital nature of these activities to patient care experiences for residents as well as their importance to maintaining a long term supply of primary care physicians through complete and scholarly training.

Submitter : Dr. Tad Venn **Date:** 06/12/2006

Organization : Palmetto Health-USC Family Medicine

Category : Individual

Issue Areas/Comments

GME Payments

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I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,

Tad A. Venn, MD

Submitter : **Dr. Joseph Brock** **Date: 06/12/2006**

Organization : **Norton Family Practice**

Category : **Physician**

Issue Areas/Comments

GME Payments

GME Payments

Please fund GME activities at current levels. Proposed cutbacks will have a devastating impact on the operational funding in Family Medicine Training Centers.

Sincerely,
Joseph Brock MD

Submitter : William Morgan **Date:** 06/12/2006

Organization : William Morgan

Category : Individual

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS or the Agency) proposed rule entitled Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates. 71 Fed. Reg. 23996 (April 25, 2006).

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Background
The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a non-hospital setting, such as a physician s office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not related to patient care .

This position reverses the Agency s position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty. [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency s 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs.

Residency Program Activities and Patient Care
I firmly believe that with the possible exception of extended time for bench research, there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician s educational development into an autonomous practitioner.

To separate out CMS s newly defined patient care time from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Submitter : **Dr. Ted Haland** **Date: 06/12/2006**

Organization : **United Family Medicine Residency Program**

Category : **Physician**

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS or the Agency) proposed rule entitled Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates. 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in patient care activities. The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

Background
The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a nonhospital setting, such as a physicians office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not related to patient care.

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I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,
Ted Haland, M.D.
Family Medicine Resident - PGY3
United Family Medicine Residency Program
545 W. 7th St.
St. Paul, MN 55102
651-241-1001

Submitter : **Mrs. Shirley Bishop** **Date: 06/12/2006**

Organization : **Clarian Health Partners, Inc.**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

Various comments - See attachment

CMS-1488-P-1276-Attach-1.DOC

#1276

June 8, 2006

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-1488-P
P. O. Box 8011
Baltimore, MD 21244-1850

Re: CMS-1488-P and P2, Medicare Program; Proposed Changes to the Hospital Inpatient Perspective Payment systems and Fiscal Year 2007 Rates; Proposed Rule

Dear Dr. McClellan:

On behalf of Clarian Health Partners, Inc., I appreciate the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) on the fiscal year (FY) 2007 inpatient prospective payment system (IPPS).

Clarian Health Partners, Inc. supports meaningful changes to the IPPS, however, we have concerns regarding proposed changes related to:

- DRG Changes
- Methodology utilized in developing HSRVcc
- Severity of Illness classifications
- Proposed changes in "allowable" rotations of Medical Residents
- Future Changes related to Quality Measure & Reporting

We appreciate the opportunity to comment on the proposed changes and your consideration of those comments.

Attached, please find detailed comments.

Sincerely,

Shirley W. Bishop
Director, Revenue, Reimbursement & Government Programs

enclosures

Clarian Health Partners, Inc.
Comments on the FY 2004 IPPS Proposed Rule

Proposed Changes

HSRV Weights

We support the move to a cost based weighting system. However, the approach utilized by CMS aggregates the costing into 10 "national" cost centers (routine day, intensive care days, and eight ancillary cost centers); this is an over simplification of a hospital's operations and we believe could lead to increased variation as cost of services available only at high acuity facilities, such as tertiary and/or teaching facilities are "normalized" into 8 ancillary categories and thus factor into payment to providers that do not offer such services while harming those that do by diluting a "cost center" by defining too broadly. Review of cost center and related cost report line subscripting as they relate will reflect the variation of services and related cost.

More time is needed to determine a "best methodology" for cost-based weights. Clarian Health Partners is willing to work with CMS, as we believe most providers would be, to develop sound changes relative to such a conversion.

New Patient Classification: Severity of Illness

We support the move to a more refined DRG system which recognizes severity of the individual patient. However, we are concerned that implementing proposed changes to specialty DRG's, as proposed for FY 2007, without implementation of severity will further harm those general acute care facilities from which the "specialty" facilities diverted the less severe patients in those DRG's.

Additionally, we are concerned that another grouping system has been developed. We would suggest simply utilizing the APR DRG system that is already developed, and addresses severity issues and does not add more expense and administrative burden for many facilities.

Resident Time in Patient Activities

We strongly urge the Agency to rescind the purported "clarification" in the proposed rule that excludes medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments. The stated rationale for the exclusion of time devoted to these activities is that they are not "related to patient care". The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a non-hospital setting, such as a physician's office or affiliated medical school.

The proposed rule position is in stark contrast to the Agency's position as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include "scholarly activities, such as educational seminars, classroom lectures...and presentation of papers and research results to fellow residents, medical students, and faculty." [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins].

We support the Agency's 1999 position. The activities cited are an integral component of the patient care activities engaged in by residents during their residency programs. We urge CMS to withdraw its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Other Future Concepts (Transparency of Health Care Information, Hospital Value-based Purchasing, Information Technology, Hospital-acquired Infections

We support the movement to such transparency and reporting, however we believe the comment period was too short to adequately evaluate and comment on such broad sweeping ideas and urge continued dialogue with providers and industry experts to develop these important measures.

Submitter : Martyn Hotvedt

Date: 06/12/2006

Organization : St. John Health

Category : Hospital

Issue Areas/Comments

GME Payments

GME Payments

CMS-1448-P

Submitter : **Date: 06/12/2006**

Organization :

Category : Individual

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS or the Agency) proposed rule entitled Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates. 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in patient care activities. The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

Background
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This position reverses the Agency s position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty. [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency s 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs.

Residency Program Activities and Patient Care
I firmly believe that with the possible exception of extended time for bench research, there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician s educational development into an autonomous practitioner.

To separate out CMS s newly defined patient care time from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,

Kathleen Macken, M.D.
Program Director
United Family Medicine Residency Program
545 7th Street West
St. Paul, MN 55102
Phone: 651-241-1002
Fax: 651-241-1116

Submitter : Dr. Eric Henley **Date:** 06/12/2006

Organization : U of Illinois College of Medicine at Rockford

Category : Academic

Issue Areas/Comments

GME Payments

GME Payments

To reiterate, I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,

Eric Henley MD, MPH

Submitter : Mr. Joseph Cramer **Date:** 06/12/2006

Organization : Appalachian Regional Healthcare

Category : Hospital

Issue Areas/Comments

Rural Referral Centers

Rural Referral Centers

Refer to the section regarding discharge criteria for initial RRC status. This section states:

'Therefore, we are proposing that, in addition to meeting other criteria, a hospital, if it is to qualify for initial rural referral center status for cost reporting periods beginning on or after October 1, 2006, must have as the number of discharges for its cost reporting period that began during FY2003 a figure that is at least - 5,000 (3000 for an osteopathic hospital); or .....

The problem with this section is that CMS does NOT administer initial RRC applications based on this language. If you refer to the regulation on this issue (42 CFR 412.96(c)(2)(i), the language 'most recently completed cost reporting period' defines the cost reporting period to be used to determine if the discharge criteria is met. If you refer to the CMS RRC Fact Sheet on the CMS web-site and other CMS publications, the discharge count is defined as coming from the 'latest available cost report data'.

While it may be reasonable to interpret 'most recently completed', 'latest available', and a specific year referenced in these Final Rules as being consistent wording, CMS staff does NOT adjudicate initial RRC applications this way. Meaning that the specific year referenced in the Final Rule is not used by CMS staff to count discharges for initial RRC applications. Instead, CMS staff interpret the Final Rule language as being in conflict with CFR 412.96 and do not use the specific year referenced in the Final Rule. For example, for a hospital with a June 30 year-end, the 2007 Final Rule specifies that the hospital should use the discharge count from the FYE 6/30/04 cost report. Based on our experience, if a hospital submits an application in June 2007, CMS will not use FYE 6/30/04 but will instead indicate that the FYE 6/30/06 is the 'most recent' and will use that year instead.

This is of little consequence if the hospital always has over 5000 discharges. However, our hospital met the discharge criteria specified in the Final Rule but did not meet the discharge criteria in the subsequent year specified by CMS staff. So the application was denied. For the 2007 Final Rule, we believe that the language needs to be changed to indicate that the 'most recently completed cost reporting period' is indeed the cost reporting period that began during FY2003. Meaning that the language in the Final Rule must use the SAME 'most recently completed' language as that contained in CFR 412.96. Otherwise, hospitals will continue to get caught up in what appear to be wrongfully denied applications with no way to get relief other than a lengthy and expensive PRRB process.

CMS-1488-P-1280-Attach-1.PDF

#1280

Medicare
Part A Intermediary/Part B Carrier
Beneficiary - 1-800-MEDICARE
Part A Provider - 1-866-419-9457
Part B Provider - 1-866-250-5665

August 12, 2005

Robert Hankinson
Director of Reimbursement
Appalachian Regional Healthcare
2285 Executive Drive Suite 400 PO Box 8086
Lexington KY 40505

RE: Harlan ARH Hospital
Rural Referral Center Request

Dear Mr. Hankinson:

On June 30, 2005 you submitted an application for Rural Referral Center status. In the application you pointed out a difference in Regulation 412.96(c)(2) and the August 11, 2004 Federal Register regarding the year to be used to determine if the hospital meets the 5,000 discharge requirement. Based on the Regulation the most recently completed cost report should be used while the Federal Register indicates the 6/30/2002 cost report should be used. We have been informed by CMS that the Regulations have precedence over the Federal Register. Since there were 4,335 discharges on the 6/30/2004 cost report, Harlan ARH does not meet the 5,000 discharge requirement, therefore the request is denied.

If you have any questions, please call Gary McDowell at (502) 423-2630.

Sincerely,

Raymond Bale

Raymond Bale, Director
Medicare Audit and Reimbursement

Submitter : Dr. Rocio Quintero **Date:** 06/12/2006

Organization : University of Miami, Dept of Family Medicine

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

As a family medicine residency attending, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS or the Agency) proposed rule entitled Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates. 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in patient care activities. The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.
Background

The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a nonhospital setting, such as a physician s office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not related to patient care .

This position reverses the Agency s position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty. [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency s 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs.

Residency Program Activities and Patient Care

I firmly believe that with the possible exception of extended time for bench research, there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician s educational development into an autonomous practitioner.

In addition, as director of this program, I cannot conceive of how I would be able to administratively comply with this requirement. It would require documentation that would be extremely burdensome, if possible at all. To separate out CMS s newly defined patient care time from didactic sessions in which general issues

devolve to discussions of particular patients seems an exercise in futility. Where am I to find the funding to pay for the staff person that would be needed to sit in on each of these didactic sessions and keep count of patient care time? The documentation requirements that this position would necessitate are unreasonable and would cause an extremely large administrative burden.

To reiterate, I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,

Rocio Quintero MD
Family Medicine - Attending
University of Miami
Dept. of Family Medicine
PO BOX 016700 R700
Miami, Florida 33101

Submitter : Dr. Aaron Shives **Date:** 06/12/2006

Organization : South Dakota Academy of Family Physicians

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS or the Agency) proposed rule entitled Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates. 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in patient care activities. The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

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To separate out CMS s newly defined patient care time from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,

Submitter : **Dr. Diana Curran** **Date: 06/12/2006**

Organization : **Hendersonville Family Practice Residency**

Category : **Physician**

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS or the Agency) proposed rule entitled "Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates." 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in "patient care activities." The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

Background The proposed rule cites journal clubs, classroom lectures and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a non-hospital setting, such as a physician's office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not "related to patient care."

This position reverses the Agency's position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include "scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students and faculty." [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency's 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs.

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To separate out CMS's newly defined "patient care time" from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,
Diana Curran, MD

Submitter : Dr. Robert Nold **Date:** 06/12/2006

Organization : Kentucky Academy of Family Physicians

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS or the Agency) proposed rule entitled Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates. 71 Fed. Reg. 23996 (April 25, 2006).

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I urge CMS to rescind its clarification in the proposed rule relating to the couting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Submitter : Dr. Timothy Rumsey **Date:** 06/12/2006

Organization : United Family Medicine Residency Program

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS or the Agency) proposed rule entitled Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates. 71 Fed. Reg. 23996 (April 25, 2006).

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I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,
Timothy Rumsey, M.D.
Teaching/Supervising Faculty
United Family Medicine Residency Program
545 W. 7th St.
St. Paul, MN 55102
651-241-1001

Submitter : Dr. Jim L. Wilson **Date:** 06/12/2006

Organization : Dr. Jim L. Wilson

Category : Individual

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS or the Agency) proposed rule entitled Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates. 71 Fed. Reg. 23996 (April 25, 2006).

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Background
The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a nonhospital setting, such as a physician s office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not related to patient care .

This position reverses the Agency s position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty. [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency s 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs.

Residency Program Activities and Patient Care
I firmly believe that with the possible exception of extended time for bench research, there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician s educational development into an autonomous practitioner.

To separate out CMS s newly defined patient care time from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,

Jim L. Wilson

Submitter : **Dr. Jimmie Browning** **Date: 06/12/2006**

Organization : **United Family Medicine Residency Program**

Category : **Physician**

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS or the Agency) proposed rule entitled Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates. 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in patient care activities. The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

Background
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I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,
Jimmie Browning, M.D.
Family Medicine
Faculty Physician
United Family Medicine Residency Program
545 W. 7th St.
St. Paul, MN 55102
651-241-1001

Submitter : **Dr. Joseph Tribuna** **Date: 06/12/2006**

Organization : **Overlook Family Practice Residency Program**

Category : **Physician**

Issue Areas/Comments

GME Payments

GME Payments

To whom it may concern,
As a family physician, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS or the Agency) proposed rule entitled Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates. 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in Outpatient care activities. The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

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I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,

Joseph Tribuna MD

Submitter : **Mr. Ian Jamieson** **Date: 06/12/2006**

Organization : **Shands Transplant Cntr at University of Floridia**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

Am concerned about the negative financial impact to transplant centers for lung transplantation, specifically bilateral transplantation-which is becoming more common (approx. 60% of all cases). The new DRG payment system is projected to decrease reimbursement for lung transplantation by 14.4% and this may ultimately limit patient access to lung transplant programs.

Submitter : **Date: 06/12/2006**

Organization :

Category : **Individual**

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS or the Agency) proposed rule entitled "Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates." 71 Fed. Reg. 23996 (April 25, 2006).

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Submitter : Mr. David Buckley **Date:** 06/12/2006

Organization : St. John Health

Category : Health Care Professional or Association

Issue Areas/Comments

Update Factors

Update Factors

"See attached Comment letter"

#1291

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter : Dr. Wendy Beyer **Date:** 06/12/2006

Organization : Memorial Hospital of Rhode Island

Category : Individual

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS or the Agency) proposed rule entitled "Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates." 71 Fed. Reg. 23996 (April 25, 2006).

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responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,
Wendy Beyer

Submitter : Dr. Samuel Adkins **Date:** 06/12/2006

Organization : Austin Medical Education Program

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS or the Agency) proposed rule entitled "Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates." 71 Fed. Reg. 23996 (April 25, 2006).

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This position reverses the Agency's position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include "scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty." [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency's 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs.

Residency Program Activities and Patient Care
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I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs

Submitter : **Mr. Jerry Adair** **Date: 06/12/2006**

Organization : **Good Shepherd Health System**

Category : **Hospital**

Issue Areas/Comments

DRG Weights

DRG Weights

June 8, 2006

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1488-P
Mailstop: C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-1488-P; Proposed Changes to the Hospital Inpatient Prospective Payment System

On behalf of Good Shepherd Medical Center, a non-profit, 412-bed comprehensive hospital in Longview, Texas, I appreciate the opportunity to submit comments to the Centers for Medicare and Medicaid Services on the proposed changes to the hospital inpatient prospective payment system.

Good Shepherd supports CMS s intent to improve the accuracy of the hospital payment system. I understand that the proposed revision will lead to better incentives for hospital quality and efficiency, and will ensure that payment rates relate more closely to patient resource needs. I encourage early adoption of the new payment classification system as well as the new DRG-weighting methodology, as this will reduce the incentive that specialty hospitals have by treating only the most profitable patients.

Forty-eight percent of the Good Shepherd s patients are Medicare beneficiaries, for which Medicare reimbursement does not cover the costs of treating those patients. Further revision to the Medicare payment system must be favorable to general/medical facilities such as Good Shepherd. The alternative would be to further erode the hospital s small operating margin and sacrifice the efforts made to provide nationally-ranked quality to the residents of east Texas. I encourage the leadership of CMS to act expeditiously to implement the proposed changes to the prospective payment system to correct the current inequities.

I appreciate the opportunity to submit these comments. If you have any questions about my remarks, please contact me at jadair@gsmc.org.

Respectfully,

Jerry D. Adair
President and CEO
Good Shepherd Health System
Longview, Texas

Submitter : Dr. Jennifer Mullendore **Date:** 06/12/2006

Organization : Moses Cone Family Medicine Residency Program

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

As a family physician who is finishing her residency this month, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS or the Agency) proposed rule entitled "Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates." 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in "patient care activities." The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

Background: The proposed rule cites journal clubs, classroom lectures and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a non-hospital setting, such as a physician's office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not "related to patient care."

This position reverses the Agency's position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include "scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students and faculty." [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency_s 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs.

Residency Program Activities and Patient Care: I firmly believe that with the possible exception of extended time for "bench research," there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician's educational development into an autonomous practitioner.

To separate out CMS's newly defined "patient care time" from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,

Jennifer Mullendore MD

Submitter : Mr. David Buckley **Date:** 06/12/2006

Organization : St. John Health

Category : Health Care Professional or Association

Issue Areas/Comments

DRG Weights

DRG Weights

See attached comment letter

#1296

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

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Please direct your questions or comments to 1 800 743-3951.

Submitter : Dr. Marianne McKennett **Date:** 06/12/2006

Organization : Scripps Mercy Family Medicine Residency Program

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

6-11-06

To: CMS Director,

As a Program Director of a residency program in family medicine, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS or the Agency) proposed rule entitled Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates. 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in patient care activities. The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

Background
The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a nonhospital setting, such as a physician s office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not related to patient care .

This position reverses the Agency s position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty. [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency s 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs.

Residency Program Activities and Patient Care
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In addition, I cannot conceive of how I would be able to administratively comply with this requirement. It would require documentation that would be extremely burdensome, if possible at all. To separate out CMS s newly defined patient care time from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Where am I to find the funding to pay for the staff person that would be needed to sit in on each of these didactic sessions and keep count of patient care time? The documentation requirements that this position would necessitate are unreasonable and would cause an extremely large administrative burden.

To reiterate, I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,

Marianne McKennett, M.D.
Program Director
Scripps Family Medicine Residency
Clinical Professor
UC San Diego Department of Family and Preventive Medicine

Submitter : Dr. Anne Ambarian **Date:** 06/12/2006

Organization : The Reading Hospital and Medical Center

Category : Individual

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS or the Agency) proposed rule entitled Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates. 71 Fed. Reg. 23996 (April 25, 2006).

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I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,

Anne Ambarian, MD

Submitter :

Date: 06/12/2006

Organization :

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

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BACKGROUND
The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a nonhospital setting, such as a physician s office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not related to patient care.

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RESIDENCY PROGRAM ACTIVITIES AND PATIENT CARE
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I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,
Gail Amison, MD

Submitter : Mr. Christopher Bailey **Date:** 06/12/2006

Organization : Virginia Hospital

Category : Hospital

Issue Areas/Comments

DRG Weights

DRG Weights

See Attachment

CMS-1488-P-1300-Attach-1.DOC

#1300

4200 INNSLAKE DRIVE, SUITE 203, GLEN ALLEN, VIRGINIA 23060-3307
P.O. BOX 31394, RICHMOND, VIRGINIA 23294-1394
(804) 965-1227 FAX (804) 965-0475

June 12, 2006

The Honorable Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1488-P and P2
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

RE: CMS-1488-P and P2, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates; Proposed Rule.
Dear Administrator McClellan:

The Virginia Hospital & Healthcare Association (VHHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) fiscal year (FY) 2007 inpatient prospective payment system (IPPS) and occupational mix adjustment proposed rules. The VHHA includes 61 member health systems and hospitals, representing 99 community, psychiatric and specialty hospitals throughout the Commonwealth of Virginia.

The VHHA strongly supports CMS' goal of meaningful improvements in the hospital inpatient payment system. Indeed, we believe that CMS and hospitals share the same basic objectives and principles when it comes to the IPPS – rates that are stable, accurate (i.e., correspond to patient acuity and underlying delivery costs) and equitable (i.e., provide sufficient incentive to treat all types of patients and conditions). We recognize and commend the significant effort that you and your staff have committed to these ends in the drafting of this Notice of Proposed Rulemaking (NPRM).

As you know, this NPRM proposes the most substantial changes in the DRG system since its implementation. The proposed rule describes an approach to cost-based weights for implementation this year, and also proposes refining the DRG grouper or classification system to better account for patient severity with implementation likely in FY 2008. Additionally, the NPRM would institute a variety of other policy changes, including updating the payment rates, outlier threshold, hospital wage index, and quality reporting requirements.

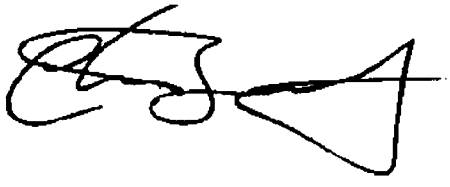
The VHHA has worked with other state hospital associations and the American Hospital Association (AHA) in our review of this NPRM. We share many of the field's concerns. The VHHA fully recognizes that the revised DRG weights and calculations in the NPRM would provide important assistance to many hospitals that sorely need it. However, the proposed changes also would result in negative effects for other hospitals. If these distributional effects were the natural result of a system that fully conformed to the above principles, we would have no objection. However, while we support the general thrust toward cost-based weights, analysis has demonstrated that minor changes in method and underlying data in the weighting calculations have dramatic effect on resulting payments – in violation of the stability principle. Further, we have serious concerns and questions about the proposed DRG classification system changes – including the limitation on coding inputs and apparent shift away from a methodology in the public domain. The former flaw severely limits the accuracy of the classification system, and the latter constrains the ability of hospitals to analyze and replicate it. Exerting all due diligence in ensuring that such substantial changes in public policy appropriately balance the needs and concerns of all who care for Medicare beneficiaries must be paramount in this process.

The VHHA supports the AHA's position that CMS take additional time to fully consider the technical and policy complexities associated with the NPRM's proposed changes. **We remain mindful of the potential for improvement that the proposed changes hold, but believe a one-year delay in implementation is appropriate. We also urge CMS to implement any finalized changes through a three-year phase-in period.** This would give all hospitals time to adapt to the changes and limit the risk for disruption to patient care that could result from the proposed policy changes.

Finally, we note that altering the calculation of DRG weights could produce one set of changes for hospitals to absorb, while adopting the proposed changes to the patient classification system would produce another. These two sets of changes may help to counterbalance one another, and at the very least will present challenges at their time of implementation. **If both sets are to be implemented, please do so simultaneously, transitioning in both sets of changes together over three years.** This will help to preserve predictable, stable payment levels and limit disruption to patient care.

Thank you again for your consideration of these comments. We would be pleased to answer any questions or help in any way we can.

Sincerely,



Christopher S. Bailey, Senior Vice President

Submitter : Dr. William Moran **Date:** 06/12/2006

Organization : Dr. William Moran

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Please do not exclude didactic teaching hours from GME payment calculations. It is not possible to train resident physicians about proper patient care without time devoted to didactic presentations. Precepting residents is extremely important but the foundations and philosophy of what we do is best taught through lecture and literature review.

Submitter : Dr. Gregory O'Donnell **Date:** 06/12/2006

Organization : Research Family Medicine Residency

Category : Individual

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS or the Agency) proposed rule entitled Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates. 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in patient care activities. The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

Background
The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a nonhospital setting, such as a physician s office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not related to patient care .

This position reverses the Agency s position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty. [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency s 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs.

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I firmly believe that with the possible exception of extended time for bench research, there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician s educational development into an autonomous practitioner.

To separate out CMS s newly defined patient care time from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,
Gregory P. O'Donnell, M.D.

Submitter : Dr. Michael Schooff **Date:** 06/12/2006

Organization : Dr. Michael Schooff

Category : Physician

Issue Areas/Comments

GME Payments

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Submitter : **Dr. Richard L Muller** **Date: 06/12/2006**

Organization : **Dr. Richard L Muller**

Category : **Physician**

Issue Areas/Comments

GME Payments

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Sincerely,

Richard L. Muller

Submitter : Dr. Susan Kaye

Date: 06/12/2006

Organization : Dr. Susan Kaye

Category : Individual

Issue Areas/Comments

GME Payments

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Sincerely,

Susan T. Kaye, MD

Submitter : Dr. Sonja Hansen **Date:** 06/12/2006

Organization : Dr. Sonja Hansen

Category : Physician

Issue Areas/Comments

GME Payments

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Submitter : Mr. Scott Street **Date:** 06/12/2006

Organization : Duncan Regional Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1307-Attach-1.DOC

#1367

June 12, 2006

Duncan Regional Hospital
1407 Whisenant
Duncan, OK 73533

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1488-P and P2
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

RE: CMS-1488-P and P2, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates; Proposed Rule.

Dear Dr. McClellan:

On behalf of Duncan Regional Hospital, we appreciate the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) on the fiscal year (FY) 2007 inpatient prospective payment system (PPS) and occupational mix adjustment proposed rules.

The rule proposes the most significant changes in the calculation of diagnosis-related group (DRG) relative weights since 1983 by creating a version of cost-based weights using the newly developed hospital-specific relative values cost center methodology (HSRVcc). It also proposes refining the DRGs to account for patient severity, with implementation likely in FY 2008. In addition, the rule would update the payment rates, outlier threshold, hospital wage index, quality reporting requirements, and payments for rural hospitals and medical education, among other policies.

While Duncan Regional Hospital supports many of the proposed rule's provisions, we have serious concerns about the proposed changes to the DRG weights and classifications.

The hospital field supports meaningful improvements to Medicare's inpatient PPS. We believe the hospital industry and CMS share a common goal in refining the system to create an equal opportunity for return across DRGs, which will provide an equal incentive to treat all types of patients and conditions. However, more time is needed to understand the significant proposed policy changes, which redistribute from $1.4 to $1.7 billion within the inpatient system. Analysis shows

the impact of the proposed changes to be highly unstable, with small changes in method leading to large changes in hospital payment. And the validity of CMS' proposals versus potential alternatives to improve the DRG weights and classification system is uncertain. Moving forward requires thoughtful change.

Specifically, Duncan Regional Hospital supports the following:

- **One-year Delay:** Our hospital supports a one-year delay in the proposed DRG changes given the serious concerns with the HSRVcc and CS-DRG methodology. The American Hospital Association, the Oklahoma Hospital Association and the hospital field are committed to working with CMS over the next year to address these concerns.

- **Valid Cost-based Weights:** We support moving to a DRG-weighting methodology based on hospital costs rather than charges, but we believe CMS' proposed HSRVcc method is flawed. The method and source data requires further study in order to develop a rational and improved system.

- **A New Classification System Only if the Need Can Be Demonstrated:** We do not support a new classification system at this time, as the need for a new system is still unclear. Much more work understanding the variation within DRGs and the best classification system to address that variation is still needed before CS-DRGs or any other system should be selected or advanced.

- **Simultaneous Adoption of Any Changes to Weights and Classifications:** If the need for a new, more effective classification system is demonstrated and developed, it should be implemented simultaneously with the new weighting system to provide better predictability and smooth the volatility created by these two, generally off-setting changes.

- **Three-year Transition:** Any changes should be implemented with a three-year transition, given the magnitude of payment redistribution across DRGs and hospitals. We believe that a transition period is necessary because of the significant redistributional effect of such changes.

- **Collaborative Approach to Moving Forward**: The American Hospital Association, the Oklahoma Hospital Associations, the hospital industry and Duncan Regional Hospital commits to working with CMS to develop and evaluate alternatives for new weights and classifications.

We would refer you to the detailed comments provided to you by the AHA that further explain our concerns and recommendations on the proposed DRG weight and classification system changes, as well as our position on many other issues in the proposed rule.

Duncan Regional Hospital appreciates the opportunity to submit these comments. If you have any questions about our remarks, please feel free to contact me at (580) 251-8555.

June 12, 2006

Sincerely,

Scott Street
President & CEO
Duncan Regional Hospital

Submitter : Dr. Frederick Rosin **Date:** 06/12/2006

Organization : University Family Physicians

Category : Individual

Issue Areas/Comments

GME Payments

GME Payments

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Sincerely,

Frederick C. Rosin, M.D.

Submitter :

Date: 06/12/2006

Organization :

Category : Individual

Issue Areas/Comments

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Submitter : Mrs. Bernadette Spong **Date:** 06/12/2006

Organization : Rex Healthcare

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

CMS-1488-P-1310-Attach-1.DOC

#1310

Centers for Medicare & Medicaid Services, DHHS
Attention: CMS-1488-P
Mail Stop C4-26-05
7500 Security Blvd
Baltimore, MD 21244-1850

Dear Sir:

I am directing these comments to the provisions established in the April 25, 2006 Federal Register regarding the requirements for receipt of the full 2007 Medicare Annual Payment Update.

Rex Healthcare is a 433-bed acute care facility located in Raleigh, North Carolina and is a member of the University of North Carolina Healthcare System. We average over 90 inpatient admissions daily. Rex treats 150 patients each day in our emergency department. Community physicians perform over 35,000 surgeries each year at our facilities.

Rex is the proud recipient of a number of awards and accolades, including being ranked by Healthgrades in the top five percent of hospitals nationally for clinical excellence in 2005 and 2006. Healthgrades considers Rex one of the best North Carolina hospitals for overall cardiac services, vascular services, gastrointestinal services and critical care services. The Rex Heart and Vascular Center-home to the Triangle's first nationally accredited Chest Pain Center-provides comprehensive invasive and non-invasive services to the community. Rex's most recent accomplishment is this year's achievement of Magnet Hospital designation by the American Nurses Credentialing Center. Only 200 hospitals in the United States and only 9 hospitals in North Carolina have earned this distinction. This award is based on a grueling review of the quality care provided to our patients. All these recognitions and awards demonstrate that Rex is a hospital that seriously embraces the concept of quality care for its patients.

We constantly ensure that quality is a focal point of our mission. Rex is in the midst of implementing an electronic medical record program that will take the organization to the next level of quality care and patient safety beginning later this year. At a recent board meeting, the entire day was devoted to educating the 13 board members on quality initiatives at the hospital.

For all the focus on quality, Rex finds itself out of compliance with the proposed 2007 Medicare APU regulations as published in the April 25, 2006 Federal Register. We believe that these proposed regulations unduly burden hospitals, which like Rex, have great quality track records but failed to meet very stringent reporting requirements established by CMS.

A brief synopsis of Rex's story illustrates the issue that we and probably other facilities may face if the regulations are implemented as currently proposed.

In order to receive the full APU hospitals must:

(1) register at least one person as a QNET Exchange Administrator
(2) Complete a new Notice of Participation form and send to CCME by August 1, 2006
(3) Continue to collect and submit all 10 starter set measures to QNET Exchange
(4) Sign an additional form pledging to submit 21 measures to QNET Exchange
(5) Pass validation at an 80% reliability rate for the first 3 quarters of CY2005
(6) Send a form to CCME attesting to the completeness of the data submitted.

Rex agrees with and supports provisions 1 through 4 and 6. However, we strongly encourage CMS to revisit the language of provision 5. Rex works with Mediqual to provide data to QIO Clinical Warehouse in accordance with the data transmission deadlines published by CMS. Our records support that we have submitted all data to that repository on a timely basis.

Once the data is received by CMS through the QIO Clinical Warehouse, CMS then requests the hospitals submit complete medical records for 5 random patients. Hospitals have 30 days to submit this data. Rex provided this data for the following quarters:

Quarter	CDAC Reliability Score
10/04-12/04	88%
01/05-03/05	93%
07/05-09/05	93%

The 5 medical records for the quarter 04/05 through 06/05 were copied by the Medical Records department in December 2005, delivered to the Shipping and Receiving Department the week of Christmas 2005 and misplaced. It was not until mid January that the package was discovered in the Shipping area. The package was immediately sent to CDAC via overnight carrier but the 30-day deadline had passed and CDAC could not process the data.

Looking at Rex's trend in reliability scores and our review of the 5 cases, we conclude that CMS's processing of those 5 medical records would have resulted in reliability scores similar to the other three quarters. Now Rex finds itself in a situation where it does not meet one of the provisions in the proposed regulations for receipt of the full APU amount. This 2% penalty equates to almost $2 million in lower reimbursement to Rex for a clerical mistake. This represents more than 16% of Rex's operating income. A penalty of this magnitude will significantly impact the services Rex provides to the community. We do not believe CMS intended for this rule to negatively impact hospitals' ability to render services to both Medicare and other patients.

Rex believes this penalty is unduly burdensome in light of the circumstances. We clearly have focused on quality for the last several years. The data supplied to CMS confirms Rex's accomplishments and yet we find ourselves penalized by a proposed rule that is so tightly written there is no room for errors in manual processes.

Hospitals need to be held to high quality standards. Rex is a proponent of this. However, CMS needs to provide some latitude in the process to ensure that quality hospitals are not inappropriately punished.

We suggest that the provision be written to allow CMS and the hospital to have the flexibility to meet 2 of 3 or 3 of 4 quarters. This provides some assurance that if and when processes break down hospitals are not unilaterally punished while providing the quality care CMS is seeking with this initiative.

Sincerely,

Bernadette M. Spong

Bernadette Spong
CFO
Rex Healthcare

Submitter : Mr. Bruce McClymonds **Date:** 06/12/2006

Organization : West Virginia University Hospitals, Inc.

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1311-Attach-1.DOC

#1311

June 7, 2006

Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: *CMS-1488-P*
P.O. Box 8011
Baltimore, MD 21244-1850

Re: CMS-1488-P – Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates. *(71 Federal Register April 25, 2006).*

Dear Administrator McClellan:

We appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule regarding changes to the Hospital Inpatient Prospective Payment Systems, published on April 25, 2006 in the *Federal Register*. I am the President and CEO of West Virginia University Hospitals, Inc., a 522-bed university teaching hospital located in Morgantown, West Virginia. We have an approved Intern & Residency program with approximately 350 residents.

While we agree with some components of the proposed rule, we have significant concerns with some aspects, which potentially have a negative impact on the entire hospital community. Our letter focuses primarily on two areas that have a significant impact on teaching hospitals and the academic community: 1) proposed changes to the diagnosis-related group (DRG) weighting and classification system and 2) a "clarification" that would prohibit hospitals from counting much of the resident time spent in didactic activities when calculating indirect medical education (IME) and direct graduate medical education (DGME) payments.

While we agree with CMS's intention to address the flaws in the current DRG system, we strongly urge CMS to delay implementation of the change to HSRV weights and implement it concurrently with the Consolidated Severity Adjusted DRG's. We believe that by delaying this implementation and implementing these changes concurrently, there will be more time to analyze this very complex change and in addition, the payment volatility as a result of these two separate changes will be minimized.

In regard to the DGME and IME issues, we strongly urge the CMS to rescind the purported "clarification" in the proposed rule that excludes medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments. Didactic activities are an integral component of a resident's training, are required to remain accredited, and are clearly integral to the delivery of quality patient care.

HSRV Weights/DRG's: Severity of Illness

Under the proposed rule, Medicare would move to a "hospital-specific relative value cost center" (HSRVcc) DRG weighting methodology in FY 2007. In FY 2008 ("if not earlier" according to the proposed rule), Medicare would move to "consolidated severity adjusted DRG's (CS-DRG's). Both of these proposed changes are very complex and have significant financial impacts. Although the proposed rule changes are budget-neutral, they would result in significant redistribution among hospitals and among DRG's.

First of all, developing "cost based" weights is a very complex undertaking. The cost of providing hospital care is not easily identified unlike other industries. Therefore, these costs must be "estimated" using cost-to-charge ratios (CCRs) from hospital's Medicare Cost Reports and applying them to charge amounts that are reported on Medicare claims. Even under this methodology, there are various ways of utilizing the CCRs in order to implement a cost based methodology. We believe that more work is needed to analyze and develop this cost based methodology.

Secondly, upon analysis, it appears that providers that lose under the HSRV weights may gain under a consolidated severity-adjusted DRG system. WVU Hospitals case mix index would decrease as a result of the implementation of HSRV DRG's in FY 2007 resulting in a reduction in payments of $1.7 million. However, with the implementation of consolidated severity-adjusted DRG's in FY 2008, our case mix would increase with a resulting increase in payment. If the changes are not implemented concurrently, WVU Hospitals will have a significant negative impact in FY 2007 only to gain it back in FY 2008.

Based on the complexity of these changes and the fact that many providers would be unjustly disadvantaged by not implementing these changes concurrently, we strongly urge CMS to delay implementation of the HSRV weighting and to implement it concurrently with the CS-DRG's in FY 2008.

FTE Resident Count and Documentation/Time Spent in Nonpatient Care Activities

The proposed rule cites journal clubs, classroom lectures and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent

resident count for IME and DGME payments when the activities occur in a nonhospital setting, such as a physician's office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not "related to patient care".

This position is in stark contrast to the Agency's position as recently as 1999, which states that patient care activities should be interpreted broadly to include "scholarly activities such as educational seminars, classroom lectures...and presentations of papers and research results to fellow residents, medical students and faculty".

We strongly disagree with CMS' position in the proposed rule. Didactic activities for the resident are an integral part of the patient care experience. At WVU Hospitals, the medical school is physically connected to the Hospital and has state of the art classrooms specifically for this purpose. Didactics are required in order to remain accredited and didactic time counts as part of the duty hour tracking time. Everything that a resident physician learns as part of an approved residency training program is integral to the delivery of quality patient care.

Based on the above, we urge CMS to withdraw it's clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency period.

Thank you for your consideration of these comments.

Sincerely,

Bruce McClymonds, President and CEO
West Virginia University Hospitals, Inc.

Submitter : **Mr. Michael Pelc** **Date: 06/12/2006**

Organization : **Detroit Medical Center**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See attachment Re: file code CMS-1488-P

CMS-1488-P-1312-Attach-1.DOC

#1312

Detroit Medical Center
Wayne State University

Orchestra Place
3663 Woodward Ave.,
Suite 200
Detroit, MI 48201-2403

June 12, 2006

Mark McClellan, M.D., Ph.D, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1488-P
P.O. Box 8011
Baltimore, MD 21244-1850

Re: FY 2007 Medicare Inpatient Prospective Payment System Proposed Rule CMS-1488-P

Dear Dr. McClellan:

On behalf of its 6 member hospitals, Children's Hospital of Michigan, Detroit Receiving Hospital, Harper-Hutzel Hospital, Huron Valley Hospital, Rehabilitation Institute of Michigan and Sinai-Grace Hospital, the Detroit Medical Center (DMC) welcomes this opportunity to comment to the Centers for Medicare & Medicaid Services (CMS) regarding the proposed rule to update the Inpatient Prospective Payment System for FY 2007.

Major Changes to Diagnosis-Related Group (DRG) Classification System

(Federal Register Pages 24004-24049*)*

CMS is proposing the most significant changes to the calculation of the DRG relative weights since the beginning of the PPS. These changes would result in a dramatic redistribution among both the DRGs and hospitals. For FY 2007, the CMS proposes two major changes: use of hospital-specific relative values (HSRVs) and a modified version of cost-based weights instead of weights based on charges. The DMC is not opposed to moving to a DRG weighting methodology based on the costs of providing care so long as it improves the accuracy of the payment system and the methodology is sound, stable and reliable.

We support the idea of moving to cost-based weights. However, the following changes are required to make the cost based weights more accurate and reliable:

- Recognize hospital specific cost to charge ratios vs national averages in the cost calculation
- CMS should use aggregate weighted arithmetic mean RCCs and not unweighted geometric RCCs
- CMS should not use 2003 cost reports to derive the FY2007 weights because 2003 was the year in which drug-eluting stents were first introduced and there was a shortage of supply that year. Therefore, the cost of these stents was not adequately reflected in the 2003 cost reports. Since CMS has a full set of 2004 cost, it should use those.
- The HSRVcc weights published in the proposed rules are incorrect because CMS did not exclude organ acquisition costs from the transplant DRGs, which made the weights for those cases much too high and the weights for the other DRGS are too low.

Consolidated Severity-Adjusted DRGS

Along with the other problems regarding CS-DRGs, which were described above, concerns have been expressed that the severity levels are largely based on clinical and demographic patient characteristics, which may not correlate well with resource consumption.

Therefore, it is imperative that CMS compute cost margins for the CS-DRGs and verify that the CS-DRGs are valid and appropriate.

Cost Outliers

***(Federal Register* pages 24149 – 24151)**

The CMS is proposing to increase the fixed-loss cost outlier threshold from the current $23,600 to $25,530, which represents an 8.2 percent increase. Although a 5.1 percent pool was set aside each year, CMS estimates that it spent only 4.1 percent for outliers in FY 2005 and will spend 4.7 percent in FY 2006. As a result, the DMC believes the increase in the outlier threshold is unwarranted. Due to the fact that CMS did not spend the entire pool of funds set aside for outlier payments during FY 2005 and 2006, we urge CMS to maintain the outlier threshold at the current level of $23,600.

Hospital Quality Data

The Deficit Reduction Act of 2005 (DRA) expands the quality reporting requirements for hospitals to be eligible to receive their full market basket update. The proposed rule states that to qualify for their full market basket update, hospital s would have to pledge to submit data on all 21 measures currently part of the Hospital Quality Alliance's (HQA) public reporting on www.HospitalCompare.hhs.gov for patients discharged on or after January 1. Hospitals failing to submit data for the first calendar quarter of 2006 by August 15 would receive an inpatient update equal to the market basket minus two percentage points. Hospitals that fail data validation tests for data submitted for the first, three calendar quarters of 2005 would also lose the two percentage points from the market basket update.

The DMC hospitals fully support the HQA's effort to make more information on hospital quality available to the public, and we join with CMS in wanting to make it happen quickly and accurately. However, as written , the proposed rule would require hospitals to reopen files from which data have already been abstracted, renegotiate agreements with the vendors that assist them in collecting and processing the required information, and resubmit information to the clinical data warehouse. Such retroactive alterations in the data files are difficult and costly, and open the door for the introduction of many new kinds of errors in the data. To require this reopening of the files makes no sense. CMS should make the data collection prospective. This could be accomplished by requiring that hospitals that want a full market basket update pledge to submit the relevant data for all 21 measures for patients beginning on or after July 1.

Graduate Medical Education

(*Federal Register* pages 24107 – 24115)

We strongly urge the Agency to rescind the purported "clarification" in the proposed rule that excludes medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments. The stated rationale for the exclusion of time devoted to these activities is that they are not "related to patient care". The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a non-hospital setting, such as a physician's office or affiliated medical school.

The proposed rule position is in stark contrast to the Agency's position as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include "scholarly activities, such as educational seminars, classroom lectures...and presentation of papers and research results to fellow residents, medical students, and faculty." [September 24, 1999 Letter from Tzvi Heftner, Director, Division of Acute Care to Scott McBride, Vinson & Elkins].

The DMC supports the Agency's 1999 position. The activities cited are an integral component of the patient care activities engaged in by residents during their residency programs.

We urge CMS to withdraw its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payment and recognize the integral nature of these activities to patient care experience of residents during their residency programs.

Hospital-Acquired Infections

***(Federal Register* Page 24100)**

In the inpatient PPS, infections acquired in the hospital and other complications, can sometimes trigger higher payments, either as payment outliers or by assignment to a higher-paying DRG. Approximately 121 sets of DRGs are split based on the presence or absence of a complication or comorbidity (CC), and DRGs with a complication or comorbidity generate higher Medicare payments.

By Oct. 1, 2007, the DRA requires the CMS to identify at least two preventable conditions that categorize a patient to a CC DRG. The CMS wants hospitals to identify conditions that either occur frequently or their presence results in significantly higher costs to treat the patient. The CMS is proposing, effective October 1, 2008, hospitals would not receive additional payment for cases in which one of the selected conditions was not present on admission. Instead, the case would be paid as though the hospital-acquired complication was not present.

The DRA also requires hospitals to submit the secondary diagnoses that are present at admission when reporting payment information for discharges on or after October 1, 2007.

Some patients have conditions that are not apparent upon admission that later develop into an infection. It may be impossible to accurately distinguish these from hospital acquired infections without performing a battery of lab and/or radiology procedures on a patient upon admission to determine an accurate baseline. This would inconvenience patients and increase cost for the hospitals only to provide evidence of an infection upon admission that would not limit a hospital from receiving a higher payment if complications arise.

The DMC, along with the Michigan Hospital association member hospitals, embarked on a joint project with Johns Hopkins, funded by a $1 million grant from the U.S. Agency for Healthcare Research and Quality (AHRQ) to reduce ICU infections through the MHA Keystone Center. Over two years, 77 hospitals and 127 hospital ICUs voluntarily participated in this project to reduce infections in the ICU. After 18 months, the predictive model suggests that teams saved 1,574 lives, over 84,000 ICU days and over $175 million dollars. Infections from central IV catheters plummeted. The median CR-BSI rate in participating ICUs has now been at zero for almost a year. Ventilator associated pneumonia rates in the ICUs have been cut by 40%. Forty six ICUs have gone for over six months with no ventilator associated pneumonias. Fifty seven ICUs have gone for over six months with no blood stream infections from IV catheters.

The DMC believes proactive projects such as these will result in better patient safety and quality. However, hospitals need the training and funding in order to implement these changes.

The DMC believes the CMS proposal that complications are solely the result of hospital actions is fundamentally flawed. To reduce hospital payments for a condition present upon admission, but not documented, is too punitive. Rather, the DMC recommends that CMS expand demonstration projects such as the MHA Keystone Center to truly improve patient safety and quality for Medicare and all patients.

Again, the DMC appreciates this opportunity to provide comments to CMS regarding this proposed inpatient rule and urge you to please take them into consideration. We believe our suggested modifications will result in positive changes for hospitals and the Medicare beneficiaries they serve. If you have questions on this comment letter, please contact me at (313) 578-2820 or mpelc@dmc.org

Sincerely,

Michael A. Pelc
Vice President, Finance
Reimbursement

Submitter : PAT MCLAREN **Date:** 06/12/2006

Organization : STAMFORD MEMORIAL HOSPITAL

Category : Hospital

Issue Areas/Comments

Hospital Quality Data

Hospital Quality Data

Texas Medical Foundation brought it to our attention at a meeting on June 9, 2006 that CMS was going to revert possibly back to January 1, 2006 for abstracted data on 21 indicators for pneumonia, CHF, and myocardial infarction instead of the required 10 indicators that we have been doing all along. We feel that going back to January 1, 2006 (and this will not be final until August 2006) is unfair since we will not be notified of this change until August 2006. We have already submtited to Qnet our first quarter 2006 10 indicators and will have to go back and resubmit. Also our staff has not been trained on the remaining 11 indicators that will be required. We are requesting that the 21 required indicators to Qnet begin either on the last quarter of 2006 (after the official decision in August) or begin 2007 so that you will have a better data system. It will be a great burden to hospitals to have to revert back to January 2006 on a decision that will be made in August 2006. Thank you

Submitter : **Mr. Ronald Long** **Date: 06/12/2006**

Organization : **Health Alliance Of Greater Cincinnati**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

See Letter Attached

CMS-1488-P-1314-Attach-1.DOC

#1314

Cost Reimbursement
Tele 513.585.8069
Fax 513.585.8070

June 7, 2006

Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-1488-P
P.O. Box 8011
Baltimore, MD 21244-1850

To Whom It May Concern:

The Health Alliance of Greater Cincinnati is an alliance of six acute care hospitals, located in the greater Cincinnati area. Two of the hospitals are located in Northern Kentucky, three in Cincinnati and one hospital in Hamilton, Ohio. One of the Cincinnati hospitals is the University Hospital, which is the safety-net hospital for the greater Cincinnati area.

Our comments are prompted by our concerns over the financial impact of the proposed changes to the Perspective Payment System (PPS) for inpatient operating cost; specifically, the proposed recalibration of DRG weights, the proposed changes to the outlier payment policy and the purported "clarification" that would prohibit hospitals from counting much of the resident time spent in didactic activities when calculating indirect medical education (IME) and direct graduate medical education (DGME) payments. These proposed changes are outlined in the Federal Register/Volume 71, 79/Tuesday, April 25, 2006/Proposed Rules-Page 23996 through 24433.

The proposed rule would increase the fixed-loss cost threshold for outliers from $23,600 to $25,530, an increase of 8.2%. The perspective payment rules mandate that outlier payments be funded through a 5.1% reduction in the PPS standardized payment amount. Based on your own estimates, outlier payments in fiscal year 2005 were approximately 4.1% of the total PPS payments and in fiscal year 2006 you're estimating that outlier payments will reach 4.71% of total payments. Since your policy regarding outlier payments does not allow retroactive increase in payments in any given year, and actual outlier payments have fallen short for three consecutive years of the 5.1% reduction in PPS payments, it's not clear to us why the fixed-loss threshold should again be increased in 2007. Based on the experience of our own six hospitals, outlier payments as a percent of gross PPS payments remain steady at approximately 3.9%.

These numbers suggest that a reduction in the fixed-loss threshold would be more logical. We ask that you re-evaluate your current proposed fixed-loss threshold and lower the threshold to achieve the mandatory 5.1% payment level, or reduce the amount set aside to reduce the PPS funding.

DRG Reclassifications

While we are supportive of CMS attempt to improve the accuracy of the Medicare payment rates for hospital inpatients, we have serious concerns about the proposed approach. Based on internal analysis of the impact of the proposed changes on our six hospitals and re-enforced by third party analysis, we have determined that four of our six hospitals will receive improved reimbursement in the range of $500,000; two of our hospitals, including University Hospital, will be adversely impacted by the proposed rule. Christ Hospital, which treats a large number of cardiovascular cases, is projected to have reduced reimbursement in 2007 of $4.4 million. In focusing on the six highest volume DRG's impacted, i.e. DRG 104, 124, 125, 515, 518 and 557, a detailed analysis of the current and projected cost compared to the current and projected reimbursement produces a reduction in net revenue of $2,850,000 or 22.6%. This analysis would indicate that CMS may have over reached in their attempt to adjust the DRG weights from a charge-base to a cost-base methodology. Our analysis indicates that in these six DRG's the change has resulted in a shift from a net gain of $1,100,000 to a net loss of $1,750,000 for these six specific DRG's. It would appear based on further analysis that the deployment of the adoption of the additional severity weighted DRG's would significantly mitigate this reimbursement change. While we are in full support of the underlying principles driving these proposed changes, we believe that the adoption of the cost-based weights without the deployment of the additional severity weighted DRG's will create in the short-term a significant penalty to all high cardiovascular providers of service. Our principle concern with the changes to the expanded DRG's is a question of the industry's ability to deploy these changes on such short notice. Because of the complexity of the calculations involved in the rebasing we would encourage CMS to move slowly with the implementation of these changes and would recommend that both the rebasing to expense-based weighting determination and the deployment of the additional severity of illness DRG's be postponed until fiscal year 2008. This postponement would give the industry adequate time to evaluate in detail the methodologies and to deploy the needed software to deal with the expanded DRG's.

FTE Resident Count and Documentation

University Hospital receives approximately $30 million in DGME and IME reimbursement. We estimate that our residents spend as much as 14.0% of their time in didactic activities. The unexpected and unwarranted loss of this revenue would put a significant strain on our already stressed ability to provide services to the underserved in our community.

We strongly urge the Agency to rescind the purported "clarification" in the proposed rule that excludes medical resident time spent in didactic activities in the calculation of Medicare direct-

graduate medical education (DGME) and indirect medical education (IME) payments. The stated rationale for the exclusion of time devoted to these activities is that they are not "related to patient care." The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a non-hospital setting, such as a physician's office or affiliated medical school.

The proposed rule position is in stark contrast to the Agency's position as recently as 1999, at which time the director of acute care wrote in correspondence that patient care activities should be interpreted broadly to include "scholarly activities; such as, educational seminars, classroom lectures ...and presentation of papers and research results to fellow residents, medical students, and faculty." [September 24, 1999, Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins].

We support the Agency's 1999 position. The activities cited are an integral component of the patient care activities engaged in by residents during their residency programs. We urge CMS to withdraw its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Thank you for your consideration of these comments.

Sincerely,

Ronald Long
Executive Vice President & Chief Financial Officer

Submitter : **Dr. Julie Wood** **Date: 06/12/2006**

Organization : **AAFP**

Category : **Physician**

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS or the Agency) proposed rule entitled Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates. 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in patient care activities. The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

Background
The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a nonhospital setting, such as a physician's office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not related to patient care.

This position reverses the Agency's position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty. [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency's 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs.

Residency Program Activities and Patient Care
I firmly believe that with the possible exception of extended time for bench research, there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician's educational development into an autonomous practitioner.

To separate out CMS's newly defined patient care time from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,

Julie Wood, MD

Submitter : Dr. Kim Kruger **Date:** 06/12/2006

Organization : Duluth Family Medicine Residency Program

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

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Sincerely,
Kim Kruger MD

Submitter : **Dr. Mark Bixby** **Date: 06/12/2006**

Organization : **Broadway Family Medicine**

Category : **Individual**

Issue Areas/Comments

GME Payments

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Residency Program Activities and Patient Care
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I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs and to the patients for whom they care.

Sincerely,
Mark R Bixby, MD

Submitter : **Dr. Michael King** **Date: 06/12/2006**

Organization : **University of Kentucky**

Category : **Individual**

Issue Areas/Comments

GME Payments

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Background
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Residency Program Activities and Patient Care
I firmly believe that with the possible exception of extended time for bench research, there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician s educational development into an autonomous practitioner.

To separate out CMS s newly defined patient care time from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,

Michael King, MD

Submitter : **Dr. Prasanna Kumar** **Date: 06/12/2006**

Organization : **John Peter Smith Hospital - FMRP**

Category : **Physician**

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS or the Agency) proposed rule entitled "Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates." 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in "patient care activities." The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

Background
The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a nonhospital setting, such as a physician's office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not "related to patient care".

This position reverses the Agency's position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include "scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty." [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency's 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs.

CMS-1488-P-1319-Attach-1.DOC

The Texas Academy of Family Medicine has just informed us that CMS is considering the disallowance of faculty development activity in the calculation of faculty time for IME and DME reimbursement. These activities in our program include:

- Development of Curriculum in alignment with best current evidence
- Review of Curriculum
- Critical Evaluation of Evidence Based Medicine Guidelines for Patient Care
- Development and Utilization of Evaluation Tools for Faculty and Residents
- Delivery of Curriculum by lecture, Web-based curriculum, small group workshops and one-to-one training
- Scholarly Activities
    - Written Publications
    - Presentation of Research
    - Faculty Development Conferences
    - Participation in Critical Review Activities of Specialty
    - Research regarding the outcomes of care of resident practices
    - Clinical Quality Improvement in Resident Delivery to Patient Services
- Resident Evaluation
- Resident Academic Remediation
- Resident Testing
- Resident and Faculty Portfolio Development and Monitoring
- Faculty Training
- Alumni Evaluation and Research

My understanding is that CMS is proposing a rule that would disallow the time for these activities due to them being unrelated to patient care. Patient care is critically dependent on our ability as a faculty to carry out these activities. We can continue to deliver services to the underserved as we always have in our residency site. Duke Family Medicine Department has recently decided to do this rather than continue training family physicians.

However, we will lose our best clinicians and teachers to much higher compensated clinical positions. The patients will lose the benefit of these outstanding critical thinkers in the process of their care. We could not train physicians for the future for much longer without support for the educational aspects of their experience. As a program director, I see this as an unacceptable price to pay for the future of our patients and the patients that would have been cared for by the physicians that we would have trained for our hugely underserved state of Texas.

Submitter : **Date: 06/12/2006**

Organization :

Category : **Physician**

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS or the Agency) proposed rule entitled "Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates." 71 Fed. Reg. 23996 (April 25, 2006).

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Background The proposed rule cites journal clubs, classroom lectures and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a non-hospital setting, such as a physician's office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not "related to patient care."

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Residency Program Activities and Patient Care I firmly believe that with the possible exception of extended time for "bench research," there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician's educational development into an autonomous practitioner.

To separate out CMS's newly defined "patient care time" from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,

Dvaid E Price, MD

Submitter : Dr. Jay Siwek **Date:** 06/12/2006

Organization : Georgetown University Hospital

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

As chair of the Department of Family Medicine at Georgetown University Hospital, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS or the Agency) proposed rule entitled Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates. 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in patient care activities. The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

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This position reverses the Agency s position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty. [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency s 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs.

Residency Program Activities and Patient Care
I firmly believe that with the possible exception of extended time for bench research, there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician s educational development into an autonomous practitioner.

In addition, I cannot conceive of how I would be able to administratively comply with this requirement. It would require documentation that would be extremely burdensome, if possible at all. To separate out CMS s newly defined patient care time from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Where am I to find the funding to pay for the staff person that would be needed to sit in on each of these didactic sessions and keep count of patient care time? The documentation requirements that this position would necessitate are unreasonable and would cause an extremely large administrative burden.

To reiterate, I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely

Jay Siwek, MD
Professor and Chair
Department of Family Medicine
Editor, American Family Physician
Georgetown University Medical Center
215 Kober Cogan Hall
3800 Reservoir Road, NW
Washington, DC 20007
202-687-1600
fax: 202-687-7230
personal email: siwekj@georgetown.edu

Submitter : Dr. Holly Biola **Date:** 06/12/2006

Organization : Dr. Holly Biola

Category : Individual

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS or the Agency) proposed rule entitled "Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates." 71 Fed. Reg. 23996 (April 25, 2006).

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To separate out CMS's newly defined "patient care time" from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,
Holly Biola, MD, MPH

Submitter : Mr. Steve Kowske **Date:** 06/12/2006

Organization : Aurora St. Luke's Medical Center

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1323-Attach-1.DOC

#1323

Aurora St. Luke's Medical Center®

June 8, 2006

Mark McClellan M.D., Ph.D., Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1488-P
Mail Stop C4-26-05
7500 Security Blvd.
Baltimore, MD 21244-1850

Dear Dr. McClellan,

Aurora St. Luke's Medical Center provider # 52-0138 wishes to comment on the April 25th Federal Register entitled, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates.
In particular, Aurora St. Luke's Medical Center would like to comment on the changing of the DRG weight calculation from a charge based to a cost based system, removal of offsite non patient care time for Indirect Medical Education reimbursement, the movement to severity adjusted DRG's, the expansion of number of quality measures to report on, and non payment for infections not present at the time of admission.

DRG Reclassification

Aurora St. Luke's Medical Center takes issue in the re-weighting of the Medicare inpatient DRG's based upon costs rather than billed charges. Our main issues are as follows:

- Not all hospitals have the same cost to charge ratios. In fact, in order to remain competitive, many urban facilities do not mark up expensive surgical supplies such as drug eluding stents and pacemakers, very much at all to keep managed care companies from not authorizing a potentially life saving surgery. These supplies in the CMS calculation are marked up based upon overall department markup, which may not reflect actual supply mark-up.

- Two hundred sixty very large hospitals representing twenty five percent of the total charges were excluded from the cost center cost to charge ratio calculation. However, these hospitals were not exempt from the effects of the DRG weight change, even though the data from their Hospital(s) were not included in the calculation of the DRG weights. Large hospitals offer cutting edge technology services such as Cardiology, and Neurosurgery. Excluding these hospitals from the cost to charge ratio calculation does not give an accurate national cost to charge ratio for modeling purposes.

- Hospitals do not consistently group costs in the same manner on the Medicare cost report. This will lead to cost to charge ratio inaccuracies for the calculation of the DRG payments.

The cost to charge ratio data used in the calculation is based upon cost report information from 2003. Current technology such as drug-eluding stents, and bi-ventricular pacemakers were in its infancy in 2003, and does not accurately reflect the utilization of these services as it exists today.

- This leads to inaccuracies in the way these DRG's are proposed to be reimbursed by CMS compared to the actual costs the Hospital incurs for the inpatient stay.
- Cardiology related services will be hit unusually hard in this proposal. As a result of these changes the proposed DRG's for stents will be reduced 24 to 34%, ICD implants will be reduced 22 to 24%, and pacemakers reduced 12 to 14%. Drug eluding stents cost $3,000 a piece. The average number of stents per patient is 1.65. Cost for drug eluding stents per patient is $4,950. With the average reimbursement for DRG 558 being $7,200, this leaves $2,250 to cover the surgery, all of the other supplies, drugs, and the patient stay of two days. This will not even cover the direct costs much less the overhead it takes to run a hospital. The payment shortfall will have a devastating impact for Cardiology programs across the country, and will potentially cause access problems due to programs not being able to recover the cost of the leading edge technology. This is clearly not the intent of what CMS wanted to do.

With DRG's being a payment system of gains on some DRG's and losses on others, recalculation of the DRG weights based upon costs, will cause a lot more losers than gainers. This could cause hospitals not to invest in expensive life saving treatments due to lack of adequate payment, and therefore inhibit potentially life saving patient care.
Due to the drastic financial effect this has on hospitals, at a minimum this change should delayed for one year, or be phased in over a four year period of time to allow hospitals to adjust to the new payment.

DRG's: Severity of Illness

Aurora St. Luke's Medical Center supports CMS's concept of paying claims more accurately by having severity payment levels within each DRG. However, there needs to be a lot more work done before severity DRG's can be implemented.

- More time is needed before implementation for coding staff training.
- The Severity of illness DRG grouper needs to be released to the public so other information system vendors can perform the necessary programming for medical records and business office software systems. Having 3M maintain control of the grouper software limits access by other software vendors to begin reprogramming of the many of computer systems that needs to have the severity adjusted grouper software and are not compatible with the 3M grouper. This needs to

happen well before implementation so hospitals can test their systems, and study the impact on their facilities.

- The new version of the UB-92 needs to be released, so the additional ICD-9 codes beyond nine can be accepted by claims processing system. Without this change hospital providers may not get paid accurately under the severity adjusted system.
- ICD-10 codes need to be implemented in order to obtain an accurate patient diagnosis.
- The effect the severity adjusted payment system has on outliers needs to be studied more closely to make the sure payment is accurate for the resources consumed by the patient.

CMS also needs to take the additional time to implement this so their systems operate smoothly and not create accounts receivable problems for the hospitals.

Hospital Quality Data

Aurora St. Luke's Medical Center supports CMS's effort to expand the number of quality measures hospitals report on in order to receive the full market basket payment increase. However, more time is needed in order for hospitals to implement the expansion. With the final notice not coming out until the beginning of August, and the quarterly data that CMS wants providers to report the expanded data is due on August 15th. That is not enough time for providers to implement the change. Many hospitals use external vendors to compile and submit the data to CMS. Vendors need adequate time to deal with the programming changes necessary to implement the revised quality measures after the regulation is final. Software testing at the hospital needs to be completed to make sure the data is complete and accurate. Aurora St. Luke's Medical Center proposes delaying this provision for at least six months to allow for a smooth implementation.

Value Based Purchasing

Aurora St. Luke's Medical Center is opposed to CMS's recommendation to not pay additional payments for infections acquired while the patient is in the hospital. Hospitals, most of the time, have no control over what the patient complications arise when they are in the hospital. Many visitors who may come to the hospital have drug resistant staph infections, and not even realize it. This can be passed along to the patient quite easily.
Hospital's infection control departments have measures in place to prevent infections as much as they can. However, they cannot possibly control all of

the infections all of the time. Hospital's still need to be paid adequately for taking care of the patient, especially the complex hard to treat patient with acquired infections.

FTE Resident Count and Documentation

Aurora St. Luke's Medical Center remains opposed to CMS's interpretation of Public Law 105-33 requiring only patient care time spent be allowed in the FTE count calculation when the Intern or Resident is training outside of the Hospital

Interns and residents, in order to obtain proper training must spend significant non-patient care time out of the hospital. Time spent at external seminars, reviewing clinic patient charts, researching patient symptoms for related diseases, virtual learning (practice suturing ect.) and documentation coordination with the physician in their clinic, are just of the few of very important functions the Intern or Resident spends doing activities outside of the hospital. These are very essential roles for the education of future Physicians. Residents are bound to train for a maximum of 80 hours per week, so wherever the resident
may have down time, they spend their time on these non - direct patient care functions. Without these functions, the training programs cannot exist.
CMS has made a commitment to fund Graduate Medical Education programs. Without adequate funding by CMS for these programs, many programs will not be able to survive and forced to shut down.

Aurora St. Luke's Medical Center would like to thank CMS for the opportunity to submit our comments on this very important proposed regulation. Should you have any questions, please feel free to call me at 414-647-3429.

Sincerely,

Steve Kowske
Government Relations Manager
Aurora HealthCare

Submitter : Dr. Andy Tanner **Date:** 06/12/2006

Organization : WVU - Charleston Division

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

AS a family physician, I appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services proposed rule entitled Medicare Program;Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal year 2007 Rates. 71 Fed. Reg. 23996 (4/25/06). I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in patient care activities. The effect of the rule change is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

I firmly believe that there is no resident activity that is not related to patient care. The learning modules that we use in our department are directly related to patient care activities. In our morning didactice session, the residents meet with one of our faculty members and presents the patients that were admitted to our service from the night before. We go over the history, phsyical and all related laboratory data. Many times, the information gathered from that meeting directly impacts patient care and is directly related to "patient care activity" because we are discussing the patient! The residents also need protected time during their work hours to have didactic sessions/lectures etc, and many times the topics discussed are related to patients that we have on our service.

These proposed rule changes would also place a burden on us in terms of documentation and would add a large and unnecessary burden on our staff.

I urge CMS to rescind its clarification in the proposed rule relationg to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of redidents during their residency programs.

Sincerely,

Andy R. Tanner, DO
Program Director,
Family Medicine
WVU - Charleston Division

Submitter : **Arias, Blaser, Perl** **Date: 06/12/2006**

Organization : **APIC, IDSA, SHEA**

Category : **Health Care Professional or Association**

Issue Areas/Comments

DRG Reclassifications

DRG Reclassifications

Re: Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates; Proposed Rule -- CMS 1488-P-Healthcare-associated infection

The Association for Professionals in Infection Control and Epidemiology (APIC), the Infectious Diseases Society of America (IDSA), and the Society for Healthcare Epidemiology of America (SHEA) collectively represent infectious disease and infection control authorities in our nation s acute healthcare facilities. As organizations with considerable expertise in the prevention, detection, control and treatment of healthcare-associated infections we wish to respond jointly to your questions regarding healthcare-associated infections (HAIs) as outlined on page 363 of document CMS-1488-P.

We applaud the foresight of CMS in this arena as we have a shared vision of preventing any adverse event, specifically infectious complications, in the patients we care for and serve in our respective care settings. We have some insights and suggestions that we hope will facilitate early planning, prior to finalization and implementation of the proposed rule scheduled for October 1, 2008.

CMS Proposed Rule Area of Concern
The specific proposal we wish to address refers to the statement that there are certain complications acquired in the hospital such as infections that can trigger higher payments related to specific sets of DRGs. We are addressing primarily the 121 sets of DRGs that split based on the presence or absence of a complication or comorbidity (CC). The CC DRG in each pair would generate a higher Medicare payment. If an infection acquired during the beneficiary s hospital stay is one of the conditions on the CC list, the result may be a higher payment to the hospital under a CC DRG.

The changes under consideration refer to the requirement based on Section 5001(c) of Pub. L. 109-17 which states that by Oct 1, 2007, the Secretary identify at least two conditions that are (a) high cost or high volume or both, (b) result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through the CMS-1488-P 364 application of evidence-based guidelines.

We understand that for discharges occurring on or after October 1, 2008, hospitals would not receive additional payment for cases in which one of the selected conditions was not present on admission. That is, the case would be paid as though the secondary diagnosis was not present. Section 5001(c) provides that we [CMS] can revise the list of conditions from time to time, as long as it contains at least two conditions. Section 5001(c) also requires hospitals to submit the secondary diagnoses that are present at admission when reporting payment information for discharges on or after October 1, 2007.

In the CMS 1488-P notice that announced the proposed changes in reimbursement for acute care facilities, CMS requested input about those conditions and about which evidence-based guidelines should be selected. We therefore wish to offer the following comments:
(please see attached file for full document)

CMS-1488-P-1325-Attach-1.PDF

June 12, 2006

Mark McClellan, M.D., Ph.D.
Administrator, Centers for Medicare & Medicaid Services
Attention: CMS–1488–P
Mail Stop C4–26–05, 7
500 Security Boulevard,
Baltimore, MD 21244–1850.

Re: Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates; Proposed Rule -- CMS 1488-P-Healthcare-associated infection

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In the CMS 1488-P notice that announced the proposed changes in reimbursement for acute care facilities, CMS requested input about those conditions and about which evidence-based guidelines should be selected. We therefore wish to offer the following comments:

Background

First, APIC, IDSA, and SHEA welcome the increasing attention to the prevention of HAIs, particularly the transparency of efforts involving both health care providers and consumers. We advocate evidence-based approaches to the prevention of adverse events in any healthcare setting. We believe that every effort should be made to eliminate HAIs by applying state-of the-art science even as our hospitals care for sicker patients in an increasingly complex environment. We also recognize this is only accomplished in a culture of safety that promotes fixing systems over assigning blame. While zero tolerance of HAIs is our goal, it is important to be aware that systematic review of several studies demonstrates that the preventable proportion of HAIs ranges between 10-70%. For surgical site infections in particular, the range of preventable infections is between 40-60%.[1] We note the CMS Surgical Care Improvement Project (SCIP) goal in this regard is a target of 25% reduction in morbidity and mortality associated with surgical care.

After studying this proposal, we agree with the intent of the proposed changes. As clinicians and practitioners, we do not think that HAIs which could have been prevented based on interventions developed from scientifically sound, evidence-based practices should receive higher payments.

As we participate in a variety of infection prevention strategies, we are gratified as well to acknowledge dramatic successes in infection reduction achieved by implementing an entire group (i.e., bundle) of evidenced-based practices. This strategy results in better outcomes than when each practice is implemented individually. There are numerous well-publicized initiatives that demonstrate improved outcomes when all the right processes occur together. In regions specifically measuring HAI incidence, unprecedented reductions in rates of central line-associated bloodstream infections (CLA-BSI) and ventilator-associated pneumonia (VAP) have been reported by hospitals participating in local, regional, state and national initiatives such as the Pittsburgh Regional Health Initiative, Maryland Patient Safety Center, Michigan's Keystone Center and others. However, even within these successful collaborations, HAIs occur despite near complete adherence to high quality, validated processes of care in the participating facilities. These findings suggest that additional studies are needed to elucidate other modifiable risk factors for HAIs. Such limitations of science-based interventions have implications for providers even with payer incentives for prevention.

We would like to focus on one of the most notable initiatives related to surgical site infections (SSIs) –namely CMS's success using bundling in the Surgical Infection Prevention Project (SIPP), now expanded into CMS's Surgical Care Improvement Project (SCIP). SCIP has built its processes for preventing SSIs from a series of widely accepted evidence-based (EB) guidelines including (1) the *CDC Guidelines for the Prevention of Surgical Site Infection* in which the literature is reviewed and categorized based on the weight of evidence in the recommendations[2];

(2) peer-reviewed guidelines on surgical antibiotic prophylaxis[3]; and (3) guidelines for antibiotic prophylaxis in cardiac surgery[4]. SCIP has already demonstrated that in *certain* patients, in *certain* procedures, SSIs *can* be prevented, and post-operative infection rates reduced when such guidelines are applied. For example, in the initial SIP collaborative, a 1-year demonstration project sponsored by CMS concluded that "the infection rate decreased 27%, from 2.3% to 1.7% in the first versus last 3 months."[5]

Limitations

What we do *not* know from applying even the best of EB guidelines in prospective controlled trials is –*how many HAI can truly be prevented.* To state it another way, we do not advocate withholding payment at the higher reimbursement rate if an HAI develops despite the implementation of all currently known scientific evidence based practices for that patient.

We *do* know that more than four thousand hospitals are demonstrating their determination to reduce infections by applying these guidelines systematically through participation in SCIP. CMS's Healthcare Quality Alliance (HQA), which has invested and continues to invest major resources into this partnership. New indicators for quality measurement developed by CMS should encourage acute care facilities to continue and expand their participation in this project.

Accurate, standardized measurement of processes and outcomes by all providers will be key to this newly proposed rule. CMS has demonstrated in SCIP that it understands that purely administrative coding cannot determine *if* and *how* measures are being applied. CMS has developed detailed data abstraction processes to measure the systematic application of EB guidelines, to measure compliance with such processes, and to confirm the reduction in SSIs or detect reasons for occurrences of SSIs.

Using the example of SCIP, the direct method to identify if a SSI was truly preventable would involve a review process to determine if the case met *all* the EB SCIP surgical measures currently applicable to that specific patient. If this SSI case analysis shows that the hospital did not implement and document all SCIP measures, the hospital would not receive the reimbursement rate for the associated CC.[6] However, if the hospital documented that all possible processes were applied, the hospital should not carry the financial burden for the patient's SSI, since the hospital has complied with the 'state of the art' in terms of infection prevention. This approach would provide incentives to hospitals to apply all recommended practices, and would fairly reimburse cases for which a HAI develops *despite* adherence to such practices.

However, a patient level review process using SCIP data to determine degree of compliance with SCIP measures for each SSI is impractical for numerous reasons including the data analysis burden to CMS, as well as a hospital appeals process which would have to be defined and developed in order to fairly exclude individual cases from payment. CMS will be challenged to determine the truly preventable infections and would not, and should not, penalize hospitals for what they cannot prevent or control. We therefore suggest considering an alternative approach that does not rely on patient level data, but function as a proxy for patient-level review

Proposal

In order to avoid weaknesses in sensitivity and specificity from sole reliance on administrative

databases, we propose a measurement system that emphasizes adherence to systems and processes of care that have achieved a high quality of evidence demonstrating correlation with reduction in infection rates. Documentation of systems or processes is typically straightforward and subsequent analyses can be employed to determine correlation. These systems and the frequency of outcomes, such as SSIs can be used to determine if or when the DRG CC change is actually applied. We recommend as one alternative approach that hospitals should:

a) accept that patients with the selected condition may be identified as having a specific HAI (that may or may not be preventable);
b) accept that such identified cases will result in maintaining the lower-payment DRG, *unless* the hospital can provide data that demonstrate the application of EB practices in a variety of initiatives. These initiatives can include any number of 'bundled' practices based on evidence-based guidelines and developed at the local, regional, state or federal levels.

Hospitals should continue to conduct analyses to determine why some patients still develop infection despite application of all current evidence-based practices known to prevent infections. Rewarding hospitals for intensifying efforts to systematically apply science-based prevention measures would be viewed positively by consumers and their advocates, would encourage hospital staff to work even harder to improve, and most importantly would teach us even more than we currently know about infection prevention. This approach would also support accountability to the patient –the most important factor in this equation - while still promoting a learning environment in the hospital with regard to infection prevention.

In responding directly to the request for input "about those conditions and about which evidence-based guidelines should be selected," we acknowledge the complexities of identifying two conditions that most closely correlate with preventable HAIs given the current changes underway to consolidated DRG coding affecting the DRG Grouper. In lieu of specific suggestions, we hope you will consider the merits of our proposal and we offer our expertise and input in the surveillance, diagnosis, and prevention of healthcare related infections as these processes develop and are implemented. You are aware of the multiple EB guidelines promulgated by CDC's Healthcare Infection Control Practices Advisory Committee (HICPAC). Several other recent resources beyond the prevention of surgical site infections are referenced below.[7, 8]

In summary, we urge CMS to consider in this federal mandate continuation of CMS's current direction that *rewards good performance*, supports hospital efforts to develop and maintain a non-punitive culture of safety, and yet provides the necessary accountability implied in the current Congressional budget language. We would ask that CMS link the proposed language to its current successful implementation of *process measurement*, even as the outcome of such processes is being validated in various methods.

APIC, IDSA, and SHEA appreciate the opportunity to comment on this proposed rule. We are eager to offer our expertise and participate with CMS in the development of the final rule and, more specifically, with the development of indicators and systems to implement the rule once finalized. We are committed to improving the safety of healthcare and look forward to working with CMS toward this goal.

Sincerely,

Kathy Arias MS, MT, SM, CIC	Martin Blaser, MD	Trish M. Perl, MD, MSc
President	President,	President
APIC	IDSA	SHEA

References

1. Harbarth S,Saxa H, Gastmeier P. The preventable proportion of nosocomial infections: an overview of published reports. Journal of Hospital Infection (2003) 54, 258–266

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3. Bratzler et al. Antimicrobial Prophylaxis for Surgery: An Advisory Statement from the National Surgical Infection Prevention Project. CID 2004:38 (15 June) 1706.

4. Antibiotic Prophylaxis in Cardiac Surgery - Duration of prophylaxis. *Report from the Society of Thoracic Surgeons Workforce on Evidence Based Surgery.* ©2005 The Society of Thoracic Surgeons. approved exception for discontinuance of antibiotic prophylaxis. Available from http://www.sts.org/sections/aboutthesociety/practiceguidelines/antibioticguideline/

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8. McKibben L, Fowler G, Horan T, Brennan PJ. Ensuring rational public reporting systems for health care–associated infections: Systematic literature review and evaluation recommendations Am J Infect Control 2006;34:142-9.

Submitter : Dr. Robert Baker **Date:** 06/12/2006

Organization : MSU-KCMS

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

As a family physician and educator, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS or the Agency) proposed rule entitled Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates. 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in patient care activities. The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

As background, the proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a nonhospital setting, such as a physician s office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not related to patient care .

This position reverses the Agency s position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty. [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency s 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs.

With regards to residency program activities and patient care,
I firmly believe that there is no residency experience that is not related to patient care activities. This includes even "bench Laboratory" research. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician s educational development into an autonomous practitioner.

To separate out CMS s newly defined patient care time from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,

Robert J. Baker, MD, PhD, FACSM, FAAFP
Associate Clinical Professor of Medicine
Michigan State University
Program Director, Primary Care Sports Medicine Fellowship
MSU-Kalamazoo Center for Medical Studies
Kalamazoo, Michigan
49008

Submitter : Mr. Paul McDowell **Date:** 06/12/2006

Organization : King's Daughters Medical Center

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1327-Attach-1.DOC

#1327

June 8, 2006

Sent Electronically

Centers for Medicare and Medicaid Services
Department for Health and Human Services
Attention: CMS-1488-P
PO Box 8011
Baltimore, MD 21244-1850

RE: CMS-1488-P, Proposed Changes to the Hospital Inpatient Prospective Payment System and Fiscal Year 2007 Rates

Dear Sir:

King's Daughters Medical Center (KDMC) is a private not-for-profit 385 bed acute care regional referral center located in Ashland, Kentucky providing services to a primary and secondary service area of approximately 331,000 people. KDMC has experienced continued growth over the past decade with inpatient admissions increasing from 16,000 in 1996 to a projected 25,000 in 2006.

With the development of a state of the art cardiac program KDMC is able to care for patients that previously were required to travel several hours to receive quality cardiac care. Diseases and Disorders of the Circulatory System (MCD 5) have grown to represent approximately 40% of the facility's inpatient admissions, although the Medical Center continues to provide a full range of services to the community.

We have reviewed the Inpatient Prospective Payment System proposed rule for FY 2007 and have modeled the immediate financial impact the proposed changes would have on our facility. While we agree that the prospective payment system needs continuous monitoring and adjustment to assure equitable reimbursement, we feel that the extreme adjustments proposed in MDC 5 are too severe to be implemented at one time. Additionally, we are supportive of moving to a DRG-weighting methodology based on hospital costs rather than charges but we are concerned that the process for capturing costs associated with high cost supply items is flawed resulting in the understatement of costs in cases with expensive devices or supplies.

If implemented as proposed, FY 2007 Inpatient Prospective Payment System would transform MDC 5 from our most profitable service line to the service line showing the largest deficit. Again, we agree with the concept that all DRGs should be reimbursed at a level to achieve relatively the same cost coverage or profit margin, but we feel that the proposed rule has over corrected, thus shifting reimbursement inequity to different DRGs.

In summary, we would recommend a one year delay in the implementation of the DRG changes and request that the changes be phased in over a three year period given the magnitude of the reimbursement impact. We support moving to a cost based methodology of establishing DRG weights but recommend additional analysis of the costing process be performed to ensure that costs associated with high cost devices and supplies are accurately captured.

Thank you for your consideration.

Sincerely,

Paul McDowell
Vice President and Chief Financial Officer

Submitter : Dr. Brian Smith **Date:** 06/12/2006

Organization : RCRH Family Medicine Residency

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS or the Agency) proposed rule entitled Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates. 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in patient care activities. The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

Background
The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a nonhospital setting, such as a physician s office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not related to patient care .

This position reverses the Agency s position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty. [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency s 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs.

Residency Program Activities and Patient Care
I firmly believe that with the possible exception of extended time for bench research, there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician s educational development into an autonomous practitioner.

To separate out CMS s newly defined patient care time from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,

Brian Smith, MD

Submitter : **Dr. Paula Lindner** **Date: 06/12/2006**

Organization : **Dr. Paula Lindner**

Category : **Individual**

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS or the Agency) proposed rule entitled Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates. 71 Fed. Reg. 23996 (April 25, 2006).

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I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,

Paula Nelson Lindner, M.D.

Submitter : **Dr. David Kapp** **Date: 06/12/2006**

Organization : **Dr. David Kapp**

Category : **Physician**

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS or the Agency) proposed rule entitled Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates. 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in patient care activities. The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

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I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,

David F. Kapp MD

Department of Health and Human Services
Centers for Medicare and Medicaid Services
Office of Strategic Operations & Regulatory Affairs

CMS-1488-P-1331 **Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates**

Please note that electronic comment CMS-1488-P-1331 is a duplicate of CMS-1488-P-1330. To view this comment, please see CMS-1488-P-1330.

Submitter : **Mr. John Renner** **Date: 06/12/2006**

Organization : **The Christ Hospital**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1488-P-1332-Attach-1.DOC

#1332

The Christ Hospital
Health Alliance™

2139 Auburn Avenue
Cincinnati, Ohio 45219
513-585-2000

June 9, 2006

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1488-P and P2
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Dr. McClellan:

On behalf of The Christ Hospital, Cincinnati, Ohio and the medical community it serves, we appreciate the opportunity to submit comments to the Centers for Medicare and Medicaid Services (CMS) on the fiscal year 2007 inpatient prospective payment system (PPS) and occupational mix adjustment proposed rules.

As a member hospital of the American Hospital Association (AHA), we have closely reviewed their extensive analysis of CMS-1488-P and P2, Medicare Program; Proposed Changes to Hospital Inpatient Prospective Payment Systems for Fiscal Year 2007 Rates; Proposed Rules. We support AHA's recommendations as outlined in their letter dated June 8, 2007 to CMS.

DRG Weights: HSRVcc

In the twenty-year history of PPS, The Christ Hospital, AHA and other hospital organizations have collectively proposed, evaluated and implemented numerous changes under PPS. The proposed FY07 changes represent the most significant changes in calculation of diagnosis-related groups (DRG) in its history. While The Christ Hospital supports many of the proposed rule's provisions, we have serious concerns about the calculations methodologies used in establishing the proposed changes to the DRG weights and classifications.

We support meaningful improvements to Medicare's inpatient PPS. We share a common goal in refining the system to create equal opportunity for return across DRGs, creating an equal incentive to treat all types of patients and conditions. However, more time is

needed to understand the significant proposed policy. The AHA sponsored review, Deloitte & Touche LLP analysis, and other industry sources all identify methodological problems that have large impact on relative weight calculations at the DRG level.

The Christ Hospital is an urban community hospital, with significant surgical volumes. Medicare beneficiaries account for forty percent (40%) of the total hospital volumes. Fifty-three percent (53%) of the Medicare patients are admitted for cardiology services. Another 12% of our Medicare patients are orthopedic, neurosurgical, general surgical and transplant cases. These patients categorize in the same DRGs with the most significant relative weighting changes.

We contend that the large weight changes in specific DRGs are the direct result of the errors in the proposed methodological changes. We agree with CMS proposed change to hospital-weighted cost-to-charge ratios (CCRs), rather than charge-weighted costing. However, the erred hospital-weighted methodologies resulted in a 1 to 54 percent difference versus the charge-weighted approach in the resulting scaling factors used for the conversion. The CMS calculations result in over-weight of CMS routine cost shares and under-weight of the ancillary cost shares. The AHA and others have documented the erroneously large swings in DRG weights. Specifically for The Christ Hospital, a detailed analysis of the current and projected cost compared to the current and projected reimbursement produces a reduction in net revenues of $3.6 million (23%) on eight (8) high volume DRGs. Overall, Christ is projecting reduced reimbursement of $4.4 million in 2007.

Patient Classification: Severity of Illness

The Christ Hospital believes that the need for and best approach to changing the patient classification system has not been concretely and objectively demonstrated. More careful analysis is needed, along with greater access to the specifics of CMS's methodology and the new GROUPER. Since 1983, we have operated with only minimal changes to the PPS and the DRG groupings. The industry has continuously looked to severity adjustment and other stratifications within the major diagnostic categories (MDCs). CMS has failed to validate that its proposed CS-DRG method accurately stratifies services on some type of relative value basis. There has been no demonstration that this system will improve hospital payment system compared to the existing DRG system or APR-DRGs. The current DRG system was created to distinguish the resource use required among patients. It has been modified over the years to reflect changes in clinical practice and technology. The APR-DRG system is based on severity of illness, it doesn't necessarily reflect the resource use required. The impact of the CS-DRG system is unclear. This change must be more fully explored and understood before implementation.

Based on our best analysis of the proposed CS-DRG system, Christ Hospital stands to mitigate its revenue loss projection in FY2007 when the new classification system is implemented. In the interim, our financial performance in FY2007 is at risk by $4.4 million due to implementation timing.

The Christ Hospital Recommendations

We support appropriate improvements to Medicare's inpatient PPS. We believe there are various DRGs that have been incorrectly re-weighted, both increased and decreased. These incorrect savings in revenues will unfairly penalize certain facilities that otherwise have had no opportunity to adjust costs or justification that cost reductions are appropriate. CMS has not adequately demonstrated that historical weighting of key, high volume DRGs were erred, causing unequal opportunity for return across DRGs and hospitals.

- We support **a one-year delay in proposed DRG changes** given the serious concerns with the HSRVcc and CS-DRG methodology. We are committed to work with CMS over the next year to address our concerns.
- We support **moving to a DRG-weighting methodology based on hospital costs rather than charges**; but the CMS proposed HSRVcc method is flawed.
- The appropriateness and need for change in a Classification System has not been demonstrated. We encourage CMS to **take adequate time to review DRG variation and develop the best DRG classification system.**
- If it is determined that both Weighting and Classification systems should be changed, we believe that **both should be implemented simultaneously**. Analysis of hospital financial outcomes, based on the phased implementation of HSRVcc first, followed by CS-DRGs, shows significant volatility and financial outcome swing. .
- The proposed changes are the most significant changes to inpatient PPS since its inception. Implementation should be transitioned over three-years. We recommend that CMS **provide a blend of old DRG weights and new DRG weights over three years.** This process would assimilate the blending process followed in the early years of inpatient PPS.

The Christ Hospital appreciates the opportunity to submit these comments. If you have any questions about our remarks, please feel free to contact me at (513) 585-2604 or rennerjk@Healthall.com.

Sincerely,

John K Renner

John Renner
Vice President, Finance

Susan Croushore

Susan Croushore
Executive Director / SVP

copy: Ronald Long, Executive Vice President & CFO

Submitter : **Dr. Sabna Thoppil** **Date: 06/12/2006**

Organization : **John Peter Smith Hospital - FMRP**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS or the Agency) proposed rule entitled "Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates." 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in "patient care activities." The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

Background
The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a nonhospital setting, such as a physician's office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not "related to patient care".

This position reverses the Agency's position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include "scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty." [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency's 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs.

CMS-1488-P-1333-Attach-1.DOC

#1353

PCMS Officials:

It is my understanding that support for my activities unrelated to direct patient care as a faculty member are under review. This portion of IME and DME is critical for the support of residency training.

I was attracted to the profession of family medicine faculty because the community recognized the value of experience and academic inquiry to the well-being of our communities and the training of our future physicians.

As I consider the possibility that there could no longer be funding for my work in developing academic programs, writing critical reviews, performing clinical research and reviewing and evaluating resident performance I would feel it necessary to return to full time clinical practice and donate whatever time I can create to a medical student occasionally.

As it is now, most of the time that I spend doing research or critical reading and writing is not compensated. Less that 1/3 of my total academic time is compensated. I make up the difference by seeing more patients myself without residents to offset the cost of my salary and benefits which are currently less than the MGMA 25-tile for a practicing family physician in my geographic region.

For faculty like myself, in community based programs, the thought of being told by a program that I will need to see more patients to pay for the time I am developing and delivering curriculum will be unacceptable.

If you implement this rule I wish you the best of luck. I would not continue as a faculty member. I know that many other faculty feel as I do.

Thank you for your consideration

Submitter : Mr. Steve Kowske **Date:** 06/12/2006

Organization : Aurora Sinai Medical Center

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1334-Attach-1.DOC

#1334

Aurora Sinai Medical Center®

945 N. 12th Street
Milwaukee, WI 53233
T. 414 219-2000
www.AuroraHealthCare.org

June 8, 2006

Mark McClellan M.D., Ph.D., Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1488-P
Mail Stop C4-26-05
7500 Security Blvd.
Baltimore, MD 21244-1850

Dear Dr. McClellan,

Aurora Sinai Medical Center Provider # 52-0064 wishes to comment on the April 25th Federal Register entitled, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates In particular, Aurora Sinai Medical Center would like to comment on the changing of the DRG weight calculation from a charge based to a cost based system, removal of offsite non patient care time for Indirect Medical Education reimbursement, the movement to severity adjusted DRG's, the expansion of number of quality measures to report on, and non payment for infections not present at the time of admission.

DRG Reclassification

Aurora Sinai Medical Center takes issue in the re-weighting of the Medicare inpatient DRG's based upon costs rather than billed charges. Our main issues are as follows:

- Not all hospitals have the same cost to charge ratios. In fact, in order to remain competitive, many urban facilities do not mark up expensive surgical supplies such as drug eluding stents and pacemakers, very much at all to keep managed care companies from not authorizing a potentially life saving surgery. These supplies in the CMS calculation are marked up based upon overall department markup, which may not reflect actual supply mark-up.

- Two hundred sixty very large hospitals representing twenty five percent of the total charges were excluded from the cost center cost to charge ratio calculation. However, these hospitals were not exempt from the effects of the DRG weight change, even though the data from their Hospital(s) were not included in the calculation of the DRG weights. Large hospitals offer cutting edge technology services such as Cardiology, and Neurosurgery. Excluding these hospitals from the cost to charge ratio calculation does not give an accurate national cost to charge ratio for modeling purposes.

- Hospitals do not consistently group costs in the same manner on the Medicare cost report. This will lead to cost to charge ratio inaccuracies for the calculation of the DRG payments.
- The cost to charge ratio data used in the calculation is based upon cost report information from 2003. Current technology such as drug-

eluding stents, and bi-ventricular pacemakers were in its infancy in 2003, and does not accurately reflect the utilization of these services as it exists today. This leads to inaccuracies in the way these DRG's are proposed to be reimbursed by CMS compared to the actual costs the Hospital incurs for the inpatient stay.

Cardiology related services will be hit unusually hard in this proposal. As a result of these changes the proposed DRG's for stents will be reduced 24 to 34%, ICD implants will be reduced 22 to 24%, and pacemakers reduced 12 to 14%. Drug eluding stents cost $3,000 a piece. The average number of stents per patient is 1.65. Cost for drug eluding stents per patient is $4,950

- With the average reimbursement for DRG 558 being $7,200, this leaves $2,250 to cover the surgery, all of the other supplies, drugs, and the patient stay of two days. This will not even cover the direct costs much less the overhead it takes to run a hospital. The payment shortfall will have a devastating impact for Cardiology programs across the country, and will potentially cause access problems due to programs not being able to recover the cost of the leading edge technology. This is clearly not the intent of what CMS wanted to do.

With DRG's being a payment system of gains on some DRG's and losses on others, recalculation of the DRG weights based upon costs, will cause a lot more losers than gainers. This could cause hospitals not to invest in expensive life saving treatments due to lack of adequate payment, and therefore inhibit potentially life saving patient care.
Due to the drastic financial effect this has on hospitals, at a minimum this change should delayed for one year, or be phased in over a four year period of time to allow hospitals to adjust to the new payment.

DRG's: Severity of Illness

Aurora Sinai Medical Center supports CMS's concept of paying claims more accurately by having severity payment levels within each DRG. However, there needs to be a lot more work done before severity DRG's can be implemented.

- More time is needed before implementation for coding staff training.
- The Severity of illness DRG grouper needs to be released to the public so other information system vendors can perform the necessary programming for medical records and business office software systems. Having 3M maintain control of the grouper software limits access by other software vendors to begin reprogramming of the many of computer systems that needs to have the severity adjusted grouper software and are not compatible with the 3M grouper. This needs to happen well before implementation so hospitals can test their systems, and study the impact on their facilities.

- The new version of the UB-92 needs to be released, so the additional ICD-9 codes beyond nine can be accepted by claims processing system. Without this change hospital providers may not get paid accurately under the severity adjusted system.

- ICD-10 codes need to be implemented in order to obtain an accurate patient diagnosis.
- The effect the severity adjusted payment system has on outliers needs to be studied more closely to make the sure payment is accurate for the resources consumed by the patient.

CMS also needs to take the additional time to implement this so their systems operate smoothly and not create accounts receivable problems for the hospitals.

Hospital Quality Data

Aurora Sinai Medical Center supports CMS's effort to expand the number of quality measures hospitals report on in order to receive the full market basket payment increase. However, more time is needed in order for hospitals to implement the expansion. With the final notice not coming out until the beginning of August, and the quarterly data that CMS wants providers to report the expanded data is due on August

15th. That is not enough time for providers to implement the change. Many hospitals use external vendors to compile and submit the data to CMS. Vendors need adequate time to deal with the programming changes necessary to implement the revised quality measures after the regulation is final. Software testing at the hospital needs to be completed to make sure the data is complete and accurate.

Aurora Sinai Medical Center proposes delaying this provision for at least six months to allow for a smooth implementation.

Value Based Purchasing

Aurora Sinai Medical Center is opposed to CMS's recommendation to not pay additional payments for infections acquired while the patient is in the hospital. Hospitals, most of the time, have no control over what the patient complications arise when they are in the hospital. Many visitors who may come to the hospital have drug resistant staph infections, and not even realize it. This can be passed along to the patient quite easily.
Hospital's infection control departments have measures in place to prevent infections as much as they can. However, they cannot possibly control all of the infections all of the time. Hospital's still need to be paid adequately for taking care of the patient, especially the complex hard to treat patient with acquired infections.

FTE Resident Count and Documentation

Aurora Sinai Medical Center remains opposed to CMS's interpretation of Public Law 105-33 requiring only patient care time spent be allowed in the FTE count calculation when the Intern or Resident is training outside of the Hospital. Interns and residents, in order to obtain proper training must spend significant non-patient care time out of the hospital. Time spent at external seminars, reviewing clinic patient charts, researching patient symptoms for related diseases, virtual learning (practice suturing ect.) and documentation coordination with the physician in their clinic, are just of the few of very important functions the Intern or Resident spends doing activities outside of the hospital. These are very essential roles for the education of future Physicians. Residents are bound to train for a maximum of 80 hours per week, so wherever the resident
may have down time, they spend their time on these non - direct patient care functions. Without these functions, the training programs cannot exist.
CMS has made a commitment to fund Graduate Medical Education programs. Without adequate funding by CMS for these programs, many programs will not be able to survive and forced to shut down.

Aurora HealthCare would like to thank CMS for the opportunity to submit our comments on this very important proposed regulation. Should you have any questions, please feel free to call me at 414-647-3429.

Sincerely,

Steve Kowske
Government Regulations Manager
Aurora HealthCare

Submitter :

Date: 06/12/2006

Organization :

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS or the Agency) proposed rule entitled "Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates." 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in "patient care activities." The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

Background
The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a nonhospital setting, such as a physician's office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not "related to patient care".

This position reverses the Agency's position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include "scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty." [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency's 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs.

Residency Program Activities and Patient Care
I firmly believe that with the possible exception of extended time for "bench research," there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician's educational development into an autonomous practitioner.

To separate out CMS's newly defined "patient care time" from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and

recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,
Jeanine Brunclik, M.D.

Submitter : **Dr. Rafael Torres** **Date: 06/12/2006**

Organization : **Dr. Rafael Torres**

Category : **Physician**

Issue Areas/Comments

GME Payments

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Sincerely,
Rafael Torres, MD, FAAFP

Submitter : Dr. Leslie Brott **Date:** 06/12/2006

Organization : Physicians Medical Center

Category : Individual

Issue Areas/Comments

GME Payments

GME Payments

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I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,

Submitter : **Mr. John Duval** **Date: 06/12/2006**

Organization : **VCU Health System**

Category : **Hospital**

Issue Areas/Comments

DRG Weights

DRG Weights

See attached letter

CMS-1488-P-1338-Attach-1.DOC

#1358

June 8, 2006

Mark McClellan, M.D., Ph.D.,
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Ref: **CMS-1500-P & CMS 1488-P, Change in DRG Weighting Methodology and the Clarification on counting of Resident time for purposes of GME Reimbursement**

Dear Administrator McClellan:

The Virginia Commonwealth University Health System (VCU Health System) appreciates the opportunity to submit comments on the Centers for Medicare & Medicaid Services' (CMS or the Agency) proposed rule entitled *"Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems [IPPS] and Fiscal Year 2007 Rates."* 71 Fed. Reg. 23996 (April 25, 2006). The VCU Health System is the primary safety net health system in the Commonwealth of Virginia as well as one of the major teaching hospitals in the State. The Health System would like to comment on this proposed rule because 25% of our inpatient net revenues is derived from Medicare payments under the IPPS.

We would like to primarily focus on two areas that have important implications for our institution: 1) the proposed changes to the diagnosis-related group (DRG) weighting and classification systems, and 2) the purported "clarification" that would prohibit teaching hospitals from counting resident time spent in non-patient care activities when calculating the direct graduate medical education (DGME) portion of the GME pass thru payments

In general, the VCU Health System does not oppose a new restructuring of the DRG weighting system, especially if its intentions are to better allocate funding to those hospitals who truly deserve it, but we believe that a one-year postponement is necessary to allow for further analyses to address data and computation issues and to ensure that the best possible methodology ultimately is implemented. We also support refinement of the DRGs but believe that the proposed consolidated severity-adjusted DRGs (CS-DRGs) require further examination and likely modifications before implementation. The mere fact that there was recently an issue with how organ acquisition costs were handled for purposes of the DRG reclassification supports a more thorough review. Due to the possibility that this proposed rule, if enacted, will likely result in a significant redistribution of dollars in Medicare payments among hospitals, we think minimally a transition period should accompany the changes. The VCU Health System, as well as the AAMC on our behalf, has each done an analysis that shows we will be negatively impacted by these proposed changes. Since we are one of many

teaching hospitals that may be negatively impacted by the proposed rule, we urge CMS to delay, or table, this change until more research can go into the methodology.

Concerning the DGME and IME issues related to the "clarification" of resident time spent in "non-patient care" activities (i.e. didactics, seminars, conferences), the VCU Health System would like to focus on the DGME part of the equation. Our understanding of this issue, and reaffirmed time and again by our annual Fiscal Intermediary audits, is that time spent in "non-patient care" activity, no matter where it took place (on site or off), was allowed to be counted if that activity was needed for Board certification. It appears to us that CMS largely agrees with this position IF the non-patient care activities occur on site but doesn't if the activity is offsite. This appears illogical when, in either event, the hospital is still bearing the direct costs of the resident. Although we are limiting our comments here to the DGME side, at least for the IME, your position is consistent – "non-patient care" activities are not allowed whether one is on site OR off site.

Another issue that we believe needs to be clarified is what exactly CMS means when they say a "non-hospital site" – if a hospital is part of a medical campus with a School of Medicine (SOM) and that SOM has a building in which didactic instruction takes place, would that be considered a non-hospital site? What about another building, also part of the medical campus, that houses largely private physician's offices where a hospitals' residents may get didactic instruction – would that be considered a non-hospital site?

We strongly urge CMS to rescind, or minimally, to revise the purported "clarification" in the proposed rule as it relates to the non-patient care activities for DGME reimbursement. We believe it should not matter for DGME reimbursement whether one was involved in non-patient care or patient care activities, on site or offsite, if the activity in question is required for Board certification, it should be allowed.

We thank you for the opportunity to comment on the DRG weighting aspect of the proposed rule as well as raise questions regarding the counting of resident time for purposes of DGME reimbursement.

Sincerely,

John F. Duval
Chief Executive Officer
MCV Hospitals
VCU Health System

c: Sheldon Retchin, M.D.
Don Gehring

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Sincerely,

John F. Duval
Chief Executive Officer
MCV Hospitals
VCU Health System

c: Sheldon Retchin, M.D.
Don Gehring

bc: Todd Gardner
Linda Pearson
Jean Reed
Dom Puleo

Submitter : Mr. EDWARD QUINLAN **Date:** 06/12/2006

Organization : Hospital Association of RI

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1339-Attach-1.DOC

HARI

The Hospital Association of Rhode Island
880 Butler Drive – Suite One
Providence, Rhode Island 02906
(401) 274-1838

Edward J. Quinlan
President

June 12, 2006

Mark McClellan, MD, PhD, Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1488-P and P2
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

RE: CMS-1488-P and P2, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates; Proposed Rule.

Dear Dr. McClellan:

On behalf of the Hospital Association of Rhode Island's member hospitals, we appreciate the opportunity to submit comments on the fiscal year (FY) 2007 inpatient prospective payment system (PPS) and occupational mix adjustment proposed rules.

While HARI supports many of the proposed rule's provisions, we have serious concerns about the proposed changes to the diagnosis-related group (DRG) weights and classifications. We do support meaningful improvements to Medicare's inpatient PPS, however, we believe that more time is needed to understand the significant proposed policy changes, which redistribute up to $1.7 billion within the inpatient system. Analysis shows the impact of the proposed changes to be highly unstable, with small changes in method leading to large changes in hospital payments. We also have concerns about the validity of CMS' proposals versus potential alternatives to improve the DRG weights and classification system is uncertain.

Specifically, the HARI supports the following:

- **One-year Delay** in the proposed DRG changes given the serious concerns with the hospital-specific relative values cost center (HSRVcc) and CS-DRG methodologies. HARI is committed to working with CMS over the next year to resolve these concerns.

- **Valid Cost-based Weights** moving to a DRG-weighting methodology based on hospital costs rather than charges, but, again, we have concerns about the validity of CMS' proposed HSRVcc method.

- **A New Classification System** only if the need can be demonstrated. Since that need is still unclear, HARI does not support a new classification system at this time.

- **Simultaneous Adoption of Any Changes to Weights and Classifications** supported by the demonstration of need to provide better predictability and smooth the volatility created by these two generally off-setting changes.

- **Three-year Transition** for any changes implemented, given the magnitude of payment redistribution across DRGs and hospitals.

Our letter addresses specifically other portions of the rule and we have titled those paragraphs for your convenience.

HOSPITAL QUALITY DATA

The proposed rule states that to qualify for their full market basket update, hospitals would have to pledge to submit data on the additional 11 measures currently part of the Hospital Quality Alliance's (HQA) public reporting for patients discharged on or after January 1, 2006. Hospitals failing to submit data for the first calendar quarter by August 15, 2006 would receive an inpatient update equal to the market basket minus two percentage points. Hospitals that fail data validation tests for data submitted for the first three calendar quarters of 2005 would also lose the two percentage points from the market basket update. Retrospective financial penalties for non- or inaccurate reporting of data that was not required to be collected would negatively impact more than half of the hospital in Rhode Island.

As written, the proposed rule would require the reopening of files from which data have already been abstracted, renegotiating agreements with the vendors that assist hospitals in collecting and processing the required information, and resubmitting information to the clinical data warehouse. These retroactive alterations in the data files are difficult and costly, and could possibly allow for many new kinds of errors in the data. We request that CMS make the data collection prospective.

For further expansion of the measures that must be reported to qualify for full market basket update in future years, we urge CMS to select measures only from those used by the HQA for public reporting. Choosing different measures would thwart efforts to streamline quality reporting, add to the confusion of quality measurement that currently exists in health care, and dilute the efforts

to create a single source to share solid reliable information with the public. In addition, whenever the Secretary intends to expand the set of measures linked to payment, it would be beneficial to all parties if CMS published the proposal at least one full year prior to the start of the fiscal year. That would enable hospitals and their vendors to put the needed data collection processes in place to be able to provide the requested data.

We agree with CMS that it is critical that the collected data be validated. The process used to validate the HQA data using a contractor to randomly select five patient records per quarter raises a couple of issues. One is memories of CERT and how many false positives were generated by the lack of appropriate communication, non-determination of specific hospital personnel to address the requests to, and lack of priority on the hospital's parts to respond. The other is that this methodology assumes that the contractor correctly re-abstracts the data and that discrepancies must mean erroneous data submission on the part of the hospital. We know that is not always the case. This validation process may be working to correctly validate the information submitted by many, but unfortunately not all, hospitals.

OUTLIER PAYMENTS

The rule proposes establishing a fixed-loss cost outlier threshold equal to the inpatient PPS rate for the DRG, including indirect medical education (IME), disproportionate share hospital (DSH), and new technology payments, plus $25,530. HARI is very concerned that the threshold is still too high. According to analyses performed by the American Hospital Association (AHA), actual outlier payments for FY 2006 are estimated to be 0.47 percentage points lower than the 5.1 percent of funds withheld from hospitals to fund outlier payments.

In the rule, CMS proposes to use a one-year average annual rate-of-change in charges per case from the last quarter of 2004, in combination with the first quarter of 2005, to the last quarter of 2005, in combination with the first quarter of 2006, to establish an average rate of increase in charges. This results in a 7.57 percent rate of change over one year, or 15.15 percent over two years. Using this methodology will result in an inappropriately high outlier threshold and a real payment cut to hospitals and we therefore oppose it. We agree with AHA that the use of more than one indicator will make the threshold calculation more accurate and reliable.

OCCUPATIONAL MIX ADJUSTMENT

Definitions and Covered Employees. In filling out the interim-survey, some of our members found that the placement of certain employees caused confusion. Examples include surgical technicians, paramedics who are employed by the hospital and usually work in the emergency department, and unit secretaries who are also known as ward clerks. CMS clarified after the proposed rule was released that these employees should be placed in the "all other" category for the interim-collection. These changes would necessitate the resubmission of the

first calendar quarter's data to ensure that both quarters could be used for FYs 2008 and 2009. If CMS believes that such changes are warranted, then the hospitals will need notification prior to the release of the final inpatient PPS rule in order to meet the August 31 deadline for submissions.

Cost Centers. We request that CMS consider refining the list of cost centers for future collections. Hospitals have various methods for attributing costs to the cost centers, providing for probably a few cost centers that contain a significant number of nursing personnel for certain hospitals that were not captured for this collection. We suggest that CMS ask for and accept comments on any potential changes to the cost center list before making such changes. In addition, we request that additional cost centers *not* be added to the ongoing collection as it would necessitate the resubmission on the first calendar quarter's data to ensure that both quarters could be used for FYs 2008 and 2009. If CMS believes that such changes are necessary for the current collection, then hospitals would need notification prior to the release of the final inpatient PPS rule in order to meet the August 31 deadline for submissions.

Non-responsive Hospitals. Because data from all hospitals is needed to construct an accurate national average hourly wage, full participation is critical. There is a general sentiment that hospitals that do not participate should not benefit from the participation of others. However, given the rushed collection and general confusion around the interim-collection, we believe that, to the extent possible, CMS should substitute data from the previous survey for hospitals that did not turn in their data for the first calendar quarter of 2006.

Moving forward CMS could consider a methodology that penalizes hospitals that do not participate. Substituting unfavorable data for these hospitals will impact other area hospitals that conscientiously reported data. We suggest that CMS alternatively substitute the national average hourly wage for non-responsive hospitals in calculating an area's wage index, and then require hospitals that did not turn in data to use something lower than their area's wage index – similar to the reduction in the market basket for hospitals not reporting quality measures. This would eliminate the need to create an extensive hospital-specific wage index table and would minimize the effects on the other hospitals in the area.

Corrections. HARI suggest that CMS allow hospitals to turn in both calendar quarters of data in August whether for the first time or with corrections. This allows hospitals to report more accurate data for the FYs 2008 and 2009 adjustment. And, for those hospitals that were previously non-responsive, the submission of the first calendar quarter would remove any penalty, while those that continue to be non-responsive will continue to incur a penalty.

Comment Timeframe. HARI feels that the 30-day comment period was not sufficient, as hospitals were busy during this time trying to meet the new survey deadline and answering requests for information from the Fiscal Intermediaries. Practically, it would be appropriate for CMS to take comments

on the calculation after the initial results of the survey are tabulated and posted, since the results could be material. We suggest that CMS publish the occupational mix adjustment changes as an interim-final rule in August with an associated comment period.

GRADUATE MEDICAL EDUCATION (GME) PAYMENTS

Exclusion of Didactic Training. We urge CMS to rescind the clarification in the proposed rule that excludes medical resident time spent in didactic activities in the calculation of Medicare DGME and IME payments. The rationale for the exclusion of this time is that it not related to patient care. This position is in stark contrast to CMS' position as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include those scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty.

We strongly agree with CMS' 1999 position. The activities cited are an integral component of the patient care activities engaged in by residents during their residency programs. It is also difficult and time consuming to separate out time spent at these activities. We request that CMS withdraw this change in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and affirm its recognition of the integral nature of these activities to the patient care experiences of residents during their residency programs.

NEW TECHNOLOGY

Recognizing new technology in a payment system requires that a unique procedure code be created and assigned to recognize this technology. The ICD-9-CM classification system is close to exhausting codes to identify new health technology and is in critical need of upgrading.

The National Committee on Vital and Health Statistics (NCVHS) and Congress, in committee language for the MMA, recommended that the Secretary undertake the regulatory process to upgrade ICD-9-CM to ICD-10-CM and ICD-10-PCS.

To date, despite these recommendations, HHS has not yet moved forward to adopt the ICD-10 classification upgrades. Without the change to ICD-10 classification soon, there will be a significant data crisis. This crisis will affect the efficiency of the current coding process, adding significant operational costs. Subsequently, President Bush's goal for an electronic health record by 2014 may not be achievable.

To avoid having barriers to that goal, we concur with the NCVHS recommendation to issue a proposed rule for adoption of ICD-10, with an implementation period of at least two years following issuance of a final rule.

HARI appreciates the opportunity to submit these comments on the proposed rule. If you have any questions about these comments, please feel free to contact me or Pat Moran, vice president - finance, at (401) 946-7887.

Sincerely,

Edward J. Quinlan

Edward J. Quinlan
President

Submitter : Dr. PAULA Knabe **Date:** 06/12/2006

Organization : Via Christi Regional Medical Center

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

To Whom it Concerns:
I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS or the Agency) proposed rule entitled "Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates." 71 Fed. Reg. 23996 (April 25, 2006). I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in "patient care activities."
The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments. BackgroundThe proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a nonhospital setting, such as a physician's office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not "related to patient care". This position reverses the Agency's position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include "scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty." [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency's 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by
residents during their residency programs. Residency Program
Activities and Patient CareI firmly believe that with the possible exception of extended time for "bench research," there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician's educational development into an autonomous practitioner. In addition, I cannot conceive of how I would be able to administratively comply with this requirement. It would require documentation that would be extremely burdensome, if possible at all.
To
separate out CMS's newly defined "patient care time" from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Where am I to find the funding to pay for the staff person that would be needed to sit in on each of these didactic sessions and keep count of patient care time? The documentation requirements that this position would necessitate are unreasonable and would cause an extremely large administrative burden.
To reiterate, I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency
programs.
Sincerely,
Paula L. Knabe, D.O.
Associate Director and AOA FM Residency Program Director
Via Christi Regional Medical Center
707 N. Emporia
Wichita, Kansas 67214

Submitter : **Dr. Larry Johnson** **Date: 06/12/2006**

Organization : **Medical University of Ohio**

Category : **Individual**

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the
Centers for Medicare & Medicaid Services' (CMS or the Agency)proposed rule entitled "Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates." 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in "patient care activities." The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

Background
The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a nonhospital setting, such as a physician's office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not "related to patient care".

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support the Agency's 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs.

Residency Program Activities and Patient Care I firmly believe that with the possible exception of extended time for "bench research," there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of
fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician's educational development into an autonomous practitioner.

To separate out CMS's newly defined "patient care time" from didactic
sessions in which general issues devolve to discussions of particular
patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely, Larry w. Johnson, M.D., Family Medicine Chairman

Submitter : Mr. Steve Kowske **Date:** 06/12/2006

Organization : West Allis Memorial Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1342-Attach-1.DOC

#1342

West Allis Memorial Hospital®
Aurora Health Care

June 8, 2006

Mark McClellan M.D., Ph.D., Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1488-P
Mail Stop C4-26-05
7500 Security Blvd.
Baltimore, MD 21244-1850

Dear Dr. McClellan,

West Allis Memorial Hospital Provider # 52-0139 wishes to comment on the April 25th Federal Register entitled, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates In particular, West Allis Memorial Hospital would like to comment on the changing of the DRG weight calculation from a charge based to a cost based system, removal of offsite non patient care time for Indirect Medical Education reimbursement, the movement to severity adjusted DRG's, the expansion of number of quality measures to report on, and non payment for infections not present at the time of admission.

DRG Reclassification

West Allis Memorial Hospital takes issue in the re-weighting of the Medicare inpatient DRG's based upon costs rather than billed charges. Our main issues are as follows:

- Not all hospitals have the same cost to charge ratios. In fact, in order to remain competitive, many urban facilities do not mark up expensive surgical supplies such as drug eluding stents and pacemakers, very much at all to keep managed care companies from not authorizing a potentially life saving surgery. These supplies in the CMS calculation are marked up based upon overall department markup, which may not reflect actual supply mark-up.
- Two hundred sixty very large hospitals representing twenty five percent of the total charges were excluded from the cost center cost to charge ratio calculation. However, these hospitals were not exempt from the effects of the DRG weight change, even though the data from their Hospital(s) were not included in the calculation of the DRG weights. Large hospitals offer cutting edge technology services such as Cardiology, and Neurosurgery. Excluding these hospitals from the cost to charge ratio calculation does not give an accurate national cost to charge ratio for modeling purposes.

- Hospitals do not consistently group costs in the same manner on the Medicare cost report. This will lead to cost to charge ratio inaccuracies for the calculation of the DRG payments.
- The cost to charge ratio data used in the calculation is based upon cost report information from 2003. Current technology such as drug-eluding stents, and bi-ventricular pacemakers were in its infancy in 2003, and does not accurately reflect the utilization of these services as it exists today. This leads to inaccuracies in the way these DRG's are proposed to be reimbursed by CMS compared to the actual costs the Hospital incurs for the inpatient stay.

- Cardiology related services will be hit unusually hard in this proposal. As a result of these changes the proposed DRG's for stents will be reduced 24 to 34%, ICD implants will be reduced 22 to 24%, and pacemakers reduced 12 to 14%. Drug eluding stents cost $3,000 a piece. The average number of stents per patient is 1.65. Cost for drug eluding stents per patient is $4,950. With the average reimbursement for DRG 558 being $7,200, this leaves $2,250 to cover the surgery, all of the other supplies, drugs, and the patient stay of two days. This will not even cover the direct costs much less the overhead it takes to run a hospital. The payment shortfall will have a devastating impact for Cardiology programs across the country, and will potentially cause access problems due to programs not being able to recover the cost of the leading edge technology. This is clearly not the intent of what CMS wanted to do.

With DRG's being a payment system of gains on some DRG's and losses on others, recalculation of the DRG weights based upon costs, will cause a lot more losers than gainers. This could cause hospitals not to invest in expensive life saving treatments due to lack of adequate payment, and therefore inhibit potentially life saving patient care.
Due to the drastic financial effect this has on hospitals, at a minimum this change should delayed for one year, or be phased in over a four year period of time to allow hospitals to adjust to the new payment.

DRG's: Severity of Illness

West Allis Memorial Hospital supports CMS's concept of paying claims more accurately by having severity payment levels within each DRG. However, there needs to be a lot more work done before severity DRG's can be implemented.

- More time is needed before implementation for coding staff training.
- The Severity of illness DRG grouper needs to be released to the public so other information system vendors can perform the necessary programming for medical records and business office software systems. Having 3M maintain control of the grouper software limits access by other software vendors to begin reprogramming of the many of computer systems that needs to have the severity adjusted grouper software and are not compatible with the 3M grouper. This needs to happen well before implementation so hospitals can test their systems, and study the impact on their facilities.

- The new version of the UB-92 needs to be released, so the additional ICD-9 codes beyond nine can be accepted by claims processing system. Without this change hospital providers may not get paid accurately under the severity adjusted system.
- ICD-10 codes need to be implemented in order to obtain an accurate patient diagnosis.
- The effect the severity adjusted payment system has on outliers needs to be studied more closely to make the sure payment is accurate for the resources consumed by the patient.

CMS also needs to take the additional time to implement this so their systems operate smoothly and not create accounts receivable problems for the hospitals.

Hospital Quality Data

West Aiiis Memorial Hospital supports CMS's effort to expand the number of quality measures hospitals report on in order to receive the full market basket payment increase. However, more time is needed in order for hospitals to implement the expansion. With the final notice not coming out until the beginning of August, and the quarterly data that CMS wants providers to report the expanded data is due on August 15th. That is not enough time for providers to implement the change. Many hospitals use external vendors to compile and submit the data to CMS. Vendors need adequate time to deal with the programming changes necessary to implement the revised quality measures after the regulation is final. Software testing at the hospital needs to be completed to make sure the data is complete and accurate. West Allis Memorial Hospital proposes delaying this provision for at least six months to allow for a smooth implementation.

Value Based Purchasing

West Allis Memorial Hospital is opposed to CMS's recommendation to not pay additional payments for infections acquired while the patient is in the hospital. Hospitals, most of the time, have no control over what the patient complications arise when they are in the hospital. Many visitors who may come to the hospital have drug resistant staph infections, and not even realize it. This can be passed along to the patient quite easily.
Hospital's infection control departments have measures in place to prevent infections as much as they can. However, they cannot possibly control all of

the infections all of the time. Hospital's still need to be paid adequately for taking care of the patient, especially the complex hard to treat patient with acquired infections.

FTE Resident Count and Documentation

West Allis Memorial Hospital remains opposed to CMS's interpretation of Public Law 105-33 requiring only patient care time spent be allowed in the FTE count calculation when the Intern or Resident is training outside of the Hospital.

Interns and residents, in order to obtain proper training must spend significant non-patient care time out of the hospital. Time spent at external seminars, reviewing clinic patient charts, researching patient symptoms for related diseases, virtual learning (practice suturing ect.) and documentation coordination with the physician in their clinic, are just of the few of very important functions the Intern or Resident spends doing activities outside of the hospital. These are very essential roles for the education of future Physicians. Residents are bound to train for a maximum of 80 hours per week, so wherever the resident
may have down time, they spend their time on these non - direct patient care functions. Without these functions, the training programs cannot exist.
CMS has made a commitment to fund Graduate Medical Education programs. Without adequate funding by CMS for these programs, many programs will not be able to survive and forced to shut down.

West Allis Memorial Hospital would like to thank CMS for the opportunity to submit our comments on this very important proposed regulation. Should you have any questions, please feel free to call me at 414-647-3429.

Sincerely,

Steve Kowske
Government Relations Manager
Aurora HealthCare

Submitter : **Dr. James Barbee** **Date: 06/12/2006**

Organization : **John Peter Smith Hospital-FMRP**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS or the Agency) proposed rule entitled "Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates." 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in "patient care activities." The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

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This position reverses the Agency's position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include "scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty." [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency's 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs.

CMS-1488-P-1343-Attach-1.DOC

CMS Officials:

It is my understanding that support for my activities unrelated to direct patient care as a faculty member are under review. This portion of IME and DME is critical for the support of residency training.

I was attracted to the profession of family medicine faculty because the community recognized the value of experience and academic inquiry to the well-being of our communities and the training of our future physicians.

As I consider the possibility that there could no longer be funding for my work in developing academic programs, writing critical reviews, performing clinical research and reviewing and evaluating resident performance I would feel it necessary to return to full time clinical practice and donate whatever time I can create to a medical student occasionally.

As it is now, most of the time that I spend doing research or critical reading and writing is not compensated. Less that 1/3 of my total academic time is compensated. I make up the difference by seeing more patients myself without residents to offset the cost of my salary and benefits which are currently less than the MGMA 25-tile for a practicing family physician in my geographic region.

For faculty like myself, in community based programs, the thought of being told by a program that I will need to see more patients to pay for the time I am developing and delivering curriculum will be unacceptable.

If you implement this rule I wish you the best of luck. I would not continue as a faculty member. I know that many other faculty feel as I do.

Thank you for your consideration

1,344

Submitter : Dr. Glenn Crotty **Date:** 06/12/2006

Organization : Charleston Area Medical Center

Category : Hospital

Issue Areas/Comments

Value-Based Purchasing

Value-Based Purchasing

June 12, 2006

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1488-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Proposed Changes to the Hospital Inpatient Prospective
Payment Systems and Fiscal Year 2007 Rates.
71 Fed.Reg.23996 (April 25, 2006).

Comment on Hospital- Acquired Infections:

The Charleston Area Medical Center (CAMC), located in Charleston, West Virginia, appreciates the opportunity to comment on the above CMS proposed rule. CAMC is the largest hospital in West Virginia and has one of the largest heart programs in the United States. CAMC is the true safety net provider for all of central and southern West Virginia. We have the only Level I Trauma Center in southern West Virginia as well as one of two Level III Neonatal Intensive Care Units. CAMC is the largest provider of healthcare to Medicare beneficiaries in the state as well as the largest provider of Medicaid and charity care.

In terms of hospital-acquired infections, I believe that the health care system needs to continue to build on the Surgical Care Improvement Project (SCIP) since surgical wound infections are among the most common hospital-acquired infections. The American College of Surgeons, the American Society of Anesthesiologists, the Association of Perioperative Registered Nurses and the Centers for Disease Control and Prevention all participate and provide leadership for SCIP. The SCIP partners could help identify clean surgeries, i.e., surgeries on patients whose conditions or wounds have not placed them in a higher risk of infection.

However, I also need to stress that not all infections can be prevented. CMS must not penalize tertiary care facilities like CAMC that accept referral patients from all of Southern and Central West Virginia who are extremely ill and therefore very susceptible, due to preexisting conditions, to infection. If a hospital can demonstrate that it performs the infection prevention measures called for by SCIP, It should not be penalized by CMS for accepting very ill patients.

Although we support, the concept of not reimbursing additional care resulting from preventable infections, one must acknowledge that a percentage of infections occur as a condition of various medical conditions. We strongly recommend that due consideration is taken to ensure that hospitals continue to be reimbursed for the care associated with non-preventable infections.

In a fair and just approach one should consider the process measures used in SCIP as well as a standardized outcome measure of Hospital Acquired Infections. These combined measures should be used to create a base-line and measures of performance for any organization. A statistical analysis of this performance could serve to identify those organizations with non-preventable infections.

As a part of the effort to standardize infection measurement and its impact on reimbursement one must consider the nomenclature currently used in the coding for DRGs/APRDRGs. The coding guidelines continue to create problems in correct classification of patients. These problems exist due to the differences in the coding guidelines and the physician s nomenclature for describing a patient s condition.

We can only support this effort if there is no change to reimbursement for those patients with non-preventable Hospital-Acquired Infections, a standardized measurement is used that considers process and outcomes measures and if differences between the coding guidelines and physician nomenclature is addressed.

Sincerely,

Glenn Crotty, Jr., M.D.
C.A.M.C., Executive Vice President and

ATTACHMENT TO #1344

Charleston Area Medical Center

Glenn Crotty, Jr., M.D., FACP
Executive Vice President and
Chief Operating Officer

501 Morris Street
Post Office Box 1547
Charleston, West Virginia 25326
(304) 348-7438 Fax: (304) 348-7696
e-mail: glenn.crotty@camcare.com

June 12, 2006

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1488-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

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We can only support this effort if there is no change to reimbursement for those patients with non-preventable Hospital-Acquired Infections, a standardized measurement is used that considers process and outcomes measures and if differences between the coding guidelines and physician nomenclature is addressed.

Sincerely,

Glenn Crotty, Jr., M.D.
C.A.M.C., Executive Vice President and
Chief Operating Officer

Submitter : Dr. Elizabeth Carter **Date:** 06/12/2006

Organization : John Peter Smith Hospital-FMRP

Category : Health Care Provider/Association

Issue Areas/Comments

GME Payments

GME Payments

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Background
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This position reverses the Agency's position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include "scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty." [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency's 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs.

CMS-1488-P-1345-Attach-1.DOC

The Texas Academy of Family Medicine has just informed us that CMS is considering the disallowance of faculty development activity in the calculation of faculty time for IME and DME reimbursement. These activities in our program include:

- Development of Curriculum in alignment with best current evidence
- Review of Curriculum
- Critical Evaluation of Evidence Based Medicine Guidelines for Patient Care
- Development and Utilization of Evaluation Tools for Faculty and Residents
- Delivery of Curriculum by lecture, Web-based curriculum, small group workshops and one-to-one training
- Scholarly Activities
    - Written Publications
    - Presentation of Research
    - Faculty Development Conferences
    - Participation in Critical Review Activities of Specialty
    - Research regarding the outcomes of care of resident practices
    - Clinical Quality Improvement in Resident Delivery to Patient Services
- Resident Evaluation
- Resident Academic Remediation
- Resident Testing
- Resident and Faculty Portfolio Development and Monitoring
- Faculty Training
- Alumni Evaluation and Research

My understanding is that CMS is proposing a rule that would disallow the time for these activities due to them being unrelated to patient care. Patient care is critically dependent on our ability as a faculty to carry out these activities. We can continue to deliver services to the underserved as we always have in our residency site. Duke Family Medicine Department has recently decided to do this rather than continue training family physicians.

However, we will lose our best clinicians and teachers to much higher compensated clinical positions. The patients will lose the benefit of these outstanding critical thinkers in the process of their care. We could not train physicians for the future for much longer without support for the educational aspects of their experience. As a program director, I see this as an unacceptable price to pay for the future of our patients and the patients that would have been cared for by the physicians that we would have trained for our hugely underserved state of Texas.

Submitter : **Mr. John Zedick** **Date: 06/12/2006**

Organization : **Gwinnett Hospital System**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Hospital Quality Data

Hospital Quality Data

The Gwinnett Hospital System supports the Georgia Hospital Association position and recommendations regarding 1488-P.

Submitter : Dr. Richard Fulkerson **Date:** 06/12/2006

Organization : John Peter Smith Hospital-FMRP

Category : Health Care Professional or Association

Issue Areas/Comments

GME Payments

GME Payments

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CMS-1488-P-1347-Attach-1.DOC

#1347

CMS Officials:

It is my understanding that support for my activities unrelated to direct patient care as a faculty member are under review. This portion of IME and DME is critical for the support of residency training.

I was attracted to the profession of family medicine faculty because the community recognized the value of experience and academic inquiry to the well-being of our communities and the training of our future physicians.

As I consider the possibility that there could no longer be funding for my work in developing academic programs, writing critical reviews, performing clinical research and reviewing and evaluating resident performance I would feel it necessary to return to full time clinical practice and donate whatever time I can create to a medical student occasionally.

As it is now, most of the time that I spend doing research or critical reading and writing is not compensated. Less that 1/3 of my total academic time is compensated. I make up the difference by seeing more patients myself without residents to offset the cost of my salary and benefits which are currently less than the MGMA 25-tile for a practicing family physician in my geographic region.

For faculty like myself, in community based programs, the thought of being told by a program that I will need to see more patients to pay for the time I am developing and delivering curriculum will be unacceptable.

If you implement this rule I wish you the best of luck. I would not continue as a faculty member. I know that many other faculty feel as I do.

Thank you for your consideration

Submitter : **Dr. Kelly Lowther** **Date: 06/12/2006**

Organization : **Dr. Kelly Lowther**

Category : **Physician**

Issue Areas/Comments

GME Payments

GME Payments

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Residency Program Activities and Patient Care
I firmly believe that with the possible exception of extended time for bench research, there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician s educational development into an autonomous practitioner.

To separate out CMS s newly defined patient care time from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,

Kelly H. Lowther, MD

Submitter : Dr. Rebecca Kennedy **Date:** 06/12/2006

Organization : Virginia Garcia Memorial Health Service

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS or the Agency) proposed rule entitled Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates. 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in patient care activities. The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

Background
The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a nonhospital setting, such as a physician s office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not related to patient care .

This position reverses the Agency s position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty. [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency s 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs.

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Sincerely,

Rebecca Kennedy

Submitter : Dr. Craig Glass **Date:** 06/12/2006

Organization : John Peter Smith Hospital-FMRP

Category : Health Care Professional or Association

Issue Areas/Comments

GME Payments

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CMS-1488-P-1350-Attach-1.DOC

#1350

The Texas Academy of Family Medicine has just informed us that CMS is considering the disallowance of faculty development activity in the calculation of faculty time for IME and DME reimbursement. These activities in our program include:

- Development of Curriculum in alignment with best current evidence
- Review of Curriculum
- Critical Evaluation of Evidence Based Medicine Guidelines for Patient Care
- Development and Utilization of Evaluation Tools for Faculty and Residents
- Delivery of Curriculum by lecture, Web-based curriculum, small group workshops and one-to-one training
- Scholarly Activities
    - Written Publications
    - Presentation of Research
    - Faculty Development Conferences
    - Participation in Critical Review Activities of Specialty
    - Research regarding the outcomes of care of resident practices
    - Clinical Quality Improvement in Resident Delivery to Patient Services
- Resident Evaluation
- Resident Academic Remediation
- Resident Testing
- Resident and Faculty Portfolio Development and Monitoring
- Faculty Training
- Alumni Evaluation and Research

My understanding is that CMS is proposing a rule that would disallow the time for these activities due to them being unrelated to patient care. Patient care is critically dependent on our ability as a faculty to carry out these activities. We can continue to deliver services to the underserved as we always have in our residency site. Duke Family Medicine Department has recently decided to do this rather than continue training family physicians.

However, we will lose our best clinicians and teachers to much higher compensated clinical positions. The patients will lose the benefit of these outstanding critical thinkers in the process of their care. We could not train physicians for the future for much longer without support for the educational aspects of their experience. As a program director, I see this as an unacceptable price to pay for the future of our patients and the patients that would have been cared for by the physicians that we would have trained for our hugely underserved state of Texas.

Submitter : Dr. Lesca Hadley **Date:** 06/12/2006

Organization : John Peter Smith Hospital-FMRP

Category : Health Care Professional or Association

Issue Areas/Comments

GME Payments

GME Payments

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CMS-1488-P-1351-Attach-1.DOC

#1351

CMS Officials:

It is my understanding that support for my activities unrelated to direct patient care as a faculty member are under review. This portion of IME and DME is critical for the support of residency training.

I was attracted to the profession of family medicine faculty because the community recognized the value of experience and academic inquiry to the well-being of our communities and the training of our future physicians.

As I consider the possibility that there could no longer be funding for my work in developing academic programs, writing critical reviews, performing clinical research and reviewing and evaluating resident performance I would feel it necessary to return to full time clinical practice and donate whatever time I can create to a medical student occasionally.

As it is now, most of the time that I spend doing research or critical reading and writing is not compensated. Less that 1/3 of my total academic time is compensated. I make up the difference by seeing more patients myself without residents to offset the cost of my salary and benefits which are currently less than the MGMA 25-tile for a practicing family physician in my geographic region.

For faculty like myself, in community based programs, the thought of being told by a program that I will need to see more patients to pay for the time I am developing and delivering curriculum will be unacceptable.

If you implement this rule I wish you the best of luck. I would not continue as a faculty member. I know that many other faculty feel as I do.

Thank you for your consideration

#1352

CMS-1488-P-1352

Submitter : Mr. Dan Rode **Date:** 06/12/2006

Organization : American Health Information Managment Association/

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

See Attached Letter - June 12, 2006 from AHIMA

CMS-1488-P-1352-Attach-1.DOC

#1352

AHIMA
American Health Information Management Association

June 12, 2006

Mark McClellan, MD, PhD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: **CMS-1488-P**
PO Box 8011
Baltimore, Maryland 21244-1850

Dear Dr. McClellan:

The purpose of this letter is to comment on the Centers for Medicare & Medicaid Services' (CMS') proposed changes to the Medicare Hospital Inpatient Prospective Payment Systems (IP-PPS) and fiscal year 2007 Rates, as published in the April 25, 2006 *Federal Register* (CMS-1488-P). The American Health Information Management Association (AHIMA) supports the goal of refining the DRG system to better account for severity of illness and as part of a roadmap for improving healthcare data. However, as we explain in detail below, we believe implementation of a new severity-adjusted DRG system should be delayed until after other steps have been taken to improve the quality of healthcare data used as the foundation for this system.

AHIMA is a professional association representing more than 50,000 health information management (HIM) professionals who work throughout the healthcare industry and whose work is closely engaged with the diagnoses and procedure classification systems that serve to create the diagnoses related groups discussed in this proposed rule. As part of our effort to promote consistent coding practices, AHIMA is one of the Cooperating Parties, along with CMS, the Department of Health and Human Services' (HHS) National Center for Health Statistics (NCHS), and the American Hospital Association (AHA). The Cooperating Parties oversee correct coding rules associated with the *International Classification of Diseases Ninth Revision, Clinical Modification* (ICD-9-CM).

Our recognition of the industry's need for consistency in medical coding, improved data integrity, and more precise and contemporary data that reflects 21st century medicine has led AHIMA and others to advocate for adoption and coordinated implementation of ICD-10-CM and ICD-10-PCS for the past several years. It is clear in reviewing this proposal that CMS should have, likewise, continued to advocate for this same conversion. Without the detailed and expanded data these contemporary classifications systems can provide it appears the proposed Medicare severity-based DRG system is premature and will create significant data and payment problems for both the Medicare program and the healthcare providers who serve the Medicare beneficiaries.

1730 M Street, NW, Suite 409, Washington, IL 20036
phone (202) 659-9440 · *fax* (202) 659-9422 · www.ahima.org

II-B: DRG Reclassifications

Unless otherwise noted, AHIMA supports CMS' proposed DRG modifications.

II-B-3 - DRGs: Severity of Illness (71FR24011)

AHIMA supports CMS' goal of refining the Medicare DRG system to better account for severity of illness. However, **after analysis of the proposed rule, and input from HIM professionals who have used the APR-DRG system, it is our conclusion that APR-DRGs should not be implemented in FY 2007 or 2008.** While AHIMA recognizes that CMS is under a Congressional mandate to implement a refinement of the DRG system by FY 2007, our concerns are as follows:

- The proposed implementation timeline for the new DRG system fails to take into account the adoption of ICD-10-CM and ICD-10-PCS, even though CMS has been actively involved in the development of these systems: Continued use of an obsolete and increasingly ambiguous classification system such as ICD-9-CM limits, and to a certain extent could negate, some of the anticipated benefits of a severity-adjusted DRG system. The greater clinical detail in ICD-10-CM may result in different consolidated severity-adjusted DRG assignments due to a greater differentiation in severity of illness than is possible with ICD-9-CM. Also, since implementation of ICD-10-CM and ICD-10-PCS is anticipated in the next few years, it would be administratively burdensome to implement a new DRG system now and then have to implement modifications to accommodate ICD-10-CM and ICD-10-PCS in a few years. The experience both CMS and hospitals will have gained from using an ICD-9-CM based severity-adjusted DRG system may not be entirely relevant under an ICD-10-CM/PCS based system.

- The consolidated severity-adjusted DRG system, as proposed, is too complex for a two-month implementation and long-term use: The complexity of the APR-DRG system makes it very difficult to analyze case mix changes or evaluate accuracy of DRG assignment, due to the complicated interaction of multiple diagnoses and other factors. Coding professionals are often called upon to audit the coding of an episode of care to determine coding accuracy. Coding professionals with APR-DRG audit experience have indicated that the complexity of this system makes it difficult to determine the reason(s) for similar cases being classified differently and to identify errors. **The richer clinical detail captured by a more detailed classification system, such as ICD-10-CM and ICD-10-PCS, might facilitate the design of a severity-adjusted DRG system with less complex decision logic. A simpler severity-adjusted DRG system that is based on a more modern classification system has the potential for increased coder productivity, improved ability to detect and prevent errors and fraud, and more widespread use of computer-assisted technology**

- The proposed severity-adjusted DRG system needs to account for a complete picture of the diagnoses and procedures involved: In order for appropriate severity-adjusted DRG assignment to occur, it is imperative that all reported diagnosis and procedure codes be included in the DRG calculation. Medicare does not process more than nine diagnoses and six procedures, CMS' analysis of the impact of APR-DRGs and the development of the consolidated severity-adjusted DRG system did not include all reported diagnoses and procedures, which means that this process relied on incomplete data. AHIMA has recommended in previous comment letters on annual IPPS revisions that CMS process all reported diagnoses and procedures. The severity of illness of hospital inpatients has increased over the last decade, due to shifts in the provision of care from the inpatient to outpatient setting. This has

led to an increase in the number of comorbidities per hospital admission. Demands for greater coding specificity have also led to an increase in the number of reported diagnosis and procedure codes. Given this situation, AHIMA recommends that hospitals report all codes that are reportable according to the *ICD-9-CM Official Guidelines for Coding and Reporting* and that CMS accept and use all submitted codes in the DRG calculation. Since the proposed DRG system determines severity of illness based on the interaction of multiple diseases, as well as on procedures performed and other factors, it is very possible that diagnoses below the ninth diagnosis field and procedures below the sixth procedure field on the claim could impact the final severity-adjusted DRG assignment. **Until CMS has a full picture of the severity and services received by its Medicare patients, any system will result in inaccurate data and resulting decisions.**

- Circumstances that impact resource utilization are not fully accounted for in the proposed APR-DRG system: AHIMA agrees with the statement in the Proposed Rule that modifications to the consolidated severity-adjusted DRG system need to be made in order to account for increased complexity that is unrelated to severity of illness, such as the use of certain technologies. However, in **addition to the use of medical technologies, there are other circumstances that impact resource utilization that are not currently accounted for in the APR-DRG system and need to be addressed in the new severity-adjusted DRG system, such as the performance of bilateral procedures.**

  As CMS considers modifications to the consolidated severity-adjusted DRG system to capture increased complexity related to the use of technologies and other distinctions in the performance of procedures, it is important to keep in mind that ICD-9-CM procedure codes are increasingly limited in their ability to capture distinctions in medical procedures, including the use of medical technologies. The structure of ICD-9-CM is insufficiently flexible to continue to accommodate revisions needed to identify the use of new medical technology. In order to appropriately capture increased complexity related to the use of certain technologies, it is essential that these technologies be adequately identified by our procedure coding system. **The CMS designed and maintained ICD-10-PCS must be implemented as a replacement for the ICD-9-CM procedure coding system in order for a severity-adjusted DRG system to effectively reflect the complexity of the care provided.**

- Implementation of the proposed APR-DRG system could result in violations of official coding guidelines mandated under HIPAA: We are aware of instances in the APR-DRG system where code sequencing and combinations violate the *ICD-9-CM Official Guidelines for Coding and Reporting.* In some cases, diagnoses are automatically resequenced for APR-DRG assignment due to inappropriate assumptions about the relationship between two diagnoses. For example, if a patient has a final diagnosis of non-cardiac chest pain and a history of coronary artery disease, the case is automatically assigned to a coronary artery disease APR-DRG, even though the documentation indicates the chest pain is not related to the coronary artery disease. In other cases, code combinations that should not be reported according to the *ICD-9-CM Official Guidelines for Coding and Reporting* (such as conditions integral to an established diagnosis) impact the final APR-DRG assignment.

  We believe that any Medicare DRG system should conform to the official coding guidelines and that CMS should make necessary modifications to ensure that that the system logic supports proper coding practices. **We recommend that CMS work with the other Cooperating Parties (American Health Information Management Association, American Hospital Association, National Center for Health Statistics) to make modifications to the severity-adjusted DRGs to ensure consistency**

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with official coding rules and guidelines. We also suggest as we have above that a less-complex system using contemporary classification codes would better ensure a system that can continue to adhere to the *Official Guidelines for Coding and Reporting.*

- The Proposed Rule does not address concerns for ongoing public input into the DRG process or the methodology and logic contained in the system: Given the proprietary nature of the APR-DRG system, it remains unclear just how and when changes in the system will occur and how the industry will be involved in this system in the future. **We believe that the methodology and logic of any Medicare DRG system should be in the public domain and the revision process should allow for educated public input.**

- The Proposed Rule does not address the impact on other Medicare policies: The impact on other Medicare policies, such as the post-acute transfer policy, needs to be addressed well before any implementation. Currently, 182 DRGs are subject to the post-acute transfer policy. Since there is no crosswalk between the current DRGs and the APR-DRGs, **CMS will need to determine how cases subject to this policy, and similar policies, will be identified.**

- The Proposed Rule does not address the impact on other PPS systems: The impact on other Medicare PPS systems that use the hospital inpatient DRGs also needs to be addressed. For instance, will other PPS systems, such as long-term acute care hospitals and psychiatric facilities, continue to use the existing DRGs, or will they also transition to the consolidated severity-adjusted DRGs?

In response to your comment on partial implementation, it is obvious that AHIMA agrees with CMS that there are many practical difficulties associated with partial implementation of the consolidated severity-adjusted DRGs in FY 2007 and complete implementation in FY 2008.

While AHIMA believes implementation of a severity-adjusted DRG system should be delayed, we support making changes to the current DRG system to better account for severity of illness (such as the changes made in FY2006 to the cardiac DRGs). Once ICD-10-CM and ICD-10-PCS have been implemented, then adoption of a severity-adjusted DRG system can occur. In the meantime, further analysis can be done to identify the best system, or modification thereof, for improving the effectiveness of the IP-PPS.

II-C-3c – Changes to Case Mix Index (CMI) from a New DRG System (71FR24019)

The proposed rule notes a concern about the potential for more accurate and complete documentation and coding under the consolidated severity-adjusted DRG system, since coding that has no effect on payment under the current DRG system may result in a case being assigned to a higher paid DRG under the new system. However, hospitals and other healthcare providers are required to adhere to the *ICD-9-CM Official Guidelines for Coding and Reporting*, which provide direction for reporting diagnoses and procedures without regard to the reimbursement impact. Therefore, some of the conditions and procedures that are already being coded and reported, and have no current impact on reimbursement, may impact the consolidated severity-adjusted DRG assignment. Additionally, in some cases, these conditions and procedures may be reported below the ninth diagnosis and sixth procedure field and therefore have not been processed by Medicare under the current system. It is crucial that classification codes be assigned as dictated under the Official Guidelines for reasons beyond the reimbursement for services. And as we

stated earlier, it is also essential that all reported diagnoses and procedures be processed by Medicare in order for the appropriate severity-adjusted DRG to be calculated. **We recommend that Medicare begin to process all reported diagnoses and procedures as soon as possible.**

II-D: Proposed Changes to Specific DRG Classifications

II-D-5 – Severe Sepsis (71FR24037)

As noted during previous discussions with CMS staff, we believe that one of the major problems hospitals are experiencing with the classification of sepsis in the DRG system is that patients with a principal diagnosis of sepsis on mechanical ventilation are not classified to a DRG that accounts for the use of mechanical ventilation. Under the ICD-9-CM rules and guidelines, a patient admitted with sepsis who develops respiratory failure as a result of the sepsis will have a principal diagnosis of sepsis, which means the admission will not be classified to DRG 475. We believe there are other principal diagnoses where this situation occurs – when a non-respiratory condition is reported as the principal diagnosis and the patient is on mechanical ventilation.

We continue to urge CMS to consider modifying the current DRG system such that admissions involving mechanical ventilation are classified to different DRGs than those that do not involve mechanical ventilation, including instances when the principal diagnosis is a non-respiratory condition. We also urge CMS to consider mechanical ventilation as modifications are made to the severity-adjusted DRGs to account for increased complexity due to the use of technologies.

Table 6E- Revised Diagnosis Codes (71FR24292)

In Table 6E, revised diagnosis codes 403.10, 403.90, 404.10, and 404.90 show a CC status of "N." However, all these codes are currently considered CCs. The fifth digits for these codes have been revised to split the chronic kidney disease component between stages I through IV (and unspecified) and stage V or end stage renal disease. The codes with fifth digits indicating chronic kidney disease of stages I through IV (or unspecified) are being changed to non-CCs for FY2007. It is not clear why the status is being changed or what data are being used to support this change. Currently, all of the codes in category 585, chronic kidney disease, are considered CCs, including the codes for stages I through IV and unspecified. We believe the CC status of the codes in categories 403 and 404 should be consistent with the CC status of the codes in category 585.

Also, codes 403.00, 403.10, and 403.90 (hypertensive kidney disease with stages I through IV or unspecified chronic kidney disease) have been classified to DRGs 331, 332, and 333 (Other Kidney and Urinary Tract Diagnoses). This means that hypertensive kidney disease with stages I through IV (or unspecified) chronic kidney disease will no longer be classified to DRG 316 (Renal Failure). Currently, all chronic kidney disease codes are classified to DRG 316, regardless of the stage. Since no changes have been proposed for category 585, chronic kidney disease of any stage in a patient without hypertension will continue to be classified to DRG 316. But if the patient has hypertension, and stage I through IV (or unspecified) chronic kidney disease, the case will be classified to DRGs 331, 332, and 333. **We recommend that the DRG assignment for chronic kidney disease should be consistent for categories 403 and 585.**

IV-A: Reporting of Hospital Quality Data for Annual Hospital Payment Update

IV-A-3 – Electronic Medical Records (71FR24095)

AHIMA welcomes CMS' ongoing support for adoption of certified electronic health records (EHRs) with their potential to significantly improve the quality, safety, and efficiency of healthcare.

The adoption of uniform standards for the EHR will permit the submission of standard reporting of secondary data, such as the quality monitoring data noted in section IV-A-3. Quality reporting should be a byproduct of a well designed EHR, and CMS must be clear that it is the EHR architecture that will convert the primary data of the EHR into the secondary data for reporting such as for quality monitoring data. It is inappropriate to suggest building monitoring measures into the EHR (primary data) itself – clinicians should not be forced to chart to these external measures that could change over time. National uniform standards for the EHR should be in place to ensure proper charting or documentation requirements will produce primary data that can be combined to produce the secondary data needed for quality monitoring, public health reporting, biosurveillance, reimbursement and so forth, as well as for development of internal point-of-care decision support.

AHIMA applauds the efforts that CMS has made to standardize its quality monitoring measures. However, we continue to be concerned that this effort for quality measurements is not uniform or standard across all third parties - governmental and private. The lack of an industry standard is a negative incentive to providers of such information, and to the vendors who must work with providers to attempt to produce the direct or automatic reporting suggested in section IV-A-3. While the proposed rule cites the Federal Health Architecture Data Standards, these standards have not been adopted as standards across the entire healthcare industry. Today, providers often find themselves having to meet competing measurement requirements that result in conflicting reports of an organization's quality of care. These conflicts make the entire process extremely expensive and frustrating, and create barriers to full clinician involvement and consumer trust.

AHIMA suggests that once measurement standards can be adopted by the healthcare industry via the Health Information Technology Standards Panel (HITSP), criteria for the architecture needed to produce such measurements could then come from the Commission for the Certification of Health Information Technology (CCHIT) certification of EHRs. This would provide the end result that CMS is seeking.

IV-B: Value-Based Purchasing

As noted above uniform data content standards will be crucial in the effort to achieve value-based purchasing. A standard EHR will facilitate the process for automated data transmission, and EHR vendors will be more apt to incorporate measurement reporting capabilities into EHR products if measure specifications were standardized across the industry and various segments of provides. This would streamline the hospital data submission procedures and provide the ability for providers to view real-time measurement results to initiate their own improvement interventions in a timelier manner.

IV-B-a –Measure Development and Refinement (71FR24097)

AHIMA commends CMS for the steps it has taken to develop performance or quality measurements in a consensus process with stakeholders. As previously stated only though the development and acceptance of uniform, consistent measurement standards can the US establish uniform data and provide incentives to providers currently faced with myriad requests for inconstant secondary data. As we have noted elsewhere in this letter, it is unfortunate that HHS has chosen not to move forward with the 2003 National Committee on Vital and Health Statistic recommendation that HHS adopt the ICD-9-CM upgrades (That is ICD-10-CM and ICD-10-PCS) developed by the CDC and CMS. Had the ICD-9-CM upgrades been moved through the adoption process, claims data would be available now that would significantly add to the knowledge needed to judge severity, quality, and other factors under consideration.

Likewise, we have mentioned above the need to consider requiring and accepting more than the current nine diagnosis and six procedure codes on the Medicare claims transmission. The Accredited Standards Committee X12's transactions standards – approved under HIPAA – can carry the full set of codes reflecting an episode of care, which in turn can give a fuller picture of the patient's health and care than the limited number of codes now used in the Medicare process and evaluations.

AHIMA remains concerned that even though there is an active program under way to develop standard measurements for quality, the lack of detailed diagnoses and procedure data, that could be available with the use of ICD-10-CM and ICD-10-PCS, will make the information gathered incomplete and inconsistent when it comes to using it for the measurement of quality and other factors.

IV-B-4b – Data Infrastructure (71FR24097)

As CMS considers the data infrastructure associated with its value-based purchasing system, it must keep in mind the transformation to a standard EHR that is currently underway. Expansion of the existing data submission and validation process used for the RHQDAPU program could be streamlined if data could be submitted directly from hospitals with the standard EHR system – this in turn would be an incentive for such facilities to adopt the standard EHR. CMS must also keep in mind and play a role in the development of a nationwide health information network (NHIN). It would be inappropriate to have a mechanism developed unilaterally for Medicare that could conceivably be incorporated into the NHIN at the same time as similar measures for other health plans creating duplicate but disparate systems. Similarly, CMS' QIO contractors should be involved in the local efforts underway in many communities for health information exchange to assure consistency and uniformity, as encouraged by HHS.

As long as hospital medical records reside in a paper-based format, or electronic formations that are inconsistent and don't allow for the necessary data capture and architecture to permit uniform reporting the validation process will remain labor intensive. In the interim between now and when a substantial number of hospitals are up on a standard EHR, the data submission and validation process could be improved if hospitals were only required to submit the portions of the medical records that are required for validation abstraction. This would reduce copying costs and other related costs as well as speed abstraction times for the Clinical Data Abstraction Center. A "validation waiver" process could also be considered. This process would allow those hospitals that achieve validation results at or above 90 percent for two consecutive quarters to receive a "validation waiver" for one or two validation quarters.

IV-B-c – Incentive Methodology

While the proposed rule seeks input on incentives for participation in value-based purchasing, we would simply reaffirm our comments that the structure and standards underway and under contemplation could do much to ensure the national adoption of EHR and NHIN standards, which in turn could, to some extent, lower the costs of procuring EHRs and providing the necessary data to CMS. Administrative costs are still far too high in the US health system. AHIMA agrees there is value in building a system and network that will allow us to identify quality, reduce medical injury, and promote population health. Whatever system CMS decides to build in the interest of value-based purchasing should also reflect these goals and not present barriers to them.

IV-B-5 – Considerations Related to Certain Conditions, Including Hospital-Acquired Infections (71FR24100)

In response to CMS' comments regarding the legislative requirement for hospitals to report the secondary diagnoses that are present on admission, effective October 1, 2007, we are interested in CMS' plans for how this information will be collected. Since the current version of the electronic claim (X12 version 4010) does not contain a field for collecting "present on admission" information, and the next version will not be implemented by October 2007, we are concerned about the potential for an administratively burdensome reporting process outside the claim submission process.

Conclusion

AHIMA appreciates the opportunity to comment on the proposed modifications to the Medicare Hospital Inpatient PPS program for fiscal year 2007. AHIMA supports CMS' goal of refining and developing a severity-adjusted DRG system. However, many of the proposed rule's recommendations ignore the fact that providers currently use a 30-year old classification system and are prohibited from sending all of the data that could be used to develop an more accurate and comprehendible severity-adjusted DRG system that would achieve the goals laid out by Congress.

With this proposed rule, we face the prospect of a rapidly changed reimbursement system without having first improved the obsolete classification system on which it is based and the transaction standards necessary to carry such data. **If CMS and HHS fail to meet the need for 21st century classification systems and up-to-date transaction standards, we believe the goals set out by CMS, and required by Congress, to improve the DRG system and the collection and use of quality monitoring data will fail.**

AHIMA agrees that uniform adoption of a standard EHR will significantly improve clinical care and has the potential to provide good secondary data for a variety of purposes including quality. AHIMA is an active developer and promoter of the standard EHR and AHIMA and its 50,000 HIM professions want to see the standard EHR succeed. We want to see a day when secondary data, whether it is being produced for quality measurement, public health reporting, or reimbursement accurately portrays the diagnoses, severity, and services or procedures provided.

AHIMA stands ready to work with CMS and the healthcare industries to see that all these goals, including those of CMS for accurate payment, are met. If AHIMA can provide any further information, or if there are any questions or concerns in regard to this letter and its recommendations, please contact Sue

Bowman, RHIA, CCS, AHIMA's director of coding policy and compliance at (312) 233-1115 or sue.bowman@ahima.org, or myself at (202) 659-9440 or dan.rode@ahima.org.

Sincerely,

Dan Rode, MBA, FHFMA
Vice President, Policy and Government Relations

cc: Sue Bowman, RHIA, CCS

Submitter : Dr. Rebecca Miller **Date:** 06/12/2006

Organization : Dr. Rebecca Miller

Category : Individual

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS or the Agency) proposed rule entitled Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates. 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in patient care activities. The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

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To separate out CMS s newly defined patient care time from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,
Rebecca Miller MD

Submitter : Dr. Steve Hamilton **Date: 06/12/2006**

Organization : John Peter Smith Hospital-FMRP

Category : Health Care Professional or Association

Issue Areas/Comments

GME Payments

GME Payments

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CMS-1488-P-1354-Attach-1.DOC

The Texas Academy of Family Medicine has just informed us that CMS is considering the disallowance of faculty development activity in the calculation of faculty time for IME and DME reimbursement. These activities in our program include:

- Development of Curriculum in alignment with best current evidence
- Review of Curriculum
- Critical Evaluation of Evidence Based Medicine Guidelines for Patient Care
- Development and Utilization of Evaluation Tools for Faculty and Residents
- Delivery of Curriculum by lecture, Web-based curriculum, small group work-shops and one-to-one training
- Scholarly Activities
    - Written Publications
    - Presentation of Research
    - Faculty Development Conferences
    - Participation in Critical Review Activities of Specialty
    - Research regarding the outcomes of care of resident practices
    - Clinical Quality Improvement in Resident Delivery to Patient Services
- Resident Evaluation
- Resident Academic Remediation
- Resident Testing
- Resident and Faculty Portfolio Development and Monitoring
- Faculty Training
- Alumni Evaluation and Research

My understanding is that CMS is proposing a rule that would disallow the time for these activities due to them being unrelated to patient care. Patient care is critically dependent on our ability as a faculty to carry out these activities. We can continue to deliver services to the underserved as we always have in our residency site. Duke Family Medicine Department has recently decided to do this rather than continue training family physicians.

However, we will lose our best clinicians and teachers to much higher compensated clinical positions. The patients will lose the benefit of these outstanding critical thinkers in the process of their care. We could not train physicians for the future for much longer without support for the educational aspects of their experience. As a program director, I see this as an unacceptable price to pay for the future of our patients and the patients that would have been cared for by the physicians that we would have trained for our hugely underserved state of Texas.

Submitter : **Mr. Gregory Lane** **Date: 06/12/2006**

Organization : **McLaren Health Care Corporation**

Category : **Hospital**

Issue Areas/Comments

Impact Analysis

Impact Analysis

Please see attached. Thank you.

CMS-1488-P-1355-Attach-1.PDF

CMS-1488-P-1355-Attach-2.PDF

#1355

McLAREN
HEALTH CARE

G-3235 Beecher Road • Suite B • Flint, Michigan 48532-3615
(810) 342-1170 • Fax (810) 342-1123

Gregory R. Lane,
Sr. Vice President and CAO

- **McLaren Regional Medical Center**
  - *McLaren Foundation*
- **Lapeer Regional Hospital**
  - *Lapeer Area Hospital Fund*
- **Ingham Regional Medical Center**
  - *Greenlawn Campus*
  - *Pennsylvania Avenue Campus*
  - *Ingham Foundation*
- **Bay Regional Medical Center**
  - *Bay Medical Foundation*
  - *Bay Special Care*
- **McLaren Medical Management, Inc.**
  - *McLaren Ambulatory Care Centers*
  - *Regional EMS*
- **Visiting Nurse Services of Michigan**
- **McLaren Health Plan**
  - *Health Advantage, Inc.*

www.mclaren.org

June 12, 2006

Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1488-P
P.O. Box 8011
Baltimore, MD 21244-1850

Re: Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates; Proposed Rule

Dear Dr. McClellan:

On behalf of McLaren Health Care Corporation, we appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) proposed rule on the FY 07 Medicare Inpatient Prospective Payment System (IPPS) published in the April 25, 2006 *Federal Register*. Given the complexities of CMS' proposal to revise the diagnosis-related group (DRG) system and the magnitude of impact this could have on our health system, we are writing to urge a one-year delay in implementing these policy proposals.

CMS proposes to move from the historical charge-based DRG system to a cost-based system and to implement hospital-specific relative weights by October 1, 2006. CMS also proposes modifying the DRG classification system to account for differences in patient severity and allow for a payment amount that more closely tracks the cost of providing care. In its proposal, CMS states that it would replace the current 526 DRGs with either the proposed 861 consolidated severity-adjusted DRGs by FY 08 or a similar system that accounts for the level of patient severity, developed in response to public comments that it receives.

McLaren Health Care Corporation supports meaningful improvement to Medicare payments for inpatient services and applauds the tremendous effort CMS has put forth to devise a DRG system that more accurately reflects the costs of providing inpatient services. We recognize that your agency has taken these steps to make payments fairer to hospitals and to assure beneficiary access to services in the

most appropriate setting. In the proposed rule, CMS seeks input on the proposed methodologies and solicits alternatives to the consolidated severity-adjusted DRG model. While we welcome the opportunity to work with CMS and other stakeholders in ensuring that any system implemented accomplishes the stated goals, we are extremely concerned with the tight timeline provided for developing comments and the implementation dates outlined in the proposal. Restructuring the DRG system as proposed in the rule would represent the most significant policy change to the IPPS since its inception. A change of this magnitude warrants a thoughtful and thorough review by hospitals, a task not easily accomplished during a 60-day comment period, given the complexity of the proposals.

As such, we strongly urge CMS to delay implementing both the proposed DRG reclassification and the changes to the relative weights until FY 08. The additional time will allow McLaren Health Care Corporation and other hospitals and health systems to more thoroughly evaluate the proposals and offer constructive feedback to your agency.

Again, thank you for the opportunity to share our comments on the DRG provisions of the proposed IPPS rule.

Sincerely,

Gregory R. Lane
Sr. Vice President and CAO

McLAREN
HEALTH CARE

G-3235 Beecher Road • Suite B • Flint, Michigan 48532-3615
(810) 342-1170 • Fax (810) 342-1123

Gregory R. Lane,
Sr. Vice President and CAO

• McLaren Regional Medical Center
- McLaren Foundation
• Lapeer Regional Hospital
- Lapeer Area Hospital Fund
• Ingham Regional Medical Center
- Greenlawn Campus
- Pennsylvania Avenue Campus
- Ingham Foundation
• Bay Regional Medical Center
- Bay Medical Foundation
- Bay Special Care
• McLaren Medical Management, Inc.
- McLaren Ambulatory Care Centers
- Regional EMS
• Visiting Nurse Services of Michigan
• McLaren Health Plan
- Health Advantage, Inc.

June 12, 2006

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Centers for Medicare and Medicaid Services
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Again, thank you for the opportunity to share our comments on the DRG provisions of the proposed IPPS rule.

Sincerely,

Gregory R. Lane
Sr. Vice President and CAO

Submitter : Mr. Christopher Dehlin **Date:** 06/12/2006

Organization : Michigan State University College of Human Medicin

Category : Individual

Issue Areas/Comments

GME Payments

GME Payments

As a future family physician, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS or the Agency) proposed rule entitled Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates. 71 Fed. Reg. 23996 (April 25, 2006).

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I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,
Chris Dehlin

Submitter : **Dr. Alma Littles** **Date: 06/12/2006**

Organization : **AAFP**

Category : **Physician**

Issue Areas/Comments

GME Payments

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Sincerely,

Alma B. Littles, M. D.

Submitter : **Dr. David Swee** **Date: 06/12/2006**

Organization : **UMDNJ-Robert Wood Johnson Medical School**

Category : **Individual**

Issue Areas/Comments

GME Payments

GME Payments

As a family physician and as Acting Senior Associate Dean for Education at UMDNJ-Robert Wood Johnson Medical School, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS or the Agency) proposed rule entitled "Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates." 71 Fed. Reg. 23996 (April 25, 2006).

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To separate out CMS's newly defined "patient care time" from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden. In sum, educational sessions in a residency program are, by definition, about patient care, so this should not even be a consideration.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,

David E. Swee, MD

Submitter : **Dr. Erin Netteland** **Date: 06/12/2006**

Organization : **Hinsdale Family Medicine Residency**

Category : **Physician**

Issue Areas/Comments

GME Payments

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Sincerely,

Erin Netteland DO

Submitter : Dr. Wayne Hale **Date:** 06/12/2006

Organization : MCHS Family Practice Center

Category : Individual

Issue Areas/Comments

GME Payments

GME Payments

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Sincerely,
Wayne A. Hale, MD, MS

Submitter : Dr. Gregory Dehmer **Date:** 06/12/2006

Organization : Society for Cardiovascular Angiography and Interve

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

see attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter : **Mr. Charles Colvin** **Date: 06/12/2006**

Organization : **Central Baptist Hospital**

Category : **Hospital**

Issue Areas/Comments

HSRV Weights

HSRV Weights

See Attachment

CMS-1488-P-1362-Attach-1.DOC

#1362

BAPTIST HEALTHCARE SYSTEM

4007 Kresge Way
Louisville, Kentucky 40207
502-896-5000

Electronically Submitted

June 12, 2006

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1488-P
7500 Security Boulevard
Baltimore, Maryland 21244-1850

RE: Provider Comments
Proposed Changes to Inpatient PPS
DRG Reclassifications and Severity of Illness

On behalf of the Central Baptist Hospital, a member of Baptist Healthcare System, Inc. (BHS), we appreciate the opportunity to comment on the fiscal year (FY) 2007 proposed changes to the hospital inpatient prospective payment system.

BHS supports meaningful improvements to Medicare's inpatient prospective system and shares CMS's desire to develop a payment system that provides an equal financial incentive (margin) to treat all patients, regardless of diagnosis or severity of illness. BHS further acknowledges that this payment system must be statistically robust, clinically meaningful and at the same time, administratively feasible.

BHS submits the following recommendations to the current proposals:

1. The proposed changes to the DRG weights based upon Hospital Specific Relative Value cost center (HSRVcc) and introduction of Consolidated Severity Adjusted DRGs (CS-DRGs) should be implemented simultaneously.

2. The proposed changes to the DRG weights (HSRVcc) and introduction of CS-DRGs should be implemented on or after October 1, 2008.

3. Valid cost-based weights must be developed and utilized.

4. Further refinement of the proposed CS-DRG methodology needs to be done to ensure it promotes (rather than inhibits) the accomplishment of CMS's stated goals.

Discussion and rationale for recommendations:

Recommendation 1: Simultaneous Implementation

a. The proposed HSRVcc changes in FY2007 are projected to reduce reimbursement to BHS from the current FY2006 amount by nearly $8.5 million.

b. The proposed implementation of CS-DRGs in FY2008 is projected to increase reimbursement from the FY2007 amount by nearly $8.2 million (which represents a reduction of approximately $300,000 from the current FY2006 amount). This significant volatility in reimbursement has several implications.

   First, BHS will **permanently** lose $8.2 million in reimbursement in FY2007.

   Second, BHS will **potentially** receive an increase in reimbursement in FY2008. BHS has utilized the 3M APR-DRG grouper for many years, largely as part of internal quality initiatives and the Premier Hospital Quality Incentive Demonstration. As a result, BHS had the internal APR-DRG data to convert to CS-DRGs and calculate the impact of the FY2008 proposal.

   However, the underlying assumptions in the impact analysis are: (1) coding in the future is consistent with current coding practices, and (2) that Medicare will allow current coding in the future reimbursement model. Because these are assumptions and not givens, BHS has significant concerns regarding the ability to accurately forecast the proposals impact beyond FY2007, which is critical.

   Third, the increase in reimbursement in FY2008 under the CS-DRG system indicates that BHS hospitals treat more severe patients on average. This finding is consistent with the mission and values of its member hospitals.

   BHS is comprised of five hospitals within the state of Kentucky. It operates urban hospitals in Louisville, La Grange and Lexington, rural referral centers in Corbin and Paducah. Collectively, BHS has the largest number of inpatient admissions in Kentucky and is one of the largest providers of Medicaid services within the state.

   The primary and secondary markets for BHS hospitals is comprised of 40 of the 120 counties in Kentucky and range across the central, western and southeastern parts of the state. Five of the poorest ten counties are located with the BHS service area.

   Medicaid, charity and uninsured patients represent over 17% of BHS inpatient business. As part of BHS's Christ-centered mission, each BHS hospital has not only expanded its general acute care services, but also its highly specialized tertiary programs in an effort to provide a full range of surgical and medical services to all patients regardless of their ability to pay or severity of illness. Central Baptist Hospital, a disproportionate share facility, serves an even higher percentage of Medicaid, charity and uninsured patients than BHS as a whole, with this population accounting for over 18.5% of our inpatient business. Central Baptist Hospital offers a broad range of tertiary care services to all

patients, regardless of ability to pay, including being a regional leader in the offering of high acuity services and new technologies in neonatology, oncology, neurology, cardiology, and orthopedics.

Given the mission of BHS and demographics of the communities it serves, it is clear that BHS hospitals are not specialty hospitals that target services that provide higher margins. However, given the high severity of illness for the patient population BHS hospitals serve, unless the HSRVcc and CS-DRG proposals are implemented simultaneously, unfair financial hardship will be experienced, threatening our ability to provide the same level of access to cutting edge technologies currently offered.

Fourth, CMS suggests that a budget neutrality factor may be applied to offset improvements in coding practices. This too, represents a significant unknown in the current proposal that needs to be accurately evaluated and communicated for which additional time is necessary.

Recommendation 2: Delay until October 1, 2008

a. It is imperative that the GROUPER technology be made available to hospitals and vendors. Without direct access to the GROUPER by hospitals, it will be virtually impossible to understand its logic. Without access by multiple vendors, it will be more difficult to purchase at a competitive price and will be more difficult to integrate into existing hospital systems.

b. In addition, many current hospital software programs will need to be modified to handle the new payment and billing system. An implementation date before October 1, 2008 will not allow adequate time to make all the necessary system changes and upgrades.

c. CMS stated that one option to the software issue is for hospitals to submit claims without being grouped and allow CMS to assign the CS-DRG. This raises several serious concerns.

   First, without the CS-DRG information, revenues and patient receivables cannot be recorded accurately. Statement of Position (SOP)-00-1(6) states, "Health care entities need to estimate amounts that ultimately will be realizable in order for revenues to be fairly stated in accordance with generally accepted accounting principles (GAAP)." Paragraph (9) states "Management is responsible for the fair presentation of its financial statements in conformity with GAAP".

   Currently, the DRG assignment is critical in making an accurate estimate of the net realizable value of accounts receivable. Given the significance of and the increased uncertainty of the impact of the proposed changes for FY2007 and FY2008, it will be even more important for patient bills to be grouped prior to billing.

   Second, the Medicare inpatient business represents over 41% of BHS total inpatient business. As such, changes to the Medicare payment system have a significant impact on BHS's ability to accurately estimate payments in evaluating strategic initiatives, business

plans, budgets, marketing, staffing and other critical decisions. With the significance of the proposed changes, more time is required to understand and perform impact analysis.

d. Four of five BHS hospitals are disproportionate share hospitals (DSH). Last year these hospitals received approximately $14.7 million in DSH reimbursement. It is anticipated that the CS-DRGs will have a material impact on DSH payments and in order for hospitals to adequately plan and make appropriate adjustments in a timely manner, BHS recommends that further analysis be prepared and accurate impact estimates published prior to implementation of the proposed changes.

e. Additional time is required to determine the impact from other third party payers (including Medicaid) that have historically modeled reimbursement rules and methodologies from the Medicare payment system. It is anticipated that these third party payers will adopt the new Medicare payment system at some time in the near future following implementation by Medicare. However, given the complexity of the proposed changes, additional time is necessary for payers and hospitals to better understand these changes and make appropriate systematic changes.

Recommendation 3: Valid Cost Weights

a. Under the HSRV weight calculation method, the ten cost center categories were developed based on broad accounting definitions, where each cost center category represents at least five percent of the charges in the claims data. BHS acknowledges the need to remove bias introduced by individual hospital characteristics (i.e. unique cost centers reported on the cost report), but it appears that this resulted in incorrect cost center groupings in the CMS study that raises concerns regarding the accuracy of the cost-to-charge ratio (CCR) data.

   For example, according to CMS-1488-P, Table-A (pp.66-67 and pp.186-187) the HSRV Cardiology cost center includes cost report lines 53 and 54. However, one BHS hospital includes its Catherization Lab revenues and expenses on cost report line 42.01, which according to the table appears to be incorrectly grouped with the HSRV Radiology cost center that includes cost report lines 41,42 and 43.

   BHS is very concerned that grouping errors such as the one described here could materially impact the CCR used to calculate the DRG weights. Therefore, BHS recommends that CMS work through the Medicare intermediaries to audit the cost report line definitions for all hospitals to ensure groupings are accurate.

b. The weighting calculation used to determine the scaling factors gives equal weight to each hospital regardless of size or volume. This methodology results not only in an inaccurate national cost-to-charge ratio, but is inconsistent with the method used when averaging the ten cost center DRG weights to which the scaling factors are applied. Therefore, BHS recommends that a consistent weighting methodology be utilized to calculate the scaling factors.

c. HSRVcc costs were based on the 2004 cost reports. Significant changes in medical technologies, products and services have been introduced, which have significantly impacted the CCR. Therefore, BHS recommends that a more recent audited cost report be used, after audit procedures have been performed as recommended in (a.) above.

d. Central Baptist Hospital is also concerned that partial data from a number of large hospitals whose cost to charge ratios were classified as outliers were excluded from the analysis. The exclusion of this data, which, because of the size of excluded facilities, collectively accounts for a large percentage of Medicare inpatient admissions nationally, materially impacts the resulting calculations, and, in particular, causes routine care cost to charge ratios to be much higher as used in the CMS calculations than the actual national averages reflect. Furthermore, this problem is compounded by the fact that CMS continues to use partial data from these same facilities

Recommendation 4: Consolidated Severity-Adjusted DRG Methodology

a. CS-DRGs are developed by grouping APR DRGs considering average length of stay and average charges. This grouping methodology is inconsistent with the cost-based intention of the proposed changes. Average cost, using the HSRVcc methodology (applying the recommended changes), for each APR DRG by severity level should be the determinant for grouping APR DRGs into CS DRGs.

b. CMS believes that the adoption of consolidated severity-adjusted DRGs would create a risk of increased aggregate levels of payment, similar to the 2% increase associated with the implementation of the current DRG system in 1983 and has recommended the application of a compensating budget neutrality factor. Because of the significance of even a 2% reduction in reimbursement, BHS recommends that this be further studied before implementation.

Thank you for your consideration of our recommendations. We certainly hope you can see and appreciate the legitimacy of the concerns raised. If you have any questions, please feel free to contact me at (859) 260-6472 or ccolvin@bhsi.com.

Charles Colvin
Director of Reimbursement
Central Baptist Hospital

Submitter : Dr. Michelle Kirk **Date:** 06/12/2006

Organization : John Peter Smith Hospital-FMRP

Category : Health Care Professional or Association

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS or the Agency) proposed rule entitled "Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates." 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in "patient care activities." The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

Background
The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a nonhospital setting, such as a physician's office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not "related to patient care".

This position reverses the Agency's position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include "scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty." [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency's 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs.

CMS-1488-P-1363-Attach-1.DOC

#1363

CMS Officials:

It is my understanding that support for my activities unrelated to direct patient care as a faculty member are under review. This portion of IME and DME is critical for the support of residency training.

I was attracted to the profession of family medicine faculty because the community recognized the value of experience and academic inquiry to the well-being of our communities and the training of our future physicians.

As I consider the possibility that there could no longer be funding for my work in developing academic programs, writing critical reviews, performing clinical research and reviewing and evaluating resident performance I would feel it necessary to return to full time clinical practice and donate whatever time I can create to a medical student occasionally.

As it is now, most of the time that I spend doing research or critical reading and writing is not compensated. Less that 1/3 of my total academic time is compensated. I make up the difference by seeing more patients myself without residents to offset the cost of my salary and benefits which are currently less than the MGMA 25-tile for a practicing family physician in my geographic region.

For faculty like myself, in community based programs, the thought of being told by a program that I will need to see more patients to pay for the time I am developing and delivering curriculum will be unacceptable.

If you implement this rule I wish you the best of luck. I would not continue as a faculty member. I know that many other faculty feel as I do.

Thank you for your consideration

Submitter : **Mrs. Donna Ghobadi** **Date: 06/12/2006**

Organization : **Central Baptist Hospital**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1364-Attach-1.DOC

#1364

BAPTIST HEALTHCARE SYSTEM

4007 Kresge Way
Louisville, Kentucky 40207
502-896-5000

Electronically Submitted

June 12, 2006

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1488-P
7500 Security Boulevard
Baltimore, Maryland 21244-1850

RE: Provider Comments
Proposed Changes to Inpatient PPS
DRG Reclassifications and Severity of Illness

On behalf of the Central Baptist Hospital, a member of Baptist Healthcare System, Inc. (BHS), we appreciate the opportunity to comment on the fiscal year (FY) 2007 proposed changes to the hospital inpatient prospective payment system.

BHS supports meaningful improvements to Medicare's inpatient prospective system and shares CMS's desire to develop a payment system that provides an equal financial incentive (margin) to treat all patients, regardless of diagnosis or severity of illness. BHS further acknowledges that this payment system must be statistically robust, clinically meaningful and at the same time, administratively feasible.

BHS submits the following recommendations to the current proposals:

1. The proposed changes to the DRG weights based upon Hospital Specific Relative Value cost center (HSRVcc) and introduction of Consolidated Severity Adjusted DRGs (CS-DRGs) should be implemented simultaneously.

2. The proposed changes to the DRG weights (HSRVcc) and introduction of CS-DRGs should be implemented on or after October 1, 2008.

3. Valid cost-based weights must be developed and utilized.

4. Further refinement of the proposed CS-DRG methodology needs to be done to ensure it promotes (rather than inhibits) the accomplishment of CMS's stated goals.

Discussion and rationale for recommendations:

Recommendation 1: Simultaneous Implementation

a. The proposed HSRVcc changes in FY2007 are projected to reduce reimbursement to BHS from the current FY2006 amount by nearly $8.5 million.

b. The proposed implementation of CS-DRGs in FY2008 is projected to increase reimbursement from the FY2007 amount by nearly $8.2 million (which represents a reduction of approximately $300,000 from the current FY2006 amount). This significant volatility in reimbursement has several implications.

   First, BHS will **permanently** lose $8.2 million in reimbursement in FY2007.

   Second, BHS will **potentially** receive an increase in reimbursement in FY2008. BHS has utilized the 3M APR-DRG grouper for many years, largely as part of internal quality initiatives and the Premier Hospital Quality Incentive Demonstration. As a result, BHS had the internal APR-DRG data to convert to CS-DRGs and calculate the impact of the FY2008 proposal.

   However, the underlying assumptions in the impact analysis are: (1) coding in the future is consistent with current coding practices, and (2) that Medicare will allow current coding in the future reimbursement model. Because these are assumptions and not givens, BHS has significant concerns regarding the ability to accurately forecast the proposals impact beyond FY2007, which is critical.

   Third, the increase in reimbursement in FY2008 under the CS-DRG system indicates that BHS hospitals treat more severe patients on average. This finding is consistent with the mission and values of its member hospitals.

   BHS is comprised of five hospitals within the state of Kentucky. It operates urban hospitals in Louisville, La Grange and Lexington, rural referral centers in Corbin and Paducah. Collectively, BHS has the largest number of inpatient admissions in Kentucky and is one of the largest providers of Medicaid services within the state.

   The primary and secondary markets for BHS hospitals is comprised of 40 of the 120 counties in Kentucky and range across the central, western and southeastern parts of the state. Five of the poorest ten counties are located with the BHS service area.

   Medicaid, charity and uninsured patients represent over 17% of BHS inpatient business. As part of BHS's Christ-centered mission, each BHS hospital has not only expanded its general acute care services, but also its highly specialized tertiary programs in an effort to provide a full range of surgical and medical services to all patients regardless of their ability to pay or severity of illness. Central Baptist Hospital, a disproportionate share facility, serves an even higher percentage of Medicaid, charity and uninsured patients than BHS as a whole, with this population accounting for over 18.5% of our inpatient business. Central Baptist Hospital offers a broad range of tertiary care services to all

patients, regardless of ability to pay, including being a regional leader in the offering of high acuity services and new technologies in neonatology, oncology, neurology, cardiology, and orthopedics.

Given the mission of BHS and demographics of the communities it serves, it is clear that BHS hospitals are not specialty hospitals that target services that provide higher margins. However, given the high severity of illness for the patient population BHS hospitals serve, unless the HSRVcc and CS-DRG proposals are implemented simultaneously, unfair financial hardship will be experienced, threatening our ability to provide the same level of access to cutting edge technologies currently offered.

Fourth, CMS suggests that a budget neutrality factor may be applied to offset improvements in c oding p ractices. T his t oo, r epresents a s ignificant unkno wn in t he current proposal that needs to be accurately evaluated and communicated for which additional time is necessary.

Recommendation 2: Delay until October 1, 2008

a. It is imperative that the GROUPER technology be made available to hospitals and vendors. Without direct access to the GROUPER by hospitals, it will be virtually impossible to understand its logic. Without access by multiple vendors, it will be more difficult to purchase at a competitive price and will be more difficult to integrate into existing hospital systems.

b. In addition, many current hospital software programs will need to be modified to handle the new payment and billing system. An implementation date before October 1, 2008 will not allow adequate time to make all the necessary system changes and upgrades.

c. CMS stated that one option to the software issue is for hospitals to submit claims without being grouped and allow CMS to assign the CS-DRG. This raises several serious concerns.

   First, without the CS-DRG information, revenues and patient receivables cannot be recorded accurately. Statement of Position (SOP)-00-1(6) states, "Health care entities need to estimate amounts that ultimately will be realizable in order for revenues to be fairly stated in accordance with generally accepted accounting principles (GAAP)." Paragraph (9) states "Management is responsible for the fair presentation of its financial statements in conformity with GAAP".

   Currently, the DRG assignment is critical in making an accurate estimate of the net realizable value of accounts receivable. Given the significance of and the increased uncertainty of the impact of the proposed changes for FY2007 and FY2008, it will be even more important for patient bills to be grouped prior to billing.

   Second, the Medicare inpatient business represents over 41% of BHS total inpatient business. As such, changes to the Medicare payment system have a significant impact on BHS's ability to accurately estimate payments in evaluating strategic initiatives, business

plans, budgets, marketing, staffing and other critical decisions. With the significance of the proposed changes, more time is required to understand and perform impact analysis.

d. Four of five BHS hospitals are disproportionate share hospitals (DSH). Last year these hospitals received approximately $14.7 million in DSH reimbursement. It is anticipated that the CS-DRGs will have a material impact on DSH payments and in order for hospitals to adequately plan and make appropriate adjustments in a timely manner, BHS recommends that further analysis be prepared and accurate impact estimates published prior to implementation of the proposed changes.

e. Additional time is required to determine the impact from other third party payers (including Medicaid) that have historically modeled reimbursement rules and methodologies from the Medicare payment system. It is anticipated that these third party payers will adopt the new Medicare payment system at some time in the near future following implementation by Medicare. However, given the complexity of the proposed changes, additional time is necessary for payers and hospitals to better understand these changes and make appropriate systematic changes.

Recommendation 3: Valid Cost Weights

a. Under the HSRV weight calculation method, the ten cost center categories were developed based on broad accounting definitions, where each cost center category represents at least five percent of the charges in the claims data. BHS acknowledges the need to remove bias introduced by individual hospital characteristics (i.e. unique cost centers reported on the cost report), but it appears that this resulted in incorrect cost center groupings in the CMS study that raises concerns regarding the accuracy of the cost-to-charge ratio (CCR) data.

   For example, according to CMS-1488-P, Table-A (pp.66-67 and pp.186-187) the HSRV Cardiology cost center includes cost report lines 53 and 54. However, one BHS hospital includes its Catherization Lab revenues and expenses on cost report line 42.01, which according to the table appears to be incorrectly grouped with the HSRV Radiology cost center that includes cost report lines 41,42 and 43.

   BHS is very concerned that grouping errors such as the one described here could materially impact the CCR used to calculate the DRG weights. Therefore, BHS recommends that CMS work through the Medicare intermediaries to audit the cost report line definitions for all hospitals to ensure groupings are accurate.

b. The weighting calculation used to determine the scaling factors gives equal weight to each hospital regardless of size or volume. This methodology results not only in an inaccurate national cost-to-charge ratio, but is inconsistent with the method used when averaging the ten cost center DRG weights to which the scaling factors are applied. Therefore, BHS recommends that a consistent weighting methodology be utilized to calculate the scaling factors.

c. HSRVcc costs were based on the 2004 cost reports. Significant changes in medical technologies, products and services have been introduced, which have significantly impacted the CCR. Therefore, BHS recommends that a more recent audited cost report be used, after audit procedures have been performed as recommended in (a.) above.

d. Central Baptist Hospital is also concerned that partial data from a number of large hospitals whose cost to charge ratios were classified as outliers were excluded from the analysis. The exclusion of this data, which, because of the size of excluded facilities, collectively accounts for a large percentage of Medicare inpatient admissions nationally, materially impacts the resulting calculations, and, in particular, causes routine care cost to charge ratios to be much higher as used in the CMS calculations than the actual national averages reflect. Furthermore, this problem is compounded by the fact that CMS continues to use partial data from these same facilities

Recommendation 4: Consolidated Severity-Adjusted DRG Methodology

a. CS-DRGs are developed by grouping APR DRGs considering average length of stay and average charges. This grouping methodology is inconsistent with the cost-based intention of the proposed changes. Average cost, using the HSRVcc methodology (applying the recommended changes), for each APR DRG by severity level should be the determinant for grouping APR DRGs into CS DRGs.

b. CMS believes that the adoption of consolidated severity-adjusted DRGs would create a risk of increased aggregate levels of payment, similar to the 2% increase associated with the implementation of the current DRG system in 1983 and has recommended the application of a compensating budget neutrality factor. Because of the significance of even a 2% reduction in reimbursement, BHS recommends that this be further studied before implementation.

Thank you for your consideration of our recommendations. We certainly hope you can see and appreciate the legitimacy of the concerns raised. If you have any questions, please feel free to contact me at (502) 896-5011 or dghobadi@bhsi.com .

Donna Ghobadi
Vice President
Central Baptist Hospital

Submitter : **Dr. Margaret Handley** **Date: 06/12/2006**

Organization : **UCSF Dept of Family and Comm Medicine**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

As a faculty member of a department of family medicine, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS or the Agency) proposed rule entitled Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates. 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in patient care activities. The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

Submitter : **Dr. Glenn Crotty** **Date: 06/12/2006**

Organization : **Charleston Area Medical Center**

Category : **Hospital**

Issue Areas/Comments

Value-Based Purchasing

Value-Based Purchasing

Comment on Hospital- Acquired Infections:

The Charleston Area Medical Center (CAMC), located in Charleston, West Virginia, appreciates the opportunity to comment on the above CMS proposed rule. CAMC is the largest hospital in West Virginia and has one of the largest heart programs in the United States. CAMC is the true safety net provider for all of central and southern West Virginia. We have the only Level I Trauma Center in southern West Virginia as well as one of two Level III Neonatal Intensive Care Units. CAMC is the largest provider of healthcare to Medicare beneficiaries in the state as well as the largest provider of Medicaid and charity care.

In terms of hospital-acquired infections, I believe that the health care system needs to continue to build on the Surgical Care Improvement Project (SCIP) since surgical wound infections are among the most common hospital-acquired infections. The American College of Surgeons, the American Society of Anesthesiologists, the Association of Perioperative Registered Nurses and the Centers for Disease Control and Prevention all participate and provide leadership for SCIP. The SCIP partners could help identify clean surgeries, i.e., surgeries on patients whose conditions or wounds have not placed them in a higher risk of infection.

However, I also need to stress that not all infections can be prevented. CMS must not penalize tertiary care facilities like CAMC that accept referral patients from all of Southern and Central West Virginia who are extremely ill and therefore very susceptible, due to preexisting conditions, to infection. If a hospital can demonstrate that it performs the infection prevention measures called for by SCIP, It should not be penalized by CMS for accepting very ill patients.

Although we support, the concept of not reimbursing additional care resulting from preventable infections, one must acknowledge that a percentage of infections occur as a condition of various medical conditions. We strongly recommend that due consideration is taken to ensure that hospitals continue to be reimbursed for the care associated with non-preventable infections.

In a fair and just approach one should consider the process measures used in SCIP as well as a standardized outcome measure of Hospital Acquired Infections. These combined measures should be used to create a base-line and measures of performance for any organization. A statistical analysis of this performance could serve to identify those organizations with non-preventable infections.

As a part of the effort to standardize infection measurement and its impact on reimbursement one must consider the nomenclature currently used in the coding for DRGs/APRDRGs. The coding guidelines continue to create problems in correct classification of patients. These problems exist due to the differences in the coding guidelines and the physician s nomenclature for describing a patient s condition.

We can only support this effort if there is no change to reimbursement for those patients with non-preventable Hospital-Acquired Infections, a standardized measurement is used that considers process and outcomes measures and if differences between the coding guidelines and physician nomenclature is addressed.

Sincerely,

Glenn Crotty, Jr., M.D.
C.A.M.C., Executive Vice President and
Chief Operating Officer

CMS-1488-P-1366-Attach-1.PDF

#1266

Charleston Area Medical Center

Glenn Crotty, Jr., M.D., FACP
Executive Vice President and
Chief Operating Officer

501 Morris Street
Post Office Box 1547
Charleston, West Virginia 25326
(304) 348-7438 Fax: (304) 348-7696
e-mail: glenn.crotty@camcare.com

June 12, 2006

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1488-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates.
71 Fed.Reg.23996 (April 25, 2006).

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Submitter : Dr. Mark Koch **Date:** 06/12/2006

Organization : John Peter Smith Hospital-FMRP

Category : Health Care Professional or Association

Issue Areas/Comments

GME Payments

GME Payments

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I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in "patient care activities." The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

Background
The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a nonhospital setting, such as a physician's office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not "related to patient care".

This position reverses the Agency's position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include "scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty." [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency's 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs.

CMS-1488-P-1367-Attach-1.DOC

The Texas Academy of Family Medicine has just informed us that CMS is considering the disallowance of faculty development activity in the calculation of faculty time for IME and DME reimbursement. These activities in our program include:

- Development of Curriculum in alignment with best current evidence
- Review of Curriculum
- Critical Evaluation of Evidence Based Medicine Guidelines for Patient Care
- Development and Utilization of Evaluation Tools for Faculty and Residents
- Delivery of Curriculum by lecture, Web-based curriculum, small group work-shops and one-to-one training
- Scholarly Activities
    - Written Publications
    - Presentation of Research
    - Faculty Development Conferences
    - Participation in Critical Review Activities of Specialty
    - Research regarding the outcomes of care of resident practices
    - Clinical Quality Improvement in Resident Delivery to Patient Services
- Resident Evaluation
- Resident Academic Remediation
- Resident Testing
- Resident and Faculty Portfolio Development and Monitoring
- Faculty Training
- Alumni Evaluation and Research

My understanding is that CMS is proposing a rule that would disallow the time for these activities due to them being unrelated to patient care. Patient care is critically dependent on our ability as a faculty to carry out these activities. We can continue to deliver services to the underserved as we always have in our residency site. Duke Family Medicine Department has recently decided to do this rather than continue training family physicians.

However, we will lose our best clinicians and teachers to much higher compensated clinical positions. The patients will lose the benefit of these outstanding critical thinkers in the process of their care. We could not train physicians for the future for much longer without support for the educational aspects of their experience. As a program director, I see this as an unacceptable price to pay for the future of our patients and the patients that would have been cared for by the physicians that we would have trained for our hugely underserved state of Texas.

#1368

CMS-1488-P-1368

Submitter : Ms. Elyse Forkosh **Date:** 06/12/2006

Organization : Advocate Health Care

Category : Hospital

Issue Areas/Comments

IME Adjustment

IME Adjustment

see attached

CMS-1488-P-1368-Attach-1.PDF

#1368

2025 Windsor Drive
Oak Brook, Illinois 60523
Telephone 630 572 9393

Advocate Health Care

June 12, 2006

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1488-P and P2
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

RE: CMS-1488-P and P2, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates; Proposed Rule.

Dear Dr. McClellan:

Thank you for the opportunity to comment on proposed rule CMS-1488 P and P2. Advocate Health Care, based in Oak Brook, Illinois, is the largest fully integrated health care delivery system in metropolitan Chicago and the state of Illinois, and is recognized as one of the top health care systems in the country. Affiliated with University of Illinois at Chicago Health Sciences Center, Advocate trains more primary care physicians than any non-university teaching hospital in the state of Illinois. While our colleagues in the hospital community will submit comments to you on the entire scope of the proposed rule, our comments below are specific to the medical education changes within the proposed rule.

Reduction in IME Payments (page 24107)

The proposed rule implements the current law requirement that the IME adjustment be reduced in FFY 2007 to 5.35 from 5.55. Advocate believes that any reduction in IME multipliers places additional burden on an already stressed independent academic medical education delivery system.

Resident Time Spent in Non patient Care Activities as Part of Approved Residency Programs (pages 24114-115)

The result of CMS' statements is that **NO** didactic time may be counted for IME payment calculations, regardless of whether it occurs in a hospital or non-hospital site. Advocate, along with the American Association of Medical Colleges (AAMC), disagrees strongly with CMS' position on this issue. We support AAMC's position based on the belief that didactic activities engaged in by residents are an integral part of the patient care experience.[1] This

[1] Association of American Medical Colleges Summary of DGME and IME Changes in the FY 2007 Inpatient PPS Proposed Rule, April 2006, p. 2.

position appears similar to a 'clarification' made in FY 2002 when CMS added language to the IME regulations stating time spent in research, that is not associated with the treatment or diagnosis of a particular patient is also not defined as patient care activity.

We urge CMS to rescind the provision. As teachers and learners in the medical and research community, we find the interrelationship between didactic activities and patient care to be a seamless melding of different methodologies with one outcome: the development of an individual who demonstrates competency in the care of human beings.

The impact of classifying activities into reimbursed (patient care) and non-reimbursed (didactic) activities adds again to the administrative burden and creates needless confusion over what qualifies and what does not qualify. The end result will be that precious training resources wasted to demonstrate compliance with a regulation based on a faulty premise: that one can separate didactic activities from patient care activities.

Requirements for Counting and Appropriate Documentation of FTE Residents: Clarification (pages 24113-114)

The regulations at 42 CFR 413.75 (d) in the proposed rule set forth again documentation requirements for resident time that is claimed on the hospital's Medicare cost report. In addition, the regulations also state that the documentation information is to be certified by a hospital official. If the hospital official is not responsible for administration of the residency program, then another certification is necessary by an administrator of the residency program.

AAMC states that the organization has communicated many times with the CMS office concerning the following as it relates to documentation:

- Lack of uniform standards around documentation
- The burdens associated with duplicative documentation requests
- Issues related to the Medicare audit process.

We support the reduction of duplicative documentation requests. We request guidance or standards for what is necessary documentation in the determination of FTE counts.

Thank you for the opportunity to comment on this proposed rule. Should you or your staff have any questions or concerns, please call me at 630-990-5388.

Very truly yours,

Elyse S. Forkosh, MBA, MPP
Director, Government Relations

Submitter : Dr. Neil Lovitt **Date:** 06/12/2006

Organization : John Peter Smith Hospital-FMRP

Category : Health Care Professional or Association

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS or the Agency) proposed rule entitled "Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates." 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in "patient care activities." The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

Background
The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a nonhospital setting, such as a physician's office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not "related to patient care".

This position reverses the Agency's position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include "scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty." [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency's 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs.

CMS-1488-P-1369-Attach-1.DOC

CMS Officials:

It is my understanding that support for my activities unrelated to direct patient care as a faculty member are under review. This portion of IME and DME is critical for the support of residency training.

I was attracted to the profession of family medicine faculty because the community recognized the value of experience and academic inquiry to the well-being of our communities and the training of our future physicians.

As I consider the possibility that there could no longer be funding for my work in developing academic programs, writing critical reviews, performing clinical research and reviewing and evaluating resident performance I would feel it necessary to return to full time clinical practice and donate whatever time I can create to a medical student occasionally.

As it is now, most of the time that I spend doing research or critical reading and writing is not compensated. Less that 1/3 of my total academic time is compensated. I make up the difference by seeing more patients myself without residents to offset the cost of my salary and benefits which are currently less than the MGMA 25-tile for a practicing family physician in my geographic region.

For faculty like myself, in community based programs, the thought of being told by a program that I will need to see more patients to pay for the time I am developing and delivering curriculum will be unacceptable.

If you implement this rule I wish you the best of luck. I would not continue as a faculty member. I know that many other faculty feel as I do.

Thank you for your consideration

Submitter : **Dr. Elizabeth Hutton** **Date: 06/12/2006**

Organization : **Tufts Family Medicine Residency Program**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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Residency Program Activities and Patient Care
I firmly believe that with the possible exception of extended time for "bench research," there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician's educational development into an autonomous practitioner.

To separate out CMS's newly defined "patient care time" from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,
Elizabeth Hutton M.D., 1st year resident at Tufts University Family Medicine Residency, Boston, MA

Submitter : **Dr. Rowena Maclin** **Date: 06/12/2006**

Organization : **John Peter Smith Hospital-FMRP**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS or the Agency) proposed rule entitled "Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates." 71 Fed. Reg. 23996 (April 25, 2006).

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CMS-1488-P-1371-Attach-1.DOC

CMS Officials:

It is my understanding that support for my activities unrelated to direct patient care as a faculty member are under review. This portion of IME and DME is critical for the support of residency training.

I was attracted to the profession of family medicine faculty because the community recognized the value of experience and academic inquiry to the well-being of our communities and the training of our future physicians.

As I consider the possibility that there could no longer be funding for my work in developing academic programs, writing critical reviews, performing clinical research and reviewing and evaluating resident performance I would feel it necessary to return to full time clinical practice and donate whatever time I can create to a medical student occasionally.

As it is now, most of the time that I spend doing research or critical reading and writing is not compensated. Less that 1/3 of my total academic time is compensated. I make up the difference by seeing more patients myself without residents to offset the cost of my salary and benefits which are currently less than the MGMA 25-tile for a practicing family physician in my geographic region.

For faculty like myself, in community based programs, the thought of being told by a program that I will need to see more patients to pay for the time I am developing and delivering curriculum will be unacceptable.

If you implement this rule I wish you the best of luck. I would not continue as a faculty member. I know that many other faculty feel as I do.

Thank you for your consideration

Submitter : Mr. thomas zajac **Date:** 06/12/2006

Organization : CareScience

Category : Health Care Industry

Issue Areas/Comments

GENERAL

GENERAL

see attachment for the general comments from Care Science

CMS-1488-P-1372-Attach-1.DOC

June 9, 2006

Mark B. McClellan, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

REF: **CMS-1488-P "Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates"**

Dear Administrator McClellan:

CareScience, a division of Quovadx Inc., appreciates the opportunity to provide comments on the proposed rule regarding Medicare's inpatient hospital payment system. As a healthcare vendor who has developed one of the most respected and most advanced patient data technologies, we currently assist over two-hundred hospitals and health systems in identifying areas for clinical improvement and in implementing better treatment processes and improving patient outcomes. At the heart of our solutions, which were built by physicians, clinicians and healthcare experts, is our highly accurate mathematical techniques that ensure that our customer's data is appropriately risk-adjusted at the patient- level for each organization's unique patient population. This emphasis on risk adjustment and our ability to integrate clinical, quality and financial outcomes uniquely positions us to comment on the laudable goal of improving the accuracy of the hospital payment system.

Like our many customers we fully support CMS' efforts to implement the provisions of the Deficit Reduction Act of 2005 and in particular improve the performance of the DRG system by more accurately allocating payments for inpatient operating costs. While we are not paid by Medicare under the inpatient hospital prospective payment system (IPPS), we provide considerable support to numerous customers who are. In this capacity we have some concerns with the Proposed Rule that we ask CMS to consider as it works towards improvements of IPPS. Specifically, from our customer's perspective, we want to ensure that they are afforded ample time and opportunity to adapt to the proposed changes at all operational levels. Many of them have shared with us their concerns that in the attempts to correct the "overpayments" to specialty hospitals their hospitals would be adversely impacted. Moreover, they indicated to us that they would like full access to all aspects of the revised methodology, as they currently have, to enable them to continue to make the appropriate operational and economical determinations within the framework of the IPPS.

From our perspective, we have identified a number of concerns, particularly regarding the changes to the DRG classification system, the advent of ICD-10 and the interaction with billing and coding operations that will have an impact on any vendor's ability to continue to support their customers. These concerns, as well as comments on a number of issues, are addressed in more detail below:

(Reference) **DRG Recalibration and Changes and Refinement of DRGs Based on Severity of Illness**

The proposed rule focuses solely on the consolidated APR-DRG system developed by 3M. We understand that CMS did not conduct any independent evaluations of alternative methodologies nor considered its own funded research. Since there are several other classification methodologies that were developed around the CMS-DRGs that could achieve the same level of statistical performance and could very well result in better recognition of severity (i.e., the All-Payer Severity Adjusted DRGs, Refined DRGs, S-DRGs, or the original Yale RDRGs- possibly in combination with the methodology for assessing comorbid conditions developed at AHRQ by Elixhauser), while minimizing the impact on the hospital information technology, coding and billing operations, **we ask that CMS address other alternatives and allow the healthcare community to comment on the DRG classification system change before formally adopting any change.**

CareScience's own risk adjusted methodology as an example, harnesses the statistical power of multiple regression analysis that in addition to using the same principal and key secondary diagnoses, incorporates additional and clinical information that have been demonstrated to affect patient outcomes in their risk adjustment. Further, in addition to focusing on risk of mortality or severity of illness, it also looks at four other risk adjusted outcomes, namely; average cost, average length of stay, morbidity and complication rates. CareScience's methodology, it should also be noted, provides a continuum of risk assessments with a nearly infinite number of possibilities per principal diagnosis, whereas the consolidated APR-DRGs provide only four. For this reason and because Care Science uses more information about the patient our customers believe that it is a more accurate risk adjuster.

The sequencing of the Proposed Rule changes and the timing of the migration to ICD-10-CM (and PCS) is a major concern. Any revision to a new payment methodology is contingent upon the accurate coding of a medical encounter. The current CMS-DRG and the consolidated APR-DRG systems, however, use ICD-9-CM which is a thirty year old system that can no longer accurately describe today's practice of medicine. The terminology and classification of numerous conditions and procedures are outdated and inconsistent with current medical knowledge and applications. It cannot address the increasing pressure for more specific codes, especially codes that represent new technology. Furthermore, the continued use of this outdated version of ICD diminishes the investment that has been made in SNOMED CT as the clinical language of medicine.

ICD-10-CM, in contrast to ICD-9-CM, has approximately 120,000 codes as compared to 13,000 in ICD-9-CM and 8,000 categories as compared to 5,000. The level of specificity in ICD-10-PCS will provide payers, policy makers and providers with more detailed information from which to establish appropriate reimbursement rates. Legislation has been pending since last fall to adopt it and it would appear that in the very near future this country will transition to ICD-10. A concern that this raises is that most likely all healthcare billing and coding software will have to be updated, or in the worse case scenario replaced to accommodate all the changes necessitated by ICD-10. This, in all likelihood, will lead to coding delays that can affect the hospitals cash flow and days in accounts receivable. In addition, such internal hospital systems

as clinical decision support, health information management functions, and physician orders would be significantly affected. Furthermore, coders, patient financial services staff and physicians will need to be trained since ICD-10 requires more precise documentation and a higher level of coding expertise in anatomy and physiology than does ICD-9.

Inasmuch as adopting the APR-DRG system at this time will cause hospitals to invest a significant amount of resources in modifying their systems and in training personnel to incorporate the ICD-9 based system, it is unlikely these same institutions would be willing or even able to accommodate a change to ICD-10 in the near future. Therefore, it is quite likely that the adoption of the APR-DRG system at this time will cause a significant delay in the implementation of the clinically superior ICD-10. As such, it would appear to make more sense to **accelerate the release and implementation of ICD-10 and then base the coding-payment system on the greater specificity of the ICD-10 system.** Any new severity-adjusted payment system would then be based upon the more complete and clinically acceptable ICD-10 classification system.

Each change to this issue identifier is by itself significant and in previous years would have been considered a major modification to the payment system. Proposing both a cost- based system (HSRVcc) and a consolidated APR-DRG system is unprecedented and moreover, asking hospital to be prepared for this change in less than five months appears unrealistic. As such we would like to ask CMS to carefully consider the timing of these major changes and their impact on the hospitals and grant the hospitals more time to effectively analyze the scope of the changes and to plan for and effectively implement these changes.

The proprietary nature of APR-DRG's and the fact that it was developed by the same vendor that benefited from and controlled the original DRG adoption is a concern. Unless CMS poses the same unique conditions that currently exist to make the detail of the methodology available to the healthcare industry (including the source code, documentation and test data), a proprietary system will limit the full disclosure and transparency of its case mix grouping and severity adjustment rules. For vendors that require the disclosure to create their coding and billing solutions this will pose a major concern. For hospitals that will need software and interfaces to be written, tested and activated and databases to be restructured as well as staff to be educated and trained, full disclosure is an absolute necessity.

The proprietary system is of further concern in that it positions the vendor to have a significant competitive advantage over other vendors. It can potentially create a situation where the vendor, 3M, would be able to set a market price for their APR-DRG grouper. It is our understanding that in current pricing that 3M is negotiating with vendors that Care Science deals with, they are pricing their software at levels that are cost-prohibitive to their purchase and use. This concern can only be alleviated by insuring that all interested parties were able to gain access to the source code, comprehensive system and user documentation, test data and quality support from the owner of methodology at costs similar to what the healthcare industry now pays relative to the current DRG system and well enough in advance of implementation to be able to support customers as effectively as possible.

While we are aware that access to some information about APR-DRGs is presently made available through a website, the level of detail is limited, almost to the point of making it insufficient for business purposes or, in the case of our customer hospitals, difficult to fully respond to the Proposed Rule.

Our review of the Proposed Rule in the Federal Register and the feedback we received from our customer base further identifies the following specific issues:

- It appears that CMS' data trimming method used in the creation of cost centers for inclusion in the calculation of the scaling factors (1.96 standard deviations from the geometric mean) excluded 198 large hospitals with high routine charge mark-ups. These hospitals account for approximately 25-26 % of the total routine charges. As the AHA noted and showed in two illustrative tables this "creates a mismatch between the CCRs used and the charges they are applied to, as the hospitals that are trimmed out of the CCRs are still included in the charges that are then reduced to costs and determine the cost shares".
- There is a mismatch between the time period for the hospital claims and the hospital cost reports which would distort the calculations. For FY 2007 rates, CMS would be using FY 2005 hospital claims. The cost reports for the calculations, on the other hand, would be for the periods ending in FY 2003. As such, and as I am sure others have identified, many of the new hospital technologies that are currently available and used will not be included in the claims data nor the cost reports data used to calculate payments.
- The combining of multiple cost centers into ten CMS designated cost centers while not weighting the ratios by each hospital's Medicare's charges, would appear to distort the estimation of accurate costs. This computation would allow very small hospitals to have just as large an impact on the national cost-to-charge ratios as larger hospitals. Moreover, hospitals with low mark-ups (high CCRs) would have just as large impact as hospitals with high mark-ups (low CCRs). This will definitely affect the DRG weights and hospital impacts.
- The general validity of the cost reporting data itself is in question, by the given nature that only approximately 15% of the cost reports are audited. Since hospitals never envisioned the use of these reports to guide reimbursement, they are not accurate enough to support the establishment of appropriate reimbursement.
- As CMS has noted, a drawback to the APR-DRG structure is that it currently does not accommodate distinctions based upon the complexity related to medical technology that does not necessarily involve greater severity of illness (i.e. coronary angioplasty performed with or without insertion of stents).

Operationally, our customers have already identified several concerns that they believe will greatly increase their operational costs and decrease their productivity; namely:

- APR-DRGs are not compatible with the current Medicare payment system and as such it is felt that the changeover will require substantial retraining and expansion of hospital coding staffs. By contrast, the Yale-CMS R-DRGs were developed to be completely compatible with Medicare DRGs; so that would offer a smoother, less costly transition.

- Providers will have to change how they document patient encounters to better account for secondary diagnoses that will affect severity levels.
- Coding for APR-DRGs is considered much more complex than for CMS-DRGs and physicians will be required to document more completely to accommodate accurate level assignments. Coders will now need to code each component of the patient's encounter to reach the correct APR-DRGs as opposed to capturing just the principal diagnosis or procedure and one or two accompanying complications as they currently do with CMS-DRGs. This increased complexity, it is feared, will lengthen the revenue cycles.
- Since APR-DRGs are based upon a proprietary system as previously noted, it is believed that software acquisition and service costs will increase.
- Workflow with patient financial services must be reevaluated for time-saving methods because the determination of APR-DRGs by coders will make it more time consuming to code individual cases.
- Software and interfaces will have to be written, tested and deployed and databases will have to be restructured. Historical databases will have to be updated and aligned with new systems and the staff will need to be educated and/or retrained.
- The complexity of the system is of further concern in that in some instances coding signs and symptoms related to the established diagnosis will increase the severity level, even when coding guidelines indicate the signs and symptoms should not be coded separately.

(Reference) **Market Basket Update-Reporting of Twenty One Quality Measures**

We endorse CMS' proposal requiring that hospitals submit the full set of 21 measures, however, we do not endorse the requirement that his be done retroactively to January 1st. For most of our customer hospitals that are not currently reporting SIP measures, this will cause a significant collection burden. Instead **we would like to urge CMS to start the reporting period for services provided beginning July 1, 2006.**

(Reference) **Hospital Acquired Infections**

With the increased focus being placed on hospital/healthcare acquired infections (HAI) many state governments are becoming active in asking hospitals to report information about HAI's. The Institute for Healthcare Improvement's (IHI) 100,000 Lives Campaign, highlighted 50% reductions in blood stream infection rates and a 75% reduction in ventilator-associated pneumonia at 23 New Jersey teaching hospitals. The Michigan Health and Hospital Association also reported measurable improvements in reducing HAI's for these same two acquired infections. Other studies such as those conducted by the Maryland Patient Safety Center also focused on preventable catheter related blood stream infections and ventilator associate pneumonia.

We are in agreement that the HAI's chosen for reduced payment should be infections that are preventable and a result of hospital care. **As the above indicates the most recent studies highlight the device-related infections such as catheter associate blood stream and ventilator associated pneumonias and as such consideration should be given to selecting these two conditions be selected for monitoring and reporting.**

Although we are in agreement with CMS's proposal of reducing payments to hospitals for cases where the patient is treated for a condition that was not present on admission, many of our customer hospitals are concerned that this proposal would reduce payment based on conditions beyond their control, unless the methodology can clearly separate what are truly preventable infections from those in which pre-existing co morbid conditions played a role in predisposing the patient to infection. This presents a challenge in defining the actual codes that will trigger the case for a reduced payment. (In the case of the two HAI's we identified it is our understanding that ICD-9 does not have a specific code for either of these).

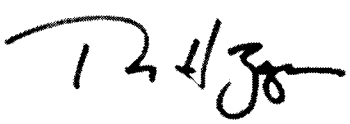
* * * * * * * * * * * * *

CareScience is in full support of CMS' efforts to improve the functioning of the Inpatient Prospective Payment System by more accurately allocating payments for inpatient hospital services. However, we and the customer hospitals we support are concerned that the Proposed Rule changes are being expedited without appropriate thought given to the impact of other changes facing healthcare such as the quality provisions of the Deficit Reduction Act, the transition to ICD-10, and though not commented on the adoption of UB-04 to replace UB-92 which represents a significant shift to improve the clinical coding section of the uniform bill. Moreover, there is a concern that the healthcare providers have not had the opportunity to fully grasp the complexities of the proposal nor have full access to the information necessary to provide meaningful commentary on the proposal.

We appreciate the opportunity to provide commentary on the Proposed Rule and we hope that the agency will carefully consider our comments and the feedback we have received from the customer institutions we support as it begins to move forward in implementing the proposed changes.

Thank you for your kind consideration.

Sincerely,



Thomas Zajac
President, CareScience
Division of Quovadx, Inc
3600 Market Street, 7th Floor
Philadelphia, PA 19104

Thomas.Zajac@quovadx.com

CMS-1488-P-1373

Submitter : Mr. Gary Ermers **Date:** 06/12/2006

Organization : Saint Joseph Healthcare

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See attached comment letter

CMS-1488-P-1373-Attach-1.DOC

CMS-1488-P-1373-Attach-2.DOC

CMS-1488-P-1373-Attach-3.DOC

#1373-1

June 12, 2006

Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1488-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-1488-P; Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates

Dear Dr. McClellan:

Saint Joseph HealthCare appreciates the opportunity to comment on the proposed rule (CMS-1488-P) that would change the Hospital Inpatient Prospective Payment System (PPS) and Fiscal Year 2007 Rates. Saint Joseph HealthCare is a not-for-profit Catholic, three hospital system serving Central and Eastern Kentucky.

The proposed rule would revise the methodologies used to calculate the relative weights of the Diagnosis Related Groups (DRGs) used to determine Medicare inpatient hospital services payment. The proposal would replace charge-based weights with a modified version of cost-based weights using hospital-specific relative values (HSRVs). The Centers for Medicare and Medicaid Services (CMS) also proposes a major revision to the DRG classification system to account for patient severity.

Adoption of the proposed DRG weight changes and proposed severity adjustments would result in the biggest change to the hospital inpatient prospective payment system (IPPS) since its inception. These changes would significantly redistribute payments among the DRGs and among hospitals.

SJH is greatly concerned about the equity of Medicare payments under the proposed rule and we envision an environment where material disparities may exist between a hospital's actual resources expended for treating Medicare patients and the corresponding Medicare payments received. The first phase of the proposal alone represents a reduction of payments to SJHC of approximately 7 million dollars using data from the current fiscal year. Our projections demonstrate that if the proposed weights were overlaid in the current fiscal period the cost of care for our Medicare patients would exceed reimbursement at SJHC. The change to a cost-based weight system must recognize the

impact on established not-for-profit providers that have evolved into specialty areas of clinical excellence, upon which large geographic portions of a state are dependent.

We support improving DRG payments to more accurately reflect resources used in caring for Medicare patients, but it is not clear that the proposed DRG weight changes or new patient classification system will result in a more accurate hospital payment system. Impact estimates at the DRG and hospital level are extremely sensitive to methodological variations. Implementation in FY 2007 would be premature.

We urge CMS to delay these changes, undertake more in-depth analyses of their impact, and evaluate alternative methodologies for improving the DRG system.

While the proposed rule has many provisions impacting our hospital, we would like to comment specifically on the following issues:

HRSV Weights

We support a move to cost-based weights but have several concerns about the adequacy and validity of the proposed methodology. More work is needed to determine the best way to create cost-based weights. If changes are made to DRG weights, those changes should be phased in over three years with "stop loss" protections to allow significantly impacted hospitals time to prepare for payment changes.

In particular, **CMS should further analyze and evaluate the impact of:**

- **Use of 2004 Data** – CMS uses claims data taken from the FY 2004 MedPAR file in its methodology. Clinical practice has changed in many areas, especially cardiology, over the past two years. The data used may not reflect current clinical practice. CMS may need to make specific changes to specific DRGs to reflect the change in clinical practice. For example, interventional cardiology DRGs do not reflect the cost of current clinical practice.

- **Variation in Markups** – The CMS methodology assumes a uniform hospital markup, but markups vary from product to product.

- **Distortion of Costs** – The proposed methodology would distort the accuracy of cost estimates by combining multiple cost centers on hospital cost reports into ten CMS-designated cost center. CMS would then determine ten national average cost-to-charge ratios for each of the designated costs centers but the ratios would not be weighted by each hospital's Medicare charges. This would allow very small hospitals to have just as much of an impact on the national cost-to-charge ratios as larger hospitals.

- **Access to Centers of Excellence** – The proposed changes are particularly significant for large volume hospitals and may have a negative impact on

Centers of Excellence, which could impede beneficiary access to high quality services.

We recommend delaying until at least FY 2008 the proposed cost-based DRG weights. CMS should undertake a more thorough analysis, including parallel pilot testing, of the proposed changes to identify any unintended consequences. If DRG weight changes are implemented, they should be phased in over three years with "stop loss" protections.

DRGs: Severity of Illness

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Saint Joseph HealthCare
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#1373-2

June 12, 2006

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Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1488-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

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impact on established not-for-profit providers that have evolved into specialty areas of clinical excellence, upon which large geographic portions of a state are dependent.

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Submitter : Dr. Prakash Desai **Date:** 06/12/2006

Organization : Amarillo Heart Group

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1374-Attach-1.DOC

#1374

June 13, 2006

The Honorable Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
PO Box 8011
Baltimore, MD 21244-1850

RE: CMS-1488-P; Proposed Changes to the Hospital Inpatient Payment Systems and Fiscal Year 2007 Rates

Commenting on: General Comments; HSRV Weights

Dear Dr. McClellan:

I am an Electrophysiologist in practice in Amarillo Texas. I deal with lots of patients with Ventricular arrhythmias and ICDs have been shown to improve survival in many patient populations. However the proposed Medicare plan to drastically cut ICD reimbursements for the hospitals will lead to severe catastrophic reduction in survival of the hospitals which allow these procedures performed at these hospitals. The survival of the hospitals will be in jeopardy.

We have to a situation when the re were drastic cuts on Biventricular ICD implants and the only two hospitals in Amarillo were losing money in performing these procedures that they discouraged the practice of Bi ventricular ICD implants. As a physician if the hospital denies letting the physician perform these procedures, a large number of Medicare patients will have to go to another center 200 or 300 miles away and quality of care will seriously suffer. Medicare patients are an important part of my practice, and the inpatient hospital payment system can affect how I am able to treat them.

I'd like to share my concerns with you regarding the proposed inpatient rule for FY2007. I believe if these changes are implemented, it could have a negative effect on some hospitals, and ultimately could impact the patients that I treat.

These comments will discuss:

1. <u>That payment rates should accurately reflect the cost of services provided; inaccurate rates could limit hospitals' capabilities to perform services, and thus limit patient access to some therapies.</u>

2. The potential impact of these payment inaccuracies on patients, particularly cardiovascular patients when treated with high-technology solutions.

As such, I urge CMS to allow time for further study of the proposals but in the meantime continue with the current charge-based system.

Payment rates should accurately reflect the cost of services provided. Inaccurate rates could limit hospitals' capabilities to perform services, and thus limit patient access to some therapies. The current proposal, if implemented, could have unintended and inappropriate consequences.

- **Questions have been raised about CMS's proposed rate-setting methodology.** At a high level, some of these issues include CMS's use of data that are 3–5 years old to calculate the payment rates; technical mistakes such as counting a small hospital equal to a large hospital in calculations; throwing out a quarter of the hospitals' routine day charges in calculating cost-to-charge ratios; as well as questionable technical assumptions that can alter the estimated impact on payments. Charge compression, a major issue for high-value, high-technology devices, also continues to be a problem and is not properly addressed in the proposal.

- **The current proposed DRG payment rates are in some cases the same or lower than the purchase price for ICDs and CRT-Ds.** Proposed rates for ICD and CRT-D procedures are sometimes below the device acquisition cost, not allowing hospitals payment for operating procedures, supplies, and personnel. For example, DRG 515, where a majority of ICD implants fall, was paid at a base of $28,441 in 2006; for 2007 Medicare is proposing a sharp decrease in payment of 23%, down to $22,015—one of the biggest percentage decreases any DRG faces this year.

Poor economics mean hospitals have to make difficult decisions when it comes to using leading-edge, high-technology solutions for their patients

- If this change is implemented, hospitals could find themselves with limited capabilities to offer their patients some advanced and technologically-driven therapies, particularly for certain cardiovascular therapies such as implantable cardioverter defibrillator (ICD) and cardiac resynchronization therapy with defibrillator (CRT-D) therapy.

- **This could result in hospitals altering normal treatment patterns, restricting technology selection, and limiting patient access in order to avoid extraordinary financial losses.** As a result, patients may not receive the already underutilized lifesaving ICD and CRT-D therapies because hospitals are not receiving payment that recognizes the full cost of the services provided.

- **Hospitals cannot sustain themselves economically when inaccurate payments do not cover the cost of supplies, equipment, staff, and medical devices.**

- **ICD and CRT-D therapies are the standards of care** as recognized by the American College of Cardiology (ACC), the American Heart Association (AHA), and the Heart Rhythm Society (HRS) practice guidelines for many patients. It is important to set payment rates that allow for physicians to provide the right care at the right time for the right patient.

Conclusion

Sweeping decisions of this nature need thorough analysis, stakeholder input, and time and consideration prior to being implemented. Additionally, intended and unintended consequences need to be carefully examined prior to making major changes to a stable environment that could adversely affect hospitals, physicians, and most importantly, patients.

To ensure continued access to high quality care for Medicare beneficiaries, appropriate payment under the prospective payment system is critical. **As such, I reiterate my request that CMS allow time for further study of the proposals but in the mean time continue with the current charge-based system.**

We appreciate CMS's efforts to improve the inpatient payment system, and agree that it is our mutual goal to improve the lives of Medicare beneficiaries. We all must work together with diligence and dedication to address these complex issues.

Sincerely,

Prakash Desai, MD
1901 Port Lane
Amarillo, TX 79109
806-358-4596
pkdesai@amaonline.com

Submitter : Dr. Curtis McGinley **Date:** 06/12/2006

Organization : John Peter Smith Hospital-FMRP

Category : Health Care Professional or Association

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS or the Agency) proposed rule entitled "Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates." 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in "patient care activities." The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

Background
The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a nonhospital setting, such as a physician's office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not "related to patient care".

This position reverses the Agency's position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include "scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty." [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency's 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs.

CMS-1488-P-1375-Attach-1.DOC

The Texas Academy of Family Medicine has just informed us that CMS is considering the disallowance of faculty development activity in the calculation of faculty time for IME and DME reimbursement. These activities in our program include:

- Development of Curriculum in alignment with best current evidence
- Review of Curriculum
- Critical Evaluation of Evidence Based Medicine Guidelines for Patient Care
- Development and Utilization of Evaluation Tools for Faculty and Residents
- Delivery of Curriculum by lecture, Web-based curriculum, small group workshops and one-to-one training
- Scholarly Activities
    - Written Publications
    - Presentation of Research
    - Faculty Development Conferences
    - Participation in Critical Review Activities of Specialty
    - Research regarding the outcomes of care of resident practices
    - Clinical Quality Improvement in Resident Delivery to Patient Services
- Resident Evaluation
- Resident Academic Remediation
- Resident Testing
- Resident and Faculty Portfolio Development and Monitoring
- Faculty Training
- Alumni Evaluation and Research

My understanding is that CMS is proposing a rule that would disallow the time for these activities due to them being unrelated to patient care. Patient care is critically dependent on our ability as a faculty to carry out these activities. We can continue to deliver services to the underserved as we always have in our residency site. Duke Family Medicine Department has recently decided to do this rather than continue training family physicians.

However, we will lose our best clinicians and teachers to much higher compensated clinical positions. The patients will lose the benefit of these outstanding critical thinkers in the process of their care. We could not train physicians for the future for much longer without support for the educational aspects of their experience. As a program director, I see this as an unacceptable price to pay for the future of our patients and the patients that would have been cared for by the physicians that we would have trained for our hugely underserved state of Texas.

Submitter : Dr. Larry Beaty **Date:** 06/12/2006

Organization : Broadlawns Medical Center

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

As a family medicine residency program director, I appreciate the opportunity to comment on the CMS proposed rule entitled "Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates." 71 Fed. Reg. 23996 (April 25, 2006). I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in "patient care activities". The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments. The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting) and for DGME payments when the activities occur in a nonhospital setting, such as a physicians's office or afiliated medical school. The stated reationale for the exclusion of this time is that the time si not 'related to patient care". This position reverses the Agency's position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include "scholarly activities, such as educational seminars, classroom lectures ... and presentation fo papers and researcvh results to fellow residents, medical students,and faculty." I support the Agency's 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by resident during their residency programs. Residency Program Activities and Patient Care - I firmly believe that with the possible exception of extended time for "bench research", there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician's educational development into an autonomous practitioner. Inaddition, as director of this program, I cannot conceive of how I would be able to administratively comply with this requirement. It would require documentation that would be extremely burdensome, if possible at all. To separate out CMS's newly defined "patient care time" from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Where am I to find the funding to pay for the staff person that would be needed to sit in on each of these didactic session and keep count of patient care time? The documentation requirements that this position would necessitate are unreasonable and would cause an extremely large administrative burden. To reiterate, I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,
Larry D. Beaty, MD
Director Family Medicine Residency Program
Broadlawns Medical Center
1801 Hickman Road
Des Moines, IA 50314

Submitter : Dr. Sandra Moreno **Date:** 06/12/2006

Organization : John Peter Smith Hospital-FMRP

Category : Health Care Professional or Association

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS or the Agency) proposed rule entitled "Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates." 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in "patient care activities." The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

Background
The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a nonhospital setting, such as a physician's office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not "related to patient care".

This position reverses the Agency's position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include "scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty." [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency's 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs.

CMS-1488-P-1377-Attach-1.DOC

#1377

CMS Officials:

It is my understanding that support for my activities unrelated to direct patient care as a faculty member are under review. This portion of IME and DME is critical for the support of residency training.

I was attracted to the profession of family medicine faculty because the community recognized the value of experience and academic inquiry to the well-being of our communities and the training of our future physicians.

As I consider the possibility that there could no longer be funding for my work in developing academic programs, writing critical reviews, performing clinical research and reviewing and evaluating resident performance I would feel it necessary to return to full time clinical practice and donate whatever time I can create to a medical student occasionally.

As it is now, most of the time that I spend doing research or critical reading and writing is not compensated. Less that 1/3 of my total academic time is compensated. I make up the difference by seeing more patients myself without residents to offset the cost of my salary and benefits which are currently less than the MGMA 25-tile for a practicing family physician in my geographic region.

For faculty like myself, in community based programs, the thought of being told by a program that I will need to see more patients to pay for the time I am developing and delivering curriculum will be unacceptable.

If you implement this rule I wish you the best of luck. I would not continue as a faculty member. I know that many other faculty feel as I do.

Thank you for your consideration

Submitter : Dr. Risheet Patel **Date:** 06/12/2006

Organization : Dr. Risheet Patel

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS or the Agency) proposed rule entitled Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates. 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in patient care activities. The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

Background
The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a nonhospital setting, such as a physician s office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not related to patient care .

This position reverses the Agency s position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty. [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency s 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs.

Residency Program Activities and Patient Care
I firmly believe that with the possible exception of extended time for bench research, there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician s educational development into an autonomous practitioner.

To separate out CMS s newly defined patient care time from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,
Risheet R. Patel, MD

Submitter : **Dr. Bart Pate** **Date: 06/12/2006**

Organization : **John Peter Smith Hospital-FMRP**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS or the Agency) proposed rule entitled "Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates." 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in "patient care activities." The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

Background
The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a nonhospital setting, such as a physician's office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not "related to patient care".

This position reverses the Agency's position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include "scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty." [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency's 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs.

CMS-1488-P-1379-Attach-1.DOC

The Texas Academy of Family Medicine has just informed us that CMS is considering the disallowance of faculty development activity in the calculation of faculty time for IME and DME reimbursement. These activities in our program include:

- Development of Curriculum in alignment with best current evidence
- Review of Curriculum
- Critical Evaluation of Evidence Based Medicine Guidelines for Patient Care
- Development and Utilization of Evaluation Tools for Faculty and Residents
- Delivery of Curriculum by lecture, Web-based curriculum, small group workshops and one-to-one training
- Scholarly Activities
    - Written Publications
    - Presentation of Research
    - Faculty Development Conferences
    - Participation in Critical Review Activities of Specialty
    - Research regarding the outcomes of care of resident practices
    - Clinical Quality Improvement in Resident Delivery to Patient Services
- Resident Evaluation
- Resident Academic Remediation
- Resident Testing
- Resident and Faculty Portfolio Development and Monitoring
- Faculty Training
- Alumni Evaluation and Research

My understanding is that CMS is proposing a rule that would disallow the time for these activities due to them being unrelated to patient care. Patient care is critically dependent on our ability as a faculty to carry out these activities. We can continue to deliver services to the underserved as we always have in our residency site. Duke Family Medicine Department has recently decided to do this rather than continue training family physicians.

However, we will lose our best clinicians and teachers to much higher compensated clinical positions. The patients will lose the benefit of these outstanding critical thinkers in the process of their care. We could not train physicians for the future for much longer without support for the educational aspects of their experience. As a program director, I see this as an unacceptable price to pay for the future of our patients and the patients that would have been cared for by the physicians that we would have trained for our hugely underserved state of Texas.

Submitter :

Date: 06/12/2006

Organization :

Category : Individual

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS or the Agency) proposed rule entitled "Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates." 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in "patient care activities." The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

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The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a nonhospital setting, such as a physician's office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not "related to patient care".

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Residency Program Activities and Patient Care
I firmly believe that with the possible exception of extended time for "bench research," there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician's educational development into an autonomous practitioner.

To separate out CMS's newly defined "patient care time" from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are

unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,
andrew feller, md

Submitter : Dr. Michael Grady **Date:** 06/12/2006

Organization : Oregon Academy of Family Physicians

Category : Individual

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS or the Agency) proposed rule entitled Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates. 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in patient care activities. The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

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This position reverses the Agency s position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty. [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency s 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs.

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To separate out CMS s newly defined patient care time from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,

Michael Grady, MD

Submitter : **Dr. Mary Anne Barnhill** **Date: 06/12/2006**

Organization : **John Peter Smith Hospital-FMRP**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GME Payments

GME Payments

Residency Program Activities and Patient Care
I firmly believe that with the possible exception of extended time for "bench research," there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician's educational development into an autonomous practitioner.

To separate out CMS's newly defined "patient care time" from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

CMS-1488-P-1382-Attach-1.DOC

#1382

Currently I am completing my residency in family medicine. When I became aware that CMS would stop funding payment to faculty for teaching, preparing curriculum and evaluating my performance through GME -- IME and DME support – I became alarmed.

We are in a state with a huge health care professional shortage in communities under 25,000. These communities cannot afford to support several nurse practitioners and visiting specialists when the services are delivered by a pluri-potential well trained family medicine specialist who is part of their community. The training programs, like mine, which prepare us for these types of venues are in very short supply. We need to be exceptionally well trained.

Someone at CMS will need to explain to me, how the teaching, curriculum development and evaluation process for the six required ACGME physician skill competencies is not related to patient care. Isn't this exactly what the IOM has criticized our training professions for? In fact, our program currently evaluates us in all these competencies as a continuing quality improvement process DURING patient care. Without time to discuss and reflect our experiences and outcomes we will not be serving the needs of our current and future patients.

Should indeed this come to pass, we will have faculty who will be caught in the productivity race with no time for us. We may get pop-up feed back from an Electronic Health Record in sites that have them that we have made an error or we are not following a guideline. No discussion there. What is being proposed is dangerous for our current patients and our future patients. Our patients deserve for us to have a better education than you are proposing.

Why does the American taxpayer support medical students at over $200,000 per student per year and offers the faculty of residencies less than $15,000 for teaching per resident per year? I am getting a lot more from my residency training to protect and serve my patients of the future than all of medical school combined. Please do not cut us any more – rescind the clarification of this dangerous and capricious rule.

Medical Resident

Submitter : **Dr. Matthew Rios** **Date: 06/12/2006**

Organization : **John Peter Smith Hospital-FMRP**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS or the Agency) proposed rule entitled "Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates." 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in "patient care activities." The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

Background
The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a nonhospital setting, such as a physician's office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not "related to patient care".

This position reverses the Agency's position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include "scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty." [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency's 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs.

CMS-1488-P-1383-Attach-1.DOC

#1383

CMS Officials:

It is my understanding that support for my activities unrelated to direct patient care as a faculty member are under review. This portion of IME and DME is critical for the support of residency training.

I was attracted to the profession of family medicine faculty because the community recognized the value of experience and academic inquiry to the well-being of our communities and the training of our future physicians.

As I consider the possibility that there could no longer be funding for my work in developing academic programs, writing critical reviews, performing clinical research and reviewing and evaluating resident performance I would feel it necessary to return to full time clinical practice and donate whatever time I can create to a medical student occasionally.

As it is now, most of the time that I spend doing research or critical reading and writing is not compensated. Less that 1/3 of my total academic time is compensated. I make up the difference by seeing more patients myself without residents to offset the cost of my salary and benefits which are currently less than the MGMA 25-tile for a practicing family physician in my geographic region.

For faculty like myself, in community based programs, the thought of being told by a program that I will need to see more patients to pay for the time I am developing and delivering curriculum will be unacceptable.

If you implement this rule I wish you the best of luck. I would not continue as a faculty member. I know that many other faculty feel as I do.

Thank you for your consideration

Submitter : Ms. Susan Greenwood-Clark **Date:** 06/12/2006

Organization : University Hospital

Category : Hospital

Issue Areas/Comments

FTE Resident Count and Documentation

FTE Resident Count and Documentation

Dear Administrator McClellan:

I would like to take this opportunity to comment on the Centers for Medicare & Medicaid Services (CMS or the Agency) proposed rule entitled Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates. 71 Fed. Reg. 23996 (April 25, 2006). I strongly urge the Agency to rescind the purported clarification in the proposed rule that excludes medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments. The stated rationale for the exclusion of time devoted to these activities is that they are not related to patient care . The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a non-hospital setting, such as a physician s office or affiliated medical school.

I support the Agency s 1999 position. The activities cited are an integral component of the patient care activities engaged in by residents during their residency programs. We urge CMS to withdraw its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs. The goal of graduate medical education is to train outstanding physicians who can treat patients in both hospital settings and non-hospital settings and to have the proper education and decision making skills to be the physicians of the future. The decision to exclude payments for the aforementioned activities in short-sighted and will lead to a lower quality of care provided in both the short and long-term.

Sincerely,
Susan Greenwood-Clark

Submitter : **Mr. Thomas Zajac** **Date: 06/12/2006**

Organization : **CareScience**

Category : **Health Care Industry**

Issue Areas/Comments

GENERAL

GENERAL

Please see attachment for the general comments and impact from Care Science

CMS-1488-P-1385-Attach-1.DOC

June 9, 2006

Mark B. McClellan, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

REF: **CMS-1488-P "Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates"**

Dear Administrator McClellan:

CareScience, a division of Quovadx Inc., appreciates the opportunity to provide comments on the proposed rule regarding Medicare's inpatient hospital payment system. As a healthcare vendor who has developed one of the most respected and most advanced patient data technologies, we currently assist over two-hundred hospitals and health systems in identifying areas for clinical improvement and in implementing better treatment processes and improving patient outcomes. At the heart of our solutions, which were built by physicians, clinicians and healthcare experts, is our highly accurate mathematical techniques that ensure that our customer's data is appropriately risk-adjusted at the patient- level for each organization's unique patient population. This emphasis on risk adjustment and our ability to integrate clinical, quality and financial outcomes uniquely positions us to comment on the laudable goal of improving the accuracy of the hospital payment system.

Like our many customers we fully support CMS' efforts to implement the provisions of the Deficit Reduction Act of 2005 and in particular improve the performance of the DRG system by more accurately allocating payments for inpatient operating costs. While we are not paid by Medicare under the inpatient hospital prospective payment system (IPPS), we provide considerable support to numerous customers who are. In this capacity we have some concerns with the Proposed Rule that we ask CMS to consider as it works towards improvements of IPPS. Specifically, from our customer's perspective, we want to ensure that they are afforded ample time and opportunity to adapt to the proposed changes at all operational levels. Many of them have shared with us their concerns that in the attempts to correct the "overpayments" to specialty hospitals their hospitals would be adversely impacted. Moreover, they indicated to us that they would like full access to all aspects of the revised methodology, as they currently have, to enable them to continue to make the appropriate operational and economical determinations within the framework of the IPPS.

From our perspective, we have identified a number of concerns, particularly regarding the changes to the DRG classification system, the advent of ICD-10 and the interaction with billing and coding operations that will have an impact on any vendor's ability to continue to support their customers. These concerns, as well as comments on a number of issues, are addressed in more detail below:

(Reference) **DRG Recalibration and Changes and Refinement of DRGs Based on Severity of Illness**

The proposed rule focuses solely on the consolidated APR-DRG system developed by 3M. We understand that CMS did not conduct any independent evaluations of alternative methodologies nor considered its own funded research. Since there are several other classification methodologies that were developed around the CMS-DRGs that could achieve the same level of statistical performance and could very well result in better recognition of severity (i.e., the All-Payer Severity Adjusted DRGs, Refined DRGs, S-DRGs, or the original Yale RDRGs- possibly in combination with the methodology for assessing comorbid conditions developed at AHRQ by Elixhauser), while minimizing the impact on the hospital information technology, coding and billing operations, **we ask that CMS address other alternatives and allow the healthcare community to comment on the DRG classification system change before formally adopting any change.**

CareScience's own risk adjusted methodology as an example, harnesses the statistical power of multiple regression analysis that in addition to using the same principal and key secondary diagnoses, incorporates additional and clinical information that have been demonstrated to affect patient outcomes in their risk adjustment. Further, in addition to focusing on risk of mortality or severity of illness, it also looks at four other risk adjusted outcomes, namely; average cost, average length of stay, morbidity and complication rates. CareScience's methodology, it should also be noted, provides a continuum of risk assessments with a nearly infinite number of possibilities per principal diagnosis, whereas the consolidated APR-DRGs provide only four. For this reason and because Care Science uses more information about the patient our customers believe that it is a more accurate risk adjuster.

The sequencing of the Proposed Rule changes and the timing of the migration to ICD-10-CM (and PCS) is a major concern. Any revision to a new payment methodology is contingent upon the accurate coding of a medical encounter. The current CMS-DRG and the consolidated APR-DRG systems, however, use ICD-9-CM which is a thirty year old system that can no longer accurately describe today's practice of medicine. The terminology and classification of numerous conditions and procedures are outdated and inconsistent with current medical knowledge and applications. It cannot address the increasing pressure for more specific codes, especially codes that represent new technology. Furthermore, the continued use of this outdated version of ICD diminishes the investment that has been made in SNOMED CT as the clinical language of medicine.

ICD-10-CM, in contrast to ICD-9-CM, has approximately 120,000 codes as compared to 13,000 in ICD-9-CM and 8,000 categories as compared to 5,000. The level of specificity in ICD-10-PCS will provide payers, policy makers and providers with more detailed information from which to establish appropriate reimbursement rates. Legislation has been pending since last fall to adopt it and it would appear that in the very near future this country will transition to ICD-10. A concern that this raises is that most likely all healthcare billing and coding software will have to be updated, or in the worse case scenario replaced to accommodate all the changes necessitated by ICD-10. This, in all likelihood, will lead to coding delays that can affect the hospitals cash flow and days in accounts receivable. In addition, such internal hospital systems

as clinical decision support, health information management functions, and physician orders would be significantly affected. Furthermore, coders, patient financial services staff and physicians will need to be trained since ICD-10 requires more precise documentation and a higher level of coding expertise in anatomy and physiology than does ICD-9.

Inasmuch as adopting the APR-DRG system at this time will cause hospitals to invest a significant amount of resources in modifying their systems and in training personnel to incorporate the ICD-9 based system, it is unlikely these same institutions would be willing or even able to accommodate a change to ICD-10 in the near future. Therefore, it is quite likely that the adoption of the APR-DRG system at this time will cause a significant delay in the implementation of the clinically superior ICD-10. As such, it would appear to make more sense to **accelerate the release and implementation of ICD-10 and then base the coding-payment system on the greater specificity of the ICD-10 system.** Any new severity-adjusted payment system would then be based upon the more complete and clinically acceptable ICD-10 classification system.

Each change to this issue identifier is by itself significant and in previous years would have been considered a major modification to the payment system. Proposing both a cost- based system (HSRVcc) and a consolidated APR-DRG system is unprecedented and moreover, asking hospital to be prepared for this change in less than five months appears unrealistic. As such we would like to ask CMS to carefully consider the timing of these major changes and their impact on the hospitals and grant the hospitals more time to effectively analyze the scope of the changes and to plan for and effectively implement these changes.

The proprietary nature of APR-DRG's and the fact that it was developed by the same vendor that benefited from and controlled the original DRG adoption is a concern. Unless CMS poses the same unique conditions that currently exist to make the detail of the methodology available to the healthcare industry (including the source code, documentation and test data), a proprietary system will limit the full disclosure and transparency of its case mix grouping and severity adjustment rules. For vendors that require the disclosure to create their coding and billing solutions this will pose a major concern. For hospitals that will need software and interfaces to be written, tested and activated and databases to be restructured as well as staff to be educated and trained, full disclosure is an absolute necessity.

The proprietary system is of further concern in that it positions the vendor to have a significant competitive advantage over other vendors. It can potentially create a situation where the vendor, 3M, would be able to set a market price for their APR-DRG grouper. It is our understanding that in current pricing that 3M is negotiating with vendors that Care Science deals with, they are pricing their software at levels that are cost-prohibitive to their purchase and use. This concern can only be alleviated by insuring that all interested parties were able to gain access to the source code, comprehensive system and user documentation, test data and quality support from the owner of methodology at costs similar to what the healthcare industry now pays relative to the current DRG system and well enough in advance of implementation to be able to support customers as effectively as possible.

While we are aware that access to some information about APR-DRGs is presently made available through a website, the level of detail is limited, almost to the point of making it insufficient for business purposes or, in the case of our customer hospitals, difficult to fully respond to the Proposed Rule.

Our review of the Proposed Rule in the Federal Register and the feedback we received from our customer base further identifies the following specific issues:

- It appears that CMS' data trimming method used in the creation of cost centers for inclusion in the calculation of the scaling factors (1.96 standard deviations from the geometric mean) excluded 198 large hospitals with high routine charge mark-ups. These hospitals account for approximately 25-26 % of the total routine charges. As the AHA noted and showed in two illustrative tables this "creates a mismatch between the CCRs used and the charges they are applied to, as the hospitals that are trimmed out of the CCRs are still included in the charges that are then reduced to costs and determine the cost shares".
- There is a mismatch between the time period for the hospital claims and the hospital cost reports which would distort the calculations. For FY 2007 rates, CMS would be using FY 2005 hospital claims. The cost reports for the calculations, on the other hand, would be for the periods ending in FY 2003. As such, and as I am sure others have identified, many of the new hospital technologies that are currently available and used will not be included in the claims data nor the cost reports data used to calculate payments.
- The combining of multiple cost centers into ten CMS designated cost centers while not weighting the ratios by each hospital's Medicare's charges, would appear to distort the estimation of accurate costs. This computation would allow very small hospitals to have just as large an impact on the national cost-to-charge ratios as larger hospitals. Moreover, hospitals with low mark-ups (high CCRs) would have just as large impact as hospitals with high mark-ups (low CCRs). This will definitely affect the DRG weights and hospital impacts.
- The general validity of the cost reporting data itself is in question, by the given nature that only approximately 15% of the cost reports are audited. Since hospitals never envisioned the use of these reports to guide reimbursement, they are not accurate enough to support the establishment of appropriate reimbursement.
- As CMS has noted, a drawback to the APR-DRG structure is that it currently does not accommodate distinctions based upon the complexity related to medical technology that does not necessarily involve greater severity of illness (i.e. coronary angioplasty performed with or without insertion of stents).

Operationally, our customers have already identified several concerns that they believe will greatly increase their operational costs and decrease their productivity; namely:

- APR-DRGs are not compatible with the current Medicare payment system and as such it is felt that the changeover will require substantial retraining and expansion of hospital coding staffs. By contrast, the Yale-CMS R-DRGs were developed to be completely compatible with Medicare DRGs; so that would offer a smoother, less costly transition.

- Providers will have to change how they document patient encounters to better account for secondary diagnoses that will affect severity levels.
- Coding for APR-DRGs is considered much more complex than for CMS-DRGs and physicians will be required to document more completely to accommodate accurate level assignments. Coders will now need to code each component of the patient's encounter to reach the correct APR-DRGs as opposed to capturing just the principal diagnosis or procedure and one or two accompanying complications as they currently do with CMS-DRGs. This increased complexity, it is feared, will lengthen the revenue cycles.
- Since APR-DRGs are based upon a proprietary system as previously noted, it is believed that software acquisition and service costs will increase.
- Workflow with patient financial services must be reevaluated for time-saving methods because the determination of APR-DRGs by coders will make it more time consuming to code individual cases.
- Software and interfaces will have to be written, tested and deployed and databases will have to be restructured. Historical databases will have to be updated and aligned with new systems and the staff will need to be educated and/or retrained.
- The complexity of the system is of further concern in that in some instances coding signs and symptoms related to the established diagnosis will increase the severity level, even when coding guidelines indicate the signs and symptoms should not be coded separately.

(Reference) **Market Basket Update-Reporting of Twenty One Quality Measures**

We endorse CMS' proposal requiring that hospitals submit the full set of 21 measures, however, we do not endorse the requirement that his be done retroactively to January 1st. For most of our customer hospitals that are not currently reporting SIP measures, this will cause a significant collection burden. Instead **we would like to urge CMS to start the reporting period for services provided beginning July 1, 2006.**

(Reference) **Hospital Acquired Infections**

With the increased focus being placed on hospital/healthcare acquired infections (HAI) many state governments are becoming active in asking hospitals to report information about HAI's. The Institute for Healthcare Improvement's (IHI) 100,000 Lives Campaign, highlighted 50% reductions in blood stream infection rates and a 75% reduction in ventilator-associated pneumonia at 23 New Jersey teaching hospitals. The Michigan Health and Hospital Association also reported measurable improvements in reducing HAI's for these same two acquired infections. Other studies such as those conducted by the Maryland Patient Safety Center also focused on preventable catheter related blood stream infections and ventilator associate pneumonia.

We are in agreement that the HAI's chosen for reduced payment should be infections that are preventable and a result of hospital care. **As the above indicates the most recent studies highlight the device-related infections such as catheter associate blood stream and ventilator associated pneumonias and as such consideration should be given to selecting these two conditions be selected for monitoring and reporting.**

Although we are in agreement with CMS's proposal of reducing payments to hospitals for cases where the patient is treated for a condition that was not present on admission, many of our customer hospitals are concerned that this proposal would reduce payment based on conditions beyond their control, unless the methodology can clearly separate what are truly preventable infections from those in which pre-existing co morbid conditions played a role in predisposing the patient to infection. This presents a challenge in defining the actual codes that will trigger the case for a reduced payment. (In the case of the two HAI's we identified it is our understanding that ICD-9 does not have a specific code for either of these).

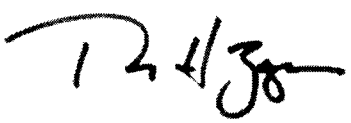
* * * * * * * * * * * * *

CareScience is in full support of CMS' efforts to improve the functioning of the Inpatient Prospective Payment System by more accurately allocating payments for inpatient hospital services. However, we and the customer hospitals we support are concerned that the Proposed Rule changes are being expedited without appropriate thought given to the impact of other changes facing healthcare such as the quality provisions of the Deficit Reduction Act, the transition to ICD-10, and though not commented on the adoption of UB-04 to replace UB-92 which represents a significant shift to improve the clinical coding section of the uniform bill. Moreover, there is a concern that the healthcare providers have not had the opportunity to fully grasp the complexities of the proposal nor have full access to the information necessary to provide meaningful commentary on the proposal.

We appreciate the opportunity to provide commentary on the Proposed Rule and we hope that the agency will carefully consider our comments and the feedback we have received from the customer institutions we support as it begins to move forward in implementing the proposed changes.

Thank you for your kind consideration.

Sincerely,



Thomas Zajac
President, CareScience
Division of Quovadx, Inc
3600 Market Street, 7th Floor
Philadelphia, PA 19104

Thomas.Zajac@quovadx.com

Submitter : **Dr. Steve Simmons** **Date: 06/12/2006**

Organization : **John Peter Smith Hospital-FMRP**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS or the Agency) proposed rule entitled "Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates." 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in "patient care activities." The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

Background
The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a nonhospital setting, such as a physician's office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not "related to patient care".

This position reverses the Agency's position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include "scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty." [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency's 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs.

CMS-1488-P-1386-Attach-1.DOC

The Texas Academy of Family Medicine has just informed us that CMS is considering the disallowance of faculty development activity in the calculation of faculty time for IME and DME reimbursement. These activities in our program include:

- Development of Curriculum in alignment with best current evidence
- Review of Curriculum
- Critical Evaluation of Evidence Based Medicine Guidelines for Patient Care
- Development and Utilization of Evaluation Tools for Faculty and Residents
- Delivery of Curriculum by lecture, Web-based curriculum, small group workshops and one-to-one training
- Scholarly Activities
    - Written Publications
    - Presentation of Research
    - Faculty Development Conferences
    - Participation in Critical Review Activities of Specialty
    - Research regarding the outcomes of care of resident practices
    - Clinical Quality Improvement in Resident Delivery to Patient Services
- Resident Evaluation
- Resident Academic Remediation
- Resident Testing
- Resident and Faculty Portfolio Development and Monitoring
- Faculty Training
- Alumni Evaluation and Research

My understanding is that CMS is proposing a rule that would disallow the time for these activities due to them being unrelated to patient care. Patient care is critically dependent on our ability as a faculty to carry out these activities. We can continue to deliver services to the underserved as we always have in our residency site. Duke Family Medicine Department has recently decided to do this rather than continue training family physicians.

However, we will lose our best clinicians and teachers to much higher compensated clinical positions. The patients will lose the benefit of these outstanding critical thinkers in the process of their care. We could not train physicians for the future for much longer without support for the educational aspects of their experience. As a program director, I see this as an unacceptable price to pay for the future of our patients and the patients that would have been cared for by the physicians that we would have trained for our hugely underserved state of Texas.

Submitter : **Dr. Christopher Chambers** **Date: 06/12/2006**

Organization : **Department of Family Medicine Jefferson Medical Co**

Category : **Physician**

Issue Areas/Comments

GME Payments

GME Payments

As a faculty member of a department of family medicine, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS or the Agency) proposed rule entitled Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates. 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in patient care activities. The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

Background
The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a nonhospital setting, such as a physician s office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not related to patient care .

This position reverses the Agency s position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty. [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency s 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs.

Residency Program Activities and Patient Care
I firmly believe that with the possible exception of extended time for bench research, there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician s educational development into an autonomous practitioner.

To reiterate, I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely

Christopher V. Chambers, MD

1388

Submitter : Mr. Todd Jones **Date:** 06/12/2006

Organization : Central Baptist Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1388-Attach-1.DOC

#1388

BAPTIST HEALTHCARE SYSTEM

4007 Kresge Way
Louisville, Kentucky 40207
502-896-5000

Electronically Submitted

June 12, 2006

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1488-P
7500 Security Boulevard
Baltimore, Maryland 21244-1850

RE: Provider Comments
Proposed Changes to Inpatient PPS
DRG Reclassifications and Severity of Illness

On behalf of the Central Baptist Hospital, a member of Baptist Healthcare System, Inc. (BHS), we appreciate the opportunity to comment on the fiscal year (FY) 2007 proposed changes to the hospital inpatient prospective payment system.

BHS supports meaningful improvements to Medicare's inpatient prospective system and shares CMS's desire to develop a payment system that provides an equal financial incentive (margin) to treat all patients, regardless of diagnosis or severity of illness. BHS further acknowledges that this payment system must be statistically robust, clinically meaningful and at the same time, administratively feasible.

BHS submits the following recommendations to the current proposals:

1. The proposed changes to the DRG weights based upon Hospital Specific Relative Value cost center (HSRVcc) and introduction of Consolidated Severity Adjusted DRGs (CS-DRGs) should be implemented simultaneously.

2. The proposed changes to the DRG weights (HSRVcc) and introduction of CS-DRGs should be implemented on or after October 1, 2008.

3. Valid cost-based weights must be developed and utilized.

4. Further refinement of the proposed CS-DRG methodology needs to be done to ensure it promotes (rather than inhibits) the accomplishment of CMS's stated goals.

Discussion and rationale for recommendations:

Recommendation 1: Simultaneous Implementation

a. The proposed HSRVcc changes in FY2007 are projected to reduce reimbursement to BHS from the current FY2006 amount by nearly $8.5 million.

b. The proposed implementation of CS-DRGs in FY2008 is projected to increase reimbursement from the FY2007 amount by nearly $8.2 million (which represents a reduction of approximately $300,000 from the current FY2006 amount). This significant volatility in reimbursement has several implications.

   First, BHS will **permanently** lose $8.2 million in reimbursement in FY2007.

   Second, BHS will **potentially** receive an increase in reimbursement in FY2008. BHS has utilized the 3M APR-DRG grouper for many years, largely as part of internal quality initiatives and the Premier Hospital Quality Incentive Demonstration. As a result, BHS had the internal APR-DRG data to convert to CS-DRGs and calculate the impact of the FY2008 proposal.

   However, the underlying assumptions in the impact analysis are: (1) coding in the future is consistent with current coding practices, and (2) that Medicare will allow current coding in the future reimbursement model. Because these are assumptions and not givens, BHS has significant concerns regarding the ability to accurately forecast the proposals impact beyond FY2007, which is critical.

   Third, the increase in reimbursement in FY2008 under the CS-DRG system indicates that BHS hospitals treat more severe patients on average. This finding is consistent with the mission and values of its member hospitals.

   BHS is comprised of five hospitals within the state of Kentucky. It operates urban hospitals in Louisville, La Grange and Lexington, rural referral centers in Corbin and Paducah. Collectively, BHS has the largest number of inpatient admissions in Kentucky and is one of the largest providers of Medicaid services within the state.

   The primary and secondary markets for BHS hospitals is comprised of 40 of the 120 counties in Kentucky and range across the central, western and southeastern parts of the state. Five of the poorest ten counties are located with the BHS service area.

   Medicaid, charity and uninsured patients represent over 17% of BHS inpatient business. As part of BHS's Christ-centered mission, each BHS hospital has not only expanded its general acute care services, but also its highly specialized tertiary programs in an effort to provide a full range of surgical and medical services to all patients regardless of their ability to pay or severity of illness. Central Baptist Hospital, a disproportionate share facility, serves an even higher percentage of Medicaid, charity and uninsured patients than BHS as a whole, with this population accounting for over 18.5% of our inpatient business. Central Baptist Hospital offers a broad range of tertiary care services to all

patients, regardless of ability to pay, including being a regional leader in the offering of high acuity services and new technologies in neonatology, oncology, neurology, cardiology, and orthopedics.

Given the mission of BHS and demographics of the communities it serves, it is clear that BHS hospitals are not specialty hospitals that target services that provide higher margins. However, given the high severity of illness for the patient population BHS hospitals serve, unless the HSRVcc and CS-DRG proposals are implemented simultaneously, unfair financial hardship will be experienced, threatening our ability to provide the same level of access to cutting edge technologies currently offered.

Fourth, CMS suggests that a budget neutrality factor may be applied to offset improvements in coding practices. This too, represents a significant unknown in the current proposal that needs to be accurately evaluated and communicated for which additional time is necessary.

Recommendation 2: Delay until October 1, 2008

a. It is imperative that the GROUPER technology be made available to hospitals and vendors. Without direct access to the GROUPER by hospitals, it will be virtually impossible to understand its logic. Without access by multiple vendors, it will be more difficult to purchase at a competitive price and will be more difficult to integrate into existing hospital systems.

b. In addition, many current hospital software programs will need to be modified to handle the new payment and billing system. An implementation date before October 1, 2008 will not allow adequate time to make all the necessary system changes and upgrades.

c. CMS stated that one option to the software issue is for hospitals to submit claims without being grouped and allow CMS to assign the CS-DRG. This raises several serious concerns.

   First, without the CS-DRG information, revenues and patient receivables cannot be recorded accurately. Statement of Position (SOP)-00-1(6) states, "Health care entities need to estimate amounts that ultimately will be realizable in order for revenues to be fairly stated in accordance with generally accepted accounting principles (GAAP)." Paragraph (9) states "Management is responsible for the fair presentation of its financial statements in conformity with GAAP".

   Currently, the DRG assignment is critical in making an accurate estimate of the net realizable value of accounts receivable. Given the significance of and the increased uncertainty of the impact of the proposed changes for FY2007 and FY2008, it will be even more important for patient bills to be grouped prior to billing.

   Second, the Medicare inpatient business represents over 41% of BHS total inpatient business. As such, changes to the Medicare payment system have a significant impact on BHS's ability to accurately estimate payments in evaluating strategic initiatives, business

plans, budgets, marketing, staffing and other critical decisions. With the significance of the proposed changes, more time is required to understand and perform impact analysis.

d. Four of five BHS hospitals are disproportionate share hospitals (DSH). Last year these hospitals received approximately $14.7 million in DSH reimbursement. It is anticipated that the CS-DRGs will have a material impact on DSH payments and in order for hospitals to adequately plan and make appropriate adjustments in a timely manner, BHS recommends that further analysis be prepared and accurate impact estimates published prior to implementation of the proposed changes.

e. Additional time is required to determine the impact from other third party payers (including Medicaid) that have historically modeled reimbursement rules and methodologies from the Medicare payment system. It is anticipated that these third party payers will adopt the new Medicare payment system at some time in the near future following implementation by Medicare. However, given the complexity of the proposed changes, additional time is necessary for payers and hospitals to better understand these changes and make appropriate systematic changes.

Recommendation 3: Valid Cost Weights

a. Under the HSRV weight calculation method, the ten cost center categories were developed based on broad accounting definitions, where each cost center category represents at least five percent of the charges in the claims data. BHS acknowledges the need to remove bias introduced by individual hospital characteristics (i.e. unique cost centers reported on the cost report), but it appears that this resulted in incorrect cost center groupings in the CMS study that raises concerns regarding the accuracy of the cost-to-charge ratio (CCR) data.

   For example, according to CMS-1488-P, Table-A (pp.66-67 and pp.186-187) the HSRV Cardiology cost center includes cost report lines 53 and 54. However, one BHS hospital includes its Catherization Lab revenues and expenses on cost report line 42.01, which according to the table appears to be incorrectly grouped with the HSRV Radiology cost center that includes cost report lines 41,42 and 43.

   BHS is very concerned that grouping errors such as the one described here could materially impact the CCR used to calculate the DRG weights. Therefore, BHS recommends that CMS work through the Medicare intermediaries to audit the cost report line definitions for all hospitals to ensure groupings are accurate.

b. The weighting calculation used to determine the scaling factors gives equal weight to each hospital regardless of size or volume. This methodology results not only in an inaccurate national cost-to-charge ratio, but is inconsistent with the method used when averaging the ten cost center DRG weights to which the scaling factors are applied. Therefore, BHS recommends that a consistent weighting methodology be utilized to calculate the scaling factors.

c. HSRVcc costs were based on the 2004 cost reports. Significant changes in medical technologies, products and services have been introduced, which have significantly impacted the CCR. Therefore, BHS recommends that a more recent audited cost report be used, after audit procedures have been performed as recommended in (a.) above.

d. Central Baptist Hospital is also concerned that partial data from a number of large hospitals whose cost to charge ratios were classified as outliers were excluded from the analysis. The exclusion of this data, which, because of the size of excluded facilities, collectively accounts for a large percentage of Medicare inpatient admissions nationally, materially impacts the resulting calculations, and, in particular, causes routine care cost to charge ratios to be much higher as used in the CMS calculations than the actual national averages reflect. Furthermore, this problem is compounded by the fact that CMS continues to use partial data from these same facilities

Recommendation 4: Consolidated Severity-Adjusted DRG Methodology

a. CS-DRGs are developed by grouping APR DRGs considering average length of stay and average charges. This grouping methodology is inconsistent with the cost-based intention of the proposed changes. Average cost, using the HSRVcc methodology (applying the recommended changes), for each APR DRG by severity level should be the determinant for grouping APR DRGs into CS DRGs.

b. CMS believes that the adoption of consolidated severity-adjusted DRGs would create a risk of increased aggregate levels of payment, similar to the 2% increase associated with the implementation of the current DRG system in 1983 and has recommended the application of a compensating budget neutrality factor. Because of the significance of even a 2% reduction in reimbursement, BHS recommends that this be further studied before implementation.

Thank you for your consideration of our recommendations. We certainly hope you can see and appreciate the legitimacy of the concerns raised. If you have any questions, please feel free to contact me at (859) 260-6275 or tjones2@bhsi.com.

C. Todd Jones
Vice President
Central Baptist Hospital

Submitter : **Mr. James J. Barba** **Date: 06/12/2006**

Organization : **Albany Medical Center**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1488-P-1389-Attach-1.DOC

ATTACHMENT TO #1389

Albany Medical Center

I am writing as the Chairman of the Board, President and Chief Executive Office of Albany Medical Center (Albany, NY), the only private not for profit academic medical center serving 25 counties in Northeastern New York and Western Massachusetts. The purpose of my letter is to respond to the CMS proposed rule for Medicare payments for federal fiscal year 2007 and 2008. I ask that you adopt the recommendation of the AHA and the AAMC. Specifically the recommendation that I ask be adopted is as follows:

1) Postpone for one year the proposed DRG weight changes.
2) Further analyze the best way to create cost-based weights.
3) Further assess the need for a new patient classification system to understand whether it results in an improved payment system.
4) If a new patient classification system is warranted, then implement simultaneously with the DRG weight changes.
5) Implement the ultimate changes over a three year period.
6) Work with the AHA and AAMC to evaluate alternatives.
7) Rescind the proposed payment rules for residents and reaffirm the 1999 position on defining patient care activity.

These issues are of paramount importance to Albany Medical Center. The impact of the changes to the DRG weights and patient classification represent a reduction in Medicare payments of (2.5%) and (1.9%) respectively in federal fiscal year 2007 and 2008, for a combined total of (4.4%) annually. This represents ($4.3 million) annual reduction in Medicare revenues for Albany Medical Center. The impact of the proposed rule for resident payments, which purportedly clarify existing rules, is being evaluated but will also amount to a significant reduction in Medicare payments.

Our operating margin for 2006 is a mere 1.3%. When implemented, the changes in DRG weights and patient classification alone will reduce this margin to 0.7%. By any objective standard this margin is not adequate to sustain an academic medical center over time. As the only academic medical center serving the region, we are the only provider of trauma care, organ transplantation, pediatric subspecialty care, including neonatal and pediatric intensive care, among other unique services.

The Hospital industry, and Albany Medical Center specifically, need the assurance that the cost based weighting methodology is sound and truly reflective of cost. Further it should be reflective of current cost given the rapid changes in externally driven costs, and ever changing and expensive medical technology. Hospitals nationally and in New York, AMC included, lose money on the care of Medicare patients. This in large part is due to the fact that Medicare payment policies and update factors do not reflect current cost. In addition, AHA has identified flaws in the current proposed weighting methodology. To assure this is fully studied, we believe the one year delay is most appropriate. We also believe that the need for a new patient classification system needs further study before implementation and, if appropriate, it should be implemented

simultaneous with the DRG weighting changes so that providers don't have to adapt twice to potentially significant change. And whatever changes are made, we feel a three year phase in is needed. CMS historically phases in major changes such as this. These changes might be the greatest change to Medicare PPS since its initial introduction in 1983. Hospitals need more time at adapt to a new DRG system that has been rather consistent for the past 23 years.

Submitter : **Dr. Barbara Slee** **Date: 06/12/2006**

Organization : **John Peter Smith Hospital-FMRP**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS or the Agency) proposed rule entitled "Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates." 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in "patient care activities." The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

Background
The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a nonhospital setting, such as a physician's office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not "related to patient care".

This position reverses the Agency's position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include "scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty." [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency's 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs.

CMS-1488-P-1390-Attach-1.DOC

#1310

Dear CMS Policy Maker:

I am a family medicine resident in a very busy HPSA. I really need my faculty to teach. Why would you interpret a rule designed to do just that as being unrelated to patient care time? Whether we are having a discussion after a patient encounter, a small group discussion regarding a difficult clinical situation, reviewing our evaluation for our care and didactic tests in a certain disease domain, or participating in lectures – we are learning about, caring for current and protecting our future patients.

My concern is that the faculty are already stretched to produce more patient visits with poor compensation and must cover four of us at a time for supervision in clinic. The hour they spend before and after clinic to discuss a specific topic that is not related to a specific individual patient will disappear with the implementation of the rule you suggest. They will not have time to sit down with us to discuss our overall performance – we will get an email.

The faculty, without support for their own development, will be likely to lose their academic edge as they work to see patients, see more patients and supervise patient care without any incentive to reflect, discuss and research our and their work.

Please help us be better physicians to our patients by supporting a competent and refreshed faculty. Rescind the interpretation of the IME and DME support rule.

Sincerely,

Submitter : **Dr. Lindsay Bolton** **Date: 06/12/2006**

Organization : **John Peter Smith Hospital-FMRP**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GME Payments

GME Payments

Residency Program Activities and Patient Care
I firmly believe that with the possible exception of extended time for "bench research," there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician's educational development into an autonomous practitioner.

To separate out CMS's newly defined "patient care time" from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

CMS-1488-P-1391-Attach-1.DOC

#1391

Dear CMS Policy Maker:

I am a family medicine resident in a very busy HPSA. I really need my faculty to teach. Why would you interpret a rule designed to do just that as being unrelated to patient care time? Whether we are having a discussion after a patient encounter, a small group discussion regarding a difficult clinical situation, reviewing our evaluation for our care and didactic tests in a certain disease domain, or participating in lectures – we are learning about, caring for current and protecting our future patients.

My concern is that the faculty are already stretched to produce more patient visits with poor compensation and must cover four of us at a time for supervision in clinic. The hour they spend before and after clinic to discuss a specific topic that is not related to a specific individual patient will disappear with the implementation of the rule you suggest. They will not have time to sit down with us to discuss our overall performance – we will get an email.

The faculty, without support for their own development, will be likely to lose their academic edge as they work to see patients, see more patients and supervise patient care without any incentive to reflect, discuss and research our and their work.

Please help us be better physicians to our patients by supporting a competent and refreshed faculty. Rescind the interpretation of the IME and DME support rule.

Sincerely,

Submitter : Dr. Mark Greenawald **Date:** 06/12/2006

Organization : Carilion Health System/AAFP

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS or the Agency) proposed rule entitled "Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates." 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in "patient care activities." The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

Background
The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a nonhospital setting, such as a physician's office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not "related to patient care".

This position reverses the Agency's position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include "scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty." [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency's 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs.

Residency Program Activities and Patient Care
I firmly believe that with the possible exception of extended time for "bench research," there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician's educational development into an autonomous practitioner.

To separate out CMS's newly defined "patient care time" from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,

Mark H. Greenawald, MD

Submitter : **Date: 06/12/2006**

Organization :

Category : **Individual**

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS or the Agency) proposed rule entitled "Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates." 71 Fed. Reg. 23996 (April 25, 2006).

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I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care
experiences of residents during their residency programs.

Sincerely,
Tracy Marx, DO
OUCOM

Submitter : **Mr. Joseph Zager** **Date: 06/12/2006**

Organization : **Shore Health Services**

Category : **Other Health Care Professional**

Issue Areas/Comments

DRG Reclassifications

DRG Reclassifications

Dear CMS Associates,

As the administrator of a sole community/rural health network, I am very concerned about the impact of the proposed changes on our organization. After both iterations of changes have been made, our Medicare reimbursements will decrease by approximately 3% from current levels. For the past three years our organization has reported significant losses from operations, and overall, despite layoffs, reorganizations, and other management actions. It would appear that the Federal Government's persistance in paying rural hospitals less than their urban counterparts cannnot be offset by changes in operating systems if the mission of the organization is to care for the community as a whole. Specifically, our charity and other indigent care case load do not allow us sufficient margin from private payors to make up governmental shortfalls.

I would respectfully request CMS devise a more appropriate and equitable payment methodology that adequately addresses the role rural sole community providers play, and begins to make them whole from the years of comparative underpayments when compared to their urban counterparts.

Thank you very much for your time and interest. I realize your work is not only demanding, but that you are trying to balance among many competing interests and community needs. I think perhaps you can look at the income statements and balance sheets of the various entities with whom you work to get a very good idea of the classes of organizations which have been sufficiently rewarded for their work, and those which have not been appropriately recognized. I would hope this will lead your decision making in a practical direction.

Sincercly,

Joseph P. Zager
President and CEO
Shore Health Services
Nassawadox, Virginia

Submitter : **Dr. Richard Young** **Date: 06/12/2006**

Organization : **John Peter Smith Hospital-FMRP**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS or the Agency) proposed rule entitled "Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates." 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in "patient care activities." The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

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This position reverses the Agency's position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include "scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty." [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency's 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs.

CMS-1488-P-1395-Attach-1.DOC

#1395

The Texas Academy of Family Medicine has just informed us that CMS is considering the disallowance of faculty development activity in the calculation of faculty time for IME and DME reimbursement. These activities in our program include:

- Development of Curriculum in alignment with best current evidence
- Review of Curriculum
- Critical Evaluation of Evidence Based Medicine Guidelines for Patient Care
- Development and Utilization of Evaluation Tools for Faculty and Residents
- Delivery of Curriculum by lecture, Web-based curriculum, small group workshops and one-to-one training
- Scholarly Activities
    - Written Publications
    - Presentation of Research
    - Faculty Development Conferences
    - Participation in Critical Review Activities of Specialty
    - Research regarding the outcomes of care of resident practices
    - Clinical Quality Improvement in Resident Delivery to Patient Services
- Resident Evaluation
- Resident Academic Remediation
- Resident Testing
- Resident and Faculty Portfolio Development and Monitoring
- Faculty Training
- Alumni Evaluation and Research

My understanding is that CMS is proposing a rule that would disallow the time for these activities due to them being unrelated to patient care. Patient care is critically dependent on our ability as a faculty to carry out these activities. We can continue to deliver services to the underserved as we always have in our residency site. Duke Family Medicine Department has recently decided to do this rather than continue training family physicians.

However, we will lose our best clinicians and teachers to much higher compensated clinical positions. The patients will lose the benefit of these outstanding critical thinkers in the process of their care. We could not train physicians for the future for much longer without support for the educational aspects of their experience. As a program director, I see this as an unacceptable price to pay for the future of our patients and the patients that would have been cared for by the physicians that we would have trained for our hugely underserved state of Texas.

Submitter : **Dr. Mitchell Kaminski** **Date: 06/12/2006**

Organization : **Crozer-Chester Medical Center**

Category : **Individual**

Issue Areas/Comments

GME Payments

GME Payments

As a family physician and Chairman of a Family Medicine Department which includes medical student and resident training, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS or the Agency) proposed rule entitled Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates. 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in patient care activities. The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

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I firmly believe that with the possible exception of extended time for bench research, there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician s educational development into an autonomous practitioner.

To separate out CMS s newly defined patient care time from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,

Mitchell A. Kaminski, M.D.
Chairman, Department of Family Medicine
Crozer-Chester Medical Center
Upland, PA 19013

Submitter : Mr. James T. Kirkpatrick **Date:** 06/12/2006

Organization : Massachusetts Hospital Association

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1397-Attach-1.DOC

MHA

#1397

Massachusetts Hospital Association

June 6, 2006

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1488-P
P.O. Box 8011
Baltimore, MD 21244-1850

RE: **CMS-1488-P, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates; Proposed Rule.**

Dear Dr. McClellan:

The Massachusetts Hospital Association (MHA), on behalf of our member hospitals and health systems, appreciates this opportunity to comment on the proposed rule for the FY 2007 Inpatient Prospective Payment System (IPPS).

DRG Weights and Severity of Illness Classification

The rule contains the most significant changes to the inpatient PPS since its inception, with our hospitals standing to potentially gain or lose. MHA supports the principle of meaningful improvements to Medicare's inpatient PPS. We believe in the goal of refining the system to create an equal opportunity for return across DRGs which will provide an equal incentive to treat all types of patients and conditions.

However, we believe that care must be taken to understand the significant proposed policy changes, which redistribute millions of dollars within the inpatient system. Questions remain about the concepts and methodology used to create the changes, and about whether the changes will create a better payment system. Impact estimates at the DRG and hospital level are highly unstable, with small changes in method leading to large changes in hospital payment. Also, the validity of CMS' proposals versus potential alternatives to improve the DRG weights and classification system is uncertain. We urge CMS to provide hospitals and others with additional information on the impact of alternative methods and methodological corrections and to include policies that cushion the impact on negatively affected hospitals.

Wage Index

Exclusion of Critical Access Hospitals

Recently the Connecticut Hospital Association conducted an analysis of the impact of excluding the approximately 1,200 Critical Access Hospitals (CAHs) from the wage index file. The results of this analysis indicated that the National Average Hourly Wage for FFY 2007 is overstated by .707% since these small lower paying hospitals have been deleted from the wage index file. This results in an understatement of the various wage indexes throughout the country. Based on the analysis, we estimated the impact of this change on

Massachusetts hospitals IPPS payments and our estimates show that for the five years (2003-2007) Massachusetts hospitals payment were understated by $36 million (see table below). Note that this figure does not include the impact on inpatient capital payments or outpatient payments, both of which would be affected by the decrease in the wage index.

Year	% Overstatement of National Average Hourly Wage	Impact on IP pmts to Massachusetts Hospitals
2003 Impact	0.0190%	$ 327,970
2004 Impact	0.3670%	$ 6,335,003
2005 Impact	0.4270%	$ 7,370,698
2006 Impact	0.562%	$ 9,701,013
2007 Impact	0.707%	$ 12,203,943
TOTAL		**$ 35,938,627**

MedPAC has previously recommended that the CAH data be included in the wage index file (at least in the denominator). Since these hospitals in rural areas still compete for scare hospital resources in rural areas as the IPPS hospitals CAH data should continue to be included in the wage index file.

We ask CMS to use estimated CAH data to include in the FFY 2007 wage index file to compute the National Average Hourly wage. A Medicare Occupational Mix factor of 1.0000 could be assigned to these hospitals. Further we ask that CMS develop a plan to pay IPPS hospitals the $1.021 billion overstatement of the National Average Hourly Wage applicable to prior years.

Lastly, we ask CMS to obtain wage index data from CAHs and subject that data to the same rigorous intermediary review as is done for IPPS hospitals and to include the CAH data in future wage index calculations (at least in determining the National Average Hourly Wage).

New Rural Hospital

In the rule, CMS discusses the situation where a "new rural hospital" opens up in a previously all-urban state, either as an entirely new facility or a Critical Access Hospital (CAH) converting to PPS. CMS clarifies that the wage data from a period when the hospital was not a PPS provider could not be included in the wage index and, in fact, even when the provider files its first cost report as a PPS provider, that data would not be used in the wage index calculation *until four years later*. The only wage index that would be available to a new rural hospital of this type would be the imputed rural floor.

Our Position: When CMS issued its final fiscal year (FY) 2004 Medicare inpatient prospective payment system (PPS) rule on July 31, 2003, it made an unprecedented change in the calculation of the wage index for all Massachusetts Hospitals, primarily impacting hospitals in the western part of the state. In the Inpatient PPS rule, CMS excluded from the calculation of the Area Wage Index data for hospitals had converted to Critical Access Hospital (CAH) status, ***even though these hospitals were PPS hospitals in the base year.***

Now, CMS is proposing that, should a "new rural hospital" open in a previously all-urban state, CMS will, in stark contrast to the immediate exclusion policy, wait for ***four full years***

before data from such a hospital could be included in the wage index calculation. In the meantime, the hospital will be paid at a wage index level which completely unrelated to its own labor market costs. If such a "new rural hospital" has a significantly higher average hourly wage than reflected by the "imputed rural floor", it would have to suffer losses due to Medicare under-reimbursement for four years, and might even close, before CMS will consider paying the hospital at an appropriate rate.
We therefore urge CMS to reconsider this proposal and be as prompt in including data from "new" rural hospitals at it was in excluding them. We urge that the new hospital's data be included as soon as a full year's cost report with the hospital operating as a PPS hospital is available.

Geographic Reclassifications: Multi-campus Hospital's Wage Index

While this issue and the following comments do not pertain to Geographic Reclassifications, the issue at hand, i.e., a multi-campus hospital with campuses located in more than one CBSA, is raised by CMS in this section of the proposed rule. We therefore include the caption "Geographic Reclassifications" at the beginning of our comment.
We believe that CMS' policy regarding wage index and payment in the case of a multi-campus hospital located in two different wage areas is flawed and inconsistent. The current policy requires **all** the wage data for the multi-campus hospital to be included in the wage area where the main campus is located, (we will call this Area A) even when the majority of beds (and Medicare patients) are located in campuses in another wage area (Area B)—that is unless the hospital files information separately for each of the campuses. Therefore, the wage index for area A *includes* the data from all campuses of the multi-campus hospital, while the wage index for area B *excludes* the data for all campuses of the hospital.

Yet, under the current policy, CMS also rules that Medicare cases treated at the campuses actually located in Area B (accounting for the majority of Medicare cases) must be ***paid at*** Area B's wage index. Note that this is the same wage index from which the hospital's wage data has been *excluded.*

These are conflicting—first CMS rules in effect that the wages for the entire hospital reflect the labor market of (and therefore should be included in the wage index of) area A, then rules that Area B's wage index is most reflective of the labor market for the campuses accounting for most of the Medicare cases treated by the hospital, and therefore these cases should be paid for using Area B's wage index.

Add to this conflict the inconsistencies when the campuses in Area B apply for and receive reclassification to Area A and the flaws of this policy become even more apparent. Section 1886(d)(C)(i) of the statute requires that regardless of whether the reclassification of a hospital(s) results in a decline in the "host area's" wage index (in this case, Area A is the host area) of less or more than 1 percent, the core "host area"(Area A) wage index is to be determined ***exclusive of*** the wage data of the reclassified hospital(s).

In order to correct these flaws and inconsistencies, we believe that the wages for multi-campus hospitals in this situation must be allocated by some method. There are, we believe, at least two viable alternatives to apportion such a hospital's wages to each of its campuses:

- Number of beds
- The volume of Medicare discharges, perhaps adjusted for case mix.

Because the number of medical / surgical beds by campus are readily available from the hospital license, we believe allocating such a multi-campus hospital's wage data using the relative distribution of beds as a proxy is the most accurate and practicable solution, at least for the 2007 IPPS rate year.

Effect of Change of Ownership on Urban County Group Reclassifications

Regulations only allow a new provider to apply for individual reclassification after accumulating wage data for one year. However, CMS has clarified on page 24110 of the April 25th Federal Register that ***it will permit*** a new provider to join a group reclassification even without one full year of data. CMS explains that if a new hospital was *not* allowed to join a *group* reclassification (till it accumulated one year of data), it would preclude the entire group from reclassifying at that time (since the condition that *all* hospitals in the county apply would not be met).

Urban county group reclassifications are effective for three years. In an e-mail from a CMS official an informal opinion was issued that prohibits a *second* group application while there is an existing approved group reclassification, until the MGCRB cycle allows for a new three year application for the countywide group could be filed under existing regulations. The prohibition of a second filing, *including* the new provider, (while there is an existing approved group reclassification), within the three year reclassification period effectively denies the new provider the timely opportunity to have a wage index that is comparable to the hospitals in its county. The new provider would essentially have to "wait out" the remaining reclassification period. In contrast, a new provider in a county that *is about to* apply for group reclassification will be allowed to join in the application (even without a full year of data).

The interaction of the prohibition of a second filing within the three year reclassification period with the proposal made by CMS in this section would effectively deny implementation to one type of new provider, while allowing it for another.
We suggest that where there is already an approved group reclassification, either the new provider be automatically granted the wage index of all the other hospitals in the county or another creative approach, using the broad authority of the Secretary be implemented to allow for timely implementation of this important provision.

Reclassification applications for multi campus hospitals

MHA opposes the proposed repeal of a CMS rule that currently allows multi-campus hospitals with campuses in different wage index areas to report all of the wages for all of their campuses when applying for Medicare wage index reclassification. Multi-campus hospitals are very different than multi-hospital health systems, and changing this rule would be burdensome in both time and expense to these hospitals, necessitating fundamental, costly changes in how they are structured and in their accounting systems.

In addition, repealing this rule now would leave any such hospitals – and there are a number of such hospitals in the country – unable to apply for Medicare wage index reclassification at any time less than three years after such a change is implemented because they would lack the three years of data required for a reclassification application. Any such bid for reclassification therefore would be rejected without even considering the merits of the application because of the lack of the required data. Consequently, we urge CMS not to

change the current rule. If this is not possible, CMS should at least extend the current rule for five more years so it does not inappropriately preempt any affected hospitals' ability to seek Medicare wage reclassification.

Hospital Quality Data

In accordance with the requirements in the Deficit Reduction Act of 2005 (DRA), the Centers for Medicare & Medicaid Services (CMS) has proposed expansion of the 10 quality measure starter set and linked the reporting of a total of 21 quality measures to the CMS data warehouse to the hospital annual payment update (APU) for FY 2007. The focus areas of the 11 additional measures are acute myocardial infarction, heart failure, pneumonia, and surgical infection prevention (SIP). The SIP measures include administration of an antibiotic within one hour of incision and the discontinuation of antibiotics within 24 hours after the surgery has been completed.

Retroactive Reporting:

The rule also proposes that the data collection for the expanded set of quality measures begin with discharges occurring in the first calendar quarter of 2006 – January 1, 2006 discharges. This data must be submitted to the CMS data warehouse by no later than August 15, 2006 for hospitals paid under the CMS prospective payment system to receive their full market basket update. Failure to submit the data on these additional measures in the time frame proposed will result in those hospitals receiving the full market basket update minus 2 percent.

We believe that this requirement, announced on April 25, 2006 in the proposed rule, effectively required many hospitals to needlessly incur the costs and disruption associated with unplanned retrospective data collection back to January 1, 2006 for, primarily, the two Surgical Infection Prevention (SIP) measures. As CMS knows, SIP measure reporting through the Hospital Quality Alliance was growing at a slower pace than the other 19 measures because it was adopted for JCAHO core measure reporting at a later date than many of the other measures and represented a new clinical focus area for JCAHO core measure reporting without the requirement that it be adopted for accreditation purposes. We say needlessly because, as CMS acknowledged in the proposed rule ("We believe that the statute gives the Secretary the discretion to choose what 'begin to adopt' should involve in FY 2007 and the number of additional measures, if any, that would be 'appropriate' during that time."), there was discretion to delay adoption (just as the Secretary chose to delay adopting HCAHPS® and the Leapfrog measures) until a time that would have been less disruptive and could have been anticipated in hospital budgets and work plans.

While the damage is largely done, we do recommend that the final rule delay the requirement for reporting on the expanded set of quality measures to qualify for the full payment update until 3rd Quarter CY 2006, as there may be some hospitals that may have been unable to meet the August 15 reporting deadline for 1st Quarter CY 2006 data, and it would be unfair to penalize them for this needless and arbitrary deadline.

Chart Validation

Our hospitals strongly encourage CMS to allow hospitals to challenge any mismatches in the chart validation that they may have with CDAC in order to score as high as they possibly can in any quarter, learn from the process, and remedy any identified problems to prevent them from occurring in subsequent quarters. Additionally, our hospitals recommend that CMS

consider a validation process that would focus more resources on those hospitals that are having difficulty in passing the validation thresholds on a consistent basis. Finally, going forward, CMS should prospectively establish and communicate to the field which quarters will be used in the calculation of the validation threshold.

Long-term Care Hospital (LTCH) DRGs

MHA is very concerned about the proposed re-weighting of the long-term care hospital (LTCH) DRGs for FY 2007. The projected payment cut resulting from the re-weighting – 1.4 percent – in combination with the payment cut resulting from the recent LTCH PPS final rule for 2007 – 7.1 percent – will cause substantial volatility for LTCH providers, and ultimately restrict access for patients needing long-term acute care services. It would be extremely difficult for any provider group to withstand an 8.5 percent cut in one year.

By pursuing this change, CMS is misinterpreting MedPAC's estimate of 2006 Medicare margins for LTCHs and creating an extremely unstable regulatory environment for LTCHs. MedPAC projected a 7.8 percent Medicare margin for LTCHs in 2006 and recommended no market basket update for FY 2007. However, this MedPAC projection does not include two major policy changes that also decrease Medicare margins for LTCHs: the projection excludes the impact of the "25% Rule" limiting payments to co-located LTCHs and the new reductions associated with the LTCH short-stay outlier policy. **Given these considerations, we urge the agency to forgo the proposed 1.4 percent cut and instead implement the re-weighting in a budget-neutral manner.**

Outlier Payments

The rule proposes establishing a fixed-loss cost outlier threshold equal to the inpatient PPS rate for the DRG, including indirect medical education (IME), disproportionate share hospital (DSH), and new technology payments, plus $25,530. We remain very concerned that the threshold is too high. According to AHA analyses, actual outlier payments for FY 2006 are estimated to be 0.47 percentage points lower than the 5.1 percent of funds withheld from hospitals to fund outlier payments.

CMS spent only 3.8 percent, or $1.15 billion less than set aside in FY 2005, and only 3.5 percent, or $1.3 billion less than the funds withheld in 2004.
However, using the proposed charge inflation methodology results in an inappropriately high outlier threshold and a real payment cut to hospitals. MHA strongly opposes using this methodology to estimate the outlier threshold **and** we urge CMS to adopt the alternative methodology proposed by AHA to calculate the outlier threshold.

Graduate Medical Education (GME) Payments

Exclusion of Didactic Training. The proposed rule states that resident training that occurs at non-hospital sites must be related to patient care if a hospital wishes to count that time for direct medical education (DGME) and indirect medical education (IME) payment purposes. Resident time spent in didactic activities that often occur in associated medical schools – such as educational conferences, journal clubs and seminars – would specifically be excluded. CMS noted that its statement in a previous letter on this topic "implying that didactic time spent in non-hospital settings could be counted for direct GME and IME ... was inaccurate." CMS also noted that time spent in these activities could be counted for DGME

purposes if they occur in a hospital; however, the counting prohibition applies for IME payments regardless of where the educational activity occurs.

We strongly urge CMS to rescind the purported "clarification" in the proposed rule that excludes medical resident time spent in didactic activities in the calculation of Medicare DGME and IME payments. The stated rationale for the exclusion of this time is that it not "related to patient care." This position is in stark contrast to CMS' position as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include "scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty."

We strongly agree with CMS' 1999 position. The activities cited are an integral component of the patient care activities engaged in by residents during their residency programs. With the possible exception of extended time for "bench research," there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of a fully-trained physician. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician's educational development into an autonomous practitioner. In addition, it would be very difficult to separate out time spent at these activities.

We urge CMS to withdraw this change in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

If I can provide you with any additional information regarding our comments, please do not hesitate to contact me at (781) 272-8000, ext. 173.

Sincerely,

James T. Kirkpatrick
Vice President, Health Care Finance and Managed Care

Submitter : **Dr. Ty Bush** **Date: 06/12/2006**

Organization : **John Peter Smith Hospital-FMRP**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GME Payments

GME Payments

Residency Program Activities and Patient Care
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To separate out CMS's newly defined "patient care time" from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

CMS-1488-P-1398-Attach-1.DOC

#1398

Currently I am completing my residency in family medicine. When I became aware that CMS would stop funding payment to faculty for teaching, preparing curriculum and evaluating my performance through GME -- IME and DME support – I became alarmed.

We are in a state with a huge health care professional shortage in communities under 25,000. These communities cannot afford to support several nurse practitioners and visiting specialists when the services are delivered by a pluri-potential well trained family medicine specialist who is part of their community. The training programs, like mine, which prepare us for these types of venues are in very short supply. We need to be exceptionally well trained.

Someone at CMS will need to explain to me, how the teaching, curriculum development and evaluation process for the six required ACGME physician skill competencies is not related to patient care. Isn't this exactly what the IOM has criticized our training professions for? In fact, our program currently evaluates us in all these competencies as a continuing quality improvement process DURING patient care. Without time to discuss and reflect our experiences and outcomes we will not be serving the needs of our current and future patients.

Should indeed this come to pass, we will have faculty who will be caught in the productivity race with no time for us. We may get pop-up feed back from an Electronic Health Record in sites that have them that we have made an error or we are not following a guideline. No discussion there. What is being proposed is dangerous for our current patients and our future patients. Our patients deserve for us to have a better education than you are proposing.

Why does the American taxpayer support medical students at over $200,000 per student per year and offers the faculty of residencies less than $15,000 for teaching per resident per year? I am getting a lot more from my residency training to protect and serve my patients of the future than all of medical school combined. Please do not cut us any more – rescind the clarification of this dangerous and capricious rule.

Medical Resident

Submitter : Dr. Arthur Ollendorff **Date:** 06/12/2006

Organization : University of Cincinnati

Category : Physician

Issue Areas/Comments

IME Adjustment

IME Adjustment

See attached letter

CMS-1488-P-1399-Attach-1.DOC

#1399

UNIVERSITY OF Cincinnati

College of Medicine
Department of Obstetrics and Gynecology
University of Cincinnati
PO Box 670526
Cincinnati, Ohio 45267-0526

Arthur Ollendorff, M.D.
Associate Professor and Residency Director

Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services

Attention: CMS-1488—P "Resident Time in Patient Activities"

Dear Administrator McClellan:

I would like to take this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS or the Agency) proposed rule entitled "Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates." 71 Fed. Reg. 23996 (April 25, 2006). I strongly urge the Agency to rescind the purported "clarification" in the proposed rule that excludes medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments. The stated rationale for the exclusion of time devoted to these activities is that they are not "related to patient care". The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a non-hospital setting, such as a physician's office or affiliated medical school.

I support the Agency's 1999 position. The activities cited are an integral component of the patient care activities engaged in by residents during their residency programs. We urge CMS to withdraw its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature o f these activities to the p atient care experiences of residents during their residency programs. The goal of graduate medical education is to train outstanding physicians who can treat patients in both hospital settings and non-hospital settings and to have the proper education and decision making skills to be the physicians of the future. The decision to exclude payments for the aforementioned activities in short-sighted and will lead to a lower quality of care provided in both the short and long-term.

Sincerely,

Arthur Ollendorff, M.D.
Residency Program Director
Department of Obstetrics and Gynecology

An affirmative action/equal opportunity institution

Submitter : Michele DeSmet **Date:** 06/12/2006

Organization : Oaklawn Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

#1400

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter : **Dr. Shalor Craig** **Date: 06/12/2006**

Organization : **John Peter Smith Hospital-FMRP**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GME Payments

GME Payments

Residency Program Activities and Patient Care
I firmly believe that with the possible exception of extended time for "bench research," there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician's educational development into an autonomous practitioner.

To separate out CMS's newly defined "patient care time" from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

CMS-1488-P-1401-Attach-1.DOC

Currently I am completing my residency in family medicine. When I became aware that CMS would stop funding payment to faculty for teaching, preparing curriculum and evaluating my performance through GME -- IME and DME support – I became alarmed.

We are in a state with a huge health care professional shortage in communities under 25,000. These communities cannot afford to support several nurse practitioners and visiting specialists when the services are delivered by a pluri-potential well trained family medicine specialist who is part of their community. The training programs, like mine, which prepare us for these types of venues are in very short supply. We need to be exceptionally well trained.

Someone at CMS will need to explain to me, how the teaching, curriculum development and evaluation process for the six required ACGME physician skill competencies is not related to patient care. Isn't this exactly what the IOM has criticized our training professions for? In fact, our program currently evaluates us in all these competencies as a continuing quality improvement process DURING patient care. Without time to discuss and reflect our experiences and outcomes we will not be serving the needs of our current and future patients.

Should indeed this come to pass, we will have faculty who will be caught in the productivity race with no time for us. We may get pop-up feed back from an Electronic Health Record in sites that have them that we have made an error or we are not following a guideline. No discussion there. What is being proposed is dangerous for our current patients and our future patients. Our patients deserve for us to have a better education than you are proposing.

Why does the American taxpayer support medical students at over $200,000 per student per year and offers the faculty of residencies less than $15,000 for teaching per resident per year? I am getting a lot more from my residency training to protect and serve my patients of the future than all of medical school combined. Please do not cut us any more – rescind the clarification of this dangerous and capricious rule.

Medical Resident

Submitter : Dr. Kimberly Townsend-scott **Date:** 06/12/2006

Organization : Advocate Christ Family Medicine Residency

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS or the Agency) proposed rule entitled Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates. 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in patient care activities. The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

Background
The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a nonhospital setting, such as a physician s office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not related to patient care .

This position reverses the Agency s position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty. [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency s 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs.

Residency Program Activities and Patient Care
I firmly believe that with the possible exception of extended time for bench research, there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician s educational development into an autonomous practitioner.

To separate out CMS s newly defined patient care time from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,

Kimberly Townsend-Scott,MD
Advocate Christ Family Medicine Residency
Chicago, IL

Submitter : Dr. Michael Kennedy **Date:** 06/12/2006

Organization : Univ of Kansas Family Medicine Residency

Category : Academic

Issue Areas/Comments

GME Payments

GME Payments

As a family medicine residency faculty, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS or the Agency) proposed rule entitled Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates. 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in patient care activities. The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

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This position reverses the Agency s position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty. [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency s 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs.

Residency Program Activities and Patient Care
I firmly believe that with the possible exception of extended time for bench research, there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician s educational development into an autonomous practitioner.

In addition, as director of this program, I cannot conceive of how I would be able to administratively comply with this requirement. It would require documentation that would be extremely burdensome, if possible at all. To separate out CMS s newly defined patient care time from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Where am I to find the funding to pay for the staff person that would be needed to sit in on each of these didactic sessions and keep count of patient care time? The documentation requirements that this position would necessitate are unreasonable and would cause an extremely large administrative burden.

To reiterate, I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,

Michael L Kennedy, MD
Assistant Professor of Family Meidicine
Assistant Dean for Rural Health Education
Dept Family Medicine
University of Kansas School of Medicine

President Elect of the Kansas Academy of Family Physicians

Submitter : **Dr. Amber Dunn** **Date: 06/12/2006**

Organization : **John Peter Smith Hospital-FMRP**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GME Payments

GME Payments

Residency Program Activities and Patient Care
I firmly believe that with the possible exception of extended time for "bench research," there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician's educational development into an autonomous practitioner.

To separate out CMS's newly defined "patient care time" from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

CMS-1488-P-1404-Attach-1.DOC

#1401

Dear CMS Policy Maker:

I am a family medicine resident in a very busy HPSA. I really need my faculty to teach. Why would you interpret a rule designed to do just that as being unrelated to patient care time? Whether we are having a discussion after a patient encounter, a small group discussion regarding a difficult clinical situation, reviewing our evaluation for our care and didactic tests in a certain disease domain, or participating in lectures – we are learning about, caring for current and protecting our future patients.

My concern is that the faculty are already stretched to produce more patient visits with poor compensation and must cover four of us at a time for supervision in clinic. The hour they spend before and after clinic to discuss a specific topic that is not related to a specific individual patient will disappear with the implementation of the rule you suggest. They will not have time to sit down with us to discuss our overall performance – we will get an email.

The faculty, without support for their own development, will be likely to lose their academic edge as they work to see patients, see more patients and supervise patient care without any incentive to reflect, discuss and research our and their work.

Please help us be better physicians to our patients by supporting a competent and refreshed faculty. Rescind the interpretation of the IME and DME support rule.

Sincerely,

Submitter : **Dr. Thom Edwards** **Date: 06/12/2006**

Organization : **John Peter Smith Hospital-FMRP**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GME Payments

GME Payments

Residency Program Activities and Patient Care
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I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

CMS-1488-P-1405-Attach-1.DOC

#1405

Currently I am completing my residency in family medicine. When I became aware that CMS would stop funding payment to faculty for teaching, preparing curriculum and evaluating my performance through GME -- IME and DME support – I became alarmed.

We are in a state with a huge health care professional shortage in communities under 25,000. These communities cannot afford to support several nurse practitioners and visiting specialists when the services are delivered by a pluri-potential well trained family medicine specialist who is part of their community. The training programs, like mine, which prepare us for these types of venues are in very short supply. We need to be exceptionally well trained.

Someone at CMS will need to explain to me, how the teaching, curriculum development and evaluation process for the six required ACGME physician skill competencies is not related to patient care. Isn't this exactly what the IOM has criticized our training professions for? In fact, our program currently evaluates us in all these competencies as a continuing quality improvement process DURING patient care. Without time to discuss and reflect our experiences and outcomes we will not be serving the needs of our current and future patients.

Should indeed this come to pass, we will have faculty who will be caught in the productivity race with no time for us. We may get pop-up feed back from an Electronic Health Record in sites that have them that we have made an error or we are not following a guideline. No discussion there. What is being proposed is dangerous for our current patients and our future patients. Our patients deserve for us to have a better education than you are proposing.

Why does the American taxpayer support medical students at over $200,000 per student per year and offers the faculty of residencies less than $15,000 for teaching per resident per year? I am getting a lot more from my residency training to protect and serve my patients of the future than all of medical school combined. Please do not cut us any more – rescind the clarification of this dangerous and capricious rule.

Medical Resident

Submitter : **Dr. Triwanna Fisher** **Date: 06/12/2006**

Organization : **John Peter Smith Hospital-FMRP**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GME Payments

GME Payments

Residency Program Activities and Patient Care
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To separate out CMS's newly defined "patient care time" from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

CMS-1488-P-1406-Attach-1.DOC

#1406

Dear CMS Policy Maker:

I am a family medicine resident in a very busy HPSA. I really need my faculty to teach. Why would you interpret a rule designed to do just that as being unrelated to patient care time? Whether we are having a discussion after a patient encounter, a small group discussion regarding a difficult clinical situation, reviewing our evaluation for our care and didactic tests in a certain disease domain, or participating in lectures – we are learning about, caring for current and protecting our future patients.

My concern is that the faculty are already stretched to produce more patient visits with poor compensation and must cover four of us at a time for supervision in clinic. The hour they spend before and after clinic to discuss a specific topic that is not related to a specific individual patient will disappear with the implementation of the rule you suggest. They will not have time to sit down with us to discuss our overall performance – we will get an email.

The faculty, without support for their own development, will be likely to lose their academic edge as they work to see patients, see more patients and supervise patient care without any incentive to reflect, discuss and research our and their work.

Please help us be better physicians to our patients by supporting a competent and refreshed faculty. Rescind the interpretation of the IME and DME support rule.

Sincerely,

1,407

Department of Health and Human Services
Centers for Medicare and Medicaid Services
Office of Strategic Operations & Regulatory Affairs

CMS-1488-P-1407 **Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates**

Please note that electronic comment CMS-1488-P-1407 is a duplicate of CMS-1488-P-1402. To view this comment, please see CMS-1488-P-1402.

Submitter : Dr. Brett Kissela **Date:** 06/12/2006

Organization : University of Cincinnati

Category : Physician

Issue Areas/Comments

FTE Resident Count and Documentation

FTE Resident Count and Documentation

Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services

Attention: CMS-1488 P Resident Time in Patient Activities

Dear Administrator McClellan:

The University of Cincinnati/ University Hospital welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services (CMS or the Agency) proposed rule entitled Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates. 71 Fed. Reg. 23996 (April 25, 2006).

We strongly urge the Agency to rescind the purported clarification in the proposed rule that excludes medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments. The stated rationale for the exclusion of time devoted to these activities is that they are not related to patient care The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a nonhospital setting, such as a physician s office or affiliated medical school.

The proposed rule position is in stark contrast to the Agency s position as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty. [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins].

We support the Agency s 1999 position. The activities cited are an integral component of the patient care activities engaged in by residents during their residency programs. We urge CMS to withdraw its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Furthermore, it is important for CMS to recognize the long term impact of such proposals. It is increasingly difficult to train physicians in that teaching is poorly compensated if at all, and there are continually increasing demands put on graduate medical education programs by the ACGME. There is only a small core of the physician community who choose to make education part of their mission, and with every additional burden placed upon the GME system by CMS or ACGME we lose a few valuable members of this important group. Surveys of neurology program directors have shown that the average duration in the position is only 3 years, and this is true in many fields. This CMS proposal is yet another impediment to maintaining excellence in graduate medical education.

Sincerely,
Brett Kissela, M.D.

Submitter : Dr. Mark Garza **Date:** 06/12/2006

Organization : John Peter Smith Hospital-FMRP

Category : Health Care Professional or Association

Issue Areas/Comments

GME Payments

GME Payments

Residency Program Activities and Patient Care
I firmly believe that with the possible exception of extended time for "bench research," there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician's educational development into an autonomous practitioner.

To separate out CMS's newly defined "patient care time" from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

CMS-1488-P-1409-Attach-1.DOC

#1409

Currently I am completing my residency in family medicine. When I became aware that CMS would stop funding payment to faculty for teaching, preparing curriculum and evaluating my performance through GME -- IME and DME support – I became alarmed.

We are in a state with a huge health care professional shortage in communities under 25,000. These communities cannot afford to support several nurse practitioners and visiting specialists when the services are delivered by a pluri-potential well trained family medicine specialist who is part of their community. The training programs, like mine, which prepare us for these types of venues are in very short supply. We need to be exceptionally well trained.

Someone at CMS will need to explain to me, how the teaching, curriculum development and evaluation process for the six required ACGME physician skill competencies is not related to patient care. Isn't this exactly what the IOM has criticized our training professions for? In fact, our program currently evaluates us in all these competencies as a continuing quality improvement process DURING patient care. Without time to discuss and reflect our experiences and outcomes we will not be serving the needs of our current and future patients.

Should indeed this come to pass, we will have faculty who will be caught in the productivity race with no time for us. We may get pop-up feed back from an Electronic Health Record in sites that have them that we have made an error or we are not following a guideline. No discussion there. What is being proposed is dangerous for our current patients and our future patients. Our patients deserve for us to have a better education than you are proposing.

Why does the American taxpayer support medical students at over $200,000 per student per year and offers the faculty of residencies less than $15,000 for teaching per resident per year? I am getting a lot more from my residency training to protect and serve my patients of the future than all of medical school combined. Please do not cut us any more – rescind the clarification of this dangerous and capricious rule.

Medical Resident

Submitter : **Mr. Bobbie Prather** **Date: 06/12/2006**

Organization : **Central Baptist Hospital**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1410-Attach-1.DOC

#1410

BAPTIST HEALTHCARE SYSTEM

4007 Kresge Way
Louisville, Kentucky 40207
502-896-5000

Electronically Submitted

June 12, 2006

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1488-P
7500 Security Boulevard
Baltimore, Maryland 21244-1850

RE: Provider Comments
Proposed Changes to Inpatient PPS
DRG Reclassifications and Severity of Illness

On behalf of the Central Baptist Hospital, a member of Baptist Healthcare System, Inc. (BHS), we appreciate the opportunity to comment on the fiscal year (FY) 2007 proposed changes to the hospital inpatient prospective payment system.

BHS supports meaningful improvements to Medicare's inpatient prospective system and shares CMS's desire to develop a payment system that provides an equal financial incentive (margin) to treat all patients, regardless of diagnosis or severity of illness. BHS further acknowledges that this payment system must be statistically robust, clinically meaningful and at the same time, administratively feasible.

BHS submits the following recommendations to the current proposals:

1. The proposed changes to the DRG weights based upon Hospital Specific Relative Value cost center (HSRVcc) and introduction of Consolidated Severity Adjusted DRGs (CS-DRGs) should be implemented simultaneously.

2. The proposed changes to the DRG weights (HSRVcc) and introduction of CS-DRGs should be implemented on or after October 1, 2008.

3. Valid cost-based weights must be developed and utilized.

4. Further refinement of the proposed CS-DRG methodology needs to be done to ensure it promotes (rather than inhibits) the accomplishment of CMS's stated goals.

Discussion and rationale for recommendations:

Recommendation 1: Simultaneous Implementation

a. The proposed HSRVcc changes in FY2007 are projected to reduce reimbursement to BHS from the current FY2006 amount by nearly $8.5 million.

b. The proposed implementation of CS-DRGs in FY2008 is projected to increase reimbursement from the FY2007 amount by nearly $8.2 million (which represents a reduction of approximately $300,000 from the current FY2006 amount). This significant volatility in reimbursement has several implications.

   First, BHS will **permanently** lose $8.2 million in reimbursement in FY2007.

   Second, BHS will **potentially** receive an increase in reimbursement in FY2008. BHS has utilized the 3M APR-DRG grouper for many years, largely as part of internal quality initiatives and the Premier Hospital Quality Incentive Demonstration. As a result, BHS had the internal APR-DRG data to convert to CS-DRGs and calculate the impact of the FY2008 proposal.

   However, the underlying assumptions in the impact analysis are: (1) coding in the future is consistent with current coding practices, and (2) that Medicare will allow current coding in the future reimbursement model. Because these are assumptions and not givens, BHS has significant concerns regarding the ability to accurately forecast the proposals impact beyond FY2007, which is critical.

   Third, the increase in reimbursement in FY2008 under the CS-DRG system indicates that BHS hospitals treat more severe patients on average. This finding is consistent with the mission and values of its member hospitals.

   BHS is comprised of five hospitals within the state of Kentucky. It operates urban hospitals in Louisville, La Grange and Lexington, rural referral centers in Corbin and Paducah. Collectively, BHS has the largest number of inpatient admissions in Kentucky and is one of the largest providers of Medicaid services within the state.

   The primary and secondary markets for BHS hospitals is comprised of 40 of the 120 counties in Kentucky and range across the central, western and southeastern parts of the state. Five of the poorest ten counties are located with the BHS service area.

   Medicaid, charity and uninsured patients represent over 17% of BHS inpatient business. As part of BHS's Christ-centered mission, each BHS hospital has not only expanded its general acute care services, but also its highly specialized tertiary programs in an effort to provide a full range of surgical and medical services to all patients regardless of their ability to pay or severity of illness. Central Baptist Hospital, a disproportionate share facility, serves an even higher percentage of Medicaid, charity and uninsured patients than BHS as a whole, with this population accounting for over 18.5% of our inpatient business. Central Baptist Hospital offers a broad range of tertiary care services to all

patients, regardless of ability to pay, including being a regional leader in the offering of high acuity services and new technologies in neonatology, oncology, neurology, cardiology, and orthopedics.

Given the mission of BHS and demographics of the communities it serves, it is clear that BHS hospitals are not specialty hospitals that target services that provide higher margins. However, given the high severity of illness for the patient population BHS hospitals serve, unless the HSRVcc and CS-DRG proposals are implemented simultaneously, unfair financial hardship will be experienced, threatening our ability to provide the same level of access to cutting edge technologies currently offered.

Fourth, CMS suggests that a budget neutrality factor may be applied to offset improvements in c oding p ractices. T his t oo, r epresents a s ignificant unkno wn in t he current proposal that needs to be accurately evaluated and communicated for which additional time is necessary.

Recommendation 2: Delay until October 1, 2008

a. It is imperative that the GROUPER technology be made available to hospitals and vendors. Without direct access to the GROUPER by hospitals, it will be virtually impossible to understand its logic. Without access by multiple vendors, it will be more difficult to purchase at a competitive price and will be more difficult to integrate into existing hospital systems.

b. In addition, many current hospital software programs will need to be modified to handle the new payment and billing system. An implementation date before October 1, 2008 will not allow adequate time to make all the necessary system changes and upgrades.

c. CMS stated that one option to the software issue is for hospitals to submit claims without being grouped and allow CMS to assign the CS-DRG. This raises several serious concerns.

   First, without the CS-DRG information, revenues and patient receivables cannot be recorded accurately. Statement of Position (SOP)-00-1(6) states, "Health care entities need to estimate amounts that ultimately will be realizable in order for revenues to be fairly stated in accordance with generally accepted accounting principles (GAAP)." Paragraph (9) states "Management is responsible for the fair presentation of its financial statements in conformity with GAAP".

   Currently, the DRG assignment is critical in making an accurate estimate of the net realizable value of accounts receivable. Given the significance of and the increased uncertainty of the impact of the proposed changes for FY2007 and FY2008, it will be even more important for patient bills to be grouped prior to billing.

   Second, the Medicare inpatient business represents over 41% of BHS total inpatient business. As such, changes to the Medicare payment system have a significant impact on BHS's ability to accurately estimate payments in evaluating strategic initiatives, business

plans, budgets, marketing, staffing and other critical decisions. With the significance of the proposed changes, more time is required to understand and perform impact analysis.

d. Four of five BHS hospitals are disproportionate share hospitals (DSH). Last year these hospitals received approximately $14.7 million in DSH reimbursement. It is anticipated that the CS-DRGs will have a material impact on DSH payments and in order for hospitals to adequately plan and make appropriate adjustments in a timely manner, BHS recommends that further analysis be prepared and accurate impact estimates published prior to implementation of the proposed changes.

e. Additional time is required to determine the impact from other third party payers (including Medicaid) that have historically modeled reimbursement rules and methodologies from the Medicare payment system. It is anticipated that these third party payers will adopt the new Medicare payment system at some time in the near future following implementation by Medicare. However, given the complexity of the proposed changes, additional time is necessary for payers and hospitals to better understand these changes and make appropriate systematic changes.

Recommendation 3: Valid Cost Weights

a. Under the HSRV weight calculation method, the ten cost center categories were developed based on broad accounting definitions, where each cost center category represents at least five percent of the charges in the claims data. BHS acknowledges the need to remove bias introduced by individual hospital characteristics (i.e. unique cost centers reported on the cost report), but it appears that this resulted in incorrect cost center groupings in the CMS study that raises concerns regarding the accuracy of the cost-to-charge ratio (CCR) data.

   For example, according to CMS-1488-P, Table-A (pp.66-67 and pp.186-187) the HSRV Cardiology cost center includes cost report lines 53 and 54. However, one BHS hospital includes its Catherization Lab revenues and expenses on cost report line 42.01, which according to the table appears to be incorrectly grouped with the HSRV Radiology cost center that includes cost report lines 41,42 and 43.

   BHS is very concerned that grouping errors such as the one described here could materially impact the CCR used to calculate the DRG weights. Therefore, BHS recommends that CMS work through the Medicare intermediaries to audit the cost report line definitions for all hospitals to ensure groupings are accurate.

b. The weighting calculation used to determine the scaling factors gives equal weight to each hospital regardless of size or volume. This methodology results not only in an inaccurate national cost-to-charge ratio, but is inconsistent with the method used when averaging the ten cost center DRG weights to which the scaling factors are applied. Therefore, BHS recommends that a consistent weighting methodology be utilized to calculate the scaling factors.

c. HSRVcc costs were based on the 2004 cost reports. Significant changes in medical technologies, products and services have been introduced, which have significantly impacted the CCR. Therefore, BHS recommends that a more recent audited cost report be used, after audit procedures have been performed as recommended in (a.) above.

d. Central Baptist Hospital is also concerned that partial data from a number of large hospitals whose cost to charge ratios were classified as outliers were excluded from the analysis. The exclusion of this data, which, because of the size of excluded facilities, collectively accounts for a large percentage of Medicare inpatient admissions nationally, materially impacts the resulting calculations, and, in particular, causes routine care cost to charge ratios to be much higher as used in the CMS calculations than the actual national averages reflect. Furthermore, this problem is compounded by the fact that CMS continues to use partial data from these same facilities

Recommendation 4: Consolidated Severity-Adjusted DRG Methodology

a. CS-DRGs are developed by grouping APR DRGs considering average length of stay and average charges. This grouping methodology is inconsistent with the cost-based intention of the proposed changes. Average cost, using the HSRVcc methodology (applying the recommended changes), for each APR DRG by severity level should be the determinant for grouping APR DRGs into CS DRGs.

b. CMS believes that the adoption of consolidated severity-adjusted DRGs would create a risk of increased aggregate levels of payment, similar to the 2% increase associated with the implementation of the current DRG system in 1983 and has recommended the application of a compensating budget neutrality factor. Because of the significance of even a 2% reduction in reimbursement, BHS recommends that this be further studied before implementation.

Thank you for your consideration of our recommendations. We certainly hope you can see and appreciate the legitimacy of the concerns raised. If you have any questions, please feel free to contact me at (859) 260-6109 or at bprather@bhsi.com.

Bobbie L. Prather
Vice President /CFO
Central Baptist Hospital

Submitter : **Dr. Omar Hernandez** **Date: 06/12/2006**

Organization : **John Peter Smith Hospital-FMRP**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GME Payments

GME Payments

Residency Program Activities and Patient Care
I firmly believe that with the possible exception of extended time for "bench research," there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician's educational development into an autonomous practitioner.

To separate out CMS's newly defined "patient care time" from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

CMS-1488-P-1411-Attach-1.DOC

#1411

Dear CMS Policy Maker:

I am a family medicine resident in a very busy HPSA. I really need my faculty to teach. Why would you interpret a rule designed to do just that as being unrelated to patient care time? Whether we are having a discussion after a patient encounter, a small group discussion regarding a difficult clinical situation, reviewing our evaluation for our care and didactic tests in a certain disease domain, or participating in lectures – we are learning about, caring for current and protecting our future patients.

My concern is that the faculty are already stretched to produce more patient visits with poor compensation and must cover four of us at a time for supervision in clinic. The hour they spend before and after clinic to discuss a specific topic that is not related to a specific individual patient will disappear with the implementation of the rule you suggest. They will not have time to sit down with us to discuss our overall performance – we will get an email.

The faculty, without support for their own development, will be likely to lose their academic edge as they work to see patients, see more patients and supervise patient care without any incentive to reflect, discuss and research our and their work.

Please help us be better physicians to our patients by supporting a competent and refreshed faculty. Rescind the interpretation of the IME and DME support rule.

Sincerely,

Submitter : Dr. Eric Webb **Date:** 06/12/2006

Organization : Phoenix Family Practice

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS or the Agency) proposed rule entitled Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates. 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in patient care activities. The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

Background
The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a nonhospital setting, such as a physician s office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not related to patient care .

This position reverses the Agency s position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty. [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency s 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs.

Residency Program Activities and Patient Care
I firmly believe that with the possible exception of extended time for bench research, there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician s educational development into an autonomous practitioner.

To separate out CMS s newly defined patient care time from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,

Eric S. Webb, M.D.

Submitter : Dr. Mary Murphy **Date:** 06/12/2006

Organization : University of California, San Francisco

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

As a faculty member of a department of family medicine, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS or the Agency) proposed rule entitled Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates. 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in patient care activities. The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

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In addition, I cannot conceive of how I would be able to administratively comply with this requirement. It would require documentation that would be extremely burdensome, if possible at all. To separate out CMS s newly defined patient care time from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Where am I to find the funding to pay for the staff person that would be needed to sit in on each of these didactic sessions and keep count of patient care time? The documentation requirements that this position would necessitate are unreasonable and would cause an extremely large administrative burden.

To reiterate, I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Submitter : **Dr. Charles Lascano** **Date: 06/12/2006**

Organization : **John Peter Smith Hospital-FMRP**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GME Payments

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To separate out CMS's newly defined "patient care time" from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

CMS-1488-P-1414-Attach-1.DOC

#1414

Currently I am completing my residency in family medicine. When I became aware that CMS would stop funding payment to faculty for teaching, preparing curriculum and evaluating my performance through GME -- IME and DME support – I became alarmed.

We are in a state with a huge health care professional shortage in communities under 25,000. These communities cannot afford to support several nurse practitioners and visiting specialists when the services are delivered by a pluri-potential well trained family medicine specialist who is part of their community. The training programs, like mine, which prepare us for these types of venues are in very short supply. We need to be exceptionally well trained.

Someone at CMS will need to explain to me, how the teaching, curriculum development and evaluation process for the six required ACGME physician skill competencies is not related to patient care. Isn't this exactly what the IOM has criticized our training professions for? In fact, our program currently evaluates us in all these competencies as a continuing quality improvement process DURING patient care. Without time to discuss and reflect our experiences and outcomes we will not be serving the needs of our current and future patients.

Should indeed this come to pass, we will have faculty who will be caught in the productivity race with no time for us. We may get pop-up feed back from an Electronic Health Record in sites that have them that we have made an error or we are not following a guideline. No discussion there. What is being proposed is dangerous for our current patients and our future patients. Our patients deserve for us to have a better education than you are proposing.

Why does the American taxpayer support medical students at over $200,000 per student per year and offers the faculty of residencies less than $15,000 for teaching per resident per year? I am getting a lot more from my residency training to protect and serve my patients of the future than all of medical school combined. Please do not cut us any more – rescind the clarification of this dangerous and capricious rule.

Medical Resident

Submitter : **Dr. Robin Marroquin** **Date: 06/12/2006**

Organization : **John Peter Smith Hospital-FMRP**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GME Payments

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CMS-1488-P-1415-Attach-1.DOC

#1415

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We are in a state with a huge health care professional shortage in communities under 25,000. These communities cannot afford to support several nurse practitioners and visiting specialists when the services are delivered by a pluri-potential well trained family medicine specialist who is part of their community. The training programs, like mine, which prepare us for these types of venues are in very short supply. We need to be exceptionally well trained.

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Medical Resident

Submitter : Dr. Peter Smith **Date:** 06/12/2006

Organization : UCDHSC; Rose Family Medicine Residency

Category : Physician

Issue Areas/Comments

GME Payments

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Background
The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a nonhospital setting, such as a physician's office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not "related to patient care".

This position reverses the Agency's position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include "scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty." [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency's 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs.

Residency Program Activities and Patient Care
I firmly believe that with the possible exception of extended time for "bench research," there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician's educational development into an autonomous practitioner.

To separate out CMS's newly defined "patient care time" from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

With the recent loss of funding for primary care education in Title VII of the Public Health Act, in addition to small marginal revenue from clinical activity, this ruling could litterally spell the end of primary care practice in the United States.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,
Peter C. Smith, MD
Assistant Professor of Family Medicine
University of Colorado at Denver and Health Sciences Center
Faculty, Rose Family Medicine Residency
Director, BIGHORN Research Network

Submitter : **Dr. Reena Mathews** **Date: 06/12/2006**

Organization : **John Peter Smith Hospital-FMRP**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GME Payments

GME Payments

Residency Program Activities and Patient Care
I firmly believe that with the possible exception of extended time for "bench research," there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician's educational development into an autonomous practitioner.

To separate out CMS's newly defined "patient care time" from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

CMS-1488-P-1417-Attach-1.DOC

#1417

Dear CMS Policy Maker:

I am a family medicine resident in a very busy HPSA. I really need my faculty to teach. Why would you interpret a rule designed to do just that as being unrelated to patient care time? Whether we are having a discussion after a patient encounter, a small group discussion regarding a difficult clinical situation, reviewing our evaluation for our care and didactic tests in a certain disease domain, or participating in lectures – we are learning about, caring for current and protecting our future patients.

My concern is that the faculty are already stretched to produce more patient visits with poor compensation and must cover four of us at a time for supervision in clinic. The hour they spend before and after clinic to discuss a specific topic that is not related to a specific individual patient will disappear with the implementation of the rule you suggest. They will not have time to sit down with us to discuss our overall performance – we will get an email.

The faculty, without support for their own development, will be likely to lose their academic edge as they work to see patients, see more patients and supervise patient care without any incentive to reflect, discuss and research our and their work.

Please help us be better physicians to our patients by supporting a competent and refreshed faculty. Rescind the interpretation of the IME and DME support rule.

Sincerely,

Submitter : Dr. Lisa Mejia

Date: 06/12/2006

Organization : John Peter Smith Hospital-FMRP

Category : Health Care Professional or Association

Issue Areas/Comments

GME Payments

GME Payments

Residency Program Activities and Patient Care
I firmly believe that with the possible exception of extended time for "bench research," there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician's educational development into an autonomous practitioner.

To separate out CMS's newly defined "patient care time" from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

CMS-1488-P-1418-Attach-1.DOC

#1/1/18

Currently I am completing my residency in family medicine. When I became aware that CMS would stop funding payment to faculty for teaching, preparing curriculum and evaluating my performance through GME -- IME and DME support – I became alarmed.

We are in a state with a huge health care professional shortage in communities under 25,000. These communities cannot afford to support several nurse practitioners and visiting specialists when the services are delivered by a pluri-potential well trained family medicine specialist who is part of their community. The training programs, like mine, which prepare us for these types of venues are in very short supply. We need to be exceptionally well trained.

Someone at CMS will need to explain to me, how the teaching, curriculum development and evaluation process for the six required ACGME physician skill competencies is not related to patient care. Isn't this exactly what the IOM has criticized our training professions for? In fact, our program currently evaluates us in all these competencies as a continuing quality improvement process DURING patient care. Without time to discuss and reflect our experiences and outcomes we will not be serving the needs of our current and future patients.

Should indeed this come to pass, we will have faculty who will be caught in the productivity race with no time for us. We may get pop-up feed back from an Electronic Health Record in sites that have them that we have made an error or we are not following a guideline. No discussion there. What is being proposed is dangerous for our current patients and our future patients. Our patients deserve for us to have a better education than you are proposing.

Why does the American taxpayer support medical students at over $200,000 per student per year and offers the faculty of residencies less than $15,000 for teaching per resident per year? I am getting a lot more from my residency training to protect and serve my patients of the future than all of medical school combined. Please do not cut us any more – rescind the clarification of this dangerous and capricious rule.

Medical Resident

Submitter : **Dr. Cecilia Romero** **Date: 06/12/2006**

Organization : **Texas Academy of Family Physicians; UTMB Dept FM**

Category : **Physician**

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS or the Agency) proposed rule entitled "Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates." 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in "patient care activities." The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

Background
The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a nonhospital setting, such as a physician's office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not "related to patient care".

This position reverses the Agency's position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include "scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty." [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency's 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs.

Residency Program Activities and Patient Care
I firmly believe that with the possible exception of extended time for "bench research," there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician's educational development into an autonomous practitioner.

To separate out CMS's newly defined "patient care time" from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Submitter : Dr. Luis Nieves **Date:** 06/12/2006

Organization : John Peter Smith Hospital - FMRP

Category : Health Care Professional or Association

Issue Areas/Comments

GME Payments

GME Payments

Residency Program Activities and Patient Care
I firmly believe that with the possible exception of extended time for "bench research," there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician's educational development into an autonomous practitioner.

To separate out CMS's newly defined "patient care time" from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

CMS-1488-P-1420-Attach-1.DOC

#1420

Dear CMS Policy Maker:

I am a family medicine resident in a very busy HPSA. I really need my faculty to teach. Why would you interpret a rule designed to do just that as being unrelated to patient care time? Whether we are having a discussion after a patient encounter, a small group discussion regarding a difficult clinical situation, reviewing our evaluation for our care and didactic tests in a certain disease domain, or participating in lectures – we are learning about, caring for current and protecting our future patients.

My concern is that the faculty are already stretched to produce more patient visits with poor compensation and must cover four of us at a time for supervision in clinic. The hour they spend before and after clinic to discuss a specific topic that is not related to a specific individual patient will disappear with the implementation of the rule you suggest. They will not have time to sit down with us to discuss our overall performance – we will get an email.

The faculty, without support for their own development, will be likely to lose their academic edge as they work to see patients, see more patients and supervise patient care without any incentive to reflect, discuss and research our and their work.

Please help us be better physicians to our patients by supporting a competent and refreshed faculty. Rescind the interpretation of the IME and DME support rule.

Sincerely,

Submitter : Dr. brian herrick **Date:** 06/12/2006

Organization : UCSF

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

As a faculty member of a department of family medicine, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS or the Agency) proposed rule entitled Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates. 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in patient care activities. The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

Background
The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a nonhospital setting, such as a physician s office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not related to patient care .

This position reverses the Agency s position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty. [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency s 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs.

Residency Program Activities and Patient Care
I firmly believe that with the possible exception of extended time for bench research, there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician s educational development into an autonomous practitioner.

In addition, I cannot conceive of how I would be able to administratively comply with this requirement. It would require documentation that would be extremely burdensome, if possible at all. To separate out CMS s newly defined patient care time from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Where am I to find the funding to pay for the staff person that would be needed to sit in on each of these didactic sessions and keep count of patient care time? The documentation requirements that this position would necessitate are unreasonable and would cause an extremely large administrative burden.

To reiterate, I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Submitter : **Dr. Elizabeth Callaghan** **Date: 06/12/2006**

Organization : **NWPC Group**

Category : **Physician**

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS or the Agency) proposed rule entitled Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates. 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in patient care activities. The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

Background
The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a nonhospital setting, such as a physician s office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not related to patient care .

This position reverses the Agency s position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty. [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency s 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs.

Residency Program Activities and Patient Care
I firmly believe that with the possible exception of extended time for bench research, there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician s educational development into an autonomous practitioner.

To separate out CMS s newly defined patient care time from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,

Elizabeth Callaghan, M.D.

Submitter : Mr. Christopher Palazzolo **Date:** 06/12/2006

Organization : St. John Hospital & Medical Center

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1488-P-1423-Attach-1.DOC

#1423

June 12, 2006

Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services

SENT VIA e-Rulemaking

Attention: **CMS-1488—P "Resident Time in Patient Activities"**

Dear Administrator McClellan:

St. John Hospital & Medical Center ("SJHMC"), an operating unit of St. John Health, a faith based health system that provides resident training for over 400 allopathic and osteopathic medical school graduates in Southeast Michigan, welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services' ("CMS") proposed rule entitled *"Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates."* 71 Fed. Reg. 23996 (April 25, 2006).

SJHMC urges CMS to rescind the purported "clarification" in the proposed rule that excludes medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education ("DGME") and indirect medical education ("IME") payments. The stated rationale for the exclusion of time devoted to these activities is that they are not "related to patient care". The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a non-hospital setting, such as physicians offices or an affiliated medical school.

The proposed rule position is in stark contrast to the CMS's position as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include "scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty."[1]

SJHMC supports CMS's 1999 position. The activities cited are an integral component of the patient care activities engaged in by residents during their residency programs. We urge CMS to withdraw its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs. Thank you for your consideration.

Sincerely,

Christopher J. Palazzolo

Christopher J. Palazzolo
Vice President & Chief Financial Officer
St. John Hospital & Medical Center

[1]September 24, 1999 Correspondence from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins.

Submitter : Dr. Anjali Ohri **Date:** 06/12/2006

Organization : John Peter Smith Hospital- FMRP

Category : Health Care Professional or Association

Issue Areas/Comments

GME Payments

GME Payments

Residency Program Activities and Patient Care
I firmly believe that with the possible exception of extended time for "bench research," there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician's educational development into an autonomous practitioner.

To separate out CMS's newly defined "patient care time" from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

CMS-1488-P-1424-Attach-1.DOC

#1424

Currently I am completing my residency in family medicine. When I became aware that CMS would stop funding payment to faculty for teaching, preparing curriculum and evaluating my performance through GME -- IME and DME support – I became alarmed.

We are in a state with a huge health care professional shortage in communities under 25,000. These communities cannot afford to support several nurse practitioners and visiting specialists when the services are delivered by a pluri-potential well trained family medicine specialist who is part of their community. The training programs, like mine, which prepare us for these types of venues are in very short supply. We need to be exceptionally well trained.

Someone at CMS will need to explain to me, how the teaching, curriculum development and evaluation process for the six required ACGME physician skill competencies is not related to patient care. Isn't this exactly what the IOM has criticized our training professions for? In fact, our program currently evaluates us in all these competencies as a continuing quality improvement process DURING patient care. Without time to discuss and reflect our experiences and outcomes we will not be serving the needs of our current and future patients.

Should indeed this come to pass, we will have faculty who will be caught in the productivity race with no time for us. We may get pop-up feed back from an Electronic Health Record in sites that have them that we have made an error or we are not following a guideline. No discussion there. What is being proposed is dangerous for our current patients and our future patients. Our patients deserve for us to have a better education than you are proposing.

Why does the American taxpayer support medical students at over $200,000 per student per year and offers the faculty of residencies less than $15,000 for teaching per resident per year? I am getting a lot more from my residency training to protect and serve my patients of the future than all of medical school combined. Please do not cut us any more – rescind the clarification of this dangerous and capricious rule.

Medical Resident

Submitter : **Dr. Lenard Presutti** **Date: 06/12/2006**

Organization : **O'Bleness Memorial Hospital**

Category : **Physician**

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS or the Agency) proposed rule entitled "Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates." 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in "patient care activities." The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

Background
The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a nonhospital setting, such as a physician's office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not "related to patient care".

This position reverses the Agency's position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include "scholarly activities, such as educational seminars, classroom lectures .. . . and presentation of papers and research results to fellow residents, medical students, and faculty." [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency's 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs.

Residency Program Activities and Patient Care I firmly believe that with the possible exception of extended time for "bench research," there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician's educational development into an autonomous practitioner.

To separate out CMS's newly defined "patient care time" from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care
experiences of residents during their residency programs.

Sincerely,

Lenard Presutti, D.O.
Director of Medical Education
FP Residency Program Director
O'Bleness Memorial Hospital
55 Hospital Drive
Athens, OH 45701

Submitter : Dr. Zaki Qureshi **Date:** 06/12/2006

Organization : John Peter Smith Hospital - FMRP

Category : Health Care Professional or Association

Issue Areas/Comments

GME Payments

GME Payments

Residency Program Activities and Patient Care
I firmly believe that with the possible exception of extended time for "bench research," there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician's educational development into an autonomous practitioner.

To separate out CMS's newly defined "patient care time" from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

CMS-1488-P-1426-Attach-1.DOC

#1426

Dear CMS Policy Maker:

I am a family medicine resident in a very busy HPSA. I really need my faculty to teach. Why would you interpret a rule designed to do just that as being unrelated to patient care time? Whether we are having a discussion after a patient encounter, a small group discussion regarding a difficult clinical situation, reviewing our evaluation for our care and didactic tests in a certain disease domain, or participating in lectures – we are learning about, caring for current and protecting our future patients.

My concern is that the faculty are already stretched to produce more patient visits with poor compensation and must cover four of us at a time for supervision in clinic. The hour they spend before and after clinic to discuss a specific topic that is not related to a specific individual patient will disappear with the implementation of the rule you suggest. They will not have time to sit down with us to discuss our overall performance – we will get an email.

The faculty, without support for their own development, will be likely to lose their academic edge as they work to see patients, see more patients and supervise patient care without any incentive to reflect, discuss and research our and their work.

Please help us be better physicians to our patients by supporting a competent and refreshed faculty. Rescind the interpretation of the IME and DME support rule.

Sincerely,

Submitter : Dr. Ryan Dick **Date:** 06/12/2006

Organization : United Family Medicine

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS or the Agency) proposed rule entitled Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates. 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in patient care activities. The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

Background
The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a nonhospital setting, such as a physician s office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not related to patient care .

This position reverses the Agency s position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty. [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency s 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs.

Residency Program Activities and Patient Care
I firmly believe that with the possible exception of extended time for bench research, there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician s educational development into an autonomous practitioner.

To separate out CMS s newly defined patient care time from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,
Ryan Dick

Submitter : Dr. George Tibbitts **Date:** 06/12/2006

Organization : Sanford School of Med, University of S. D.

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS or the Agency) proposed rule entitled Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates. 71 Fed. Reg. 23996 (April 25, 2006).

Most importantly resident participation in Medicare patient care is an added value to that care. Resident education increases their ability and their value in that process.

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in patient care activities. The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

Background
The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a nonhospital setting, such as a physician s office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not related to patient care .

This position reverses the Agency s position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty. [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency s 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs.

Residency Program Activities and Patient Care
I firmly believe that with the possible exception of extended time for bench research, there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician s educational development into an autonomous practitioner.

To separate out CMS s newly defined patient care time from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,

G. Michael Tibbitts, MD
Dean, Graduate Medical Education
Sanford School of Medicine
University of South Dakota,

Submitter : **Dr. Tim Rudolph** **Date: 06/12/2006**

Organization : **John Peter Smith Hospital - FMRP**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GME Payments

GME Payments

Residency Program Activities and Patient Care
I firmly believe that with the possible exception of extended time for "bench research," there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician's educational development into an autonomous practitioner.

To separate out CMS's newly defined "patient care time" from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

CMS-1488-P-1429-Attach-1.DOC

#1429

Dear CMS Policy Maker:

I am a family medicine resident in a very busy HPSA. I really need my faculty to teach. Why would you interpret a rule designed to do just that as being unrelated to patient care time? Whether we are having a discussion after a patient encounter, a small group discussion regarding a difficult clinical situation, reviewing our evaluation for our care and didactic tests in a certain disease domain, or participating in lectures – we are learning about, caring for current and protecting our future patients.

My concern is that the faculty are already stretched to produce more patient visits with poor compensation and must cover four of us at a time for supervision in clinic. The hour they spend before and after clinic to discuss a specific topic that is not related to a specific individual patient will disappear with the implementation of the rule you suggest. They will not have time to sit down with us to discuss our overall performance – we will get an email.

The faculty, without support for their own development, will be likely to lose their academic edge as they work to see patients, see more patients and supervise patient care without any incentive to reflect, discuss and research our and their work.

Please help us be better physicians to our patients by supporting a competent and refreshed faculty. Rescind the interpretation of the IME and DME support rule.

Sincerely,

Submitter : **Ms. Louise Probst** **Date: 06/12/2006**

Organization : **St. Louis Area Business Health Coalition**

Category : **Other Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1430-Attach-1.DOC

CMS-1488-P-1430-Attach-2.DOC

St. Louis Area
BUSINESS HEALTH
COALITION
"Employer Partners in Healthcare"

June 12, 2006

Mark McClellan, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1488-P
PO Box 8011
Baltimore, MD 21244-1850

RE: Medicare Inpatient PPS: Proposed Rule for Fiscal Year 2007, Comments to DRGs

Dear Dr. McClellan:

The St. Louis Area Business Health Coalition (BHC) appreciates the opportunity to comment on the Medicare Inpatient PPS: Proposed Rule for Fiscal Year 2007. The BHC, formed in 1983, represents 40 employers in the St. Louis Bi-State and Central Missouri areas. Our members provide health care coverage for millions of Americans families.

The BHC applauds CMS's leadership in enacting changes to improve the hospital inpatient prospective payment systems. For too long, the DRG weights have created misaligned financial incentives, rewarded charge inflation and encouraged capital investments not driven by medical need in payments for all procedures, but mainly in cardiovascular and orthopedics. Realigning the financial incentives according to resources and changing to a cost-based system is an important and much needed step. As the steward of the taxpayers' money and as the most effective health care market influencer, CMS must act quickly and take the lead to ensure the longevity of the Medicare system and the affordability of health care for all Americans. The BHC urges that CMS:

1. Incorporate cost-based hospital specific relative value weights now. Implement with great haste MedPac's payment reductions for cardiovascular and orthopedic services.

2. Refine the current DRG classification system to capture differences in severity of illness among patients removing incentives for providers to select services and patients that are more profitable.

3. Reduce payments for "cost" outlier cases and eventually eliminate these.

4. Rapidly expand on the number and types of measures that hospitals must report as a condition to receive the annual payment update. Require hospital CEOs to certify their data and install a significant financial consequence to those that fail to report on time or provide faulty data.

5. Release physician-identifiable Medicare claims data (fully protecting patient privacy), to allow for better quality and efficiency performance reporting. Allow private-sector

organizations to download granular provider performance information from the Hospital Compare websites.

6. Augment hospital claims data with additional clinical data elements that better explain patient acuity.
7. Release risk-adjusted DRG rates for every hospital by regions in easily accessible formats.

8. Implement other Medpac recommendations as outlined by the Disclosure Group in order to eliminate payment for non-medically necessary services and reduce waste.

CMS must take every effort to preserve the Medicare system for future generations. Any proposed DRG system should not pay for medically unnecessary care, duplicative services, medical errors, and should discourage excess capacity.

The BHC appreciates the opportunity to comment on the Proposed Rules.

Sincerely,

Louise Probst
Executive Director

Submitter : Dr. Patricia R. Recupero **Date:** 06/12/2006

Organization : Butler Hospital

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1431-Attach-1.DOC

CMS-1488-P-1431-Attach-2.DOC

CMS-1488-P-1431-Attach-3.DOC

CMS-1488-P-1431-Attach-4.DOC

ATTACHMENT 1 TO # 1431

June 12, 2006

Mark McClellan, M.D., Ph.D., Administrator
Centers for Medicare and Medicaid Services
Attn: CMS-1488-P & P2
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Dr. McClellan:

RE: CMS-1488-P Proposed Changes to the Hospital Inpatient Prospective Payment System for FY 2007 – DRG weights

I am writing to indicate support for the CMS proposal to move DRG weights from charge based to cost based. The current DRG weights do not provide for an even return across DRG's.

I am concerned that the Board of Directors of the American Hospital Association has just recommended a one year delay in the implementation of the proposed changes. While the AHA says they support the concept in general, they have suggested there may be some flaws in the methodology. However, community hospitals that admit more medical and psychiatric patients than surgical patients would be more equitably reimbursed under the changes as currently proposed. Although it is worth noting that large specialty and tertiary hospitals might have some concerns with the proposed changes since their patient mix would tend to include more surgical DRGs, their exclusive grant to provide some of those services would more than offset the impact of the proposed changes. Improved reimbursement for psychiatric patients will likely improve access to care by decreasing the incentive to close psychiatry wards in general hospitals.

In summary, the cost based approach you have currently set forth provides for a more balanced distribution between medical and surgical DRGs. I do not agree with the delay requested by the American Hospital Association and recommend the changes be implemented as scheduled. As always, we are grateful for your concern and attention.

Sincerely,

Patricia R. Recupero, J.D., M.D.
President & CEO

Cc: Senator Jack Reed, Senator Lincoln Chafee, Congressman Patrick Kennedy and Congressman James Langevin

ATTACHMENT 2 TO #1431

June 12, 2006

Mark McClellan, M.D., Ph.D., Administrator
Centers for Medicare and Medicaid Services
Attn: CMS-1488-P & P2
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Dr. McClellan:

RE: CMS-1488-P Proposed Changes to the Hospital Inpatient Prospective Payment System for FY 2007 – DRG weights

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Sincerely,

Patricia R. Recupero, J.D., M.D.
President & CEO

Cc: Senator Jack Reed, Senator Lincoln Chafee, Congressman Patrick Kennedy and Congressman James Langevin

ATTACHMENT 3 TO #1431

June 12, 2006

Mark McClellan, M.D., Ph.D., Administrator
Centers for Medicare and Medicaid Services
Attn: CMS-1488-P & P2
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Dr. McClellan:

RE: CMS-1488-P Proposed Changes to the Hospital Inpatient Prospective Payment System for FY 2007 – DRG weights

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Sincerely,

Patricia R. Recupero, J.D., M.D.
President & CEO

Cc: Senator Jack Reed, Senator Lincoln Chafee, Congressman Patrick Kennedy and Congressman James Langevin

ATTACHMENT 4 TO #1431

June 12, 2006

Mark McClellan, M.D., Ph.D., Administrator
Centers for Medicare and Medicaid Services
Attn: CMS-1488-P & P2
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Dr. McClellan:

RE: CMS-1488-P Proposed Changes to the Hospital Inpatient Prospective Payment System for FY 2007 – DRG weights

I am writing to indicate support for the CMS proposal to move DRG weights from charge based to cost based. The current DRG weights do not provide for an even return across DRG's.

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In summary, the cost based approach you have currently set forth provides for a more balanced distribution between medical and surgical DRGs. I do not agree with the delay requested by the American Hospital Association and recommend the changes be implemented as scheduled. As always, we are grateful for your concern and attention.

Sincerely,

Patricia R. Recupero, J.D., M.D.
President & CEO

Cc: Senator Jack Reed, Senator Lincoln Chafee, Congressman Patrick Kennedy and Congressman James Langevin

Submitter : **Dr. Michael Statton** **Date: 06/12/2006**

Organization : **John Peter Smith Hospital - FMRP**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GME Payments

GME Payments

Residency Program Activities and Patient Care
I firmly believe that with the possible exception of extended time for "bench research," there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician's educational development into an autonomous practitioner.

To separate out CMS's newly defined "patient care time" from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

CMS-1488-P-1432-Attach-1.DOC

#1432

Dear CMS Policy Maker:

I am a family medicine resident in a very busy HPSA. I really need my faculty to teach. Why would you interpret a rule designed to do just that as being unrelated to patient care time? Whether we are having a discussion after a patient encounter, a small group discussion regarding a difficult clinical situation, reviewing our evaluation for our care and didactic tests in a certain disease domain, or participating in lectures – we are learning about, caring for current and protecting our future patients.

My concern is that the faculty are already stretched to produce more patient visits with poor compensation and must cover four of us at a time for supervision in clinic. The hour they spend before and after clinic to discuss a specific topic that is not related to a specific individual patient will disappear with the implementation of the rule you suggest. They will not have time to sit down with us to discuss our overall performance – we will get an email.

The faculty, without support for their own development, will be likely to lose their academic edge as they work to see patients, see more patients and supervise patient care without any incentive to reflect, discuss and research our and their work.

Please help us be better physicians to our patients by supporting a competent and refreshed faculty. Rescind the interpretation of the IME and DME support rule.

Sincerely,

Submitter : Mrs. Jo Dilbeck **Date:** 06/12/2006

Organization : Oroville Hospital

Category : Individual

Issue Areas/Comments

DRG Reclassifications

DRG Reclassifications

Oroville Hospital does not support a new classification system at this time, as the need for a new system is still unclear. Significant work is still needed to understand the variation within DRGs and the best classification system to address that variation before CS-DRGs or any other system is selected or advanced. Also, given that there will only be 60 days between the final rule and the implementation deadline, we strongly believe that this is insufficient time to complete this implementation. We need to install modifications to our computer systems, train our employees, etc. Our software provider has indicated that if there is a move to a 4-digit DRG, they will be unable to complete the modifications in time for a 10/1/06 implementation.

GENERAL

GENERAL

Oroville Hospital believes that whenever and whatever the changes are, that the implementation period s/b over a three-year transition period given the potential magnitude of payment redistribution across DRGs and hospitals.

HSRV Weights

HSRV Weights

While it makes certain sense to move to a cost-based DRG system, we believe there has not been sufficient information provided to hospitals to allow them to calculate the impact. What information we have been provided from our hospital association in California indicates that CHA believes the data is also flawed. We support the CHA analysis and concur with their recommendation for a more detailed approach to this change.

Impact Analysis

Impact Analysis

We do not believe there has been sufficient analysis done on the impact to individual hospitals, nor will there be sufficient time for such analysis once the final rule is issued. this could have an extremely negative impact on certain hospitals.

Submitter : Mr. Jayson Slotnik **Date:** 06/12/2006

Organization : Biotechnology Industry Organization

Category : Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1434-Attach-1.PDF

#1434

June 12, 2006

BY ELECTRONIC DELIVERY

Mark McClellan, M.D., Ph.D., Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates (CMS-1488-P)

Dear Administrator McClellan:

The Biotechnology Industry Organization (BIO) appreciates this opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) proposed rule regarding the hospital inpatient prospective payment systems (PPS) for operating and capital-related costs and fiscal year 2007 rates, published in the Federal Register on April 25, 2006 (the Proposed Rule).[1] BIO is the largest trade organization to serve and represent the biotechnology industry in the United States and around the globe. BIO represents more than 1,100 biotechnology companies, academic institutions, state biotechnology centers, and related organizations in the United States. BIO members are involved in the research and

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1 71 Fed. Reg. 23995 (April 25, 2006).

development of health-care, agricultural, industrial and environmental biotechnology products.

To achieve a goal of making payments to hospitals more fair and accurate, the Proposed Rule would implement the "first significant revision of the inpatient PPS since its implementation in 1983."[2] Although CMS refers to these changes as "refinements" of the DRG system,[3] they are far more substantial than the changes typically discussed in an annual proposed rule. CMS proposes to implement two significant changes to the payment methodology for acute hospital inpatient services: hospital-specific relative value cost center (HSRVcc) weights and severity-adjusted diagnosis related groups (DRGs). Both of these changes involve entirely new methodologies for analyzing hospitals' cost and charge data and assigning services to DRGs and will have considerable impact on payments for many inpatient services.

BIO shares CMS's goal of assuring beneficiary access to services in the most appropriate setting,[4] and we agree that improving the accuracy of Medicare payment systems will help to achieve this goal. BIO has long argued that appropriate payments are critical to protecting patient access to advanced drug and biological products and to promoting continued innovation. In our comments on prior inpatient PPS proposed rules, we have expressed concern that payments under the inpatient PPS were not adequate to ensure that hospitals can provide new technologies to patients. We are hopeful that CMS' attempts to make inpatient PPS rates more accurately reflect the costs of providing care also will include the costs of providing advanced drug and biological therapies.

Although we agree, in principle, with CMS' efforts to make the inpatient PPS more accurate, we are concerned that neither the agency nor independent evaluators have had the time to evaluate whether the Proposed Rule's methodologies are more accurate than the current system. We sincerely appreciate the Herculean efforts made by CMS' staff to complete the new methodology in the Proposed Rule in record time. By CMS' own admission, however, the agency was hard-pressed to complete this proposal for publication this spring and did not have time to confirm fully the accuracy of its methodology or its calculations. In the limited weeks since CMS released the Medicare Provider Analysis and Review File (MedPAR) data upon which the Proposed Rule is based, we are aware of

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2 CMS, Medicare Proposes Payment and Policy Changes for Acute Care Hospital Services to Inpatients, April 12, 2006, http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1833.

3 See, e.g., 71 Fed. Reg. at 23996.

4 CMS, Medicare Proposes Payment and Policy Changes for Acute Care Hospital Services to Inpatients, April 12, 2006, http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1833.

independent evaluations that have attempted to replicate CMS' results. In the course of these replications, questions about CMS' methodology have come to light. It is not clear from the Proposed Rule exactly how CMS applied this methodology to reach the published results. These changes should not be adopted in the inpatient setting until CMS explains its methodology in more detail, the agency and its stakeholders have had the opportunity to analyze the changes more fully, and CMS has responded to stakeholders' input. This explanation and analysis cannot be completed during this comment period or before the final rule is published.

BIO believes that the proposed changes are too significant and too untested to be implemented in 2007. We urge CMS to delay implementation by at least one year to allow the agency and stakeholders more time to assess, refine, and validate these proposals and update claims processing systems. We also recommend that CMS implement a refined DRG weight methodology (rather than the proposed HSRVcc method) and severity-adjusted DRGs at the same time, as recommended by the Medicare Payment Advisory Commission (MedPAC), to minimize distortions in the payment system. Severity-adjusted DRGs should be modified to recognize technologies that represent increased complexity, but not necessarily greater severity of illness. Finally, we urge CMS to reconsider its analysis of applications for new technology add-on payments in light of any methodological changes the agency adopts to ensure that access to innovative therapies is not disrupted during this transition to a new system.

I. CMS should delay implementation of the revised DRG weight methodology for at least one year

BIO recommends that CMS delay implementation of a refined DRG weight methodology for at least one year to allow the agency and stakeholders time to evaluate the proposed methodology, confirm the accuracy of CMS' calculations, and allow hospitals time to adjust to any changes in payment rates. CMS estimates that its entirely new methodology for calculating the HSRVcc weights would reduce the total weights for surgical services by 5.7 percent and increase the weights for medical services by 6 percent,[5] but the effect on individual DRGs can be much larger, ranging from cuts of over 30 percent to increases of more than 80 percent.

Although we believe that all payment rates must be calculated accurately, these dramatic changes raise particular concerns about whether

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5 71 Fed. Reg. at 24020.

Medicare payment truly will reflect the resources involved in providing care. Independent review of the proposed methodology and CMS' calculations is critical to ensure that the new DRG weights are accurate. Given the sheer complexity of the calculations, however, few stakeholders have been able to perform a thorough review of effects of the changes in methodology. Additionally, because CMS' proposal includes significant changes to the methodology developed and tested by MedPAC, CMS cannot rely on MedPAC's analysis to argue that the actual proposed rule methodology results in more accurate payments. In order to ensure that the CMS receives the "comprehensive feedback from hospitals, suppliers, and other stakeholders that will help to refine and improve the final version of the rule,"6 we need more time to study the data and methodology and work with CMS to resolve our concerns. A delay of at least one year will allow both the public and the agency to evaluate and refine the proposal.

Based on stakeholders' limited review of the proposal, we have learned of serious unanswered questions regarding the methodology. For example, CMS calculates unweighted national geometric mean cost-to-charge ratios (CCRs),7 rather than CCRs weighted by hospital size. This methodology gives small hospitals' CCRs the same weight as large hospitals' CCRs, although large hospitals have more claims and are more likely to use advanced technologies that could possibly lead to higher CCRs. Because each hospital's CCR is given the same weight, this methodology creates distortions in payments to all hospitals and is likely to harm access to new technologies by failing to account for the true costs of providing care with innovative drugs, biologicals, and devices. We ask CMS to further explain its methodology and work with stakeholders to determine if it is the most accurate way to calculate weights. We also recommend that CMS present any revised weights to the public for independent verification.

Additionally, the proposed methodology assumes that hospitals allocate costs consistently to certain cost centers. In practice, however, many hospitals assign costs to their cost centers in non-standard ways and provide cross-walks with their cost reports. The assignments do not reflect the departments to which charges are assigned in the MedPAR data. The accuracy of the proposed methodology relies on a uniform mapping of costs and charges to cost centers. Delaying implementation of a refined DRG weight methodology by at least one year would allow CMS time to study the effects of non-standard cost mappings on the results.

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6 CMS, Medicare Proposes Payment and Policy Changes for Acute Care Hospital Services to Inpatients, April 12, 2006, http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1833.

7 71 Fed. Reg. at 24010.

We also are concerned that the HSRVcc weight methodology relies on out-of-date data that do not include the costs of many newer treatment options. CMS used fiscal year 2003 cost report data and fiscal year 2005 MedPAR data to calculate the HSRVcc weights.8 This means that cost data from October 2002 will be used to set payments in effect five years later, in September 2007. CMS' efforts to clean the data and eliminate outliers may have removed many large hospitals' claims, which include advanced technologies, from the calculations. We recommend that CMS explain further how its methodology will ensure that all hospitals' costs are included in refined DRG weight methodology calculations.

Finally, we request a delay to allow hospitals enough time to make the budgetary and administrative adjustments necessitated by the new weights. CMS proposes to implement the HSRVcc weights for payment for services beginning October 1, 2006.9 This proposal would give hospitals and other stakeholders only the 60-day comment period to evaluate this methodology and only a few weeks after the final rule is published to plan for payment changes, adjust their budgets, and implement and test billing system revisions. This simply is not enough time for hospitals to adapt to these substantial changes to the Medicare inpatient payment system. A delay of at least one year will help to ensure that hospitals are prepared for them.

II. CMS should implement the severity of illness DRGs at the same time as the refined DRG weight methodology and should include a method of recognizing technologies that increase complexity of care (DRGs: Severity of Illness)

In addition to substantial changes to the DRG weights, CMS proposes to refine DRGs based on severity of illness in 2008 or earlier.10 BIO agrees with MedPAC's recommendation that any severity-based DRGs be implemented at the same time as a refined DRG weight methodology. In March 2005, MedPAC recommended four policy changes to make payments more accurate: (1) use hospital-specific relative value weights instead of charge-based weights; (2) use refined DRGs that account more completely for differences in severity of illness among patients; (3) use weights based on estimated costs of providing care instead of charges; and (4) account for differences in frequency of outliers across patient

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8 Id. at 24008, 24045.
9 Id. at 23996.
10 Id. at 23966.

categories.[11] MedPAC found that these four changes, taken together, have the best potential to make payments more accurate.[12] MedPAC recently reiterated this conclusion in comments on the Proposed Rule in which it explained that each recommendation "targets a specific source of distortion in the current payment rates. . . . Failure to adopt any of them would leave some payment distortions in place."[13] Implementing a refined DRG weight methodology without the severity-adjusted DRGs not only would allow potential payment distortions to continue, it could create additional instability in payment rates. We urge CMS to implement any changes to the inpatient PPS as smoothly as possible by implementing both the severity-adjusted DRGs and a refined DRG weight methodology, as revised with stakeholder input, at the same time.

As CMS continues to develop the severity-adjusted DRGs, BIO urges the agency to include in this system a method of recognizing technologies that represent increased complexity, but not necessarily greater severity of illness. We agree with CMS' conclusion that such a method is necessary.[14] For many years, BIO has advocated for better recognition and more appropriate payment of advanced technology in the inpatient PPS. We are pleased that CMS recognizes that factoring complexity of care into the severity-adjusted DRGs would be one method of addressing this concern. BIO believes such an adjustment is particularly important in light of the fact that the five-year old cost data used to create the HSRVcc weights does not include many currently used therapies.

Complexity must be factored into DRG groupings to ensure that hospitals will be appropriately reimbursed for providing advanced treatments to all of their patients, regardless of the severity of the patient's condition. For example, for fiscal year 2004, CMS made an important policy change to ensure that Proleukin (high-dose IL-2), a therapy for patients with metastatic renal cell cancer or malignant melanoma that is administered primarily in the inpatient setting, was appropriately reimbursed. This change was imperative to ensure that Medicare beneficiaries continued to have access to the therapy because the prior DRG assignment so dramatically under-reimbursed for the therapy that programs across the country were threatened. Now CMS' proposed implementation of the severity-adjusted DRGs would reverse the agency's prior policy decision. Specifically, although patients must be in relatively good health to receive Proleukin, and thus

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11 Medical Payment Advisory Commission, Report to the Congress: Physician-Owned Specialty Hospitals, March 2005, at 36.

12 Id. at 37.

13 Letter from Glenn M. Hackbarth, Chairman, MedPAC, to Mark McClellan, Administrator, CMS, April 19, 2006, at 4.

14 71 Fed. Reg. at 24014.

would map to low severity DRGs in the new proposed system, the treatment itself is complex and requires careful management of its potentially severe side effects. Under the proposed severity-adjusted DRGs, these patients would map to CSA-DRG 736 (chemotherapy SOI 2) or CSA-DRG 737 (chemotherapy SOI 3). Because these DRGs were created without regard for the complexity of care, they fail to account for the costs of providing this therapy. As proposed, payment for treatment with Proleukin would fall from $16,925 in 2006 (DRG 492) to $5,187 (CSA-DRG 736) or $13,529 (CSA-DRG 737), cuts of 69 percent and 20 percent, respectively. If these cuts are implemented, many hospitals may not be able to continue to provide Proleukin, the only possibility of long-term survival for patients with metastatic renal cell cancer or malignant melanoma.

BIO is also concerned that the proposed severity-adjusted DRGs would reverse the important policy change finalized last year to create DRG 559, Acute Ischemic Stroke with Use of a Thrombolytic Agent. This policy change allows hospitals to be reimbursed for the additional costs of caring for more complex stroke patients in need of thrombolytic therapy. As CMS stated in last year's final rule: "We agree... that there is an increased cost in caring for these [stroke tPA] patients including increased use of the intensive care unit, more diagnostic imaging studies, and laboratory and pharmacy resources. We also agree that-(1) the data indicate that patients receiving thrombolytic therapy have increased severity; and (2) reperfusion therapy is a good means to segregate these patients into a separate DRG." (Federal Register, Vol. 70, 47288, August 12, 2005.) However, the proposed severity-adjusted DRGs would essentially reverse this DRG change by assigning stroke patients receiving reperfusion therapy to CSA-DRGs 56-58 with other less severe stroke patients. Overall, we estimate that hospitals would experience a weighted-average 35 percent reduction for treating thrombolytic patients compared to FY 2006 if such a policy were finalized. We urge CMS to carefully examine the proposed severity-adjusted DRGs to ensure that these and other potential problems are addressed and allow for adequate public notice and comment on these changes during the FY 2008 regulatory process.

Until CMS develops a method of recognizing complexity in the severity-adjusted DRG system and makes available for comment any criteria for determining how and when to recognize increased complexity in the structure of the DRG system, CMS should not implement the severity-adjusted DRGs.

III. As CMS implements the severity of illness DRGs and HSRVcc weights, it must protect access to innovative therapies (New Technology)

The biotechnology industry provides innovative and potentially life-saving technologies for Medicare beneficiaries. When new technologies come to market, however, inadequate payment can pose a barrier to their use. Under the current and proposed DRG payment systems, it may take two or three years for the increased costs associated with the use of new technologies to be reflected in DRG payment rates. New technology add-on payments can provide support to hospitals while ensuring access to the highest quality of care for Medicare beneficiaries. In order to preserve patient access to cutting-edge care, it is critical for CMS to use the add-on payment mechanism appropriately for qualified new technologies and services under the current payment methodology as well as in whatever new methodology is adopted in the future.

In the Proposed Rule, CMS discusses several technologies that have received or have applied for new technology add-on payments but does not describe how the changes to DRG weights and groupings will affect these payments.15 Because the regulations make new technology payments available only if the technology is inadequately paid under the DRG system,16 changes in the rates or definitions of DRGs would affect CMS' assessment of whether a technology is adequately reimbursed. CMS also acknowledges that a method of including complexity in the severity-adjusted DRGs would "interact with the existing statutory provisions for new technology add-on payments."17 Before CMS implements a refined DRG weight methodologyand severity-adjusted DRGs, we ask the agency to examine the effect of these changes on new-technology add-on payments. In particular, we urge the agency to reconsider recent applicants for new technology add-on payments in light of any methodological changes CMS adopts in the inpatient PPS.

We also believe that implementation of the International Classification of Diseases, 10th Revision (ICD-10) coding system is a critical element of any effort to improve the accuracy of inpatient PPS reimbursement, especially for new technologies. This revised coding system offers more granularity than the ICD-9, allowing hospitals to describe their patients' conditions and the care provided in greater detail. As hospitals submit claims using these

15 Id. at 24068.
16 42 C.F.R. § 412.87(b)(3).
17 71 Fed. Reg. at 24014.

codes, CMS will be able to use this data to set more accurate payment rates. The ICD-10 also will improve CMS' ability to recognize new technologies and reimburse hospitals appropriately for their use. Unlike the ICD-9, which is running out of codes, the ICD-10 can be expanded to add new codes as new technologies and procedures are developed. BIO recommends that CMS adopt the ICD-10 as soon as possible to ensure that the inpatient PPS can continue to recognize new technologies and to help CMS set appropriate rates for all services.

BIO reiterates its request that CMS correct its narrow interpretation of the new technology add-on provisions. As we have explained in prior years' comments, CMS' statements that the two to three-year period for new technologies to receive add-on payments begins on the date the technology is approved by the Food and Drug Administration (FDA)[18] is contrary to both the statute and CMS' own regulations. The statute clearly requires data collection and add-on payments beginning the "date on which an *inpatient hospital code* is issued with respect to the service or technology."[19] The regulation implementing this section acknowledges that an "inpatient hospital code" is an International Classification of Diseases – 9th Revision – Clinical Modification (ICD-9-CM) code and requires a medical service or technology to be considered new within two or three years after the "point at which data begin to become available reflecting the ICD-9-CM code assigned to the new service or technology (depending on when a new code is assigned and data on the new service or technology become available for DRG recalibration).)"[20] Neither the statute nor the regulation refers to the date of FDA approval in determining whether a technology is "new." By using the date of FDA approval instead of the date of issuance of an ICD-9-CM code, CMS risks denying add-on payments to new technologies and cuts short its opportunity to collect data on the technologies that receive add-on payments. BIO again urges CMS to protect beneficiaries' access to these technologies as Congress intended by using the issuance date of a new code, not the date of FDA approval, as the starting date for new technology status.

We also urge CMS to revise the new technology add on formula to better reflect true provider costs and provide payment equity across treatment settings. The current payment formula chosen by CMS does not adequately reimburse providers for use of the new service or technology.

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18 Id. at 24068.
19 Social Security Act § 1886(d)(5)(K)(ii)(II) and (III) (emphasis added).
20 42 C.F.R. § 412.87(b)(2).

Currently, once a new service or technology has been granted new technology add on status, "Medicare pays a marginal cost factor of 50 percent for the costs of a new medical service or technology in excess of the full DRG payment. If the actual costs of a new medical service or technology case exceed the DRG payment by more than the 50-percent marginal cost factor of the new medical service or technology, Medicare payment is limited to the DRG payment plus 50 percent of the estimated costs of the new technology."21

This approach does not adequately compensate the hospitals for the new service, as in most cases they receive only half of the cost of the new technology. Given that so few technologies have met the new technology add on standard set by CMS, it would make more sense for CMS to fully compensate hospitals for those few technologies that do meet the new technology add on standards. This could be accomplished by paying on a cost basis, which could be ASP+6% for FDA approved drugs and biologicals and list price plus a percentage for devices. The use of ASP+6% for drugs and biologicals or list price plus a percentage for devices as the payment formula would ensure that providers recoup their costs, Medicare pays a fair rate, and that payment is harmonized across treatment settings.

Finally, in some instances, existing therapies have new FDA-approved indications or new therapies are appropriately captured under existing ICD-9-CM codes. We request that CMS provide clear guidance and greater transparency as to how a determination of "new" will be made when these technologies meet the substantial clinical improvement and cost thresholds of the new technology provision.

IV. Conclusion

BIO appreciates this opportunity to comment on our concerns about the Proposed Rule, and we look forward to working with CMS to protect Medicare beneficiaries' access to new and advanced therapies. Toward this end, we urge CMS to delay implementation of the significant changes it has proposed in this rule for at least one year until we and other stakeholders have more time to assess, refine, and validate them. In addition, we recommend that CMS implement the refined DRG weight methodology and the severity-adjusted DRGs at the same time and find a way to modify these methodologies to pay more appropriately for advanced technologies, particularly those that increase complexity. Please contact

21 70 Fed. Reg. 47342 (August 12,2005)

Jayson Slotnik at 202-312-9273 if you have any questions regarding our comments. Thank you for your attention to this very important matter.

Respectfully submitted,

/s/

Jayson, Slotnik, Director, Medicare
Reimbursement and Economic Policy
Biotechnology Industry Organization

Submitter : **Dr. Gerard Klinzing** **Date: 06/12/2006**

Organization : **Bryn Mawr Family Practice residency**

Category : **Physician**

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS or the Agency) proposed rule entitled Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates. 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in patient care activities. The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

Background
The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a nonhospital setting, such as a physician s office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not related to patient care .

This position reverses the Agency s position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty. [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency s 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs.

Residency Program Activities and Patient Care
I firmly believe that with the possible exception of extended time for bench research, there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician s educational development into an autonomous practitioner.

To separate out CMS s newly defined patient care time from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,

Gerard F. Klinzing, M.D.

Submitter : **Dr. Leslie Teague** **Date: 06/12/2006**

Organization : **John Peter Smith Hospital - FMRP**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GME Payments

GME Payments

Residency Program Activities and Patient Care
I firmly believe that with the possible exception of extended time for "bench research," there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician's educational development into an autonomous practitioner.

To separate out CMS's newly defined "patient care time" from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

CMS-1488-P-1436-Attach-1.DOC

#1436

Currently I am completing my residency in family medicine. When I became aware that CMS would stop funding payment to faculty for teaching, preparing curriculum and evaluating my performance through GME -- IME and DME support – I became alarmed.

We are in a state with a huge health care professional shortage in communities under 25,000. These communities cannot afford to support several nurse practitioners and visiting specialists when the services are delivered by a pluri-potential well trained family medicine specialist who is part of their community. The training programs, like mine, which prepare us for these types of venues are in very short supply. We need to be exceptionally well trained.

Someone at CMS will need to explain to me, how the teaching, curriculum development and evaluation process for the six required ACGME physician skill competencies is not related to patient care. Isn't this exactly what the IOM has criticized our training professions for? In fact, our program currently evaluates us in all these competencies as a continuing quality improvement process DURING patient care. Without time to discuss and reflect our experiences and outcomes we will not be serving the needs of our current and future patients.

Should indeed this come to pass, we will have faculty who will be caught in the productivity race with no time for us. We may get pop-up feed back from an Electronic Health Record in sites that have them that we have made an error or we are not following a guideline. No discussion there. What is being proposed is dangerous for our current patients and our future patients. Our patients deserve for us to have a better education than you are proposing.

Why does the American taxpayer support medical students at over $200,000 per student per year and offers the faculty of residencies less than $15,000 for teaching per resident per year? I am getting a lot more from my residency training to protect and serve my patients of the future than all of medical school combined. Please do not cut us any more – rescind the clarification of this dangerous and capricious rule.

Medical Resident

Submitter : **Mrs. Phyllis Saunders** **Date: 06/12/2006**

Organization : **Sentara Healthcare**

Category : **Hospital**

Issue Areas/Comments

DRGs: Severity of Illness

DRGs: Severity of Illness

I support the proposed changes for DRGs to be based on severity of illness; however request implementation to be October 1, 2007. Allowing the healthcare systems adequate time would ensure the coding staff is given fair and reasonable training time. This would lessen the loss of revenue and enhance the benefits. Thank you.

Submitter : **Mr. Scott Davis** **Date: 06/12/2006**

Organization : **Memorial Healthcare System**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

Please See Attachment.

Thank you for the opportunity to comment.

Scott Davis
Director of Revenue Cycle Management
Memorial Healthcare System
Hollywood, FL 33021
sdavis@mhs.net

CMS-1488-P-1438-Attach-1.DOC

#1438

Memorial Healthcare System

MEMORIAL REGIONAL HOSPITAL • JOE DIMAGGIO CHILDREN'S HOSPITAL
MEMORIAL HOSPITAL WEST • MEMORIAL HOSPITAL MIRAMAR • MEMORIAL HOSPITAL PEMBROKE

June 12, 2006

Mr. Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1488-P and P2
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

RE: CMS-1488-P, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates; Proposed Rule, and
CMS-1488-PS, Medicare Program; Hospital Inpatient Prospective Payment Systems Implementation of the Fiscal Year 2007 Occupational Mix Adjustment to the Wage Index

Dear Dr. McClellan:

Thank you for this opportunity to submit comments to the Centers for Medicare and Medicaid Services (CMS) on the fiscal year 2007 inpatient prospective payment system and occupational mix adjustment proposed rules.

Memorial Healthcare System is a multi-hospital, governmental healthcare organization located in South Florida. We are comprised of four hospitals, a freestanding nursing home, and a number of outpatient clinics and health services. For the year ended April 30, 2006, we admitted almost 75,000 patients and furnished over 630,000 outpatient visits and more than 250,000 emergency room visits. Medicare patients (excluding those in Medicare managed care plans) represented almost 20 percent of our service population.

The sweeping changes proposed to the calculation of diagnosis-related group (DRG) relative weights and refinement of DRGs to account for patient severity will significantly redistribute Medicare funding among hospitals and across cases within hospitals. While our initial analysis indicates a marginal benefit to our health system, methodological and data problems in CMS's calculations leave us no confidence that this benefit is real.

We believe that refining the DRG system to provide more consistent returns across all DRGs is an appropriate goal and will help address current trends of steering highly profitable patients to limited service hospitals. However, we are seriously concerned that

the methods proposed by CMS not only do not achieve this goal, but also have significant negative consequences.

Specifically, we request that you consider the following:

- **Simultaneous Adoption of Any Changes to Weights and Classifications:** If more effective methods for computing DRG weights and classifying cases are available, then we support adoption of them together, rather than sequentially, particularly since they largely offset each other. Separate implementation creates unnecessary volatility and uncertainty, counter to the goal of improving payment accuracy.

- **Valid Cost-based Weights:** We support the use of a cost-based weighting methodology for determining relative DRG weights, but the methodology proposed by CMS is flawed.

- **Selection of an Appropriate Classification System:** Any new system of classification needs to adequately address both clinical severity and resource consumption, and must be adopted only after it can be shown to be a real improvement over the current system. That analysis requires a system that is fully available to the public.

- **Delay Until Truly Ready:** We support CMS's efforts to improve the prospective payment system so that Medicare payments better reflect Medicare costs. However, analyses by a number of groups of the proposed cost-based weighting methodology and the CS-DRG system indicate there are many flaws yet to be addressed which cannot be adequately dealt with before the payment rules for fiscal year 2007 must be finalized. At a minimum, a one-year delay is advisable, which would also help synchronize adoption of both changes. If the goal is improved accuracy, we would caution against undue haste.

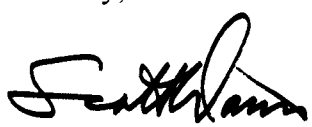
- **Transition Period:** Given the significant redistribution of payments expected as a result of these changes, and the degree of business evolution that will be required to adjust to those changes, we support implementation with a three-year transition period.

- **Mid-Year Wage Index Corrections:** Adoption of area wage index (AWI) values that incorporate a full occupational mix adjustment depends entirely on receipt of accurate and complete information. Given the rushed data collection process for the first three months data set, we recommend allowing data to be corrected and/or completed beyond July 13 as a resubmission with the second three months data set, and that the revised data for six months be used to establish weights as of January 1, 2008.

We have enclosed detailed comments that further explain our position on the points above.

Memorial Healthcare System appreciates the opportunity to submit these comments. If you have any questions about our remarks, please feel free to contact me.

Sincerely,



Scott J. Davis, CPA FHFMA
Director of Revenue Cycle Management
Memorial Healthcare System
3501 Johnson Street
Hollywood, FL 33021

(954) 987-2020 ext. 5105
SDavis@mhs.net

Submitter : **Dr. Meng Tee** **Date: 06/12/2006**

Organization : **John Peter Smith Hospital - FMRP**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GME Payments

GME Payments

Residency Program Activities and Patient Care
I firmly believe that with the possible exception of extended time for "bench research," there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician's educational development into an autonomous practitioner.

To separate out CMS's newly defined "patient care time" from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

CMS-1488-P-1439-Attach-1.DOC

Detailed Comments on Proposed Changes to the Hospital Inpatient Prospective Payment System for Fiscal Year 2007

DRG Reclassifications

DRGs: Carotid Artery Stents. We oppose the proposed delay in making any changes to carotid artery stent cases. The higher costs associated with carotid stents should be recognized within the existing DRG system, and not delayed until implementation of a new system. The cost of these stents ($2,100 each) plus the distal embolic protection devices required ($1,495 each) support a higher weight for these cases than for cases in these DRGs that do not include devices.

DRGs: Complications/Comorbidities (CC) Categories 403-404.

For categories 403 (Hypertensive Chronic Kidney Disease) and 404 (Hypertensive Heart and Chronic Kidney Disease), the fifth digit of the IDC-9-CM code relates to the patient's stage of chronic kidney disease. A fifth digit "0" is used to identify patients "with chronic kidney disease stage I through stage IV or unspecified," while fifth digit "1" identifies patients "with chronic kidney disease stage V or end stage renal disease." As such, Table 6E of the proposed rule has identified codes 403.10, 403.90, 404.10 and 404.90 as non-CCs. The stages of chronic kidney disease are a fairly new concept introduced into the ICD-9-CM classification last year, which physicians do not routinely document in the medical record. Many physicians still document the older and more common term "chronic renal failure," which translates into "unspecified stage" in the ICD-9-CM. Also, physicians differ in their opinion of what constitutes renal failure – whether it starts in the middle of stage III, stage IV or stage V.

While we understand that CMS may not want to consider a code that would include patients in the early stages of hypertensive kidney disease as a CC, because of the potential inclusion of more serious chronic renal failure patients in these codes, we recommend that CMS instead rely on the supplemental code from category 585 (Chronic Kidney Disease) to recognize the CC.

DRG System Changes

DRG Weights. CMS has proposed the use of hospital-specific relative values (HSRVs) and a modified version of cost-based weights rather than charge-based weights in fiscal year (FY) 2007. The methodology proposed by CMS differs significantly from the one proposed by MedPAC, based on the CMS concern that the MedPAC method is overly burdensome. However, analysis of the CMS proposal by the American Hospital Association, the Hospital Association of Greater New York, and others indicates serious flaws in both the methodology used for and accuracy in calculation of the proposed weights.

Insufficient details have been provided and too little validation has been done to show that this methodology actually improves payment accuracy over either the current system or the one proposed by MedPAC.

DRGs: Severity of Illness. CMS also proposes moving to a new patient classification system that would group patients into 861 consolidated severity-adjusted DRGs, or CS-DRGs. These CS-DRGs are designed to reflect the relative clinical severity of cases, but not the relative resource consumption of different types of cases, a step backwards from the current system. In addition, CMS's approach to consolidating 3M's all-patient refined DRGs (APR-DRGs) results in classifications that are neither clinically coherent or resource coherent. Finally, the actual grouper used by CMS for its analysis is a proprietary system that has not been subjected to public review and analysis.

With regard to both of the above CMS proposals, we recommend the following:

- **Simultaneous Adoption of Any Changes to Weights and Classifications:** If more effective methods for computing DRG weights and classifying cases are available, then we support adoption of them together, rather than sequentially, particularly since they largely offset each other. Separate implementation creates unnecessary volatility and uncertainty, counter to the goal of improving payment accuracy.

- **Valid Cost-based Weights:** We support the use of a cost-based weighting methodology for determining relative DRG weights, but the methodology proposed by CMS is flawed.

- **Selection of an Appropriate Classification System:** Any new system of classification needs to adequately address both clinical severity and resource consumption, and must be adopted only after it can be shown to be a real improvement over the current system. That analysis requires a system that is fully available to the public.

- **Delay Until Truly Ready:** We support CMS's efforts to improve the prospective payment system so that Medicare payments better reflect Medicare costs. However, analyses by a number of groups of the proposed cost-based weighting methodology and the CS-DRG system indicate there are many flaws yet to be addressed which cannot be adequately dealt with before the payment rules for fiscal year 2007 must be finalized. At a minimum, a one-year delay is advisable, which would also help synchronize adoption of both changes. If the goal is improved accuracy, we would caution against undue haste.

- **Transition Period:** Given the significant redistribution of payments expected as a result of these changes, and the degree of business evolution that will be required to adjust to those changes, we support implementation with a three-year transition period.

Other Proposed Rules

Occupational Mix Adjustment. CMS is required to collect data every three years on the occupational mix of employees from hospitals subject to the inpatient PPS in order to construct an occupational mix adjustment to the wage index to control for the effect of hospitals' employment choices rather than geographic differences in the costs of labor.

CMS initially stated in the proposed rule that it would again limit the occupational mix adjustment to 10 percent because of concerns regarding the validity of the data and the potential financial impact on hospitals. However, as a result of the decision handed down by the U.S. Court of Appeals for the Second Circuit on April 3 in *Bellevue Hospital Center v. Leavitt*, CMS on May 12 released a proposed rule revising the occupational mix adjustment portion of the FY 2007 inpatient PPS proposed rule. Under the court ruling, CMS must collect new data on the occupational mix of hospital employees and fully adjust the area wage index (AWI) for FY 2007.

Hospitals are required to collect the hours and wages for employees from January 1 through June 30, 2006. Data initially was supposed to be collected by July 31; however, hospitals were required to submit data by June 1 for the first calendar quarter of the year and by August 31 for the second calendar quarter. Data from the first quarter will be used to adjust the FY 2007 AWI, while data for the full six months will be used to adjust the AWI for FYs 2008 and 2009.

Because data from all hospitals is needed to construct an accurate national average hourly wage, full participation is critical. There is a general sentiment that hospitals that do not participate should not benefit from the participation of others. However, given the rushed collection and general confusion around the interim-collection, we believe that, to the extent possible, **CMS should substitute data from the previous survey for hospitals that did not turn in their data for the first calendar quarter of 2006.**

Hospitals will have more notice and time to submit data for the second calendar quarter in August. Thus, moving forward CMS should consider a methodology that penalizes hospitals that do not participate. We caution CMS not to simply substitute unfavorable data for these hospitals, as it also will impact other area hospitals that conscientiously reported data. CMS could alternatively substitute the national average hourly wage for non-responsive hospitals in calculating an area's wage index or omit those hospitals from the calculation, and then require hospitals that did not turn in data to use something lower than their area's wage index. This would avoid CMS having to create an extensive hospital-specific wage index table and would minimize the effects on the other hospitals in the area. **We urge CMS to construct an application of the occupational mix adjustment that encourages hospitals to report but does not unfairly penalize neighboring hospitals.**

Corrections. **We urge CMS to allow hospitals to turn in both calendar quarters of data in August whether for the first time or with corrections.** Again, as this

collection has been rushed, the idea is to allow hospitals to improve the data for the FYs 2008 and 2009 adjustment. For hospitals that were previously non-responsive, the submission of the first calendar quarter would remove any penalty, while those that continue to be non-responsive will continue to incur a penalty. In addition, if there is a significant difference between AWI values computed using the first quarter data and values computed using the full data set, then we encourage CMS to make a one-time mid-year correction to the AWI as of January 1, 2007.

Comment Timeframe. While we understand that CMS is under severe time pressure due to the timing of the court's decision, we do not believe that the 30-day comment period was sufficient, as hospitals were busy during this time trying to meet the new survey deadline and answering requests for information from the fiscal intermediaries. In addition, we believe it would be appropriate for CMS to take comments on the calculation after the initial results of the survey are tabulated and posted. The results of the survey could be material. For instance, if the segregation of RNs who are management versus RNs who are staff does not produce a reliable result, CMS might consider consolidating the two for the purposes of the calculation. While CMS might not have time to make such changes for FY 2007, it could entertain comments on the implementation for FYs 2008 and 2009. **Thus, we urge CMS to publish the occupational mix adjustment changes as an interim-final rule in August with an associated comment period.**

Outlier Payments. The rule proposes establishing a fixed-loss cost outlier threshold equal to the inpatient PPS rate for the DRG, including indirect medical education (IME), disproportionate share hospital (DSH), and new technology payments, plus $25,530. While this is not a particularly sizable increase from the FY 2006 payment threshold of $23,600, we are very concerned that the threshold is too high. According to analyses by the American Hospital Association, actual outlier payments for FY 2006 are estimated to be 0.47 percentage points lower than the 5.1 percent of funds withheld from hospitals to fund outlier payments. CMS spent only 3.8 percent, or $1.15 billion less than set aside in FY 2005, and only 3.5 percent, or $1.3 billion less than the funds withheld in 2004.

In the rule, CMS proposes to use a one-year average annual rate-of-change in charges per case from the last quarter of 2004, in combination with the first quarter of 2005, to the last quarter of 2005, in combination with the first quarter of 2006, to establish an average rate of increase in charges. This results in a 7.57 percent rate of change over one year, or 15.15 percent over two years.

We appreciate that CMS is proposing this methodology in an effort to avoid using data from 2003 when charges may have been atypically high. **However, using the proposed charge inflation methodology will only result in an inappropriately high outlier threshold and a real payment cut to hospitals. We strongly oppose using this methodology to estimate the outlier threshold.**

The AHA conducted a series of analyses to identify a more appropriate methodology and included a description of their methodology in their comments to this proposed rule. The AHA methodology accounts not only for inflation in charges, but also inflation in costs, so that an "apples-to-apples" comparison is made. The estimated fixed-loss amount that would result in 5.1 percent outlier payments under this methodology is $24,000. **We urge CMS to strongly consider using the methodology described by the AHA.**

Hospital Quality Data. CMS proposes expanding the list of quality measures that must be reported in order to receive a full market basket update to a hospital's payment rate. While we support the expansion of the indicator list, the proposed rule, as written, would require hospitals to reopen files from which data have already been abstracted, renegotiate agreements with the vendors that assist them in collecting and processing the required information, and resubmit information to the clinical data warehouse. Such retroactive alterations in the data files are difficult and costly, and open the door for the introduction of many new kinds of errors in the data. To require this reopening of the files makes no sense. **CMS should make the data collection prospective. This could be accomplished by requiring that hospitals that want a full market basket update pledge to submit the relevant data for all 21 measures for patients beginning on or after July 1.**

Transparency of Health Care Information. The proposed rule includes the introduction of a proposed initiative to expand the public availability of consumer information on health care quality and pricing. In the proposed rule, CMS details four options for providing pricing information to health care consumers, including:

- Publishing a list of hospital charges, either for every region of the country or selected regions of the country;

- Publishing the rates that Medicare actually pays to a particular hospital for every DRG, or for selected DRGs, which could be adjusted to account for the hospital's labor market area, teaching hospital status and DSH status;

- Establishing conditions of participation for hospitals that relate to the posting of prices and/or the posting of their policies regarding discounts or other assistance for uninsured patients; and

- Posting total Medicare payments for an episode of care. Under this proposal, CMS could include the costs for an inpatient hospital stay, physician payments (including the surgeon and the anesthesiologist), and payments for post-acute care services such as those provided in an inpatient rehabilitation facility, skilled nursing facility or LTCH for a certain service (such as hip replacement).

On June 1, 2006, CMS announced the posting of hospital payment information on its web site. This posting shows the Medicare payment rate, by DRG for all hospitals. It is presented as a range from the 25th to 75th percentiles, and is grouped by payment area

(metropolitan area or rural area), and so is not hospital-specific, but it does make progress toward the second option, above.
Publishing a list of hospital charges, either nationally or in the hospital, is not likely to yield information that is meaningful to most patients. Memorial Healthcare System's charge listing includes over 90,000 items, a necessity for dealing with the billing requirements of Medicare and other payors.

The prices attached to these items generally do not reflect the amount a patient would pay, since insured patient liability is limited to copayment amounts unique to each policy, and uninsured patients are eligible for significant discounts from charges according to their income level. In addition, patients usually do not consume the same resources, even when classified into the same DRG or when receiving the same surgery, so exact quotes of prices would not be possible in advance.

Most States have already initiated processes for obtaining and publicizing information on hospital prices. The majority of these processes are relatively new, and have not yet had time to be evaluated for their effectiveness. For example, www.floridacomparecare.gov provides both quality and charge data.

Before CMS steps in to regulate on this subject, we encourage CMS to review the efforts already undertaken at the State level and evaluate whether State regulation is more representative of local consumer needs, more effective, and more cost-effective.

Dear CMS Policy Maker:

I am a family medicine resident in a very busy HPSA. I really need my faculty to teach. Why would you interpret a rule designed to do just that as being unrelated to patient care time? Whether we are having a discussion after a patient encounter, a small group discussion regarding a difficult clinical situation, reviewing our evaluation for our care and didactic tests in a certain disease domain, or participating in lectures – we are learning about, caring for current and protecting our future patients.

My concern is that the faculty are already stretched to produce more patient visits with poor compensation and must cover four of us at a time for supervision in clinic. The hour they spend before and after clinic to discuss a specific topic that is not related to a specific individual patient will disappear with the implementation of the rule you suggest. They will not have time to sit down with us to discuss our overall performance – we will get an email.

The faculty, without support for their own development, will be likely to lose their academic edge as they work to see patients, see more patients and supervise patient care without any incentive to reflect, discuss and research our and their work.

Please help us be better physicians to our patients by supporting a competent and refreshed faculty. Rescind the interpretation of the IME and DME support rule.

Sincerely,

Submitter : **Dr. Yun Tran** **Date: 06/12/2006**

Organization : **John Peter Smith Hospital - FMRP**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GME Payments

GME Payments

Residency Program Activities and Patient Care
I firmly believe that with the possible exception of extended time for "bench research," there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician's educational development into an autonomous practitioner.

To separate out CMS's newly defined "patient care time" from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

CMS-1488-P-1440-Attach-1.DOC

CMS-1488-P-1440-Attach-2.DOC

CMS-1488-P-1440-Attach-3.DOC

#1440

Currently I am completing my residency in family medicine. When I became aware that CMS would stop funding payment to faculty for teaching, preparing curriculum and evaluating my performance through GME -- IME and DME support – I became alarmed.

We are in a state with a huge health care professional shortage in communities under 25,000. These communities cannot afford to support several nurse practitioners and visiting specialists when the services are delivered by a pluri-potential well trained family medicine specialist who is part of their community. The training programs, like mine, which prepare us for these types of venues are in very short supply. We need to be exceptionally well trained.

Someone at CMS will need to explain to me, how the teaching, curriculum development and evaluation process for the six required ACGME physician skill competencies is not related to patient care. Isn't this exactly what the IOM has criticized our training professions for? In fact, our program currently evaluates us in all these competencies as a continuing quality improvement process DURING patient care. Without time to discuss and reflect our experiences and outcomes we will not be serving the needs of our current and future patients.

Should indeed this come to pass, we will have faculty who will be caught in the productivity race with no time for us. We may get pop-up feed back from an Electronic Health Record in sites that have them that we have made an error or we are not following a guideline. No discussion there. What is being proposed is dangerous for our current patients and our future patients. Our patients deserve for us to have a better education than you are proposing.

Why does the American taxpayer support medical students at over $200,000 per student per year and offers the faculty of residencies less than $15,000 for teaching per resident per year? I am getting a lot more from my residency training to protect and serve my patients of the future than all of medical school combined. Please do not cut us any more – rescind the clarification of this dangerous and capricious rule.

Medical Resident

Submitter : Mr. Kenneth A Johnson **Date:** 06/12/2006

Organization : Scott

Category : Hospital

Issue Areas/Comments

DRGs: Severity of Illness

DRGs: Severity of Illness

DRGs Severity of Illness 24011

CMS also proposes moving to an entirely new patient classification system beginning in FY 2008 or earlier. Currently, Medicare uses 526 DRGs to classify all Medicare patients. CMS considered use of 3M s all-patient refined DRGs (APR-DRGs) as an alternative to its current DRGs, which would increase the number of categories to 1,258. However, CMS ultimately proposed refining the APR-DRG system by consolidating APR-DRGs into fewer categories. This would result in a new DRG system with 861 consolidated severity-adjusted DRGs, or CSDRGs. SWMH believes that the need for and best approach to changing the patient classification system has not been concretely and objectively demonstrated. More careful analysis is needed, along with greater access to the specifics of CMS s methodology and the new GROUPER.

Even more fundamentally, today s DRG system was created to distinguish the resource use required among patients. It has been modified over time to reflect changes in clinical practice and technology. The APR-DRG system is based on severity of illness, not necessarily the resource use required. The impact of a move to CS-DRGs an APR-DRG hybrid is unclear. However, the implications of moving from a resource-based system to a severity-based payment system must be more fully explored and understood.

The two components of the DRG changes (HSRVcc and CS-DRGs) are fraught with opportunities for improvement. SWMH supports revisions and improvements to the existing DRG system that will truly result in a more appropriate payment system. The changes as proposed do not prove that this goal is accomplished. Further, while CMS is demanding transparency from the hospital industry in pricing and other consumer decision driving factors, CMS is not providing that transparency with the changes that are proposed. SWMH would be willing to work with the various hospital associations and CMS to consider alternatives that would accomplish the stated goals.

FTE Resident Count and Documentation

FTE Resident Count and Documentation

FTE Resident Count and Documentation 24113

We strongly urge the Agency to rescind the purported clarification in the proposed rule that excludes medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments. The stated rationale for the exclusion of time devoted to these activities is that they are not related to patient care The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a non-hospital setting, such as a physician s office or affiliated medical school.

The proposed rule position is in stark contrast to the Agency s position as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty. [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins].

We support the Agency s 1999 position. The activities cited are an integral component of the patient care activities engaged in by residents during their residency programs. We urge CMS to withdraw its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

HSRV Weights

HSRV Weights

HSRV Weights 24007

While the proposed rule changes are budget-neutral, if implemented, over a billion dollars in Medicare payments would be significantly redistributed among hospitals as well as among DRGs. Of the 20 hospitals facing the greatest payment reductions in 2007 under the HSRVcc system, 19 are teaching institutions. As a teaching institution, SWMH would see a significant drop in case mix (negative 1.6%) as a direct result of moving to the HSRVcc system.

Adding CS-DRGs would ameliorate the payment reductions for SWMH, from -1.6 percent to breakeven. The CS-DRGs remain a mystery though as to whether they truly accomplish the goal of improving the classification system. Additional comments on CS-DRGs will follow.

At the DRG level, the proposed rule notes that a number of DRGs would experience payment reductions, particularly DRGs involving cardiac care. For example, cardiac procedures involving stents, both drug eluting and non drug eluting, would see payment reductions. We are concerned about such drastic reductions for these and other cardiac procedures. While, the payment reductions could potentially reduce the incentives . . . for the further development of specialty hospitals (71 Fed. Reg. at 24006), we are concerned that the reductions also would significantly affect community and teaching hospitals that do significant amounts of cardiac care. Unlike many specialty hospitals, however, these hospitals have emergency rooms, treat significant numbers of Medicaid and uninsured patients, and also

accept complex cardiac cases. The DRG system is not the mechanism to use to discourage specialty hospitals because that unfairly reduces payments to all hospitals treating those patients.

At the same time, we recognize and appreciate that a number of more routine DRGs, such as pneumonia, would see payment increases. These cases often result from emergency room admissions, which disproportionately occur in teaching and other safety net hospitals.

While the DRG system has seen little real change in its 20+ year existence, the changes proposed in this rule making process are flawed and require further analysis before implementation.

In addition, a change of the magnitude brought about by the changes as proposed will have significant ramifications to individual hospitals while remaining budget neutral to the Medicare program. This type of significant change should indicate that a transition period is warranted and needs to be implemented. All other significant changes in Medicare payment methodologies and systems have used a transition period to allow providers time to adjust their operations to accommodate the change.

Occupational Mix Adjustment

Occupational Mix Adjustment

Non-responsive Hospitals. Because data from all hospitals is needed to construct an accurate national average hourly wage, full participation is critical. There is a general sentiment that hospitals that do not participate should not benefit from the participation of others. However, given the rushed collection and general confusion around the interim-collection, we believe that, to the extent possible, CMS should substitute data from the previous survey for hospitals that did not turn in their data for the first calendar quarter of 2006.

However, hospitals will have plenty of notice and time to submit data for the second calendar quarter in August. Thus, moving forward CMS should consider a methodology that penalizes hospitals that do not participate. We caution CMS not to simply substitute unfavorable data for these hospitals, as it also will impact other area hospitals that conscientiously reported data. CMS could alternatively substitute the national average hourly wage for non-responsive hospitals in calculating an area s wage index, and then require hospitals that did not turn in data to use something lower than their area s wage index. This would avoid CMS having to create an extensive hospital-specific wage index table and would minimize the effects on the other hospitals in the area. We urge CMS to construct an application of the occupational mix adjustment that encourages hospitals to report but does not unfairly penalize neighboring hospitals.

Corrections. SWMH urges CMS to allow hospitals to turn in both calendar quarters of data in August whether for the first time or with corrections. Again, as this collection has been rushed, the idea is to allow hospitals to improve the data for the FYs 2008 and 2009 adjustment. For hospitals that were previously non-responsive, the submission of the first calendar quarter would remove any penalty, while those that continue to be non-responsive will continue to incur a penalty.

Comment Timeframe. While we understand that CMS is under severe time pressure due to the timing of the court s decision, we do not believe that the 30-day comment period was sufficient, as hospitals were busy during this time trying to meet the new survey deadline and answering requests for information from the FIs. In addition, we believe it would be appropriate for CMS to take comments on the calculation after the initial results of the survey are tabulated and posted. The results of the survey could be material. For instance, if the segregation of RNs who are management versus RNs who are staff does not produce a reliable result, CMS might consider consolidating the two for the purposes of the calculation. While CMS might not have time to make such changes for FY 2007, it could entertain comments on the implementation for FYs 2008 and 2009. Thus, we urge CMS to publish the occupational mix adjustment changes as an interim-final rule in August with an associated comment period.

Submitter : **Dr. Renika Thompson** **Date: 06/12/2006**

Organization : **John Peter Smith Hospital - FMRP**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GME Payments

GME Payments

Residency Program Activities and Patient Care
I firmly believe that with the possible exception of extended time for "bench research," there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician's educational development into an autonomous practitioner.

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I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

CMS-1488-P-1442-Attach-1.DOC

#1142

Dear CMS Policy Maker:

I am a family medicine resident in a very busy HPSA. I really need my faculty to teach. Why would you interpret a rule designed to do just that as being unrelated to patient care time? Whether we are having a discussion after a patient encounter, a small group discussion regarding a difficult clinical situation, reviewing our evaluation for our care and didactic tests in a certain disease domain, or participating in lectures – we are learning about, caring for current and protecting our future patients.

My concern is that the faculty are already stretched to produce more patient visits with poor compensation and must cover four of us at a time for supervision in clinic. The hour they spend before and after clinic to discuss a specific topic that is not related to a specific individual patient will disappear with the implementation of the rule you suggest. They will not have time to sit down with us to discuss our overall performance – we will get an email.

The faculty, without support for their own development, will be likely to lose their academic edge as they work to see patients, see more patients and supervise patient care without any incentive to reflect, discuss and research our and their work.

Please help us be better physicians to our patients by supporting a competent and refreshed faculty. Rescind the interpretation of the IME and DME support rule.

Sincerely,

Submitter : **Ms. Mary Johnson** **Date: 06/12/2006**

Organization : **Dept of Veteran Affairs**

Category : **Federal Government**

Issue Areas/Comments

Capital PPS

Capital PPS

It is understandable after 20+ years that a need exists to re-work the payment methodology. Many changes are needed within our system including the current coding format (ICD-9). ICD-10 provides much of the granularity needed to specify diseases, conditions, procedures, etc.

A two step process of implementing this level of change is admirable.

Nevertheless there is great concern regarding a potential conflict with getting all of the necessary information needed to begin these changes, within our electronic information systems. It has been stated that the changes are being accomplished by a proprietary methodology developed (and sold) by 3M for CMS to use.

As an organization, we do not contract with 3M for our coding/reference needs. We use another vendor who has proved to be a good partner.

The proposed DRG changes must be done in such a way that allows hospitals (rehab units, SNF units) the time and ability to adjust their data collection systems to assure that all requirements are met.

We have 144 + facilities within our organization - and the architecture changes, alone, will take a significant time and cost outlay to accomplish the changes that are being considered for FY 08. If the technical information is not released prior to the end of FY 06, we would not be able to react to the multitude of proposed changes (changes in the DRG structure to consolidated severity-adjusted structure). It would be impossible for us to be in compliance the beginning of FY 08 (10/01/2007).

As you move forward determining/developing changes, please allow the impacted organizations the time and provide the necessary required information to allow for a smooth transition.

Submitter : Dr. Ashu Verma **Date:** 06/12/2006

Organization : John Peter Smith Hospital - FMRP

Category : Health Care Professional or Association

Issue Areas/Comments

GME Payments

GME Payments

Residency Program Activities and Patient Care
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I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

CMS-1488-P-1444-Attach-1.DOC

#1444

Currently I am completing my residency in family medicine. When I became aware that CMS would stop funding payment to faculty for teaching, preparing curriculum and evaluating my performance through GME -- IME and DME support – I became alarmed.

We are in a state with a huge health care professional shortage in communities under 25,000. These communities cannot afford to support several nurse practitioners and visiting specialists when the services are delivered by a pluri-potential well trained family medicine specialist who is part of their community. The training programs, like mine, which prepare us for these types of venues are in very short supply. We need to be exceptionally well trained.

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Medical Resident

Submitter : **Mr. James Birchler** **Date: 06/12/2006**

Organization : **Chelsea Community Hospital**

Category : **Hospital**

Issue Areas/Comments

DRG Weights

DRG Weights

We support the CMS decision to move to a cost-basis for determining DRG weights. This is logical and long overdue. We understand that the specific methodology is less than perfect, but believe that this approach is preferable to the current approach and should be implemented as planned. Improvements in the methodology should be implemented in subsequent years. A further benefit of the cost approach is that it will remove any potential benefit of high charges from Medicare payment. Given the level of the uninsured and lawsuits against hospitals for expecting self-pay customers to pay a higher percentage of charges than contracted payors, it is proper to implement a payment methodology that removes the incentive for hospitals to benefit indirectly from higher charges. We realize that the relationship between charges and Medicare payments on the individual hospital level is probably not very strong, but it is not zero.

The Phase II changes are also logical to us. Our primary concern with the Phase II implementation is the impact on our information systems. '2008 or sooner' seems awfully quick to us.

We know that others are suggesting that both phases should be implemented at the same time. Although there is some validity in their argument that the Phase I impact will be offset by the Phase II impact (this is substantially true for us) we believe that each of these proposed changes has validity independent of the other and therefore they can each stand alone and should be implemented independently.

Hospital Quality Data

Hospital Quality Data

The timing on submittal of the expanded quality data elements appears ridiculously quick (January 1, 2006 data that no one is yet gathering to be submitted by August 15, 2006 and its already June!). You should either delay the beginning date for data collection or delay the date for submittal of the data.

Update Factors

Update Factors

Medicare payments remain inadequate to cover the cost of services. We are a very efficient hospital and yet we have a negative margin, in total, from all Medicare services. We believe Medicare payments, in total, must be at least 5% too low and encourage CMS to develop an overall payment level that fully compensates efficient hospitals for their costs of doing business.

Submitter : **Date: 06/12/2006**

Organization : **Scripps Health**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1446-Attach-1.PDF

CMS-1488-P-1446-Attach-2.PDF

#1446

Scripps Health
4275 Campus Point Court, CP223
San Diego, CA 92121-1513
Tel 858 678-7204
Fax 858 678-7225
Komar.june@scrippshealth.org

June Komar
Senior Vice President
Strategic Planning and Business Development

June 12, 2006

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-14889-P and P2
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

RE: CMS-1488-P and P2, Medicare Program: Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates; Proposed Rule

Dear Dr. McClellan:

On behalf of the Scripps Health system with five hospital campuses in San Diego County, we appreciate the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) on the fiscal year (FY) 2007 inpatient prospective payment system (PPS) and occupational mix adjustment proposed rules.

As has been widely noted, this rule proposes the most significant changes in the calculation of diagnosis-related group (DRG) relative weights since 1983 by creating a version of cost-based weights using the newly developed hospital-specific relative values cost center methodology (HSRVcc). Also proposed is the redefining of the DRGs to account for patient severity, with implementation indicated as likely in FY 2008. In addition, the rule would update the payment rates, outlier threshold, hospital wage index, quality reporting requirements, and payments for rural hospitals and medical education.

While we support meaningful improvements to Medicare's inpatient PPS, and some of the proposed rule's provisions are appropriate, we have serious concerns about many of the proposed changes, particularly those to the DRG weights and classifications.

We would like to reference the comment letter from the American Hospital Association (AHA) submitted on June 8, 2006. We concur in the full range of comment provided by that letter and the extensive attachment to the letter. We concur in the recommendations from AHA, including:

- a delay of at least one year in implementing the rule

- flaws in cost-based weights methodology must be corrected, a process that could take much of the next year
- the need for a new classification system is still unclear; need must be demonstrated
- if and when need for a more effective classification system can be demonstrated, it should be implemented simultaneously with the new weighting system to provide better predictability and smooth the volatility created by these two, generally off-setting changes
- a transition period of three or four years to phase in the payment redistribution across DRGs and hospitals and to provide opportunity to modify unintended consequences that inevitably will result from changes of this magnitude.

The detailed comments enclosed with AHA's letter referenced above provide ample evidence of the magnitude of our hospitals' concerns with the proposed rule. Changes this sweeping need much more time to review, evaluate, model and adjust.

Scripps Health appreciates the opportunity to submit these comments. If you have any questions about our remarks, please contact me or Michael Bardin, senior director of public and government affairs at (858) 678-6893 or bardin.michael@scrippshealth.org.

Sincerely,

June Komar
Senior Director Strategic Planning and Business Development

Scripps Health
4275 Campus Point Court, CP223
San Diego, CA 92121-1513
Tel 858 678-7204
Fax 858 678-7225
Komar.june@scrippshealth.org

June Komar
Senior Vice President
Strategic Planning and Business Development

June 12, 2006

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
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Sincerely,

June Komar
Senior Director Strategic Planning and Business Development

Submitter : Dr. Mike Zeringue **Date:** 06/12/2006

Organization : John Peter Smith Hospital - FMRP

Category : Health Care Professional or Association

Issue Areas/Comments

GME Payments

GME Payments

Residency Program Activities and Patient Care
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CMS-1488-P-1447-Attach-1.DOC

#1447

Dear CMS Policy Maker:

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The faculty, without support for their own development, will be likely to lose their academic edge as they work to see patients, see more patients and supervise patient care without any incentive to reflect, discuss and research our and their work.

Please help us be better physicians to our patients by supporting a competent and refreshed faculty. Rescind the interpretation of the IME and DME support rule.

Sincerely,

Submitter : Mr. Hugh Zettel **Date:** 06/12/2006

Organization : GE Healthcare Integrated IT Solutions

Category : Health Care Industry

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1448-Attach-1.DOC

#1448

GE Healthcare

540 West Northwest Highway
Barrington, IL 60010
USA

June 12, 2006

The Honorable Mark McClellan, MD, Ph.D.
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1488-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Dr. McClellan:

GE Healthcare Integrated IT Solutions (GE) is pleased to submit our comments regarding the Centers for Medicare & Medicaid Services (CMS) Proposed Rule on Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates (PPS2007). Important changes outlined in the proposed rule provide measures to improve the accuracy of data reported on the quality and cost of healthcare services. These measures are essential to improve healthcare information transparency for providers, payers and consumers.

GE is a leading provider of revenue cycle management and electronic health record systems to the healthcare marketplace, supplying IT solutions to payers and providers. GE's feedback to PPS2007 is provided from the perspective of a developer of IT applications that would be affected by proposed changes, as well as for the concerns our customers have raised regarding its implementation into their existing administrative workflows.

As described in more detail below, GE recommends that any major revisions to the DRG classification system, such as the severity adjusted DRG system proposed by CMS, must be provided in a non-proprietary, open-standards manner, consistent with the current DRG system. In addition, we are very concerned about the timing proposed by CMS for the implementation of a severity-adjusted DRG system. Implementation in FY2008, as proposed by CMS, fails to provide sufficient time to allow software developers to implement changes in their products, or for payers and providers to deploy the new changes into their work systems.

GE strongly encourages CMS to work through the American Health Information Community to create an implementation roadmap based on private and public sector input. This roadmap should portray the relationship and priorities of the revised DRG implementation in relation to other significant healthcare infrastructure platform changes, such as ePrescribing, NHIN infrastructure, electronic claims attachments and ICD10 migration.

Finally, GE recommends that efforts by CMS to support the use of electronic medical records (EMRs) be addressed in a consistent, standards-based approach as we describe herein. GE also recommends that any data infrastructure created to support value-based purchasing initiatives be based on clinical data captured through electronic medical record systems, to the extent possible, and utilize new capabilities provided by the upcoming electronic claims attachments final rule to allow effective integration of clinical and administrative health information.

Our detailed comments on these issues follow. In addition, we refer you to comments on the rule submitted by the National Electrical Manufacturers Association (NEMA). GE is a member of NEMA and fully supports comments submitted by the association regarding other proposed changes to Medicare's hospital inpatient prospective payment system..

We appreciate the opportunity to submit comments on these important issues. We look forward to working with the agency and our healthcare industry colleagues to make the necessary changes in our healthcare IT infrastructure to enable improved patient safety, quality and healthcare information transparency. Should you have any questions about our comments please contact me at (414) 721-2015 or via email at hubert.zettel@med.ge.com.

Sincerely,

Hugh

Hugh Zettel
Director, Government and Industry Relations
GE Healthcare Integrated IT Solutions

Attachment

GE Response to HHS Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates

June 12, 2006

DRGs: Severity of Illness

1. GE requests that CMS clarify the selection criteria and process used to arrive at the proposed severity weighted DRG classification system, especially relative to available alternatives. GE notes that there are several alternative solutions available for consideration, including non-proprietary models. The use of non-proprietary, open-source systems could facilitate consistent, cost-effective and rapid adoption by IT developers and payers. We seek greater understanding as to whether the agency considered such issues in its evaluation of alternative changes to the DRG classification system.

2. CMS proposes to implement the severity-adjusted DRG classification system in FY2008. GE is concerned that the timeframe needed to implement related changes in application software and then deploy those changes among its customers' current workflow will require considerable time and effort. Furthermore, GE urges CMS to consider the combined effects that this change, along with other CMS-driven changes that are competing for similar resources including, ePrescribing roll-out and the electronic claims attachment implementation, will have on providers and payers. GE believes that it is more reasonable to implement the severity adjusted DRG system no sooner than FY 2009 (or even later, depending on other implementation factors). In any event, there should be no implementation of such a new system prior to FY2008, a possibility that CMS suggested in its proposed rule.

3. GE recommends that CMS ensure transparency by providing open-source access to the algorithms, analytical tools, process and results used to determine the new severity –adjusted DRG classifications.

4. GE recommends that the Converged Severity Adjusted DRG solution that CMS proposes should be provided at no more than the current cost to the marketplace of the current DRG tables and Grouper software. We also recommend using the same distribution process via NTIS.

5. GE recommends that any private sector contracting used by CMS to create the new DRG platform result in a non-proprietary, open-source solution. GE also recommends that CMS refer to the NHIN contracting process used at the Office of the National Coordinator to ensure non-proprietary solutions.

6. GE recommends that the Converged Severity Adjusted DRG software should be developed such that it can be integrated using recognized industry standard interfaces and technology platforms. We also recommend that CMS work through the Health Information Technology Standards Panel (HITSP) and the appropriate standards development organizations to establish the necessary requirements.

Hospital Quality Data

7. GE agrees that EMR systems will play a critical role in the capture and reporting of quality measures. However, GE believes that there must be a consistent, standards-based approach with respect to the definition, capture and transmission of quality information. This requires that CMS go beyond the use of specific standards to recognize the specific quality reporting use-cases, with consideration for the following: (1) what data is captured; (2) how it is captured; (3) at what intervals; (4) how it is transmitted; and (5) the relationship and context of the data to previous submissions. To that end, GE recommends that CMS use the Integrating the Healthcare Enterprise (IHE) process to establish a Quality Domain. This new domain would include multiple stakeholders (including but not limited to EHR vendors, standards delivery organizations, payers, providers, quality transformation advocacy organizations, such as Bridges to Excellence) involved in the entire process of quality information capture and reporting. These stakeholders would establish the quality reporting use-cases, profile the requirements to satisfy the use-cases, and select the appropriate standards and related implementation and integration specifications needed to demonstrate that the use-case will work as specified. IHE has refined this process over seven years in Radiology, Cardiology, Lab and Patient Care Coordination related transactions.

Value-based Purchasing

8. GE fully supports CMS efforts to incorporate value-based purchasing into its reimbursement processes. Although the creation of infrastructure to support value-based purchasing is in its very early stages, GE recommends that, to the extent possible, any value-based purchasing system be based as much as possible on clinical data captured by electronic medical record systems, and not rely solely administrative claims data. GE would like to highlight that current research notes the limitations in using only claims-based data (*Comparison of Administrative Data and Medical Records to Measure the Quality of Medical Care Provided to Vulnerable Older Patients,* by MacLean et al, Medical Care, Volume 44, Number 2, February 2006.) In addition, we urge CMS to consider an upcoming analysis soon to be published by the RAND Corporation that provides a comparison of EMR-based clinical data versus administrative claims data. We believe that this analysis will further support the need to ensure the use of clinical content in quality and cost determinations. GE has been actively involved in developing the standards and implementation profiles for the upcoming electronic claims attachment final rule. Electronic claims attachments blur the distinction between what have been pure clinical and pure administrative transactions, and GE is excited

about the impact these new capabilities can achieve short-term for existing administrative transaction productivity, as well as expanding their role for supporting performance-based measures.

9. GE agrees that interoperable Health IT will play an important role in the transformation of healthcare quality, safety and cost. Although CMS suggests that the RAND analysis cited in the proposed rule on this issue may be optimistic in its assessment of the impact of healthcare IT, the RAND study does also suggest that its results are based on very conservative estimates for the impact of IT based on its implementation in other economic segments. Most important, any value-based purchasing system must be integrated with other healthcare IT infrastructure programs being contemplated. As a result, GE recommends that value-based purchasing be considered as an initiative that gets integrated into the work of the American Health Information Community.

Submitter : **Dr. william epperson** **Date: 06/12/2006**

Organization : **Inlet Medical Associates, PA**

Category : **Individual**

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS or the Agency) proposed rule entitled Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates., 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in patient care activities. The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

Background
The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a nonhospital setting, such as a physician's office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not "related to patient care".

This position reverses the Agency's position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include "scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty." [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency's 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs.

Residency Program Activities and Patient Care
I firmly believe that with the possible exception of extended time for bench research, there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician's educational development into an autonomous practitioner.

To separate out CMS's newly defined "patient care time" from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,

William Jackson Epperson, MD, MBA

Submitter : Mr. Dou Schneider **Date:** 06/12/2006

Organization : Thomson Medstat

Category : Health Care Industry

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1450-Attach-1.DOC

#1450

Medstat
777 East Eisenhower Parkway
Ann Arbor, MI 48108
Tel (734) 913-3000
www.medstat.com

THOMSON
MEDSTAT

June 12, 2006

Mark B. McClellan, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: CMS-1488-P (Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates)

Dear Administrator McClellan:

Thomson Medstat is grateful for the opportunity to submit comments on the proposed rule regarding Medicare's inpatient hospital payment system. Thomson provides decision support services to providers, payers and researchers to evaluate the cost and quality of healthcare services. We continue to develop and maintain a patient classification system – Disease Staging – to evaluate the progression of disease and measurement of effectiveness and efficiency within clinically defined patient populations. Disease Staging, also provides quantitative severity adjustment factors related to both resource use and clinical outcomes. Our customers rely on our analytically ready databases to evaluate experience with Medicare and other patient populations.

While we are not paid by Medicare under the inpatient hospital prospective payment system (IPPS), we assist customers that are paid under this system and other stakeholders in the healthcare industry that rely on Medicare payment constructs for analytic purposes. In this capacity, we have identified a number of concerns with the proposed rule, particularly related to the proposed changes to the Diagnosis Related Group (DRG) classification system. Foremost among these concerns is the need for transparency with regard to any changes to the DRG classification system because the lack of such transparency seriously impedes our ability to continue to assist our customers in evaluating resource use and quality in the same "currency" that is used for a large portion of inpatient payment.

Transparency

Currently, we are able to access the complete DRG classification methodology, which CMS makes available equally to all members of the public. Complete and timely access to this methodology is crucial to our business because DRGs are one of the fundamental units of analysis for a variety of risk-adjusted outcomes. It is important that as CMS changes the DRG system, we retain access to the underlying methodology at a level equivalent to our experience today. There seems to be no guarantee that this would remain the case under the proposed move to CMS' adaptation of All Patient Refined Diagnosis Related Group (APR-DRG) classification system. As you know, the APR-DRG system is a proprietary system and nothing in the proposed rule provides us with any comfort that if the agency were to move to the Consolidated DRG system based on APR-DRGs that the same level of detail currently available would continue to be available. Our concern is that the vendor whose proprietary system CMS ultimately might use would have a significant advantage over other vendors in our line of business unless CMS were to insure that all interested parties were able to get access to source code, comprehensive system and user documentation, test data and quality support from the owner of the methodology at costs similar to what the industry now pays relative to the DRG system. In addition, it is crucial that this information be available well enough in advance of implementation (10-12 months) to be able to support our clients effectively.

Given the above issues, we strongly urge CMS, irrespective of the revision of the DRG system adopted by the agency, to ensure that as much detail about the new system is made available as CMS currently makes available under the existing DRG system. We also ask that details regarding the new system become available as soon as possible so that the impact of this system on hospital data processing, billing and management systems can be fully evaluated. We also ask that Medicare continue to make the DRG update process totally transparent. We need the same level of dialogue with CMS regarding DRG changes as has existed since the advent of the inpatient PPS.

Need for Time to Adapt to DRG Change

According to the proposed rule, CMS might move to the APR-DRGs as soon as October 1, 2006. Based on our experience in working with hospitals, we believe this would be an unrealistic time frame for such a dramatic change to the inpatient hospital payment system. Hospitals and other stakeholders would not have time to effectively plan for and implement this system. Quite simply, it is highly unlikely that all necessary actions could be accomplished by October 1 of this year and we therefore recommend that CMS not change the classification system in fiscal year 2007.

Again, Thomson appreciates the opportunity to comment on the proposed rule. We hope that the agency will carefully consider these comments as it moves forward regarding the DRG system. Thank you for your consideration.

Sincerely,

Doug Schneider
Senior Vice President

Submitter : **Mr. Alfred Lerz** **Date: 06/12/2006**

Organization : **President**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1451-Attach-1.PDF

#1451

Johnson
Memorial
Hospital, Inc.

Alfred A. Lee, President

Quality service from people who care

June 12, 2006

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Attention CMA-1488-P
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Re: CMS-1488-P; Medicare Program; Proposed Changes to Hospital Inpatient Prospective payment Systems and Fiscal Year 2007 Rates

Dear Dr. McClellan:

Johnson Memorial Hospital appreciates the opportunity to provide these comments regarding the Centers for Medicare & Medicaid Services (CMS) proposed rule: Medicare Program; Proposed Changes to Hospital Inpatient Prospective payment Systems and Fiscal Year 2007 Rates [CMS-1488-P]. The CMS proposed rule sets forth numerous and sweeping operational and policy changes to the hospital inpatient prospective payment system (IPPS). These comments outline strategies to more effectively meet the proposed rules' stated objective of creating incentives for hospitals to operate efficiently and minimize costs while at the same ensuring that payments are sufficient to adequately compensate hospitals or their legitimate costs.

Johnson Memorial Hospital supports the following recommendations:

- **Increase in Base Payments and Minimize Rate Increase.** The Connecticut Hospital Association has detailed in its comments the policies that have reduced funding to high wage states, penalized hospitals that appropriately care for transferred patients, and reduce funding of teaching programs. The detailed analyses provided by CHA shows how Connecticut hospitals like Johnson Memorial Hospital have consistently been disproportionately negatively affected by Medicare rate policies during the past decade. To bring Johnson Memorial Hospital up to the national average increase, an add on adjustment should be made to step up the basis pf payments so that the 2007 year payment would be at a level equal to what it would have been had Johnson Memorial Hospital been receiving the national average increase during the past decade. The add on needed for Johnson Memorial Hospital is 8%. In addition, Johnson Memorial Hospital believes at a minimum CMS should provide as a basic matter of policy, that no hospital receive payments less in the current year than in the previous year. Optimally, CMS should provide a minimum payment increase of 2%.

201 CHESTNUT HILL ROAD P.O. BOX 860 STAFFORD SPRINGS, CONNECTICUT 06076-0860
PHONE: 860 684-4251 / 860 739-2201 FAX: 860 684-8165 TDY: 860 684-8441

- **Wage Index Budget Neutrality**: CMS eliminated Critical Access Hospital (CAH) data from the wage index file it uses to compute the national average hourly wage (NAHW). Because CAHs have lower average hourly wages than the average PPS hospital, the elimination of this data results in an overstated NAHW, which consequently reduces payments because pf the budget neutrality adjustment. CMS should apply a positive budget neutrality adjustment in FY 2007 to compensate for the prior underpayments and should remove CAH data from all parts of the calculation.

- **DRG Changes**: Johnson Memorial Hospital supports moving to a DRG-weighting methodology based on hospital costs rather than charges, but requests a one-year delay in the proposed DRG changes given the serious concerns with the HSRV cc and SC-DRG methodology. Johnson Memorial Hospital opposes the introduction of a new classification system at this time, as the need for a new system is still unclear.

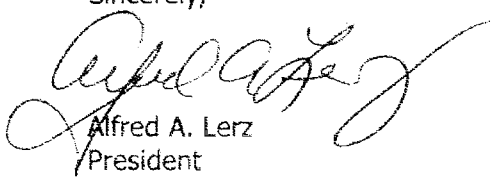
- **Quality**: When expanding quality data reporting requirements for hospitals to receive a full market basket update to include all 21 measures that are currently part of the hospital Quality Alliance's (HQA) public reporting, CMS should make the data collection prospective by requiring that hospitals pledge to submit data for patients discharged on or after July 1, 2006 rather than January 1, 2006. Johnson Memorial Hospital also urges CMS to continue to use HQA as the principal source of measures for hospital performance reporting and continue to align its efforts with those of HQA. Finally, it is critically important that CMS enhance its data submission, validation, and error correction processes, in order to ensure that hospitals are not inappropriately penalized for technical data issues.

- **Cost Outlier Threshold**: Johnson Memorial Hospital urges CMS to adopt the AHA-recommended outlier threshold methodology, lowering the outlier threshold.

- **Value-Based Purchasing**: the primary goal of value based purchasing, also as pay-for-performance systems, should be to facilitate the development of a healthcare system that is safe, effective, patient-centered, timely, efficient, and equitable, and the systems should be designed to support that goal. Pay-for-performance systems should: be practical for hospitals to implement; ameliorate, not exacerbate, the financial challenges already facing hospitals by providing and aligning physician and hospital's incentives, not imposing penalties' be based on measures that accurately assess a hospital's performance in delivering quality care; and compensate a hospital based on its own performance, irrespective of the performance of other hospitals.

We appreciate your consideration of these comments.

Sincerely,



Alfred A. Lerz
President

Submitter : **Dr. Michael Maves** **Date: 06/12/2006**

Organization : **American Medical Association**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1452-Attach-1.PDF

#1452.

AMA
AMERICAN MEDICAL ASSOCIATION

Michael D. Maves, MD, MBA, Executive Vice President, CEO

June 12, 2006

Mark B. McClellan, MD, PhD
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Medicare Program: Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates; Proposed Rule; 71 Fed. Reg. 23995 (April 25, 2006) [CMS-1488-P]

Dear Dr. McClellan:

The American Medical Association (AMA) appreciates this opportunity to provide our views on the graduate medical education provisions in the Centers for Medicare and Medicaid Services' (CMS) proposed rule concerning *Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates,* 71 *Fed. Reg.* 23995 (April 25, 2006). We have submitted comments on other sections of the rule in a joint letter with a number of other medical organizations.

RESIDENT TIME SPENT IN NONPATIENT CARE ACTIVITIES AS PART OF APPROVED RESIDENCY PROGRAMS

The Proposed Rule purports to "clarify" medical resident time spent in "didactic" activities for purposes of calculating Medicare direct medical education (DGME) and indirect medical education (IME) payments. The stated rationale for the exclusion of time devoted to these activities is that they are not "related to patient care." The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a non-hospital setting, such as a physician's office or affiliated medical school.

We urge CMS to rescind this "clarification," which is a reversal of agency policy. As recently as 1999, CMS' Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include "scholarly activities, such as educational seminars, classroom lectures ... and presentation of papers and research results to fellow residents, medical students, and faculty." [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins].
We support CMS' 1999 position. The activities cited are an integral component of the patient care activities engaged in by residents during their residency programs, and serve to improve care of individual patients. Disallowing time spent on these activities is at odds with your personal goal of improving the quality of care delivered in this country.

In addition, we are concerned that the exclusion of didactic activities is particularly stringent in non-hospital training programs which cannot be counted in the calculation of either the DGME and IME calculations. This approach would penalize hospital-based residency programs for providing their students with non-hospital training experiences, exacerbating other recent CMS policy changes that disadvantage training programs conducted outside the hospital. As you know, medical care increasingly is delivered outside the hospital and many of the quality measures CMS is proposing focus on this setting. To discourage hospitals from offering training in these settings is short-sighted to say the least.

We urge CMS to withdraw its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs. We further recommend that you review and revise CMS policies that discourage training programs in non-hospital settings where supervising physicians volunteer their services or provide this service at a nominal cost.

Sincerely,

Michael D. Maves, MD, MBA

Submitter : **Dr. Ronald Bissett** **Date: 06/12/2006**

Organization : **OSF St. Francis Hospital**

Category : **Physician**

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS or the Agency) proposed rule entitled Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates. 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in patient care activities. The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

Background
The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a nonhospital setting, such as a physician s office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not related to patient care .

This position reverses the Agency s position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty. [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency s 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs.

Residency Program Activities and Patient Care
I firmly believe that with the possible exception of extended time for bench research, there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician s educational development into an autonomous practitioner.

To separate out CMS s newly defined patient care time from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,
Ronald H. Bissett, MD
Medical Director - Quality Improvement and Patient Safety

Submitter : Dr. **Date: 06/12/2006**

Organization : United Family Practice

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS or the Agency) proposed rule entitled Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates. 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in patient care activities. The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

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I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,
Dr Rebecca Gurney

Submitter : Dr. William Shore **Date:** 06/12/2006

Organization : UCSF

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

As a faculty member of the UCSF Family Medicine Residency program, I appreciate the opportunity to comment on the Cneters for Medicare and Medicaid Services'proposed rule entitlesd "Medicare Program: Proposed Changes to the Hopsital Inpatient Perspective Payment Services and Fiscal Year 2007 Rules." 71 Fed. reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between residency training tiem spent in didactic activities and time spent in didactic activities in teh calculation of Medicare direct education (DGME) and indirect medical education (IME) payments.

Thank you.

Willilam B. Shore, MD, FAAFP
Professor Family and Community Medicine
University of California, San Francisco

Submitter :

Date: 06/12/2006

Organization : **Scripps Health**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1456-Attach-1.PDF

#1456

Scripps Health
4275 Campus Point Court, CP223
San Diego, CA 92121-1513
Tel 858 678-7204
Fax 858 678-7225
Komar.june@scrippshealth.org

June Komar
Senior Vice President
Strategic Planning and Business Development

June 12, 2006

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-14889-P and P2
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

RE: CMS-1488-P and P2, Medicare Program: Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates; Proposed Rule

Dear Dr. McClellan:

On behalf of the Scripps Health system with five hospital campuses in San Diego County, we appreciate the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) on the fiscal year (FY) 2007 inpatient prospective payment system (PPS) and occupational mix adjustment proposed rules.

As has been widely noted, this rule proposes the most significant changes in the calculation of diagnosis-related group (DRG) relative weights since 1983 by creating a version of cost-based weights using the newly developed hospital-specific relative values cost center methodology (HSRVcc). Also proposed is the redefining of the DRGs to account for patient severity, with implementation indicated as likely in FY 2008. In addition, the rule would update the payment rates, outlier threshold, hospital wage index, quality reporting requirements, and payments for rural hospitals and medical education.

While we support meaningful improvements to Medicare's inpatient PPS, and some of the proposed rule's provisions are appropriate, we have serious concerns about many of the proposed changes, particularly those to the DRG weights and classifications.

We would like to reference the comment letter from the American Hospital Association (AHA) submitted on June 8, 2006. We concur in the full range of comment provided by that letter and the extensive attachment to the letter. We concur in the recommendations from AHA, including:

- a delay of at least one year in implementing the rule

- flaws in cost-based weights methodology must be corrected, a process that could take much of the next year
- the need for a new classification system is still unclear; need must be demonstrated
- if and when need for a more effective classification system can be demonstrated, it should be implemented simultaneously with the new weighting system to provide better predictability and smooth the volatility created by these two, generally off-setting changes
- a transition period of three or four years to phase in the payment redistribution across DRGs and hospitals and to provide opportunity to modify unintended consequences that inevitably will result from changes of this magnitude.

The detailed comments enclosed with AHA's letter referenced above provide ample evidence of the magnitude of our hospitals' concerns with the proposed rule. Changes this sweeping need much more time to review, evaluate, model and adjust.

Scripps Health appreciates the opportunity to submit these comments. If you have any questions about our remarks, please contact me or Michael Bardin, senior director of public and government affairs at (858) 678-6893 or bardin.michael@scrippshealth.org.

Sincerely,

June Komar
Senior Director Strategic Planning and Business Development

Submitter : Ms. Suzanne Heck **Date:** 06/12/2006

Organization : Memorial Health University Medical Center, Inc.

Category : Hospital

Issue Areas/Comments

Cost-Based Weights: Outlier Threshold

Cost-Based Weights: Outlier Threshold

See Attached

DRG Reclassifications

DRG Reclassifications

See Attached

DRG Weights

DRG Weights

See Attached

DRGs: Severity of Illness

DRGs: Severity of Illness

See Attached

FTE Resident Count and Documentation

FTE Resident Count and Documentation

See Attached

GENERAL

GENERAL

See Attachment

HSRV Weights

HSRV Weights

See Attached

Occupational Mix Adjustment

Occupational Mix Adjustment

See Attached

CMS-1488-P-1457-Attach-1.DOC

#1457

June 12, 2006

The Honorable Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS –1488– P
P.O. Box 8011
Baltimore, MD 21244-1850

Re: CMS-1488-P – Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates; Proposed Rule (71 Fed. Reg. 23966, April 25, 2006).

Dear Administrator McClellan:

Thank you for the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule concerning the Hospital Inpatient Prospective Payment System. Memorial Health University Medical Center (MHUMC) is a 530 bed teaching hospital with Level I Trauma Center status located in Savannah, Georgia.

This letter will focus on the proposed changes to the DRG reclassifications and recalibrations of relative weights, occupational mix adjustment to the wage index, counting of resident time spent in nonpatient care activities as part of approved residency programs, and changes to the threshold amounts for outlier cases.

DRG Classifications and Relative Weights Background

Section 1886(d) of the Act specifies that the Secretary shall establish a classification system for inpatient discharges and adjust payments under the IPPS based on appropriate weighting factors assigned to each classification. Therefore, under the IPPS, inpatient hospital services are paid on a rate per discharge basis that varies according to the DRG. This assigned DRG weight is then multiplied by an individual hospital's payment rate per case. Each DRG weight represents the average resources required to care for cases in that particular DRG, relative to the average resources used to treat cases in all DRGs. Section 1886(d)(4)(C) of the Act further requires that the Secretary adjust the DRG classifications and relative weights at least annually to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources.

"DRG Reclassifications"

Under the proposed rule, effective with discharges occurring on or after October 1, 2006, Medicare would move to a "hospital-specific relative value cost center" (HSRVcc) DRG weighting methodology. In FY 2008 ("if not earlier" according to the proposed rule) the current 526 DRGs would be replaced by 861 "consolidated severity adjusted DRGs" (CS-DRGs). At CMS's own admission, these two proposals represent the "first significant revision of the Inpatient Prospective Payment System (IPPS) since its implementation in 1983."

Because it has approximately 42 million beneficiaries, the vast majority of who are over 65, the importance of the Medicare program to hospitals and the health care system generally is self-evident. Consequently, significant changes to the program, such as those proposed, have a profound effect. Moreover, one must also keep in mind that many Medicaid and private sector payers follow Medicare's payment methodology. This ripple effect reinforces the imperative that significant changes to the Medicare system, like the DRG weighting and classification changes, must be subjected to comprehensive and thorough analysis to ensure that the goals of the intended policy change are met without undue stress to the system.

MHUMC does not oppose moving from a charge to a cost-based DRG weighting methodology, but we do believe that a one-year postponement is necessary to allow for further analyses to address data and computation issues to ensure that the best possible methodology is ultimately implemented. We also support refinement of the DRGs but we believe that the proposed consolidated severity-adjusted DRGs (CS-DRGs) require further examination and likely modifications before implementation. We believe that these changes should be implemented simultaneously to ensure equity and minimize payment volatility for hospitals, but by no means do we believe that it would be prudent prior to October 2007. Finally, because they will likely result in the redistribution of over a billion dollars in Medicare payments among hospitals, a significant transition period should accompany the changes.

While seemingly a simple concept, developing "cost based" weights is actually a complex undertaking. Unlike other industries, the costs of providing hospital care cannot be identified directly. Consequently these costs must be 'estimated" using cost-to-charge ratios (CCRs) that are reported on hospitals' Medicare cost reports and applying them to charge amounts that are reported on Medicare claims. However, even then, there are various ways of utilizing the CCRs and implementing a cost-based methodology as the difference between MedPAC's methodology and the HSRVcc methodology demonstrates. Modifications to both of these methodologies should be considered. More work is needed to determine the best way to develop cost-based weights.

Although we are in favor of refining the DRGs to better reflect patient severity and complexity, we have serious concerns whether the proposed CS-DRGs achieve this goal. We appreciate CMS's recognition of the need to better account for patient severity in the IPPS (71 Fed. Reg. at 24026). It is important that the DRG classification system reflect those cases that involve the sickest and most complex Medicare patients. As a common site of care for these patients, ensuring that these cases are assigned to DRGs that adequately reflect the resources needed is a fundamental principle for teaching and safety net hospitals such as MHUMC. We have concerns, however, about the proposed CS-DRGs, in part because they reflect patient severity only and do not recognize service complexity. CMS agrees with these concerns, stating that "a method of recognizing technologies that represent

increased complexity should be included in the system." (71 Fed. Reg. at 24014). MHUMC is very interested in the proposed rule statement that CMS plans to "develop criteria for determining when it is appropriate to recognize increased complexity in the structure of the DRG system and how these criteria interact with the existing statutory provisions for new technology add-on payments." How CMS determines these criteria and their resultant impact on the classification system will have important implications for the IPPS.

In addition, we have serious concerns over the possibility of CS-DRGs being implemented sooner than October 2007. CMS's ultimate decision as to whether the grouper will be public or proprietary will have a significant impact on revenue and resources. Hospitals must be given the opportunity to plan appropriately from a cost and operational standpoint. If CMS decides that the software will be proprietary, MHUMC will be forced to purchase software for a new grouper and develop or purchase interfaces to allow the grouper to interface with existing operational systems. It could easily take a year to purchase and install the software, develop interfaces, test software and interfaces (which in itself will be extensive), and train staff on the new software. Costs associated with these requirements will be significant and unbudgeted. The issues are similar even if the grouper software is public rather than proprietary. Time must be allowed for scheduling and implementing updates, testing interfaces and training staff. Whether proprietary or public, managing these tasks will have a significant operational impact to the hospital.

Much time will be needed for training. Every coder will require training. The complexity of the new system will require additional time to code each account, which will again have a significant operational impact on HIM resources in addition to lengthening the revenue cycle. Experienced coding professionals are extremely difficult to recruit. Hospitals must have ample time to recruit and train coders in order to meet the demands of the proposed system and to avoid detrimental effects to the timeliness of coding. In addition, the detailed coding will create additional challenges in obtaining the detailed documentation necessary to code to the level of specificity that will be required. As a result physician education will be required.

Until such time that other payers have had time to evaluate and convert their systems to match Medicare's methodologies, we will likely be required to operate under multiple systems. This is very likely since payers historically follow Medicare's lead.

While the proposed rule changes are budget-neutral, over a billion dollars in Medicare payments would be significantly redistributed among hospitals as well as among DRGs. If implemented alone, the HSRVcc DRG weighting methodology will, on average, reduce reimbursement to teaching and safety net hospitals such as MHUMC by three million dollars in 2007. This average annual loss is lessened by nearly 50% once the CS-DRGs are added. MHUMC respectfully requests that CMS delay the implementation of the HSRVcc DRG weighting methodology for one year, at which time CS-DRGs would have been fully tested, providers will have time to resolve system issues and be trained on their software changes. This much-needed delay would allow for a better assessment of these proposed changes with the opportunity to avert unintended negative effects. Anything less, conflicts with the intent of the proposed changes, which is to create a classification and payment system that more accurately reflects the severity and resources involved in the delivery of care for each DRG. A delay would be more prudent than implementing a "half-fix", thus relieving safety net hospitals such as MHUMC from unjust reductions. It is critical that the underlying policy rationale for the change be

sound and, if that test is met, implementation of that change be accomplished with a methodology that best achieves the policy goal.

MHUMC is also concerned over some of the DRGs that will experience payment reductions, particularly DRGs involving cardiac care. While, the payment reductions could "potentially reduce the incentives for the further development of specialty hospitals" (71 /Fed. Reg. at 24006), our concern is that the reductions would also have a significant adverse affect on safety net and teaching hospitals such as MHUMC that provide a significant amount of cardiac care. Unlike many specialty hospitals, however, we have an emergency room, treat significant numbers of Medicaid and uninsured patients, and also accept complex cardiac cases. Cardiac procedures involving stents, both drug eluting and non-drug eluting, would see payment reductions. These imposed reductions will do nothing to limit the ability of Specialty Hospitals to cherry-pick, but instead, they penalize safety net and teaching hospitals for providing the much-needed services to the community's underserved population.

Because Medicare is a critical revenue source for hospitals, to the extent the changes result in significant payment reductions, these reductions must be phased in over a reasonable period so that hospitals have time to transition to the new system without experiencing significant and relatively unexpected disruptions to operations. Historically, Medicare changes of significant magnitude have included some type of transition period. The move to PPS capital was transitioned in over a 10 year period; implementation of operating IPPS was transitioned in over 4 years; eliminating day outliers was transitioned in over 4 years; and removing the costs of teaching physicians and residents in the calculation of the wage index was transitioned over 4 years. While it is unclear what an appropriately devised new DRG classification and weighting system might look like, it is obvious that such a change will still involve the redistribution of hundreds of millions of dollars. Accordingly a significant transition period must accompany any final changes.

Occupational Mix Adjustment to Wage Index Background

Section 1886(d)(3)(E) of the Act provides for the collection of data every 3 years on the occupational mix of employees for each short-term, acute care hospital participating in the Medicare program, in order to construct an occupational mix adjustment to the wage index. The purpose of the occupational mix adjustment is to control for the effect of hospitals' employment choices on the wage index. For example, hospitals may choose to employ different combinations of registered nurses, licensed practical nurses, nursing aides, and medical assistants for the purpose of providing nursing care to their patients. CMS contends that the varying labor costs associated with these choices reflect hospital management decisions rather than geographic differences in the costs of labor.

"Occupational Mix Adjustment"

Although we understand that the intent of the occupational mix adjustment is to control for the effects of managements employment choices, the application of this methodology penalizes providers whose mission is to provide for the healthcare needs of the community, and rewards those providers that do not. MHUMC is the regions safety net hospital and the exclusive provider of vital services such as Level I Trauma, Neonatal Intensive Care, Pediatric Nephrology, High Risk Obstetrics, and Pediatric Cardiology just to mention a few. It is MHUMC's decision to provide these vital but non-profitable

services to our community based on the healthcare needs of our population. Higher skill levels are required and higher labor costs are inherent to services such as these.

When adjusting the wage index to remove occupational mix differences, the adjustment fails to recognize differences between providers in the kinds of services that they provide, services that require a higher skill mix. Unfortunately, the only thing the occupational mix is accomplishing is the unjustified reduction in reimbursement to hospitals providing vital services to their community, services that are provided based on community need rather than profitability. In order to successfully remove the effects of occupational mix differences, the hospitals would have to deliver the exact same kinds of services with the same skill level requirements.

In addition, the intent to publish the final rule before CMS is able to make available to providers the final Occupational Mix Adjusted Wage Index is utterly ridiculous and reckless. Without the opportunity to review, it is inevitable that these adjusted wage indices will be riddled with errors. These errors could cost a provider millions in reimbursement and hundreds of thousands in litigation to rectify.

The recent decision by the Second Circuit Court of Appeals ordering CMS to apply the occupational mix adjustment to 100% of the wage index in fiscal year 2007 only exasperates this detrimental policy. The Courts decision obviously neglected to consider the negative ramifications of its actions. This is a biased decision that benefits one at the expense of many. The CBSA Wage Index, with all of its flaws and inequities, is a better indication of a provider's Wage Index than the current Occupational Mix Adjusted Wage Index fiasco. CMS should immediately repeal the Occupational Mix Adjustment to the Wage Index and begin work on a wage index methodology that is sound.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 section 501(c) directs the General Accounting Office to conduct a study upon enactment to determine (1) the appropriate level and distribution of Medicare payment in relation to costs for short-term general hospitals under the inpatient prospective payment system and (2) the need for geographic adjustments to reflect legitimate differences in hospital costs across geographic areas, kinds of hospitals, and types of cases. The lack of consideration given by the Occupational Mix Adjustment to the Wage Index to the kinds of hospitals and types of cases is a complete disregard to the intent of the MMA.

MHUMC supports the development of a hospital specific wage index methodology adjusted to reflect legitimate differences in hospital costs across geographic areas, kinds of hospitals, and types of cases. Any Wage Index Methodology must eliminate the current inequities; the biggest of all being the ability of providers that are less committed to their community from receiving undeserved reimbursement by simply riding the coattails of the more advanced hospitals within their CBSA.

Resident Time in Nonpatient Care Activities Background

In addition to prospective payment for inpatient hospital services, prospective payment system (PPS) teaching hospitals receive payments for both direct and indirect costs of Medical Education, which are designed to cover the direct costs and indirect operating, or patient care, costs that are associated with approved intern and resident programs. In determining the total number of FTE residents, 42 CFR

§413.86(f) is applicable for both GME and IME. Subject to the weighting factors, the count of FTE residents is determined as follows:

1. Residents in an approved program working in all areas of the hospital complex may be counted.
2. No individual may be counted as more than one FTE
3. The time residents spend in nonprovider settings such as freestanding clinics, nursing homes, and physicians' offices in connection with approved programs is not excluded in determining the number of FTE residents in the calculation if the resident spends his or her time in patient care activities, and the hospital incurs the cost of the resident's salary and fringe benefits while the resident is training in the nonhospital site and the hospital is providing reasonable compensation to the nonhospital site for supervisory teaching activities.

"Time Spend in Nonpatient Care Activities as part of Approved Residency Programs"

In the proposed FY 2007 Inpatient PPS Rule CMS purports to "clarify" its policy to exclude the time residents spend in "nonpatient care activities" for purposes of calculating Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments. According to CMS these "nonpatient care activities" include didactic activities, such as journal clubs, classroom lectures, and seminars. In determining whether the time can be counted, CMS distinguishes between whether the activity is occurring in a nonhospital or hospital site and applies different rules.

For time spent in nonhospital sites, CMS states that resident time spent in didactic activities cannot be included in either a hospital's DGME or IME resident count if it occurs in a nonhospital site (such as a physician's office, medical school, etc.). CMS asserts that this time is not allowable because the Medicare statute states that in order for the hospital to count resident time in nonhospital settings, it must be "spent in activities related to patient care" (DGME statute) or "in patient care" (IME statute).

For time spent in hospital sites, resident time in "all areas of the hospital complex" may be counted for DGME purposes as long as the resident is in an approved program, regardless of whether or not the resident is engaged in patient care activities. CMS states that the hospital complex consists of the hospital and hospital-based providers and subproviders. However, this position is in contrast to IME payments, in which only time spent in patient care activities may be counted.

CMS states that while they have not explicitly defined "patient care activities" they have applied the "plain meaning of that term" which according to CMS refers to the "care and treatment of a particular patient, or to services for which a physician or other practitioner may bill" and "would certainly not encompass didactic activities." This position is in stark contrast with a letter CMS wrote in 1999 stating that CMS interprets "patient care activities" broadly including scholarly activities (September 24, 1999 letter from Tzvi Hefter to Scott McBride).

Unlike the nonhospital site statue, there is no legislative requirement that the resident be engaged in "patient care activities" for purposes of counting residents within the hospital setting for DGME payments. Thus, all resident time in the hospital complex may be counted for DGME payments, so long as the resident is in an approved program. There is also no specific reference to patient care

activities in the IME legislation. CMS's position to excluded resident didactic time in hospital settings for IME payments rests solely on a presumption that because IME payments reflect an adjustment to DRG payment, these payments inherently are related to patient care and therefore the residents must be engaged in patient care to be counted.

MHUMC disagrees with CMS' position in this year's proposed rule that no didactic time may be counted for IME payment calculations, regardless of whether it occurs in a hospital or nonhospital site. Didactic activities in which residents participate are an integral part of the patient care experience and therefore such resident time should be counted for both IME and DGME payment purposes regardless of the setting. In addition, the rule raises many questions concerning how such time would be adequately documented and the increased administrative burden on hospitals associated with the documentation. MHUMC respectfully requests that CMS change its position on this issue in the final rule and confirm its interpretation as set forth in its 1999 letter.

Operating Payment Rate - Outliers Background

Section 1886(d)(5)(A) of the Act provides for payments in addition to the basic prospective payments, for "outlier" cases involving extraordinarily high costs. To qualify for outlier payments, a case must have costs above a fixed –loss cost threshold amount. Under section 1886(d)(5)(A)(iv) of the Act, outlier payments for any year must be projected to be not less than 5 percent nor more than 6 percent of total operating DRG payments plus outlier payments.

"Operating Payment Rates"

In addition to serving a disproportionate share of low-income patients in our community, MHUMC also has a significant number of cases involving extraordinarily high costs due to our Level I trauma status and the fact that we are a teaching hospital. MHUMC is the kind of hospital that the outlier payment was established for and we are not getting our just share, more than likely due to those providers that have manipulated the current outlier system. It is MHUMC's hope that the provisions of the final rule will better target outlier payments to the most costly cases because it is obvious that just raising the threshold is not having the desired effect. We believe that if the threshold continues to increase, outlier payments will all but disappear for hospitals such as MHUMC that are not gaming the system.

We appreciate CMS's effort to address the flaws in the outlier methodology, however we have serious concerns on the direction this issue is going. The rule proposes establishing a fixed-loss cost outlier threshold equal to the inpatient PPS rate for the DRG, including indirect medical education (IME), disproportionate share hospital (DSH), and new technology payments, plus $25,530. While this is not a particularly sizable increase from the FY 2006 payment threshold of $23,600, we remain very concerned that the threshold is too high. The American Hospital Association estimates that actual outlier payments for 2006 will be .47 percentage points lower than the 5.1 percent of funds withheld from hospitals to fund outlier payments. CMS spent only 3.8%, or $1.5 billion less than set aside in FY 2005, and only 3.5%, or $1.3 billion less than the funds withheld in 2004.

In the rule, CMS proposes to use a one-year average annual rate-of-change in charges per case from the last quarter of 2004, in combination with the first quarter of 2005, to the last quarter of 2005, in combination with the first quarter of 2006, to establish an average rate of increase in charges. This results in a 7.57% rate of change over one year, or 15.15% over two years. MHUMC appreciates that CMS is proposing this methodology in an effort to avoid using data from 2003 when charges may have been atypically high. However, using the proposed charge inflation methodology will only result in an inappropriately high outlier threshold and a real payment cut to hospitals. We strongly oppose using this methodology to estimate the outlier threshold. MHUMC urges CMS to consider the American Hospital Association's proposed methodology put forth to CMS in their comment letter dated June 8, 2006. Their proposed methodology incorporates both cost inflation and charge inflation. We believe that the use of more than one indicator will make the threshold calculation more accurate and reliable.

MHUMC strongly urges CMS to adopt AHA's methodology, which is applicable regardless of what DRG changes are made or not made in FY 2007. The fixed-loss threshold necessary to achieve 5.1% in FY 2006 should have been set a $21,275 as compared to the $23,600 actually utilized. MHUMC believes that CMS under spent the funds set aside for outliers by an estimated $3 billion over FYs 2004, 2005, and 2006. This is a real cut to payments to hospitals that cannot be recouped. If CMS leaves the threshold at $25,530, rather than dropping it to $24,000, we believe that CMS will again significantly under spend by over $300 million. We urge CMS to adopt AHA's recommended methodology to lower the outlier threshold.

Should CMS decide to disregard AHA's proposed methodology, we would be in support of eliminating the separate reimbursement for outliers altogether. Instead, a more equitable approach would be to simply increase the standardize payments to providers by 5.1 percent that has been set aside to fund outliers. This would at least provide MHUMC and other deserving providers with a much deserved increases in its standardize payments instead of the inappropriate 2.23 percent it is currently struggling to survive under. This methodology would completely remove the ability to game the system and although still lacking, would be more desirable to deserving providers that do not abuse the system.

Thank you for considering our remarks on the proposed rule. If you have any questions about our comments, please feel free to contact me.

Sincerely,

Suzanne Heck
CFO, MHUMC

CC: Bob Colvin, President and CEO, MHUMC
Darcy Davis, VP of Finance, MHUMC
Margaret Gill, Senior VP of Operations, MHUMC
Amy Hughes, VP of Government Relations, MHUMC

Submitter : **Ms. Kimberly Cantor** **Date: 06/12/2006**

Organization : **AWHONN**

Category : **Health Care Professional or Association**

Issue Areas/Comments

EMTALA

EMTALA

See Attachment

GENERAL

GENERAL

See Attachment

CMS-1488-P-1458-Attach-1.PDF

#1458

AWHONN
Association of Women's Health, Obstetric and Neonatal Nurses

June 12, 2006

Center for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244

Re: Proposed Rule - Hospital Inpatient Prospective Payment System (File Code: CMS-1488-P)

Dear Center for Medicare and Medicaid Services:

The Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) appreciates the opportunity to provide comment on the Center for Medicare and Medicaid Services (CMS) proposed rule regarding the Hospital Inpatient Prospective Payment System; Section IV: Other Decision and Proposed Changes to the IPPS for Operating Costs and GME Costs; Part J: Hospital Emergency Services Under EMTALA (§489.24) as published in the Federal Register on April 25, 2006 (Vol. 71, No. 79, Pages 24117 – 18).

AWHONN is a national membership organization of 22,000 nurses, and it is our mission to promote the health and well-being of women and newborns. AWHONN members are staff nurses, nurse practitioners, certified nurse-midwives, and clinical nurse specialists who work in hospitals, physicians' offices, universities, and community clinics throughout the United States. Through AWHONN, our members receive the most up-to-date information and cutting-edge, high quality resources that help enhance safety and provide superior patient care.

Section IV – Part J.: Hospital Emergency Services Under EMTALA

AWHONN concurs with the conclusions of the EMTALA TAG and CMS that limiting the diagnosis certification of "false labor" to physicians alone is overly restrictive. Current EMTALA language ignores the training and skills of certified nurse midwives (CMN), registered nurses (RN) and other advance practice nurses such as nurse practitioners (NP) and clinical nurse specialists (CNS), who have specialized education and training in obstetric care and labor and delivery. These health care professionals, in addition to physicians alone, can lend to their skills to bring further efficiency and effectiveness to a health care setting for diagnosing "false labor."

Part J background explains that the EMTALA TAG and CMS are quite clear in their support and intent to incorporate certified nurse-midwives into the "false labor" certification process. This support is based on comments received by the EMTALA TAG from the American College of Nurse-Midwives and the American College of Obstetricians and Gynecologists and its recommendations to CMS. AWHONN fully endorses this change.

However, CMS proposes additional changes to the language under §489.24(b) to more fully incorporate "other qualified medical personnel" beyond physicians into the diagnosis certification realm. Regarding this change, AWHONN is concerned with the term "medical." The proposed language ignores the distinctions made elsewhere in EMTALA statute and regulations between physicians and health care practitioners, medical services and health care services. By the use of the word "medical," the proposed language could be interpreted in an exclusionary manner to continue to limit diagnosis certification solely to physicians. AWHONN is hopeful this consequential limitation is unintended.

Thus, AWHONN proposes refining the language set forth in this proposed regulation to more accurately reflect the stated intentions of the EMTALA TAG and CMS, and to actively incorporate the valuable expertise of CNMs and other registered nurses. We recommend the regulation language read as follows:

§489.24(b)"...A woman experiencing contractions is in true labor ***unless a physician, certified nurse-midwife, or other qualified health care professional (as determined by the hospital in its bylaws or rules and regulations) acting within his or her scope of practice as defined by State law, certifies that,*** after a reasonable time of observation, the woman is in false labor."

Adopting the above language will allow for the inclusion of various health care professionals, who are permitted under their hospital bylaws and as defined by their scope of practice, to use their expertise in helping create more efficient and effective health care delivery systems in the U.S. without concerns of medical liability and noncompliance with EMTALA.

Again, thank you for the opportunity to comment. AWHONN recommends using the refined language above in the final regulation. If you have any questions, please do not hesitate to contact me at (202) 261-2400.

Sincerely,

Karen S Thomas

Karen Tucker Thomas, CAE
Executive Director

Submitter : Dr. Daniel Van Durme **Date:** 06/12/2006

Organization : Florida State University College of Medicine

Category : Academic

Issue Areas/Comments

GME Payments

GME Payments

As a chair of a department of family medicine, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS or the Agency) proposed rule entitled Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates. 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in patient care activities. The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

Background
The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a nonhospital setting, such as a physician s office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not related to patient care .

This position reverses the Agency s position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty. [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency s 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs.

Residency Program Activities and Patient Care
I firmly believe that with the possible exception of extended time for bench research, there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician s educational development into an autonomous practitioner.

In addition, I cannot conceive of how I would be able to administratively comply with this requirement. It would require documentation that would be extremely burdensome, if possible at all. To separate out CMS s newly defined patient care time from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Where am I to find the funding to pay for the staff person that would be needed to sit in on each of these didactic sessions and keep count of patient care time? The documentation requirements that this position would necessitate are unreasonable and would cause an extremely large administrative burden.

To reiterate, I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

CMS-1488-P-1459-Attach-1.DOC

As a chair of a department of family medicine, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS or the Agency) proposed rule entitled *"Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates."* 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in "patient care activities." The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

Background

The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a nonhospital setting, such as a physician's office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not "related to patient care".

This position reverses the Agency's position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include "scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty." [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency's 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs.

Residency Program Activities and Patient Care

I firmly believe that with the possible exception of extended time for "bench research," there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician's educational development into an autonomous practitioner.

In addition, I cannot conceive of how I would be able to administratively comply with this requirement. It would require documentation that would be extremely burdensome, if possible at all. To separate out CMS's newly defined "patient care time" from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Where am I to find the funding to pay for the staff person that would be needed to sit in on each of these didactic sessions and keep count of patient care time? The documentation requirements that this position would necessitate are unreasonable and would cause an extremely large administrative burden.

To reiterate, I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Submitter : Mr. Russ Ranallo **Date:** 06/12/2006

Organization : Owensboro Medical Health System

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1460-Attach-1.DOC

#1460

June 12, 2006

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Attn: CMS-4105-P
P.O. Box 8010
Baltimore, MD 21244-1850

RE: CMS 1488-P and P2, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment System and Fiscal Year 2007 Rates; Proposed Rule

Dear Dr. McClellan:

Owensboro Medical Health System (OMHS) of Owensboro, Kentucky appreciates the opportunity to comment on the proposed rule concerning the Hospital Inpatient Prospective Payment System.

My comments in this letter will be directed toward the wage index and occupational mix adjustments as we feel these are important issues that deserve special attention. A colleague in my office will be providing separate comments on the remaining parts of the proposed rule.

Geographic Reclassifications - Single Hospital MSA surrounded by Rural Counties

CMS has asked for comments on a number of issues related to the topic above. While OMHS does not exactly fit the definition provided, we believe this is an important issue and ask CMS to consider allowing all single hospital CBSAs the opportunity to reclassify their wage index and not just those surrounded by Rural Counties.

Owensboro Medical Health System is in a single-hospital CBSA (#36980) with a current wage index of .8797. OMHS is licensed for 415 beds (4th largest in Kentucky) with annual Medicare Admissions of 8,100 (most in western Kentucky) and 2,900 employees (most in Western Kentucky). OMHS is the referral hospital for a ten-county area. It is the only hospital that offers open-heart surgery, orthopedic surgery, neurosurgery, and OB services within this area.

The following surrounds OMHS:

1. Another urban area (Evansville, IN CBSA # 21780), which has a lower wage index than Owensboro.
2. Two Critical Access Hospitals (Ohio County Hospital #180041 and Perry County Hospital #150070)
3. A two hospital urban area (Bowling Green CBSA #14540, located 50 miles away) where both hospitals have reclassified their age index to a higher area (Nashville, TN). One hospital is under RRC status.

4. A single hospital CBSA (Elizabethtown, KY CBSA # 21060, located 40 miles away) with a reclassified wage index (Louisville, KY)
5. A rural hospital (Regional Medical Center #180093) with a reclassified wage index (Evansville, IN).
6. A small rural hospital (Muhlenberg Community Hospital # 180004).

OMHS could reclassify to a rural status under Title 42 412.103, which allows urban hospitals to be reclassified as rural if, as a rural hospital, the hospital would qualify as a Rural Referral Center (RRC) or Sole Community Hospital (SCH). OMHS meets the criteria to qualify both as a RRC and SCH. However, under 42 412.230 a hospital that achieves rural status though 412.103 cannot receive a reclassification by the MGCRB based in this acquired status.

OMHS, therefore, is the only in the region that lacks the opportunity to reclassify its wage index, even though the hospital could meet the SCH and RRC status criteria. This has led to OMHS receiving Medicare payments that are lower than other regional hospitals that offer similar complexity of services.

The two critical access hospitals in the region receive 101% of cost while the four reclassified hospitals receive payments in excess of the wage cost they incur. Each instance of reclassification in the area amount to payment increases of at least $2 million annually while in some cases (Medical Center of Bowling Green) the impact amounts to almost $6 million more annually even though this provider pays wages five percentage points less than OMHS.

These higher reimbursements put OMHS at a disadvantage. OMHS competes with all of these hospitals in the region. It is difficult to compete for specialized personnel, capital (building replacement, etc.), and technology (specialized imaging, devices, etc.) when a hospital in the region annually receives $6 million more than its costs incurred for wages and OMHS receives only cost.

The response form CMS in the past has been that OMHS receives a wage index value that directly reflects the wages it pays and the wage index is operating with substantial precision in our situation. This is correct. However, we do not agree that OMHS should be unable to access reclassification when faced with competitors that are receiving wage indices that are substantially higher than what they pay in wages. The CMS position would be acceptable if reclassified hospitals were capped at their own wage rate/index though reclassification. For example, a hospital that resided in an area with an index of .80 and paid wages equivalent to a .85 could reclassify to a .88 wage index area but would only be paid at the .85 hospital specific rate.

We believe the OMHS situation demonstrates the circumstances facing single hospital CBSAs. Currently there are about 60 single hospital CBSAs across the country. We recommend that CBSA hospitals be given opportunity to reclassify their wage index.

We also recommend if a hospital in a single hospital CBSA can demonstrate that it meets the criteria for SCH and RRC status (other than being in a rural area) then it should be allowed to

reclassify as if under those special status indicators. We feel these hospitals are just as critical and important to their communities as their rural counterparts and should be allowed to access the benefits provided by this status. This status also would allow the hospital to reclassify to a labor market area that is further away that other, closer urban labor markets. This would address the needs of the commenter in the proposed rule without having to adjust other proximity standards.

Geographic Reclassification – Multi-campus Hospitals

OMHS agrees with the American Hospital Association comments on this point and recommends that CMS continue to allow multi-campus hospital systems to use data from all campuses as a proxy for individual campuses to reclassify to an area where another one of the campuses is located given how few hospitals are expected to use this option.

Wage Index – Budget Neutrality

CMS eliminates the CAH data from the wage index file it uses to compute the national average hourly wage (NAHW). For FY 2007, almost 1,200 CAHs (approximately 24%) of all inpatient PPS hospitals have been eliminated from the file. Because CAHs have lower average hourly wages (AHWs) than the average PPS hospital, the elimination of this data results in an overstated NAHW. While the NAHW has been increasing, the systematic withdrawal of low-wage hospitals has artificially inflated the NAHW to some extent. This artificial increase is included in the negative budget neutrality adjustment that consequently reduces payment, resulting in the national inpatient PPS operating payments being understated by an estimated $1.5 billion over five years (2003-2007). Thus, we believe that CMS should apply a positive budget neutrality adjustment in FY 2007 to compensate for the underpayments.

Critical Access Hospitals (CAHs)

OMHS agrees with the CMS interpretive guidelines on the relocation of CAHs published on November 14, 2005. Many CAHs received their status through state designation and not through distance requirements. OMHS is near two CAHs that if allowed to move even a few miles without guidelines could cause competitive concerns. We do not support a safe harbor and believe the establishment of one could cause harm to other hospitals currently near CAHs.

Occupational Mix Adjustment

As a result of a decision handed down by the U.S. Court of Appeals for the Second Circuit on April 3rd in Bellevue Hospital Center v. Leavitt, CMS released a proposed rule on May 12th revising the occupational mix adjustment portion of the FY 2007 inpatient PPS proposed rule. Under the court ruling, CMS must collect new data on the occupation mix of hospital employees and fully adjust the area wage index for FY 2007.

On July 23, 2002 Glenn Hackbarth, Chairman of the Medicare Payment Advisory Commission provided testimony to the Subcommittee on Health Committee on Ways and Means regarding adjusting Medicare payments for local market input prices.

According to the testimony the objective of the occupational mix adjustment "is to account for differences beyond the control of the provider – local market prices – and not for the differences created by management decisions – the mix of labor. Thus, using aggregate wages and hours may distort the wage index by elevating the average wage per hour in markets where providers employ a costly mix of labor and depressing the average wage in markets where hospital employ a relatively inexpensive labor mix. These inaccuracies in the wage index may have substantial effects on payment accuracy."

Cost Centers – We agree with the CMS methodology in limiting the nursing personnel within the cost centers listed should be included in that category for the purposes of consistency. However, there are some cost centers we would like CMS to review for inclusion in future surveys (Cardiac Catheterization, for example) that we believe are appropriate for the survey.

Definitions and Covered Employees – While we have found the current survey to be relatively straight forward (with a few exceptions discussed through audit) we ask CMS to consider other categories in future surveys where occupational mix may be appropriate to incorporate (therapy, pharmacy, etc.).

Non-Responsive Hospitals – We ask that hospitals that do not participate in the survey should not benefit from their lack of participation or from the participation of others. We recommend that CMS assign the hospital the **highest** occupational mix adjustment factor for it labor market area. We realize that this may penalize some hospital and have concern over it. As another alternative, we would ask CMS to consider a methodology that penalizes hospitals that do not participate but does not disadvantage other hospitals in the same labor area.

Please feel free to contact me at 270-688-2855 or RRANALLO@OMHS.ORG if you have questions of if you need additional information.

Sincerely,

Russ Ranallo
Vice President, Financial Services

Submitter : Dr. Michael Munger **Date:** 06/12/2006

Organization : Dr. Michael Munger

Category : Individual

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS or the Agency) proposed rule entitled Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates. 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in patient care activities. The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

Background
The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a nonhospital setting, such as a physician s office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not related to patient care .

This position reverses the Agency s position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty. [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency s 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs.

Residency Program Activities and Patient Care
I firmly believe that with the possible exception of extended time for bench research, there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician s educational development into an autonomous practitioner.

To separate out CMS s newly defined patient care time from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,

Michael Munger MD

Submitter : Dr. George Saba **Date:** 06/12/2006

Organization : University of California, San Francisco

Category : Other Health Care Professional

Issue Areas/Comments

GME Payments

GME Payments

As a faculty member of a Department of Family and Community Medicine, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS or the Agency) proposed rule entitled Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates. 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in patient care activities. The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

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In addition, I cannot conceive of how I would be able to administratively comply with this requirement. It would require documentation that would be extremely burdensome, if possible at all. To separate out CMS s newly defined patient care time from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Where am I to find the funding to pay for the staff person that would be needed to sit in on each of these didactic sessions and keep count of patient care time? The documentation requirements that this position would necessitate are unreasonable and would cause an extremely large administrative burden.

To reiterate, I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Submitter : **Mr. Daniel Myers** **Date: 06/12/2006**

Organization : **Florida Hospital**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

Please see attached comments

CMS-1488-P-1463-Attach-1.DOC

CMS-1488-P-1463-Attach-2.DOC

#1463

June 12, 2006

Mark McClellan, M.D., Ph.D., Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1488-P and P2f
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

RE: CMS-1488-P and P2, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates; Proposed Rule.

Dear Dr. McClellan:

On behalf of Florida Hospital (FH), I appreciate the opportunity to submit comments regarding the Inpatient Prospective Payment System (IPPS) rule changes for 2007. IPPS beneficiaries account for more than 40,000 discharges per year at FH. We serve as both a tertiary referral center (for cardiovascular, neuroscience, orthopedic, cancer) and as a community hospital for the Orlando metropolitan area. We are committed to providing quality services to our patients.

We applaud CMS's efforts to align costs and payments. However, we do not believe that the 2007 proposed payment rates accomplish this objective. CMS has not presented evidence that the proposed methodology improves payment accuracy. Within the calculations there are several material errors, including mismatching data (sometimes using weighted data, sometimes un-weighted data) that dramatically change the 2007 proposed rates. Plus, the two-step approach of changing to HSRVcc in 2007, followed by another change to severity-adjusted in 2008 will present multiple operational and financial challenges. Until these issues can be resolved, we recommend that CMS maintain the current payment methodology for at least another year, work with the provider community to develop a proposal, and implement changes in a phased-in approach. Specifically, we are proposing that:

- CMS continue to work toward improving payment accuracy over time, by ensuring that the methodology chose does indeed match costs with payments and is free of errors.

- Because of the errors mentioned below, DELAY for at least one year any implementation of HSRVcc weights, or change to a cost-based methodology.
- Do not implement severity-adjusted weights in 2007, because not all data (outliers, transfers) has been provided by CMS. We can not determine if the CMS severity-adjusted proposal is accurate or not.
- Once a decision is reached on the previous two points, consider phasing-in that strategy over three years. Give hospitals the option to electively opt-out of the phase-in and move immediately to the 100% new rates and payment structure (similar to the implementation of IPF PPS and IRF PPS).
- Support for CMS's proposal to clarify EMTALA obligations, but with two modifications discussed in detail below.
- Agree with greater transparency of healthcare information, but must ensure that charges are distinguished from patient responsibility amounts. See detail below.

Please see our detailed comments below.

Sincerely,

Daniel Myers
Director Revenue Management
Florida Hospital
601 East Rollins Street
Orlando, FL 32803

DRG HSRVcc Weights

We appreciate the CMS attempt to improve the match of payments with resources consumed; however, we have serious concerns with the methodology CMS utilized to craft this proposal. There are multiple errors in the calculation:

- Weights for organ transplants are incorrect. CMS did not correctly exclude the organ acquisition costs.
- Trimming hospitals with a CCR above 1.96 standard deviations from the geometric mean caused hospitals to be excluded from the CCR calculation. However, those same hospital charges are included in total charges used to estimate cost. This appears to be a mismatch.
- All hospitals are weighted the same in some CCR calculations. When those un-weighted CCR numbers are utilized with other numbers that are weighted for volumes, the resulting calculations are incorrect. CMS should only use weighted volumes.
- The CMS proposed methodology is different from MedPAC's recommendation. CMS states in its rule that it is making changes for calculation simplicity. Unfortunately these changes have resulted in payment swings that MedPAC did not intend, and have violated the CMS stated objective to match payments more accurately.
- CMS utilized 2003 cost report data, but many products on claims now were not included in the costs during 2003, resulting in an incorrect calculation of CCR's for those services (specifically drug eluting stents, CRT-D implants)
- There are likely other issues that are not fully understood by the hospital community, because CMS did not release all the data and methodology behind the proposed calculations.

There are too many errors, the data appear hastily constructed, and we do not support the HSRVcc methodology CMS has proposed. CMS should delay for at least 1 year the implementation of HSRVcc when errors could be fixed, should convene workgroups to determine if other cost-based methodologies would improve payment accuracy, should release all data and calculations, and should provide more than 60 days lead time for hospitals to implement all the changes.

DRG Severity Adjustments

We support the concept of adjusting payments based on patient severity, but as with the HSRVcc weights, the CMS proposal contains errors and does not provide all the data needed to understand total operational and financial impacts.

- Information on transfer reductions was not provided. Which consolidated severity-adjusted DRG's would pay as a transfer? Which DRG's would have the normal transfer formula and which would utilize the special transfer payment formula?

- Information on outlier thresholds was not provided. Since the better matching of outliers to payments was an apparent goal of CMS, why were we not provided with the outlier threshold so we could determine if that objective had been met?
- The proposal by CMS to reduce payments by 2% with the severity adjusted DRG's (to account for changes in coding practice) is blatantly harmful to hospitals. CMS had no data to determine what that adjustment should be and would just be guessing at a payment reduction.

It is impossible to adequately understand the impact that severity-adjusted DRG's would bring. CMS should not implement severity adjusted changes for at least another year. In addition, CMS should work with the hospital community to identify a system that will work for CMS, and the other commercial payers that currently utilize DRGs. In addition, CMS should not make any prospective adjustment to payments based on potential impacts from changes in coding patterns.

EMTALA Clarifications

Florida Hospital supports CMS's proposed revision/modification to clarify EMTALA obligations for any hospital with specialized capabilities.

- Modify 489.24 (f) indicating any participating hospital with specialized capabilities or facilities, even if it does not have a dedicated emergency department, may not refuse to accept an appropriate transfer if the hospital has the capacity to treat the individual.
- Impact of clarification - A hospital without an ED, such as specialty hospitals (Heart, Ortho, Cancer, etc.), have to accept emergency transfer requests for the services offered even though the hospital does not have an ED.

Florida Hospital supports revising the definition of "labor".

- Revise 489.24 (b) revise allowing a physician, certified nurse-midwife, or other qualified medical person acting within his or her scope of practice as defined in hospital medical staff bylaws and State law, determine and document that, after a reasonable time of observation, the woman is in false labor.
- Impact of revision – Allows someone other than a physician to determine if a woman is NOT in labor. Current regulation requires a MD.

Transparency of Healthcare Information

The proposed rule intends to expand the availability of pricing information and expand the number of public quality measures. Significant progress has been made in this area, and we look forward to additional progress. Specifically, as it relates to prices, there are several proposals from CMS. Each has good points and bad points, overall pricing transparency should

- Provide meaningful, easy to understand information to Medicare patients, utilizing common language and terms.
- Clearly differentiate between charge amount and patient responsibility. Coinsurance or Deductible amounts are more useful to Medicare beneficiaries than the charge amount (since charge amount rarely impacts what the beneficiary pays out-of-pocket).
- Support the ongoing work that state hospital associations have started with pricing transparency.
- Require insurers to make available in advance the information about a patient's out-of-pocket costs (again this is more useful information than actual charge amount).
- The AHA proposal to CMS is very well worded, and those steps should also be included in pricing transparency.

#1463

June 12, 2006

Mark McClellan, M.D., Ph.D., Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1488-P and P2f
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
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- The AHA proposal to CMS is very well worded, and those steps should also be included in pricing transparency.

Submitter : **Dr. Patricia Garvey** **Date: 06/12/2006**

Organization : **Edwards Lifesciences LLC**

Category : **Device Industry**

Issue Areas/Comments

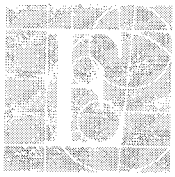
GENERAL

GENERAL

See attachment

CMS-1488-P-1464-Attach-1.DOC

#1464



Edwards

June 12, 2006

Mark McClellan, MD, PhD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Re: Comments to Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates (CMS-1488-P)

Dear Dr. McClellan:

Edwards Lifesciences is pleased to respond to the Centers for Medicare & Medicaid Services' (CMS') request for comments on the Proposed Rule entitled "Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates," published in the *Federal Register* on April 25, 2006.

For more than forty years, Edwards Lifesciences has been a world leader in advanced cardiovascular disease treatments. Edwards is the global leader in acute hemodynamic monitoring and the number-one heart valve company in the world. Headquartered in Irvine, California, Edwards offers medical technologies for debilitating and life-threatening conditions, including brands with leading global market positions such as Carpentier-Edwards, Cosgrove-Edwards, FloTrac, Fogarty, PERIMOUNT, and Swan-Ganz. Many of our technologies are used in Medicare patients undergoing surgical cardiology procedures, especially in complex cases with severe comorbidities requiring specialized care. Hence, we have a sincere interest in ensuring that changes to Medicare's Inpatient Prospective Payment Systems (IPPS) do not compromise patient access to life-saving medical technologies and services.

Edwards supports CMS' goal of improving payment accuracy under the IPPS and assuring beneficiary access to services. We commend the Agency for working very hard to produce a set of proposed changes to improve reimbursement under the IPPS and for releasing the MedPAR data in advance of the proposed rule. However, we do not believe that proposed changes are an appropriate solution or are ready for implementation in fiscal year (FY) 2007. We are specifically concerned that stakeholders require more than 60 days to thoroughly evaluate the methodological changes included in the proposed rule, which are among the most sweeping in the history of the IPPS. Further, we are concerned that the time between the close of the comment period (June 12, 2006) and the August 1, 2006 expected publication of the Final Rule is insufficient for CMS to fully consider submitted comments, test, and accurately implement changes of the magnitude contained in the proposed rule.

We, therefore, encourage CMS to delay implementation of any changes until FY 2008 and maintain the current methodologies for assigning diagnosis-related group (DRG) relative weights and patient classifications in FY 2007. Please find below additional

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One Edwards Way · Irvine, CA USA · 92614
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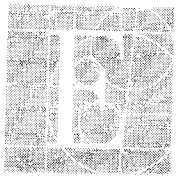

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comments on various aspects of the IPPS proposed rule. We would also direct you to comments submitted by two of our trade associations (the Advanced Medical Technology Association and the California Healthcare Institute), which provide similar perspectives.

Regardless of the specific IPPS changes that CMS ultimately implements or the timeframe in which those changes are made, we believe there are a few key issues that need to be addressed if CMS chooses to implement a payment system using estimated cost-based weights. These include:

- **Overall Timeliness of Cost Report Data**: Estimated cost-based weights would be derived, in part, from Medicare cost reports. Many have expressed concerns that cost report data are old, and are significantly older than the charge-based data currently used to determine payment weights under the IPPS. In the current system, the DRG weights are calculated using claims that are two years older than the payment year. Under an estimated cost-based IPPS, the DRG weights would be calculated using cost report data that are three to four years older than the payment year. We urge CMS to implement an approach the uses the most recent claims data available.

- **Omission of Data on New Technologies**: Inherent lags between the time period covered by the cost reports and the payment year result in the most recent advances in medical technology being omitted from the cost report data. Utilizing cost data that is outdated to determine the cost-to-charge ratios (CCRs), which in turn are used to calculate cost-based DRG weights, would exclude many important technological advances. We are concerned that use of older data will result in newer technologies being systematically undervalued and request that this issue be closely reviewed in the context of the IPPS final rule.

In addition to the issues discussed above, Edwards is concerned that the Hospital Specific Relative Value (HSRV) methodology included in the proposed rule would exacerbate the problems inherent in the use of estimated cost-based weights. We are particularly concerned about the below issues related to the use of the HSRV methodology.

- **Utilization of Aggregated Cost Center Data:** The use of 10 cost center groupings within the HSRV methodology to calculate DRG relative weights ignores detailed data in the cost reports that could be used to derive a more accurate set of weights. This will exacerbate many of the issues inherent in the use of weights based on estimated costs, including data lags, data omission, and charge compression.

- **Over-trimmed Data and Failure to Apply Appropriate Weights:** When calculating payment weights under the HSRV methodology, CMS did not use standard methods to weight hospital payment data and trim Medicare claims data. CMS omitted data from 238 hospitals, representing 25 percent of routine hospital charges. This omission and failure to apply appropriate weights significantly decreased the payments for technology intensive cases. We believe that concerns related to these methodological decisions need to be evaluated

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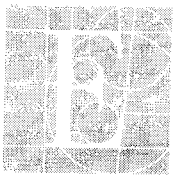

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and addressed prior to the implementation of any cost-based methodology scenario.

- **Elimination of Hospital-Level Cost Variation Not Explained by Case-Mix:** The current payment standardization methodology removes from the cost or charge data *only* the hospital-level variation that Medicare will pay for in another part of the payment formula, including wage costs, indirect teaching expenses, and disproportionate share. Under the current method, variation in hospital costs or charges that is outside the typical payment formula is allowed to be captured within the payment formula through other mechanisms. In contrast to this, the HSRV methodology excludes any unexplained variation in hospital costs or charges, which could include meaningful and valid cost variations. This policy will particularly impact services that are provided in hospitals with higher average costs, which often includes cardiology and cardiac surgery care. We believe this aspect of the HSRV methodology could result in payment rates for cardiac care being unjustifiably reduced. If these hospitals' legitimate costs are not recognized, Medicare beneficiaries' access to care may be diminished.

We also would like to submit comments regarding the consolidated, severity-based DRG system that was included in the proposed rule.

- **Accounting for Patient Severity of Illness, Complexity and Patient Benefit:** Edwards shares CMS' concern that the proposed consolidated severity-adjusted DRG system does not capture complexity of treatment. We believe that it is essential for any DRG refinements to fully recognize severity of illness, complexity, and patient benefit and strongly urge CMS to implement a DRG system that fully acknowledges these factors.

Finally, we would like to submit comments regarding recognition of the additional costs associated with new technologies.

- **Maintaining New Technology Add-On Payment:** As a company dedicated to bringing breakthrough innovative technologies to Medicare patients, Edwards believes that the new technology add-on payment is a vital component of the IPPS that helps ensure beneficiary access to life-saving medical services and technologies. The add-on payment recognizes the higher costs typically associated with new technologies more quickly than otherwise would be possible through the underlying DRG system. We urge CMS to maintain the new technology add-on payment in 2007 and beyond, regardless of whether CMS moves toward an estimated cost reimbursement system.

Given the issues raised above, we would like to express our support for the following:

- Implementation of an estimated cost-based weight system in FY 2008 with an appropriate phase-in, analogous to the methodology that is currently used in the outpatient prospective payment system (PPS). Although this methodology has challenges that would need to be addressed, it provides a more accurate reflection of costs across hospitals and procedures. We would also urge the

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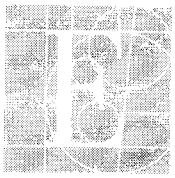

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agency to work with stakeholders to improve the timeliness and accuracy of cost report information that is used to determine PPS payment rates.

- Implementation of a DRG classification methodology that accounts for patient severity of illness, complexity, and patient benefit. These DRG refinements would take into consideration specific DRG assignments that previously have been approved through notice and comment rulemaking, including the severity-weighted cardiac DRGs that were adopted in FY 2006. We recommend that CMS start with the current DRG system and provide overlays for severity of illness, complexity of the procedure, and patient benefit.

We also recommend simultaneous implementation of a revised estimated cost methodology and a DRG classification methodology that accounts for patient severity of illness, complexity, and patient benefit so as to minimize swings in payment rates for many DRGs. We do not support a two-step implementation, whereby CMS would implement the movement from charge-based weights to estimated cost-based weights in one year followed by wholesale refinement of DRGs based on patient classification reforms in a following year.

Edwards appreciates the opportunity to comment on the IPPS FY 2007 Proposed Rule. We look forward to working with CMS to improve payment accuracy under the IPPS and ensuring continued beneficiary access to care.

Please feel free contact me at (949) 250-3504 if you have any questions about our comments or need additional information.

Sincerely,

Patricia L. Garvey

Patricia L. Garvey, PhD
Corporate Vice President, Global Reimbursement

cc: Herb Kuhn, Director, Center for Medicare Management
Neleen Eisinger, Vice President, Government Affairs, Edwards Lifesciences

Edwards Lifesciences LLC
One Edwards Way · Irvine, CA USA · 92614
Phone: 949.250.2500 · Fax: 949.250.2525 · www.edwards.com

1465

Submitter :

Date: 06/12/2006

Organization : Monmouth Medical Center

Category : Hospital

Issue Areas/Comments

FTE Resident Count and Documentation

FTE Resident Count and Documentation

VIA [electronic submission]

June 9, 2006

Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services

Attention: CMS-1488 P Resident Time in Patient Activities

Dear Administrator McClellan:

Monmouth Medical Center welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services (CMS or the Agency) proposed rule entitled Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates. 71 Fed. Reg. 23996 (April 25, 2006).

We strongly urge the Agency to rescind the purported clarification in the proposed rule that excludes medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments. The stated rationale for the exclusion of time devoted to these activities is that they are not related to patient care The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a nonhospital setting, such as a physician s office or affiliated medical school.

The proposed rule position is in stark contrast to the Agency s position as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty. [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins].

We support the Agency s 1999 position. The activities cited are an integral component of the patient care activities engaged in by residents during their residency programs. We urge CMS to withdraw its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,

Frank J. Vozos, M.D., Executive Director
Monmouth Medical Center
300 Second Avenue
Long Branch, NJ 07740

CMS-1488-P-1465-Attach-1.DOC

ATTACHMENT TO #1465

Monmouth Medical Center
Monmouth Medical Center
Monmouth Medical Center
St Barnabas Health Care S

Submitter : **Dr. Kelly Swanson** **Date: 06/12/2006**

Organization : **Dr. Kelly Swanson**

Category : **Individual**

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS or the Agency) proposed rule entitled "Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates." 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in "patient care activities." The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

Background
The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a nonhospital setting, such as a physician's office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not "related to patient care".

This position reverses the Agency's position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include "scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty." [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency's 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs.

Residency Program Activities and Patient Care
I firmly believe that with the possible exception of extended time for "bench research," there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician's educational development into an autonomous practitioner.

To separate out CMS's newly defined "patient care time" from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,
Kelly Swanson, MD

Submitter : **Ms. Janet Gallaspy** **Date: 06/12/2006**

Organization : **Forrest General Hospital**

Category : **Hospital**

Issue Areas/Comments

DRGs: Severity of Illness

DRGs: Severity of Illness

See attachment

GENERAL

GENERAL

See attachment.

Hospital Redesignations and Reclassifications

Hospital Redesignations and Reclassifications

See attachment.

Transparency of Health Care Information

Transparency of Health Care Information

See attachment.

Value-Based Purchasing

Value-Based Purchasing

See attachment.

CMS-1488-P-1467-Attach-1.DOC

#1467

FORREST GENERAL HOSPITAL
Medical Excellence. Community Loyalty.

May 30, 2006

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: **CMS-1488-P**
PO Box 8011
Baltimore, MD 21244-1850

Submitted Electronically via: http://www.cms.hhs.gov/eRulemaking

Dear CMS,

Forrest General Hospital (FGH) is a county-owned, 2-hospital system that consists of a 400-bed acute care facility; a 95 bed acute care facility; an 88-bed chemical dependency and psychiatric unit; a 24-bed rehabilitation unit; an outpatient surgery facility; a home health service; a cancer treatment center; and a variety of outpatient services. We appreciate this opportunity to provide feedback to CMS on the proposed rule for the 2007 update of the inpatient prospective payment system (IPPS). CMS has laid out an ambitious plan of change for 2007 and the immediately following years. It will take the cooperation of all parties to ensure that transitions imposed by the final rule are made smoothly and with a seamless continuation of quality services to Medicare beneficiaries.

To facilitate this smooth, seamless transition Forrest General Hospital recommends that CMS:

- make the transitions to severity-adjusted DRGs carefully and with adequate time for hospitals to prepare; and, provide tools to providers to assess the impact these changes will have not only on Medicare reimbursement but on reimbursement from other payers as well;
- not overestimate the artificial growth in CMI due to anticipated improved coding practices;
- support full-service safety net hospitals with payment for those services that differentiate them from specialty, limited-service hospitals;
- decrease the lower threshold for wage index reclassification purposes from 82% to 80% for applications filed by rural hospitals or rural referral centers located in areas affected by Hurricane Katrina for geographic reclassification for FY 2008.
- work with hospital associations to encourage and assist providers to voluntarily develop and implement transparent pricing strategies; and
- fully define and provide complete instructions to facilities for coding selected diagnoses as present or not present on admission.

The Forrest General recommendations are discussed in more detail in the following pages.

POST OFFICE BOX 16389
HATTIESBURG, MS 39401-6389
(601) 288-7000
www.forrestgeneral.com

[DRGS: SEVERITY OF ILLNESS]

We do not disagree in principle with the move to severity-adjusted DRGs but we would like to identify some issues that this change will present for hospital providers. We stress that any change such as this should be made carefully and with adequate time for hospitals to prepare.

- In Mississippi, many of the other major payers use the Medicare DRG methodology as a template for payment. Blue Cross and Blue Shield of Mississippi, State of Mississippi, United Healthcare, and Champus all use the Medicare grouper with a differing base rate and with or without DRG weights specific to the payer's population. If CMS changes the Medicare DRG system, it will affect other payers as well. Some may continue with the old DRG system, others may follow CMS to the new consolidated APR-DRG system and others may adopt the unrevised APR-DRG system. At this point in time, hospitals do not know how other payers will react and the total impact to hospitals is unknown. While the impact could be beneficial, it could also be devastating. At best, the change will likely disrupt cash flow during the transition as FIs and other payers adjust payment software and processes. CMS needs to partner with providers to evaluate and estimate the total impact before implementing this change to a severity-adjusted system.

- CMS is proposing to use a proprietary system on which the IPPS will be based. Without purchasing the APR-DRG grouper, providers are not fully able to evaluate the impact of these proposed changes. CMS has notified providers of a web site where diagnosis and procedure codes may be entered to assign an APR-DRG but this is totally inadequate. Providers need a method to evaluate at least a year's worth of data by cross walking the current DRG assignment to the proposed consolidated APR-DRG and they need to be able to do this without the additional expense of purchasing the 3M APR-DRG grouper. CMS needs to work with providers to ensure they have the tools necessary to make good business decisions.

- Section II-3-c of the proposed rule discusses changes to the case mix index (CMI) that CMS expects from the new consolidated severity-adjusted DRGs. We ask that CMS not overestimate the growth in CMI due to improved coding practices. Hospitals today use professional coders who fully and accurately code a medical record. There are many needs for accurate data in a hospital setting so that coders do not stop after finding the first complication or co-morbidity that assigns the higher weighted DRG. The practice is to review the entire record and assign as secondary diagnoses all of the conditions that "coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay." We find the limiting factor in the number of diagnoses reported is generally the number of spaces on the claim for secondary diagnoses. While there may be some providers who improve coding practices, we believe the increase will not be significant. Reimbursement should not be reduced to account for an expected increase in coding accuracy that may not be realized.

- Hospital providers have long complained that physicians and specialty hospitals "cherry pick" the profitable conditions and payers leaving the full-service safety net hospitals to provide care for the remaining patient population. CMS must support full-service safety net hospitals in this endeavor or there will be no one to provide the less profitable services and provide for the underinsured patients. Many of the proposed changes in the 2007 IPPS update are made as an attempt to improve the accuracy of IPPS payment to provide payment equity

between specialty and general hospitals. We suggest that these moves to improve DRG payments do not address many of the differences between specialty and full-service hospitals. CMS should reimburse hospitals for additional services that are required to operate a full-service hospital many of which are not necessary in a specialty hospital setting. CMS provides some support to hospitals that serve a high percentage of Medicaid patients via disproportionate share (DSH) payments. We suggest that CMS should also make add-on payments to the base DRG payment for expenses such as:

- operation of a full-service, 24-hour emergency service with on-site emergency physicians;
- operation of a trauma service, a burn unit, or other high cost medically necessary services
- maintenance of stand-by and on-call physicians services which may involve hiring of physicians to provide adequate coverage;
- sponsoring ground and helicopter ambulance services;
- operation of a range of 24-hour diagnostic services;
- provision of 24-hour emergency surgical services;
- provision of 24-hour and week-end nursing services; and
- provision of other support services such as clinical pharmacists, nutritionists, case managers, and medical social workers.

Paying hospitals via an add-on payment to the base DRG payment for these expensive services will encourage hospitals to maintain such services rather than promote specialty hospitals that may be able to operate at a lesser cost without some or all of these services.

[HOSPITAL REDESIGNATIONS AND RECLASSIFICATIONS]

Forrest General Hospital requests that CMS exercise its discretion to temporarily lower the reclassification thresholds for hospitals located in areas affected by Hurricane Katrina in 2005.

Hurricane Katrina had a devastating impact on areas of the Mississippi Gulf Coast, including Forrest General Hospital's service area.

Healthcare providers in the affected areas are dealing with two enormous ramifications of the residential destruction. First, the widespread destruction has caused such a significant displacement of the population that the patient base of healthcare providers in the most directly affected areas has been depleted to unsustainable levels. What used to be a vibrant healthcare area with an adequate number of covered lives has literally overnight become a sparse patient base. In the meantime, healthcare providers have done an admirable task of quickly restoring healthcare services in the storm-ravaged region. Unlike individuals, hospitals are not mobile thus not allowing them to move with their patient base. Such rapid loss of patient base has placed many hospitals in precarious financial straits. The loss of patient base may or may not be permanent, but hospitals must continue to be viable and incur huge standby cost to provide care to the remaining population and to be the vital precursor for recovery to the region.

Secondly, it has become extremely difficult to retain the skilled workforce necessary to ensure a stable healthcare delivery system. With the existing shortage for healthcare workers across the nation, the attraction to leave the devastation of the affected area for better living conditions is almost insurmountable. Hospitals in the affected areas have offered pay and benefit package incentives in efforts to limit the loss of this skilled workforce. Such recruitment and retention is

essential in restoring the healthcare delivery systems as well as providing the necessary ingredients for economic recovery. Wages are rising, but the wage index used for Medicare reimbursement does not keep pace. Hospitals currently find themselves in a winless situation with the inherent necessity to recruit/retain skilled workers via more attractive pay packages versus the strict limitation of doing so due to the depletion of the hospital's patient revenue base as a result of the population displacement.

Under the current Medicare payment system, an area's wage index has an enormous impact on the amount of reimbursement that hospitals receive. Unfortunately, the higher compensation costs currently being incurred by hospitals will not be reflected in their wage index values and thereby their Medicare payments until federal fiscal year 2010. Such a delay would prove disastrous to the hospitals in the Katrina region.

Hospitals are an indispensable element in the community from both an economic and healthcare perspective. Hospitals serve as the nucleus for the healthcare grid of any community and as a necessity to attract business to a community. To force hospitals in this region to wait almost five years for wage index relief would inevitably result in financial meltdown and reverberate throughout the healthcare and business community.

CMS has the discretion to decrease the reclassification thresholds to assist hospitals located on the Mississippi Gulf Coast and other areas affected by Hurricane Katrina.

Under the provisions of 42 U.S.C. § 1395ww(d)(10), beginning in fiscal year 1991, hospitals may request reclassification from one geographic area to another for purposes of using the area's wage index value. The regulation governing an individual hospital's application to reclassify from one area to another is located at 42 C.F.R. § 412.230. This regulation allows the hospital to request reclassification from: (1) a rural area to an urban area, (2) from a rural area to another rural area, or (3) from an urban area to another urban area.

The criteria for reclassification for wage index purposes include an "upper threshold" (a comparison of the hospital's average hourly wage ("AHW") to the AHW of hospitals in the area in which it is located) and a "lower threshold" (a comparison of the hospital's AHW to the AHW of hospitals in the area to which it requests reclassification). The upper and lower thresholds for urban hospitals are 108% and 84%, respectively, while the upper and lower thresholds for rural hospitals and rural referral centers are 106% and 82%, respectively.

42 U.S.C. §1395ww(d)(5)(I)(i) states that the "Secretary shall provide by regulation for such other exceptions and adjustments to such payment amounts under this subsection as the Secretary deems appropriate." This statute provides significant discretion to CMS to make exceptions to the wage index reclassification regulations in extraordinary circumstances. Surely, extraordinary circumstances exist for rural hospitals and rural referral centers located in areas affected by Hurricane Katrina.

Forrest General proposes that CMS decrease the lower threshold for rural hospitals and rural referral centers located in an area affected by Hurricane Katrina that are applying for reclassification from an urban or other rural area from 82% to 80% of the AHW of the area to which the hospital is requesting reclassification for FY 2008. This exception would allow rural

hospitals and rural referral centers[1] meeting the lower threshold to receive the urban or other rural area's reclassified wage index for a period of three years. Barring any further catastrophes, hospitals located in the affected areas should have sufficiently recovered by the end of the three-year period to allow the hospitals to meet the current reclassification threshold in time for their next reclassification application. Because reclassification is a budget neutral process, this proposal would allow CMS to assist hospitals in areas devastated by the hurricane without increasing expenditures.

Conclusion.

Based upon the factors set forth above, and within CMS's broad discretion under 42 U.S.C. § 1395ww(d)(5)(I)(i), Forrest General respectfully requests that CMS lower the lower threshold for wage index reclassification purposes from 82% to 80% for applications filed by rural hospitals or rural referral centers located in areas affected by Hurricane Katrina for geographic reclassification for FY 2008.

[TRANSPARENCY OF HEALTH CARE INFORMATION]

CMS should understand that Forrest General and many other hospitals are not resistant to communicating the price of services to their patients since this would be a major patient satisfier; however, the method to do so in a meaningful way that doesn't mislead the viewer in comparing the hospital to other providers is elusive. Posting Medicare payments or hospital charges for public view must be done with care and only after much planning and input from providers. CMS should encourage facilities to increase transparency but not mandate that they do so. We advocate that CMS work with hospital associations to assist their member hospitals to develop strategies to implement transparent charge practices that make sense for the hospital and their patient customer base. Additional thoughts regarding specific CMS proposals include:

- Posting of Reimbursement: Medicare reimbursement varies by MSA, by DSH status, whether a hospital is associated with a medical school, and other factors. If Medicare reimbursement is posted for view by individual hospital, CMS must be clear to viewers why reimbursement is different for Hospital A as opposed to Hospital B. The publication of the data should not discriminate against the provider receiving the additional reimbursement.

- Posting of Charges: The recent report by the Lewin Group prepared for MEDPAC, "A Study of Hospital Charge Setting Practices", pointed out that the methodologies used by hospitals to set and maintain charges are numerous and varied. If you post charges for public view, you will very likely have a difficult time comparing apples to apples, which will be confusing to the consumer. As an example, Hospital A may choose to charge separately for all supplies required to perform a certain procedure while hospital B may roll all of the supply charges into the procedure charge. Hospital A will appear to have a very low procedure charge while Hospital B will appear to be overcharging for the same procedure but could in reality have the lower overall cost. Hospitals dealing primarily with DRG based payers may have a totally different charge structure from those who have large percentages of managed care contracts

[1] Although located in the Hattiesburg, Mississippi CBSA, Forrest General is a rural referral center. On August 1, 2000, the Health Care Financing Administration (now CMS) published a change in policy in the Federal Register allowing Forrest General and other hospitals formerly classified as rural referral centers but now located in urban areas to regain their status as rural referral centers. *See* Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and FY 2001 Rates; Final Rule, 65 Fed. Reg. 47,054, 47,089 (Aug. 1, 2000).

because of the terms of those contracts. Charge information alone without associated hospital costs, quality, and utilization has little value to the consumer. A patient who chooses what appears to be a facility with low charges does not come out ahead if he receives poor quality care, develops complications, and requires post-acute care following the hospitalization to recover.

[VALUE-BASED PURCHASING]

CMS asks "How should incentives be structured?" CMS should NOT structure incentives that are based on a moving target that reflects the relative position of the provider in relation to all the other providers in the group. CMS should develop a fixed standard of care or performance and reward hospitals that meet or beat that standard. The standard should be one that is generally accepted and based upon scientific evidence. When all or the majority of hospitals have met that standard then it may be appropriate to re-evaluate and raise the standard or move to measurement of another standard. Standards should not be set so high or changed so frequently that hospitals focus on the standard itself rather than the real goal which is improvement of care.

CMS discusses the proposal to select two diagnoses to report as present or not present on admission. We suggest that with the significant, sweeping changes Medicare is proposing for the IPPS in 2007 and 2008, this proposal would be best delayed for implementation at a later date. However, if it must be implemented due to statutory requirements then we suggest that CMS fully define the diagnoses selected and define when they are considered present or not present on admission before asking providers to initiate reporting.

For a simple example, a patient may be admitted one afternoon with dyspnea, cough, fever, a low oxygen saturation and a chest x-ray that does not yet show an infiltrate. The next morning the chest x-ray is repeated and now shows an infiltrate which is interpreted as pneumonia. Would pneumonia in this situation be coded as present on admission or not present on admission? What if the physician stated the patient's diagnosis on admission was "infiltrate" and only days later did he identify the diagnosis as "pneumonia"? Again, would this be present on admission or not present on admission? These questions may seem simple but they are meant to illustrate that what seems to be an uncomplicated requirement on the surface may present many underlying challenges to the coder. Without proper instructions, the coder is left to make these decisions on his or her own, which could then become a question for compliance if they decide incorrectly.

CLOSING

Forrest General Hospital would like to thank CMS and its staff for taking the time to review and consider our comments. We hope our comments are helpful and submit them in that spirit. Please use the contact information below for Janet Gallaspy if there are any questions regarding these comments. Thank you for your attention.

Sincerely,

Janet V. Gallaspy
Corporate Compliance
E-mail: jgallaspy@forrestgeneral.com
Telephone: 601-288-4462
Fax: 601-288-4469

OTHER HOSPITAL REPRESENTATIVES SUBMITTING THESE COMMENTS:

Mr. G. Edward Tucker, Jr.
Chief Financial Officer

Mr. R. Andy Woodard
Director of Financial Services

Mr. Scott Smith
Director of Patient Accounts

Ms Linda Haywood
Director of Health Information Management

Mr. Greg Jackson
Director of Rehabilitation Services

Ms. Kathy Myers
Charge Master Coordinator

Submitter : Dr. Paul Lewis **Date:** 06/12/2006

Organization : Dr. Paul Lewis

Category : Individual

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the
> Centers for Medicare & Medicaid Services' (CMS or the Agency) proposed
> rule entitled "Medicare Program; Proposed Changes to the Hospital
> Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates." 71
> Fed. Reg. 23996 (April 25, 2006).

> I strongly urge CMS to rescind the language in the proposed rule that
> sets up an artificial dichotomy between resident training time spent
in
> didactic activities and time spent in "patient care activities." The
> effect of the proposed rule is to exclude medical resident time spent
in
> didactic activities in the calculation of Medicare direct graduate
> medical education (DGME) and indirect medical education (IME)
payments.
>
> Background
> The proposed rule cites journal clubs, classroom lectures, and
seminars
> as examples of didactic activities that must be excluded when
> determining the full-time equivalent resident counts for all IME
> payments (regardless of setting), and for DGME payments when the
> activities occur in a non-hospital setting, such as a physician's
office
> or affiliated medical school. The stated rationale for the exclusion
of
> this time is that the time is not "related to patient care".

> This position reverses the Agency's position expressed as recently as
> 1999, at which time the Director of Acute Care wrote in correspondence
> that patient care activities should be interpreted broadly to include
> "scholarly activities, such as educational seminars, classroom
lectures
> . . . and presentation of papers and research results to fellow
> residents, medical students, and faculty." [September 24, 1999 Letter
> from Tzvi Hefter, Director, Division of Acute Care to Scott McBride,
> Vinson & Elkins]. I support the Agency's 1999 position. The
activities
> cited in the 1999 letter and cited again in this proposal are an
> integral component of the patient care activities engaged in by
> residents during their residency programs.
>
> Residency Program Activities and Patient Care
> I firmly believe that with the possible exception of extended time for
> "bench research," there is no residency experience that is not related
> to patient care activities. The learning model used in graduate
medical
> education (GME) is delivery of care to patients under the supervision
of
> fully-trained physicians. Everything that a resident physician learns
as
> part of an approved residency training program is built upon the
> delivery of patient care and the resident physician's educational
> development into an autonomous practitioner.
>
> To separate out CMS's newly defined "patient care time" from didactic
> sessions in which general issues devolve to discussions of particular
> patients seems an exercise in futility. Moreover, as a family
physician,
> I believe this policy would require additional staff that would be

> responsible for sitting in on each of these didactic sessions and keep
> count of patient care time. Such documentation requirements are
> unreasonable and would add an extremely large and unnecessary
> administrative burden.
>
> I urge CMS to rescind its clarification in the proposed rule relating
to
> the counting of didactic time for purposes of DGME and IME payments
and
> recognize the integral nature of these activities to the patient care
> experiences of residents during their residency programs

Submitter : Mr. A. James Tinker **Date:** 06/12/2006

Organization : Mercy Medical Center

Category : Hospital

Issue Areas/Comments

DRG Reclassifications

DRG Reclassifications

On behalf of Mercy Medical Center, we appreciate the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) on the fiscal year (FY) 2007 inpatient prospective payment system (PPS) and occupational mix adjustment proposed rules.

The rule proposes the most significant changes in the calculation of diagnosis-related group (DRG) relative weights since 1983 by creating a version of cost-based weights using the newly developed hospital-specific relative values cost center methodology (HSRVcc). It also proposes refining the DRGs to account for patient severity, with implementation likely in FY 2008. In addition, the rule would update the payment rates, outlier threshold, hospital wage index, quality reporting requirements, and payments for rural hospitals and medical education, among other policies.

While Mercy Medical Center supports many of the proposed rule s provisions, we have serious concerns about the proposed changes to the DRG weights and classifications.

The hospital field supports meaningful improvements to Medicare s inpatient PPS. We believe Mercy Medical Center and CMS share a common goal in refining the system to create an equal opportunity for return across DRGs, which will provide an equal incentive to treat all types of patients and conditions. However, more time is needed to understand the significant proposed policy changes, which redistribute from $1.4 to $1.7 billion within the inpatient system. Analysis shows the impact of the proposed changes to be highly unstable, with small changes in method leading to large changes in hospital payment. And the validity of CMS proposals versus potential alternatives to improve the DRG weights and classification system is uncertain. Moving forward requires thoughtful change.

Specifically, Mercy Medical Center supports the following:

" One-year Delay: Mercy Medical Center supports a one-year delay in the proposed DRG changes given the serious concerns with the HSRVcc and CS-DRG methodology. Mercy Medical Center and the hospital field are committed to working with CMS over the next year to address these concerns.
" Valid Cost-based Weights: We support moving to a DRG-weighting methodology
based on hospital costs rather than charges, but CMS proposed HSRVcc method is flawed.
" A New Classification System only if the Need Can Be Demonstrated: Mercy Medical Center does not support a new classification system at this time, as the need for a new system is still unclear. Much more work understanding the variation within DRGs and the best classification system to address that variation is still needed before CS-DRGs or any other system should be selected or advanced.
" Simultaneous Adoption of Any Changes to Weights and Classifications: If the need for a new, more effective classification system is demonstrated and developed, it should be implemented simultaneously with the new weighting system to provide better predictability and smooth the volatility created by these two, generally off-setting changes.
" Three-year Transition: Any changes should be implemented with a three-year
transition, given the magnitude of payment redistribution across DRGs and hospitals.
" Collaborative Approach to Moving Forward: Mercy Medical Center commits to working with CMS to develop and evaluate alternatives for new weights and classifications.

Mercy Medical Center appreciates the opportunity to submit these comments. If you have any questions about our remarks, please feel free to contact me at 319-398-6133.

Sincerely,

A. James Tinker
President & CEO
Mercycare Service Corporation

Submitter : **Thomas Day**

Organization : **Thomas Day**

Category : **Individual**

Date: 06/12/2006

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS or the Agency) proposed rule entitled Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates. 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in patient care activities. The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

Background
The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a nonhospital setting, such as a physician s office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not related to patient care .

This position reverses the Agency s position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty. [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency s 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs.

Residency Program Activities and Patient Care
I firmly believe that with the possible exception of extended time for bench research, there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician s educational development into an autonomous practitioner.

To separate out CMS s nefarious definition of patient care time from didactic sessions in which general issues devolve to discussions of particular patients seems a capricious exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden. You would require the expenditure of monies so as to effectively reduce the Medicare GME payment. The program would be less able to educate residents - which was the original intent of the allocation. Perhaps you could refocus your efforts toward educating doctors instead of spending so much of your time identifying new ways of withholding funding.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,

Thomas Day

Submitter : Dr. Jason Stacy **Date:** 06/12/2006

Organization : USC Family Practice

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS or the Agency) proposed rule entitled Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates., 71 Fed. Reg. 23996 (April 25, 2006).

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To separate out CMS's newly defined "patient care time" from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,

Jason J. Stacy, MD

Submitter : Mr. William Sisson **Date:** 06/12/2006

Organization : Central Baptist Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1472-Attach-1.DOC

#1472

BAPTIST HEALTHCARE SYSTEM

4007 Kresge Way
Louisville, Kentucky 40207
502-896-5000

Electronically Submitted

June 12, 2006

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1488-P
7500 Security Boulevard
Baltimore, Maryland 21244-1850

RE: Provider Comments
Proposed Changes to Inpatient PPS
DRG Reclassifications and Severity of Illness

On behalf of the Central Baptist Hospital, a member of Baptist Healthcare System, Inc. (BHS), we appreciate the opportunity to comment on the fiscal year (FY) 2007 proposed changes to the hospital inpatient prospective payment system.

BHS supports meaningful improvements to Medicare's inpatient prospective system and shares CMS's desire to develop a payment system that provides an equal financial incentive (margin) to treat all patients, regardless of diagnosis or severity of illness. BHS further acknowledges that this payment system must be statistically robust, clinically meaningful and at the same time, administratively feasible.

BHS submits the following recommendations to the current proposals:

1. The proposed changes to the DRG weights based upon Hospital Specific Relative Value cost center (HSRVcc) and introduction of Consolidated Severity Adjusted DRGs (CS-DRGs) should be implemented simultaneously.

2. The proposed changes to the DRG weights (HSRVcc) and introduction of CS-DRGs should be implemented on or after October 1, 2008.

3. Valid cost-based weights must be developed and utilized.

4. Further refinement of the proposed CS-DRG methodology needs to be done to ensure it promotes (rather than inhibits) the accomplishment of CMS's stated goals.

Discussion and rationale for recommendations:

Recommendation 1: Simultaneous Implementation

a. The proposed HSRVcc changes in FY2007 are projected to reduce reimbursement to BHS from the current FY2006 amount by nearly $8.5 million.

b. The proposed implementation of CS-DRGs in FY2008 is projected to increase reimbursement from the FY2007 amount by nearly $8.2 million (which represents a reduction of approximately $300,000 from the current FY2006 amount). This significant volatility in reimbursement has several implications.

   First, BHS will **permanently** lose $8.2 million in reimbursement in FY2007.

   Second, BHS will **potentially** receive an increase in reimbursement in FY2008. BHS has utilized the 3M APR-DRG grouper for many years, largely as part of internal quality initiatives and the Premier Hospital Quality Incentive Demonstration. As a result, BHS had the internal APR-DRG data to convert to CS-DRGs and calculate the impact of the FY2008 proposal.

   However, the underlying assumptions in the impact analysis are: (1) coding in the future is consistent with current coding practices, and (2) that Medicare will allow current coding in the future reimbursement model. Because these are assumptions and not givens, BHS has significant concerns regarding the ability to accurately forecast the proposals impact beyond FY2007, which is critical.

   Third, the increase in reimbursement in FY2008 under the CS-DRG system indicates that BHS hospitals treat more severe patients on average. This finding is consistent with the mission and values of its member hospitals.

   BHS is comprised of five hospitals within the state of Kentucky. It operates urban hospitals in Louisville, La Grange and Lexington, rural referral centers in Corbin and Paducah. Collectively, BHS has the largest number of inpatient admissions in Kentucky and is one of the largest providers of Medicaid services within the state.

   The primary and secondary markets for BHS hospitals is comprised of 40 of the 120 counties in Kentucky and range across the central, western and southeastern parts of the state. Five of the poorest ten counties are located with the BHS service area.

   Medicaid, charity and uninsured patients represent over 17% of BHS inpatient business. As part of BHS's Christ-centered mission, each BHS hospital has not only expanded its general acute care services, but also its highly specialized tertiary programs in an effort to provide a full range of surgical and medical services to all patients regardless of their ability to pay or severity of illness. Central Baptist Hospital, a disproportionate share facility, serves an even higher percentage of Medicaid, charity and uninsured patients than BHS as a whole, with this population accounting for over 18.5% of our inpatient business. Central Baptist Hospital offers a broad range of tertiary care services to all

patients, regardless of ability to pay, including being a regional leader in the offering of high acuity services and new technologies in neonatology, oncology, neurology, cardiology, and orthopedics.

Given the mission of BHS and demographics of the communities it serves, it is clear that BHS hospitals are not specialty hospitals that target services that provide higher margins. However, given the high severity of illness for the patient population BHS hospitals serve, unless the HSRVcc and CS-DRG proposals are implemented simultaneously, unfair financial hardship will be experienced, threatening our ability to provide the same level of access to cutting edge technologies currently offered.

Fourth, CMS suggests that a budget neutrality factor may be applied to offset improvements in coding practices. This too, represents a significant unknown in the current proposal that needs to be accurately evaluated and communicated for which additional time is necessary.

Recommendation 2: Delay until October 1, 2008

a. It is imperative that the GROUPER technology be made available to hospitals and vendors. Without direct access to the GROUPER by hospitals, it will be virtually impossible to understand its logic. Without access by multiple vendors, it will be more difficult to purchase at a competitive price and will be more difficult to integrate into existing hospital systems.

b. In addition, many current hospital software programs will need to be modified to handle the new payment and billing system. An implementation date before October 1, 2008 will not allow adequate time to make all the necessary system changes and upgrades.

c. CMS stated that one option to the software issue is for hospitals to submit claims without being grouped and allow CMS to assign the CS-DRG. This raises several serious concerns.

   First, without the CS-DRG information, revenues and patient receivables cannot be recorded accurately. Statement of Position (SOP)-00-1(6) states, "Health care entities need to estimate amounts that ultimately will be realizable in order for revenues to be fairly stated in accordance with generally accepted accounting principles (GAAP)." Paragraph (9) states "Management is responsible for the fair presentation of its financial statements in conformity with GAAP".

   Currently, the DRG assignment is critical in making an accurate estimate of the net realizable value of accounts receivable. Given the significance of and the increased uncertainty of the impact of the proposed changes for FY2007 and FY2008, it will be even more important for patient bills to be grouped prior to billing.

   Second, the Medicare inpatient business represents over 41% of BHS total inpatient business. As such, changes to the Medicare payment system have a significant impact on BHS's ability to accurately estimate payments in evaluating strategic initiatives, business

plans, budgets, marketing, staffing and other critical decisions. With the significance of the proposed changes, more time is required to understand and perform impact analysis.

d. Four of five BHS hospitals are disproportionate share hospitals (DSH). Last year these hospitals received approximately $14.7 million in DSH reimbursement. It is anticipated that the CS-DRGs will have a material impact on DSH payments and in order for hospitals to adequately plan and make appropriate adjustments in a timely manner, BHS recommends that further analysis be prepared and accurate impact estimates published prior to implementation of the proposed changes.

e. Additional time is required to determine the impact from other third party payers (including Medicaid) that have historically modeled reimbursement rules and methodologies from the Medicare payment system. It is anticipated that these third party payers will adopt the new Medicare payment system at some time in the near future following implementation by Medicare. However, given the complexity of the proposed changes, additional time is necessary for payers and hospitals to better understand these changes and make appropriate systematic changes.

Recommendation 3: Valid Cost Weights

a. Under the HSRV weight calculation method, the ten cost center categories were developed based on broad accounting definitions, where each cost center category represents at least five percent of the charges in the claims data. BHS acknowledges the need to remove bias introduced by individual hospital characteristics (i.e. unique cost centers reported on the cost report), but it appears that this resulted in incorrect cost center groupings in the CMS study that raises concerns regarding the accuracy of the cost-to-charge ratio (CCR) data.

   For example, according to CMS-1488-P, Table-A (pp.66-67 and pp.186-187) the HSRV Cardiology cost center includes cost report lines 53 and 54. However, one BHS hospital includes its Catherization Lab revenues and expenses on cost report line 42.01, which according to the table appears to be incorrectly grouped with the HSRV Radiology cost center that includes cost report lines 41,42 and 43.

   BHS is very concerned that grouping errors such as the one described here could materially impact the CCR used to calculate the DRG weights. Therefore, BHS recommends that CMS work through the Medicare intermediaries to audit the cost report line definitions for all hospitals to ensure groupings are accurate.

b. The weighting calculation used to determine the scaling factors gives equal weight to each hospital regardless of size or volume. This methodology results not only in an inaccurate national cost-to-charge ratio, but is inconsistent with the method used when averaging the ten cost center DRG weights to which the scaling factors are applied. Therefore, BHS recommends that a consistent weighting methodology be utilized to calculate the scaling factors.

c. HSRVcc costs were based on the 2004 cost reports. Significant changes in medical technologies, products and services have been introduced, which have significantly impacted the CCR. Therefore, BHS recommends that a more recent audited cost report be used, after audit procedures have been performed as recommended in (a.) above.

d. Central Baptist Hospital is also concerned that partial data from a number of large hospitals whose cost to charge ratios were classified as outliers were excluded from the analysis. The exclusion of this data, which, because of the size of excluded facilities, collectively accounts for a large percentage of Medicare inpatient admissions nationally, materially impacts the resulting calculations, and, in particular, causes routine care cost to charge ratios to be much higher as used in the CMS calculations than the actual national averages reflect. Furthermore, this problem is compounded by the fact that CMS continues to use partial data from these same facilities

Recommendation 4: Consolidated Severity-Adjusted DRG Methodology

a. CS-DRGs are developed by grouping APR DRGs considering average length of stay and average charges. This grouping methodology is inconsistent with the cost-based intention of the proposed changes. Average cost, using the HSRVcc methodology (applying the recommended changes), for each APR DRG by severity level should be the determinant for grouping APR DRGs into CS DRGs.

b. CMS believes that the adoption of consolidated severity-adjusted DRGs would create a risk of increased aggregate levels of payment, similar to the 2% increase associated with the implementation of the current DRG system in 1983 and has recommended the application of a compensating budget neutrality factor. Because of the significance of even a 2% reduction in reimbursement, BHS recommends that this be further studied before implementation.

Thank you for your consideration of our recommendations. We certainly hope you can see and appreciate the legitimacy of the concerns raised. If you have any questions, please feel free to contact me at (859) 260-6105 or bsisson@bhsi.com .

William G. Sisson
President / CEO
Central Baptist Hospital

Submitter : Mr. William Parrish **Date:** 06/12/2006

Organization : Parrish, Moody

Category : Hospital

Issue Areas/Comments

DRGs: Severity of Illness

DRGs: Severity of Illness

Our firm, Parrish, Moody & Fikes, p.c., is a public accounting firm in Waco, Texas that specializes in healthcare. Our firm currently services more than 60 rural PPS hospitals throughout the State of Texas. A majority of these hospitals are faced with a dependency on the Medicare program as a result of their Medicare utilization being greater than 60%. With their total revenues being made up of 60% from Medicare and another 25% from Medicaid or charity cases, there are very few areas for increasing or replacing revenues to these hospitals. This has become a major problem they face everyday.

On behalf of Parrish, Moody Fikes s 60 client PPS hospitals we appreciate the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) on the fiscal year (FY) 2007 inpatient prospective payment system (PPS) and occupational mix adjustment proposed rules.

The rule proposes the most significant changes in the calculation of diagnosis-related group (DRG) relative weights since 1983 by creating a version of cost-based weights using the newly developed hospital-specific relative values cost center methodology (HSRVcc). It also proposes refining the DRGs to account for patient severity, with implementation likely in FY 2008. In addition, the rule would update the payment rates, outlier threshold, hospital wage index, quality reporting requirements, and payments for rural hospitals and medical education, among other policies.
While we may support some of the proposed rule s provisions, we have serious concerns about the proposed changes to the DRG weights and classifications. We share the common goal in refining the system to create an equal opportunity for return across DRGs, which will provide an equal incentive to treat all types of patients and conditions. However, we also believe more time is needed to understand the significant proposed policy changes, which redistribute from $1.4 to $1.7 billion within the inpatient system. Analysis shows the impact of the proposed changes to be highly unstable, with small changes in method leading to large changes in hospital payment. And the validity of CMS proposals versus potential alternatives to improve the DRG weights and classification system is uncertain. Moving forward requires thoughtful change.

Specifically, Parrish, Moody Fikes, p.c. supports the following:

" One-year Delay: We support a one-year delay in the proposed DRG changes given the serious concerns with the HSRVcc and CS-DRG methodology.

" Valid Cost-based Weights: We support moving to a DRG-weighting methodology based on hospital costs rather than charges only after a more thorough analysis is performed and information becomes available on the proposed method with more time to prepare for the changes that will occur financially to each of the affected hospitals.

" A New Classification System Only if the Need Can Be Demonstrated: We do not support a new classification system at this time, as the need for a new system is still unclear. Much more work understanding the variation within DRGs and the best classification system to address that variation is still needed before CS-DRGs or any other system should be selected or advanced.

" Simultaneous Adoption of Any Changes to Weights and Classifications: If the need for a new, more effective classification system is demonstrated and developed, it should be implemented simultaneously with the new weighting system to provide better predictability and smooth the volatility created by these two, generally off-setting changes.

" Three-year Transition: Any changes should be implemented with a three-year transition, given the magnitude of payment redistribution across DRGs and hospitals.

We appreciate the opportunity to submit these comments. If you have any questions about our remarks, please feel free to contact me at (254) 776-8244 or wmp@pmfwaco.com.

CMS-1488-P-1473-Attach-1.PDF

#1473

PARRISH • MOODY & FIKES, p.c.
CERTIFIED PUBLIC ACCOUNTANTS

7901 WOODWAY DRIVE, SUITE 100
WACO, TEXAS 76712-3866

(254) 776-8244
FAX (254) 776-8277
E-MAIL: pmf@pmfwaco.com
www.pmfwaco.com

OFFICES IN:
WACO & AUSTIN,
TEXAS

June 8, 2006

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1488-P and P2
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

RE: CMS-1488-P and P2, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates; Proposed Rule.

Dear Dr. McClellan:

Our firm, Parrish, Moody & Fikes, p.c., is a public accounting firm in Waco, Texas that specializes in healthcare. Our firm currently services more than 60 rural PPS hospitals throughout the State of Texas. A majority of these hospitals are faced with a dependency on the Medicare program as a result of their Medicare utilization being greater than 60%. With their total revenues being made up of 60% from Medicare and another 25% from Medicaid or charity cases, there are very few areas for increasing or replacing revenues to these hospitals. This has become a major problem they face everyday.

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- **Simultaneous Adoption of Any Changes to Weights and Classifications:** If the need for a new, more effective classification system is demonstrated and developed, it should be implemented simultaneously with the new weighting system to provide better predictability and smooth the volatility created by these two, generally off-setting changes.

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We appreciate the opportunity to submit these comments. If you have any questions about our remarks, please feel free to contact me at (254) 776-8244 or wmp@pmfwaco.com.

Sincerely,

PARRISH • MOODY & FIKES, p.c.

William M. Parrish, Jr., C.P.A.
President

Submitter : Mr. Ronald Ashworth **Date:** 06/12/2006

Organization : Sisters of Mercy Health Systems

Category : Hospital

Issue Areas/Comments

Occupational Mix Adjustment

Occupational Mix Adjustment

Mark B. McClellan, M.D., Ph.D, Administrator
Part VIII

In addition to the transition or use of corridors, Mercy would like to propose that the wage index reviews be bid out to one national fiscal intermediary as part of the Medicare Administrative Contract (MAC) bidding process scheduled to continue (for Jurisdictions 1, 2, 4, 5, 7, 12 and 13) in September 2006. A single national intermediary selection would provide both CMS and the provider community a consistent approach to the wage index process. Historically, providers located in the same state (or even the same MSA) have been subject to a wage index review/approval by different fiscal intermediaries. While the MAC bidding process should create consistency from an FI perspective going forward for those providers in a common geographic location (or jurisdiction), there will still be the ability for inconsistencies to occur among providers within varying jurisdictions. As Medicare continues to evolve, and the health care industry continues to operate within extremely tight financial constraints, we believe consistency in application of Medicare rules, regulations, and reviews is imperative. A one percent change in a provider s wage index can mean hundreds of thousands of dollars to one provider. This one percent change could be determined by what kind of documentation one fiscal intermediary either allowed or denied in one jurisdiction versus another. Wage index calculations are utilized for payment of every Medicare inpatient claim and variation among fiscal intermediaries (even across jurisdictions) could be detrimental to hospitals located within a certain geographic region.

We respectfully request CMS strongly consider using the MAC process to solicit a single national fiscal intermediary to ensure wage index reviews are handled consistently and accurately so that all providers are subject to the same Medicare interpretation. We believe the inclusion of 100% of the occupational mix wage index results intensifies the need for this approach going forward. The 100% inclusion of occupational mix data means additional scrutiny, education, and emphasis will be necessary from both a fiscal intermediary and provider prospective. Fluctuations in wage index percentages for any provider can prove to be extremely volatile and therefore must be handled with extreme care. We believe a national nomination for a single wage index intermediary would bring us closer to ensuring this process is handled effectively.

Thank you for considering our comments. Should you have additional comments please contact Ron Trulove at (314) 364-3561 or me at (314) 628-3685.

Sincerely,

Ron Ashworth
President/CEO
Sisters of Mercy Health System

Cc: Jim Jaacks
Randy Combs
Ron Trulove

Submitter : Ms. Heather Hulscher

Date: 06/12/2006

Organization : Iowa Hospital Association

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1475-Attach-1.WPD

#1475

IOWA HOSPITAL ASSOCIATION

June 12, 2006

Dr. Mark McClellan, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS 1488-P
P.O. Box 8011
Baltimore, MD 21244-1850

Ref: CMS—1488-P Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates; Proposed Rule (71 *Federal Register* 23996), April 25, 2006.

Dear Dr. McClellan,

On behalf of Iowa's 35 hospitals reimbursed under the Medicare Inpatient Prospective Payment System (PPS), the Iowa Hospital Association (IHA) is pleased to take this opportunity to provide comments on the Centers for Medicare & Medicaid Services' (CMS) proposed rule for the FY 2007 Inpatient PPS published in the April 25, 2006 *Federal Register.* This rule proposes to make the most significant changes to the Inpatient PPS since the introduction of the prospective payment system and Diagnostic Related Groups (DRGs) in1983, and is in responses to recommendations from the MedPAC March 2005 Report to the Congress on Physician-Owned Specialty Hospitals. The impetus of the March report was in response to the growing number of physician-owned specialty hospitals and the concern from community hospitals that the specialty hospitals were "cherry-picking" the least medically complex patients that would render the highest reimbursement within a particular DRG. This rule proposes to address this concern by making two specific and monumental changes to the DRG infrastructure that will significantly redistribute funding among all hospitals within the Inpatient PPS.

As proposed, Iowa's 35 PPS hospitals would see their case mix index (CMI) decline by approximately 0.80 percent with the adoption of the cost-base weights in FY 2007, and in FY 2008, the CMI for those 35 hospitals would decline by an additional 1.82 percent with the adoption of the severity-adjusted DRGs. While Iowa's hospitals provide some of the highest quality of care in the nation, they do so while managing an aggregate margin of negative 5.8 percent from their biggest source of income, the Medicare program. In total, the Iowa Hospital Association estimates that the proposed inpatient rule will reduce Iowa hospital Medicare payments by more than $18 million annually. Iowa hospitals cannot bear further cuts, direct or indirect, from the Medicare program.

100 EAST GRAND DES MOINES, IOWA 50309-1835 515.288.1955 FAX 515.283.9366
www.ihaonline.org

IHA's comments on the proposed changes to the DRGs and the number of other proposals included in this rule are detailed below.

DRG Weights and Severity of Illness

IHA supports meaningful improvements to the Medicare Diagnostic Related Group (DRG) patient classification system, but stresses **that any change of this nature and magnitude must be ensured to create a better, more accurate and equitable payment system**. In that regard, IHA supports a **one-year delay** to the proposed changes to the DRG system. During this time, a thorough evaluation must be conducted to ascertain **whether or not there is a need** for a new patient classification system. More work is needed to assess the proposed or other classification systems to understand whether it results in an improved hospital payment system. IHA supports moving to a cost-based weight structure, but the CMS method is flawed as detailed below. If the need for and best approach for changing the patient classification system can be demonstrated, IHA **supports simultaneous implementation** of the DRG weight changes and new classification system.

IHA recommends CMS **provide at least one year from the date of the publication of the final rule to the implementation of the changes** to the DRG reimbursement system. Such a precedent has been set with the HIPAA regulations by allowing a two-year implementation period upon the publication of the final regulations. The state of Maryland has recently adopted the APR-DRG system and moved to a cost-based DRG structure. CMS should more carefully evaluate Maryland's model and use it as a basis upon which to establish its own implementation period. Hospitals in that state strongly recommend providing at least one year to prepare financially and operationally for such changes, and that the changes be made concurrently. **IHA is committed to working with CMS** to develop and evaluate alternatives for new weights and patient classifications.

The proposals to adopt the Hospital-Specific Relative Value (HSRVcc) and the Consolidated Severity-Adjusted DRG (CS-DRG) system both present particular concern to Iowa hospitals. As written, neither proposal will ensure it will create a more accurate or equitable payment system.

Concerns regarding the proposal to adopt the HSRVcc and the CS-DRGs include:

- The 10 selected cost centers contain inherent flaws because there are no standard reporting requirements for determining which resources go into which cost center on the Medicare cost report. Because of this, some supplies will be grouped into other cost centers, such as the Operating Room (OR). Or, some services, such as cardiac, may be classified into other cost centers than Cardiology. For example, if a hospital inserts a pacemaker during surgery, that cost may go into the OR for hospital A, and into the Supplies & Equipment cost center for hospital B.

- The cost centers taken from the HCRIS file and the cost centers taken from the MedPAR file do not provide a one-to-one correlation. Auditors for Medicare fiscal intermediaries (FIs) are unable to navigate from hospital-to-hospital, the mapping from the MedPAR cost centers to the cost report. Because of this, the auditors provide the MedPAR reports to each hospital for them to map individually.

- CMS did not provide details on how it mapped the cost centers taken hospital claim data to the cost center from the cost report.

- CMS has not provided information on how it collapsed the other cost centers into the 10 defined cost centers.

- Several data errors have been identified since the publication of the proposed rule. Specifically:
  - Organ Acquisition costs were inadvertently included in the data used to set weights for DRGs.
  - The treatment of certain categories of hospitals between their calculation of the FY 2007 HSRVcc weights and the proposed CS-DRG weights was inconsistent, making it difficult to directly compare the results.
  - It is unclear whether the weights published for CS-DRGs included using the transfer-adjusted charges prior to calculating weights.
  - CMS hospital-weighted rather than charge-weighted the calculation of the mean cost-to-charge ratios (CCR) used to scale the charge-based weights. This approach over-weights the routine cost share and under-weights the ancillary cost shares.
  - By using a 1.96 standard deviation to trim the cost center CCRs for inclusion in the calculation of the scaling factors, 260 hospitals' data was excluded.

- Data analysis shows the impact of the changes to be highly unstable with small changes in methodology leading to large fluctuations in hospital payment.

- CMS has not made publicly available CS-DRG GROUPER software, nor has it made available the specifications for the industry to conduct analyses. Iowa hospitals are particularly concerned about the proprietary nature of this software and what this will mean in terms of purchasing this software.

- CMS has not provided a validation analysis that the proposed changes result in more accurate and equitable payments.

- CMS has failed to mention how its other reimbursement systems that rely upon the DRGs would, or would not be, affected by the changes to the DRGs, specifically, the Inpatient Psychiatric Facility and Long-Term Acute Care Facility PPSs.

- Hospitals would incur significant costs in purchasing the encoder software for a CMS-unique patient classification system, while maintaining the encoder software for the existing DRG system, **and** the APR-DRG system that other payers within the industry are moving toward.

- CMS' claims processing system only recognizes six diagnosis codes and nine procedure codes on hospital claims.

- The proposal fails to address how the outlier policy will be affected.

- The proposal fails to address how the transfer DRGs will be affected.

In response to the numerous concerns detailed above, IHA recommends the following:

- CMS must be able to illustrate to the hospital industry the proposals to change the DRG system will in fact result in a more accurate and equitable reimbursement system.

- **If CMS uses the methodology it has proposed to develop the cost-based structure to the DRGs, the agency should develop cost reporting instructions that standardize the reporting of resources to various cost centers** so that the data used to construct the weights for the DRGs is sound and consistent. If standard cost reporting instructions are to be issued, the agency will need much more time before it implements changes to the structure of the DRG weights.

- If this cost-base structure methodology is utilized, CMS must provide the following: (1) mapping from cost centers on the MEDPAR to the Medicare cost report and (2) detail on how it collapsed the other cost centers to come to the 10 defined cost centers.

- The data concerns identified above must be accounted for and corrected.

- **Iowa hospitals do not support the adoption of a Medicare-specific payment classification tool** due to the burden it creates on hospitals and for consistency purposes across the other payers that model their reimbursement from the Medicare program. The APR-DRG could be used if CMS sets the values to the unused DRGs to a neutral number.

- If CMS proceeds with its unique patient classification system, it must make publicly available GROUPER software, as has been the case with the current DRG GROUPER. This information must be made available as soon as CMS has made its final decision in time to allow hospitals to prepare both financially and operationally.

- **The regulatory impact analysis must reflect the cost for hospitals to maintain three encoding software packages if**: one for the existing DRGs, the consolidated severity-adjusted DRGs, and the All Payer Refined DRGs. If CMS chooses to use the APR-DRG system, then the analysis must include the cost for maintaining two encoding software packages.

- **Any changes to the structure of the DRG system be made across all reimbursement systems using the DRGs at the same time as the Inpatient PPS,** and appropriate lead time must be provided to allow those provider-types the necessary time to prepare operationally and financially.

- **Before moving to a severity-adjusted payment system, the new GROUPER must use all diagnosis and procedure codes on the claim.** The HIPAA 837i allows up to 25 diagnosis and 25 procedure codes on the claim, but many FIs ignore or omit these additional codes since they are not needed with the current GROUPER.

- CMS must address how its proposals will affect the outlier payments.

- CMS must address how its proposals will affect the post-acute care transfer policy. With a severity-adjusted DRG system, the number of DRGs subject to the transfer policy should decline dramatically.

- Hospitals need much more lead time to prepare financially for the scale of these changes. **IHA recommends CMS provide at least one year from the date of the publication of the final rule to the implementation of the changes to the DRG reimbursement system.** Such a precedent has been set with the HIPAA regulations by allowing a two-year implementation period.

Changes to CMI from a New DRG System

CMS suggests in the proposed rule that it would reduce payments to hospitals by instituting a budget neutrality adjustment to offset the fact that case mix may increase because of improved coding rather than actual changes in acuity. However, CMS did not propose an adjustment or even a methodology for determining an adjustment. **IHA opposes any negative adjustment to payments based on assumptions, rather than factual evidence.**

Hospital Quality Data

Iowa hospitals are fully supportive of the reporting of the additional 11 quality measures through the CMS initiative, as evidenced by the fact that 84 facilities are participating in the project, including 49 CAHs that are not affected by the payment reduction. The rule proposes to require hospitals to submit the complete set of measures for discharges occurring during the first quarter of 2006 by August 15. IHA urges CMS to reconsider this deadline given the timing of the release of the final regulation. One month following the publication of the final rule is a more reasonable time frame to allow hospitals the time necessary to meet the requirements for submitting the new data without being penalized.

The proposed rule would also require hospitals to reopen files from which data have already been abstracted, renegotiate agreements with the vendors that assist them in collecting and processing the required information, and resubmit information to the clinical data warehouse. Such retroactive alterations in the data files are difficult and costly, and open the door for the introduction of many new kinds of errors in the data. To require this reopening of the files makes no sense. **CMS should make the data collection prospective.** This could be accomplished by requiring hospitals wanting a full market basket update to pledge to submit the relevant data for all 21 measures for patients beginning on or after July 1.

Value-Based Purchasing

IHA has long been a supporter of the Medicare program becoming a purchaser of value to improve the well-being of Medicare beneficiaries and the fiscal integrity of the Medicare program. A recent study by the Dartmouth Medical School underscores the need for Medicare to move away from a payment system that is based solely on how much health care is used and to begin rewarding providers in states like Iowa where hospitals offer real value to the program. This study shows there is need to realign reimbursement to reward high quality, efficient providers, and offers a basis that may be used in developing a value-based purchasing reimbursement system.

Some key points from the study underscore the fact that Medicare spending on chronically ill patients in the last years of life varies substantially from state to state, with less than $24,000 spent per patient in Iowa and nearly $40,000 in New Jersey and the District of Columbia. Yet, there is no indication that patients in the states with the highest spending are better off than those in states with the lowest spending. The study found that if every state in the nation had used hospital and physician services in a manner similar to practice patterns in Iowa, the $123 billion spent for these patients would have been reduced by $14.4 billion.

The report also provides evidence that additional spending and resources for physician visits, hospitalizations, and diagnostic tests do not buy a longer life or better quality of life. Rather, those with chronic illnesses who live in high rate regions have slightly shorter life spans and less satisfaction with their care than those in regions with lower rates of spending.

Iowa's hospital community believes that changes in management of the Medicare program must be guided by the following principles:

Payment incentives should:

- Reward providers for improving quality and providing effective care.
- Evaluate the consumption of resources in achieving desired health outcomes as this is necessarily required in measuring effective care.
- Use a system of rewards that increases payments and reduces regulatory burdens for successful providers.
- Be aligned between hospitals and physicians.

Performance measures should:

- Be based on measures of adherence to quality improving processes.
- Should be selected to insure that all hospitals have an opportunity to participate and succeed.
- Be selected to minimize the data collection burden for providers.

IHA urges CMS to work with the hospital community and to utilize the information in the Dartmouth study as it moves forward in developing value-based purchasing for FY 2009 implementation.

Value-Based Purchasing—Health Information Technology

IHA supports the increased use of health information technology (HIT) to the extent that it carried out with new money, reduces costs in the delivery of health care, and lends itself to providing higher quality health care. By purchasing health care on behalf of existing and future Medicare beneficiaries, the Medicare program has an **obligation to ensure that its beneficiaries receive the highest quality and most efficient health care,** and any initiative to require the adoption of HIT must be carried out with additional funding. The Medicare population is the largest patient population by volume among Iowa hospitals, and these hospitals cannot afford to shoulder further losses from the Medicare program with current Medicare margins at **negative 5.8 percent.**

IHA opposes any promotion of the use of HIT through the hospital conditions of participation (CoP). The CoP are not an appropriate avenue to add requirements for hospitals to adopt HIT. Further, the adoption of HIT should not be promoted through negative reinforcements.

The HIPAA administrative simplification requirements set forth a number of requirements whereby health care providers and payers must conduct standardized electronic transactions with the ultimate goal of achieving savings in health care spending. Ten years since the enactment of

this legislation, hospitals have yet to see the expected return on investment (ROI) intended. The transactions intended to bring about the greatest decrease in administrative burden for hospitals, e.g. the 276/277 claim status inquiry and response, yet to be implemented across the industry, and have yet to be truly "standardized." To-date, most of the focus to implement the transactions has been on the claim and remittance advice transactions. The Medicare program may be the only payer that has fully implemented these standards, while the Medicaid programs and many private insurers lag far behind in implementing the HIPAA transaction code sets.
The HIPAA example is intended not only to illustrate the impact of requiring implementation of HIT, but to also illustrate that the expected ROI is long-coming. There are many considerations that must be taken into consideration with the promotion of HIT in hospitals, including:

- How is ROI measured and how long can hospitals be expected to wait before experiencing a positive return?
- What impact this will have on hospitals working with other payers? Will hospitals need to run two information systems simultaneously due to compatibility and to continue operating a business?
- Will certification of HIT products be required?

Transparency of Health Care Information
This rule proposes to introduce an initiative to expand the public availability of consumer information on health care quality and pricing. While IHA agrees with premise of making more information available to the public, **IHA is supportive of a hospital-led effort, rather than a government-led initiative, to providing meaningful information to patients,** and is working towards a proposal where IHA will make this information publicly available within the next year.

Geographic Reclassification—Critical Access Hospitals in Lugar Counties
As a result of changes in the labor market area definitions made in response to the results of the 2000 census, counties in which a number of Critical Access Hospitals (CAHs) are located became "treated" as urban instead of rural under the inpatient PPS because of a statutory provision modifying the status of rural counties with certain commuting patterns to metropolitan areas. In its FY 2005 final rule, CMS interpreted this provision as applying to CAHs located in these counties (known as "Lugar counties" after the Senate sponsor of the provision) and allowed these facilities a grace period to seek reclassification as rural in order to retain their CAH status.

While accommodating CAHs in this manner, the agency also took the position that any CAH being reclassified would no longer be eligible for pass-through payments for the services of certified registered nurse anesthetists (CRNAs). Its reasoning was that the facility was no longer "located in a rural area (as defined for purposes of section 1886(d) of the Social Security Act)" as the pass-through statute requires, but were only reclassified as rural.

In response to comments received on the FY 2006 proposed rule, CMS announced a policy change in the final rule for FY 2006 stating that Lugar county designation would not affect a CAH's rural status because the statutory provision creating such counties only applies to hospitals paid under the inpatient PPS (CAHs are paid under a separate, cost-based system). This policy change had the effect of eliminating the need for these CAHs to seek either geographic reclassification or a waiver of the Lugar statute (which CMS has maintained it has no authority to do). **In effect, under this new reading of the law, the provision creating Lugar counties does not apply *at all* for purposes of CAH eligibility.**

Despite this policy change, CMS continues to maintain that a CAH located in a newly-designated Lugar county cannot qualify for CRNA pass-through payments. **This position is at odds with the agency's view that it is geographic reclassification that renders a CAH ineligible for such payments** – since, under CMS' revised policy, a CAH located in such a county need not seek geographic reclassification to be a CAH. Apparently, it is CMS' view that these CAHs can never qualify for CRNA pass-through payments, whether they have sought reclassification (under the old policy) or not (under the new policy). **All CAHs located in a newly-designated Lugar county should receive pass-through payments, regardless of whether they sought reclassification. IHA urges CMS to revise its regulations accordingly.**

Wage Index Budget Neutrality

As the number of CAHs around the nation began to increase, IHA successfully urged CMS to remove the CAH wage data from the wage index calculation as these hospitals are no longer impacted by the wage index. IHA has recently been made aware of a letter provided to CMS that claims that because CAHs have lower average hourly wages (AHWs) than the average PPS hospital, the elimination of this data results in an overstated national AHW, and that while the national AHW has been increasing, the systematic withdrawal of low-wage hospitals has artificially inflated the national AHW to some extent. The letter states that this artificial increase is included in the negative budget neutrality adjustment that consequently reduces payment, resulting in the national inpatient PPS operating payments being understated by an estimated $1.52 billion over five years (2003-2007). If this information is in fact accurate, **IHA believes that CMS should apply a positive budget neutrality adjustment in FY 2007 to compensate for the underpayments.** The understatement increases each year as more hospitals become CAHs and more data are eliminated from the wage index data. **IHA does not support any methodological changes to the wage index calculation.**

Operating Payments—Cost Outliers

5.1 percent of total inpatient DRG payments is set aside for outlier payments each year. For the past three years, CMS has underestimated the total amount of outlier payments with only 3.5 percent estimated spent in 2004, 3.8 7percent in 2005, and 4.71 percent in 2006. IHA urges CMS to publicly account for the amount of unspent outlier payments over the past three years, and to establish a regular policy whereby those unspent funds are returned to the base rate for inpatient PPS spending. For FY 2007, CMS is again proposing to increase the fixed-loss threshold by which cases must exceed to qualify for outlier payments. Before changes are made to the outlier threshold making it increasingly difficult to receive outlier payments, CMS should establish procedures to ensure the total 5.1 percent is spent equitably each year.

SCH/MDH Volume Decrease Adjustment

IHA urges CMS to consider using the American Hospital Association Annual Survey to determine the Sole Community Hospital (SCH) or Medicare Dependent Hospital (MDH) volume decrease adjustment. IHA opposes the proposal to use data from the Medicare cost report and the occupational mix survey. First, because these two data sources are not from the same time period, and second, because there are many outstanding concerns regarding the integrity of the data collected through the occupational mix survey.

SCH/MDS Changes in Qualification Status

IHA opposes the proposal to require SCHs and MDHs to make a unique report to CMS Regional Offices should there be material changes that affect the status of either provider type designation. Currently, it is the FI's responsibility to evaluate continuing qualification for SCH or MDH status. More importantly, to participate in the Medicare program, new providers must complete

the Medicare 855 provider enrollment application, and any provider making changes to its status that would affect a SCH/MDH special designation is required to report such changes on the Medicare 855. CMS Regional Offices and Medicare contractors both have practices in place that eliminates the need for additional reporting requirements on the part of hospitals. IHA recommends this function remain a responsibility of the CMS Regional Offices and contractors.

Occupational Mix Adjustment

In response to a MedPAC recommendation, Congress passed legislation creating the occupational mix component of the wage index calculation to adjust for this payment inequity. Section 304 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) requires the Secretary of Health and Human Services to collect data every three years on the occupational mix of employees for each short-term, acute care hospital participating in the Medicare program (excluding Critical Access Hospitals), in order to construct an adjustment to the wage index beginning October 1, 2004.

IHA supports the legislation Congress passed creating an occupational mix adjustment to ease the payment inequities caused by the Medicare wage index. However, to date, CMS has been unsuccessful in developing a methodology or data collection tool that achieves the intention of the legislation and mitigates payment inequity. In fact, the methodology implemented by CMS has exacerbated the inequity in most geographic locations. **Eight of Iowa's 10 geographic locations have been financially harmed by the occupational mix adjustment.**

From 2001 to present, CMS has attempted several times to develop a reliable data collection tool and methodology to apply the occupational mix adjustment. The first application of the occupational mix adjustment occurred in fiscal year (FY) 2005. Due to substantial data integrity concerns, CMS only applied 10 percent of the occupational mix adjustment to the area wage index. The methodology applied in FY 2005 and FY 2006 resulted in 17 rural areas experiencing a decrease in wage indices, while 178 urban areas experienced an increase in wage indices nationwide. One third of rural hospitals actually fare worse under this occupational mix methodology. The state of Iowa, which is largely rural, has long experienced payment inequities in the Medicare program and continues to experience payment inequities despite Congressional action intended to ease the financial burden.

CMS intended to apply the same data and adjustment percentage applied to the FY 2005 and FY 2006 wage indices to adjust the FY 2007 wage data. However, as a result of the April 2006 Court of Appeals decision, *Bellevue Hospital Center v. Leavitt*, CMS issued a proposed rule to apply the occupational mix adjustment to 100 percent of the wage index effective for FY 2007. According to the proposed rule, CMS intends to base the FY 2007 occupational mix adjustment on only three months of un-audited data. Further, the methodology by which CMS will apply the occupational mix adjustment in FY 2007 is not yet known, making it impossible for hospitals to quantify and prepare financially. **What is known is the calculation in place today, if applied at 100 percent, would reduce payments to Iowa's 35 PPS hospitals by over $4 million annually.**

The inverse outcome of the occupational mix adjustment appears to result from data collected by CMS and the assumptions the agency is utilizing in the process. For example, it is unclear why CMS has chosen to focus on nursing hours and wages, yet has excluded other staff such

as laboratory and radiology personnel. Management decisions do not solely account for the number of registered nurses a hospital employs as compared to licensed practical nurses due to supervision ratios dictated by CMS rules. By not recognizing the occupational mix of hospital ancillary departments such as radiology, laboratory, and therapy, CMS fails to capture data for staffing patterns that are a result of management decisions. IHA supports data collection of expanded employment categories to recognize different staffing patterns in rural areas.

IHA also has concerns that CMS intends to apply the occupational mix adjustment for FY 2007 based upon three months of un-audited data. IHA firmly believes it is crucial for hospitals to have an opportunity to review the finalized occupational mix data submitted to ensure its accuracy and appeal incorrect information. IHA also asserts that the data collection should occur on a January 1 through December 31 time period to improve data accuracy by accounting for staffing fluctuations throughout the year and allow for comparisons with W-2 and other Internal Revenue Service filings. Furthermore, IHA supports the 2002 MedPAC recommendation to collect occupation-specific data on wages and hours using the hospital annual Medicare Cost report, as is done for other data collected for the wage index calculation. The use of the cost report would allow data used for the occupational mix adjustment to come from the same time period as the wage index data, instead of the current four-year gap.

IHA believes the current data collection and methodology for the Medicare occupational mix adjustment does not fulfill the intent of Congress and fails to mitigate payment inequity to rural areas such as Iowa. Rather, the methodology implemented by CMS has had the inverse outcome, generally increasing payment to urban areas and decreasing payment to rural areas. CMS needs to re-evaluate the data requested and the methodology for the Medicare occupational mix adjustment to result in more equitable payments for rural areas under the Medicare payment system.

Specifically, a new occupational mix methodology should include the following:

- **The data collection tool should be expanded to ancillary employment categories such as radiology, laboratory, and therapy to recognize different staffing patterns in rural areas that are a result of management decisions.**
- **The data collection should occur on a January 1 through December 31 time period to improve data accuracy by accounting for staffing fluctuations throughout the year and allow for comparisons with W-2 and other Internal Revenue Service filings.**
- **CMS should collect occupation-specific data on wages and hours using the hospital annual Medicare Cost report, as is done for other data collected for the wage index calculation.**
- **An opportunity for hospitals to review the finalized occupational mix data submitted to ensure its accuracy and appeal incorrect information.**

Thank you for your review and consideration of these comments. If you have questions, please contact me at the Iowa Hospital Association at 515/288-1955.

Sincerely,

Heather J. Hoscher

Director, Finance Policy

cc: Iowa Congressional Delegation
Iowa Hospitals
Iowa Hospital Association Board of Trustees
CMS Kansas City Regional Office

Submitter : Mrs. Debra Shank **Date:** 06/12/2006

Organization : Greater Lawrence Family Health Center

Category : Other Health Care Professional

Issue Areas/Comments

GME Payments

GME Payments

As the administrator of a family medicine residency and someone who is very much involved with scheduling the components of their education, I appreciate the opportunity to comment on the
Centers for Medicare & Medicaid Services' (CMS or the Agency) proposed rule entitled "Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates." 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in "patient care activities." The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

Background
The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a nonhospital setting, such as a physician's office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not "related to patient care".

This position reverses the Agency's position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include "scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty." [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency's 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs.

Residency Program Activities and Patient Care
I firmly believe that with the possible exception of extended time for "bench research," there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician's educational development into an autonomous practitioner.

To separate out CMS's newly defined "patient care time" from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,

Debra L. Shank

Submitter : Dr. Tony Pelzel **Date: 06/12/2006**

Organization : United Hospital-Allina Hospitals and Clinics

Category : Individual

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS or the Agency) proposed rule entitled "Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates." 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in "patient care activities." The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

Background
The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a nonhospital setting, such as a physician's office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not "related to patient care".

This position reverses the Agency's position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include "scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty." [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency's 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs.

Residency Program Activities and Patient Care
I firmly believe that with the possible exception of extended time for "bench research," there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician's educational development into an autonomous practitioner.

To separate out CMS's newly defined "patient care time" from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,
Tony A. Pelzel. M.D.

Submitter : **Date: 06/12/2006**

Organization :

Category : **Individual**

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS or the Agency) proposed rule entitled 'Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates.' 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in 'patient care activities.' The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

Background
The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a nonhospital setting, such as a physician's office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not 'related to patient care.'

This position reverses the Agency's position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include 'scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty.' [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency's 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs.

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I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,

Marie David, MD

Submitter : Mr. Allen Schwartz **Date:** 06/12/2006

Organization : MedCentral Health System

Category : Hospital

Issue Areas/Comments

Impact Analysis

Impact Analysis

June 9, 2006

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1488-P
P.O. Box 8011
Baltimore, MD 21244-1850

Gentlemen:

This letter is in response to the CMS proposed FY 2007 changes in funding for Cardiology Services (CMS-1488-P). Cardiac disease continues to be the number one killer of men and women in the United States. Congestive heart failure continues to be the number one admitting diagnosis for most hospitals in the U.S. For hospitals it remains a delicate balance between providing up to date, clinically and technically relevant care to patients with cardiac disease and maintaining fiscal responsibility. The proposed rules changes referenced above will have a drastic negative effect on that balance for, at least the following reasons.

q The proposed DRG weights are based on cost data that is 3-5 years old.
q The cost data does not include a complete picture of many important and commonly used technologies (e.g. drug eluting stents).
q It assumes that higher cost devices are marked up the same as low-cost supplies. This is typically not true.
q Twenty-five percent of hospital charges were excluded when deriving the cost-to-charge ratios.
q Severity adjustments must account for both complexity and severity in order to be accurate
q The proposed 33% reduction in payment for drug eluting stents would impact all PCI patients but would have its most severe effect on those patients who require multiple stents in the same vessel.
q Cardiology is a rapidly changing specialty. The continued evolution of devices such as drug eluting stents to include: bioabsorbable stents, stents where the drug and the dose can be tailored to the patient, etc. will more than likely increase supply costs as opposed to reducing them. As ICD s and pacemakers continue to be developed, new generations will be more sophisticated and more costly.
q Any proposal of this magnitude should be phased in order to allow for planning and the realignment of resources.

The proposed CMS changes are the most sweeping in 20 years. For hospitals, and the patients we serve, these changes will have a drastic negative impact on our ability to provide clinically appropriate care. Although we appreciate the effort on the part of CMS to put all hospitals on equal reimbursement footing, it would seem equally important to provide accurate reimbursement that allows us to continue to balance fiscal health with the health and wellbeing of our citizens. We look forward to working with CMS to provide the accuracy necessary to achieve our collective goals.

Sincerely,

Allen M. Schwartz Gregory Eaton, MD
Director Medical Director
Cardiovascular and Pulmonary Services Cardiac Catheterization
MedCentral Health System MedCentral Health System
Mansfield, Ohio 44903 Mansfield, Ohio 44903

Submitter : **Dr. Imran Andrabi** **Date: 06/12/2006**

Organization : **Mercy Health Partners**

Category : **Academic**

Issue Areas/Comments

GME Payments

GME Payments

As a family physician and an educator actively involved in Graduate Medical education, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS or the Agency) proposed rule entitled Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systemsand Fiscal Year 2007 Rates.71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in patient care activities.The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

Background
The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting),and for DGME payments when the activities occur in a non hospital setting, such as a physicians office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not related to patient care.

This position reverses the Agency's position expressed as recently as 1999, at which time of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include scholarly activities,such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty. [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care toScott McBride, Vinson & Elkins]. I support the Agency's 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs.

Residency Program Activities and Patient Care
I firmly believe that with the possible exception of extended time for bench research,there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician's educational development into anautonomous practitioner. This is also an expectation of the accreditations standards for ACGME/AOA programs. Any proposed changes would require us to re-think the whole accreditation requirements as they are set up at this time for GME.

To separate out CMS's newly defined patient care time from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarificationin the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,

Imran Andrabi

Submitter : **Dr. martha kershaw** **Date: 06/12/2006**

Organization : **michigan academy of family physicians**

Category : **Physician**

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS or the Agency) proposed rule entitled "Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates." 71 Fed. Reg. 23996 (April 25, 2006).

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I firmly believe that with the possible exception of extended time for "bench research," there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician's educational development into an autonomous practitioner.

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I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,
Martha O. Kershaw MD

Submitter : **Mr. Arthur Maples** **Date: 06/12/2006**

Organization : **Baptist Memorial Restorative Care Hospital**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1482-Attach-1.DOC

1482

BAPTIST. | RESTORATIVE CARE

June 9, 2006

Mark McClellan, M.D., Ph. D.
Department of Health and Human Services
Attention: CMS-1488-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Re: Comments on Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates -- CMS–1488- P

Dear Dr. McClellan:

Baptist Memorial Restorative Care Hospital (BMRCH) appreciates the opportunity to submit these comments on proposed rules published on April 25, 2006 at 71 Fed. Reg. 23996. This rulemaking proposes revisions to the regulation governing grandfathered long-term care hospitals-within-hospitals (HwHs). BMRCH is located at 6019 Walnut Grove Road, Memphis, Tennessee 38120 on the campus of Baptist Memorial Hospital-Memphis (BMHM). It is a grandfathered HwH under Section 4417(a) of the Balanced Budget Act of 1997. It serves a significant percentage of Medicare patients residing in the Mid South, Memphis area. For many years, it has been unable to provide modest increases in square footage or number of beds to improve operations and patient care.

In the proposed rate year 2007 update rule for hospitals subject to the inpatient short-term acute hospital prospective payment system (IPPS), CMS has proposed limited revisions to the rule governing grandfathered HwHs:

- to allow for increases or decreases in square footage, or decreases only in the number of beds, due to relocation of the hospital (a) to permit construction or renovation necessary to comply with state, federal or local law affecting the physical facility, or (b) because of a catastrophic event, such as a fire, flood, earthquake, or tornado;
- to allow for decreases only in the number of beds or square footage.

CMS' proposed changes to the grandfathered hospital-within-hospital rule at 42 C.F.R. §412.22(f) are inadequate.

However, CMS' proposed revisions to 42 C.F.R. §412.22(f) do not address the need for grandfathered HwHs to change programs to meet patient care requirements. BMRCH studied the needs of patients appropriate for Long Term Acute Hospital Care simultaneously with the State of Tennessee's Health Planning Commission in the early 90's. Over the years, Baptist Memorial Health Care Corporation (BMHCC) and BMRCH have continued to evaluate health care delivery needs along the continuum of care. The system adapts with appropriate technologies and capacities in accordance with state health planning and community needs to provide orderly development of health services. To maintain the efficiencies and effectiveness of a continuum of service BMRCH needs the capability to accommodate space for improved Information Technology and ancillary service development and due to the changes in population needs should be able to modestly adapt with slight increases in bed capacity in response to the community.

BMRCH needs to be allowed to make changes to its terms and conditions of operation to respond to the evolving needs of its patient population and to changes in medical practice. BMRCH believes that limits to modest changes would be inconsistent with the needs and best interests of Medicare beneficiaries.

The preamble to the proposed rule states CMS' underlying reason for imposing restraints on the operations of LTCHs grandfathered by 42 C.F.R. §412.22(f) is the potential of patient shifting between co-located entities and a host hospital. The changes in patient care services and operations which BMRCH needs to undertake to serve its patient population do not implicate the patient substitution of services issued which are of concern to CMS.

BMRCH urges CMS to expand its proposed revisions to the grandfathered HwH regulation to allow for increases in the number of beds or square footage where such increases are consistent with the needs and best interests of Medicare beneficiaries, for example, pursuant to a state Certificate of Need, to create isolation rooms, to provide ancillary services or therapeutic services necessary for patient care, to add or expand off-site outpatient provider-based activities related to patient care, to add or expand on-site provider-based activities related to patient care, or to increase ventilator support. In addition, there should be an exception for increases in square footage to accommodate administrative offices since such increases do not result in increased costs to the Medicare program.

BMRCH endorses the comments submitted by the National Association of Long Term Hospitals and thanks you for your consideration of these comments.

Sincerely,

Janice Hill
Administrator and CEO

Submitter : **Dr. Brent Wright** **Date: 06/12/2006**

Organization : **U of L Department of Family and Geriatric Medicine**

Category : **Physician**

Issue Areas/Comments

GME Payments

GME Payments

Dear CMS,

I would like provide comments on the proposed changes to the Hospital Inpatient Prospective Payment Systems. Currently I am a Family Medicine Residency Program Director. Family Medicine represents true value to our healthcare system by being able to care for patients with multiple chronic conditions in an efficient manor. Over the last several years U. S. Medical School Graduate interest has declined to approximately 1100 U. S. Grads pursuing a career in Family Medicine. This is concerning in that these applicants only fill roughly 1/3 of available positions. Changing the payment to alleviate time spent in lectures and in physician offices would not hurt only Family Medicine, but support of all residency programs.

Graduate Medical Education is a unique entity and with continual demands to educate our residents in evidenced-based care coupled with the humanistic qualities that medicine needs to embrace decreasing payment would create challenges that some programs may not be able to overcome.

All time spent in a residency environment is geared towards the effective education of a physician who will provide care for thousands of patients throughout his or her lifetime. I encourage you to not make any changes in this system that would create burden on graduate medical education programs.

Sincerely,

R. Brent Wright, M.D.
U of L/Glasgow FMR

Submitter : Dr. Donna Nelson **Date:** 06/12/2006

Organization : Nebraska Academy of F. P.

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

In an era when all health care providers need to be life ong learners, this sends a very negative message to in essence not fund didactic activities and would most severely limit the less procedural based fields of medicine. Please recind the currently proposed language as it relates to didactic training. Donna Nelson, M.D.

Submitter : Mr. Patrick Clark **Date:** 06/12/2006

Organization : Avera Queen of Peace

Category : Hospital

Issue Areas/Comments

SCH/MDH Changes in Qualification Status

SCH/MDH Changes in Qualification Status

See Attachment

CMS-1488-P-1485-Attach-1.DOC

#1485

June 9, 2006

Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1488-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Medicare Program: Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates; Fed. Reg. 23,996 et seq. (Apr. 25, 2006); CMS-1488-P

Dear Sir or Madam:

The purpose of this letter is to provide comments related to the above proposed changes. My comments will focus on those related to **SCH/MDH Changes in Qualification Status**.

Avear Queen of Peace is a Sole Community Hospital located in South Dakota. We serve a primary and secondary service area of approximately 65,000. Our facility provides comprehensive acute health care services to this area and is the largest hospital within a 60 mile radius. We have many specialties that would are found in larger urban areas.

From a demographic standpoint, we are surrounded by many Critical Access Hospitals (CAH). With respect to the CAH facilities, the closest facilities would be 25 miles to the south, 50 miles to the southwest, 65 miles to the west and 50 miles to the northwest. As you are aware, most CAH lack full-time emergency room services, obstetrics, intensive care, surgical services, and various technological services. The closest acute care hospitals (non-specialty hospitals) are 75 miles from Mitchell.

As the above paragraph describes, there is no like acute hospital within 75 miles of our facility. We are truly a SCH that provides the single access for many services due to our geographic isolation and give the other CAH facilities the healthcare infrastructure that is critical to their communities.

Our concerns with the proposed regulations and reporting requirement and penalties are problematic for a number of reasons. These need to be clarified and revised to be consistent with the intended purpose of the SCH program.

We suggest the following:

CMS and its fiscal intermediaries should maintain hospital status, patient admissions and patient day data and periodically evaluate this data for SCH eligibility due to:

- Hospitals, even though they are aware of the market place, are not in the best position to monitor compliance. They may not know if a CAH converts back to an acute facility.
- Obtaining the information necessary to calculate the various numeric values to qualify is sometimes hard to obtain by a hospital and requires many facilities to obtain this data from the intermediary through the Freedom of Information Act. This means cost reports are not available until at least five months after a year end. This also means there is no way to prospectively calculate certain data and everything is on a retrospective basis.
- For those that use the 8 percent threshold to identify "Like Hospitals" the data is simply not available on a timely basis.
- It is not reasonable for a hospital to monitor and know all the other factors associated with SCH designation at a given time. These include road closures, weather conditions, etc.

CMS needs to expand the 30 day timetable for canceling SCH status when a hospital self-reports. We would suggest at least 12 months.

Retroactive penalties should only apply when a hospital had actual knowledge that it no longer qualified for the reasons noted above plus a hospital's inability to know everything it its region that relates to how it qualifies or does not qualify.

CMS should re-evaluate the definition of "Like Hospital" due to:

- The current 8 percent threshold was arbitrarily decided and not based on any empirical study or evidence.
- Specialty hospitals are a threat to SCHs due to siphoning off patients with payer mixes that produce very high margins (30-50%), increasing expenses at the SCH since there are fewer patients to cover the overhead of a full service hospital.
- Specialty hospitals in many cases do not provide a community the full scope of services. They will minimize costs by not including a full-time lab, full-time radiology, 24 hours in-house physician coverage in the ER, obstetrical services, medical services, respiratory therapy, complete array of technology, community services, etc.
- Their ability to provide emergency care to their inpatients is very limited and procedures involve calling the ambulance or 911 in the case of an emergency to transfer the patient to a "True" acute hospital.
- Patient days in an acute facility continue to decrease due to technology and outpatient services. Patient days at a specialty hospital may increase due to talking more patients out of the market that do not require a high level of care or that are more profitable in the for-profit setting. In the end, with the 8 percent test, it becomes much harder to meet since the 8 percent is over a lesser number

for the acute hospital. This again shows how problematic the 8 percent is given no concrete data or analysis was used to determine what should be used.

- In a rural market such as ours, the population is not growing but rather decreasing. This results in fewer inpatients, therefore, less days. While a specialty hospital is seeing a small subset of the population, they continue to see the same patient days or they bring additional procedures with high profitability at the expense of the acute hospital, increase their days and the full service acute hospital then sees the patient day margin (8%) becoming an issue.
- MEDPAC and CMS have both realized there is a disparity on how an acute hospital is paid compared to a specialty hospital and have proposed changes in DRGs to somewhat compensate for this. We support this change and would add that by making this change, CMS is agreeing that specialty hospitals are different than acute hospitals. This alone should result in CMS examining the definition of a "Like Hospital."
- Some specialty hospitals consider themselves as a "Surgical Center" since it is used in their name. This can easily be interpreted to mean they consider themselves not to be an acute hospital.

Please call me at 605-995-2251 if you have any questions about these comments.

Sincerely,

Patrick Clark
Senior Vice President and Chief Financial Officer

Submitter : Mr. Casey Crimmins **Date:** 06/12/2006

Organization : The University of Michigan Health Systems

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1486-Attach-1.DOC

#1486

University of Michigan
Hospitals and
Health Centers

Accounting and Reimbursement Services
2500 Green Rd. Suite 100
Ann Arbor, Michigan 48105-1500
734-647-3321
734-647-0026 Fax

June 12, 2006

Mark McClellan, M.D., Ph.D, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1488-P
P.O. Box 8011
Baltimore, MD 21244-1850

Re: FY 2007 Medicare Inpatient Prospective Payment System Proposed Rule CMS-1488-P

Dear Dr. McClellan:

The University of Michigan Health System (UMHS) welcomes this opportunity to comment to the Centers for Medicare & Medicaid Services (CMS) regarding the proposed rule to update the Inpatient Prospective Payment System for FY 2007. Our comments are as follows:

NEW DRG WEIGHTS – HSRV (COST-BASED)

We appreciate CMS' efforts to improve the accuracy of the DRG system by adopting a cost-based methodology, and the initiative to recognize severity differences within each DRG. However, a change of the magnitude proposed by CMS should not be made until hospitals can be reasonably assured that the assumptions are valid, the calculations are accurate and the results are appropriate. Unfortunately, the proposed DRG weights are based on invalid assumptions, and organizations that have reviewed the data have discovered serious errors in the calculations. The proposed DRG changes will cause massive redistribution of Medicare payments, a result that is not at all appropriate given the major uncertainties and issues about the DRG weights.

According to the provider impact file published by CMS, UMHS was projected to receive a 0.9% increase in case mix index under the 2007 DRG weights. However, since publication it was discovered that there were errors in the calculation of the relative weights for solid organ transplants which overstated the projected UMHS impact by $5 million. As a result, UMHS would suffer a 1.1% decrease in case mix index after correction of the error. The majority of the 1.1% decrease is in cases involving cardiac procedures, where a 12% decrease in Medicare payment is projected under the proposal. We have very significant concerns that CMS' methodology understates the relative value of cardiac procedures, and other cases that utilize expensive devices and implants. We believe that it would be inappropriate to implement the changes for cardiac care and other major surgical procedures until these concerns are properly addressed, just as it would be improper to adopt the proposed weights for solid organ transplants. Simply stated, more time is needed for both CMS and the hospital industry to analyze, evaluate and make corrections as needed.

Specific concerns are noted below:

Assumptions

1. CMS proposes to calculate the cost estimates for Fiscal Year 2007 payments by utilizing hospital claims data from Fiscal Year 2005 and hospital cost reports from Fiscal Year 2003. The use of data from Fiscal Year 2003 fails to account for current technology such as drug-eluting stents and bi-ventricular pacemakers/defibrillators. Any estimate of cost developed without this information will be inaccurate and will inadequately compensate hospitals for the care of patients treated with these technologies.

2. CMS assumed that every hospital maps its charges and costs the same way. This is definitely not the case. At UMHS, for example, most supplies and devices are mapped to the department utilizing the item – Operating Room, Cardiology, etc – and not to the Supplies Charged to Patients cost center. Applying a Supplies cost-to-charge ratio to a device that we map to Operating Room will dramatically distort the estimated cost of the device.

3. CMS assumed that every test, procedure and item within a cost center has the same cost-to-charge ratio. This is also an incorrect assumption. Many hospitals utilize different "mark-up" strategies for high cost devices and drugs than for low cost, routine items. Often the "mark-up rate" for a high cost item is far less than the rate for a low cost item. As a result, high cost items may have greater cost-to-charge ratios than low cost items. By applying a single cost-to-charge ratio to all items in a cost center, CMS is understating the relative value of high cost items and overstating the value of low cost items. We believe that this distortion is one of the main reasons for the proposed decrease in payment for cardiac surgery cases and other cases involving expensive devices and implants.

Methodologies and Errors

In the limited time that the proposed HSRV weights and the supporting data have been publicly available, organizations have had insufficient time to review the methods and calculations. However, in the short time that has been provided, the industry has identified numerous errors, invalid or questionable assumptions, and opportunities to improve the estimated relative values.

- As noted above, CMS inadvertently included organ acquisition costs in the calculation of weights for solid organ transplant cases, causing a very material overstatement in the weights for these cases.
- It appears that CMS excluded data from several hospitals with very low cost-to-charge ratios in routine cost centers.
- CMS' weighting methodology gives equal weight to every hospital, even though hospitals can range in size from fewer than 25 to more than 1,000 beds.

The industry analyses referred to above conclude that CMS has significantly overstated the value of routine cost centers and understated the value of ancillary cost centers.

More time is needed to evaluate the model, validate the data and assumptions, and ensure the results are reasonable. Clearly there are significant problems with the proposed DRG weights.

Recommendation

Given that the change to cost-based weights is not mandated, the only acceptable rationale for a change of this magnitude is to improve the accuracy of DRG weights. This proposal does not improve

accuracy and in many cases, such as weights for cardiac surgery, we believe the proposed weights are significantly less accurate.

We urge CMS to delay implementation of the cost-based DRG weights for at least one year to ensure that the results are as accurate as possible. This will allow CMS to partner with industry leaders to evaluate methods and assumptions and determine the best data to accomplish the objectives. Furthermore, if the improved version still generates material redistribution of payments, a transition period of at least three years should be adopted, consistent with nearly all other major Medicare changes.

CS-DRG (SEVERITY OF ILLNESS) STRUCTURE

UMHS supports the refinement of the DRGs but believes that the proposed consolidated severity-adjusted DRGs (CS-DRG) require further examination and will likely require modifications before implementation. We believe that these changes should be implemented simultaneously with HSRV to ensure equity and minimize payment volatility for hospitals.

Our analysis shows a large amount of payment volatility if both systems (HSRV and CS-DRG) are not implemented simultaneously. Roughly 1/3 of UMHS' DRG weights would have inconsistent changes over the two years of implementation. When compared to Grouper 23 DRG weights, 20 % of UMHS DRG weights would have increases under HSRV and decreases under CS-DRG, while 12% of our DRG weights would have decreases under HSRV but increases under CS-DRG.

UMHS recommends the CS-DRG should be implemented simultaneously with HSRV to ensure equity and minimize payment volatility for hospitals.

CMS acknowledges in the April 25, 2006 Federal Register page 24014 "the APR DRG structure does not currently accommodate distinctions based on complexity. Technologies that represent increased complexity, but not necessarily greater severity of illness, are not explicitly recognized in the APR-DRG system... We plan to develop criteria for determining when it is appropriate to recognize increased complexity in the structure of the DRG system".

UMHS analysis of the 3M grouper software showed a significant decrease in case mix associated with the nine PRE-MAJOR DIAGNOSTIC CATEGORIES (PRE-MDCS) DRGs, especially DRG 541, ECMO or Tracheostomy with M V 96+ Hours.

The UMHS analysis shows some cases that were originally grouped into DRG 541 with a DRG weight of 19.80 would be grouped into a CS-DRG with a weight less than 1.00. This would result in a significant and unacceptable decrease in reimbursement when CMS' own analysis in FY06 IPPS Final Rule lists the average charges for DRG 541 in excess of $250,000 and ECMO case average charges exceed $560,000.

This is one example of a flaw in the proposed CS-DRG weights.

UMHS recommends the adjustments for increased complexity include the same criteria used when determining the PRE-MAJOR DIAGNOSTIC CATEGORIES (PRE-MDC).

CMS is soliciting comments related to the potential change in case mix because the large increase in the number of DRGs will provide opportunities for hospitals to do more accurate documentation and coding of information contained in the medical record. The Secretary has broad discretion under

section 1886(d)(3)(A)(vi) of the Act to adjust the standardized amount so as to eliminate the effect of changes in coding or classification of discharges that do not reflect real changes in case mix. CMS wants to ensure that documentation and coding improvements do not result in material case mix increases, as was the case with the implementation of IPPS in 1983. However, unlike the creation of IPPS, the CS-DRG has a similar basic structure to current payment methodology.

- There are 25 MDCs in both systems.
- The DRG assignments for both systems are based on the reporting of ICD–9–CM diagnosis and procedure codes.
- Both DRG systems are composed of a base DRG that describes the reason for hospital admission and a subdivision of the base DRG based on other patient attributes that affect the care of the patient.

The main difference is, the current system subdivides the base DRGs using age and the presence of a secondary diagnosis that represents a complication or comorbidity, while the CS-DRG system is highly dependent on the patient's underlying problem (severity of illness). These multiple serious diseases or illnesses causing severity adjustments are most likely already being documented in the current system. Also, CMS is proposing to consolidate APR-DRGs so that some of the potential incremental documentation will be offset with this consolidation.

UMHS recommends that CMS not use a coding improvement factor in its budget-neutrality calculations until actual claims data and results can be analyzed after one or two years under the new system.

OUTLIER THESHOLD

CMS is proposing to increase the fixed-loss cost outlier threshold from the current $23,600 to $25,530, which represents an 8.2 percent increase. Although a 5.1% pool was set aside each year, the CMS estimates that outlier payments were only 4.1% in FY 2005 and 4.7% in FY2006. The American Hospital Association (AHA) and many other hospital associations believe the increase in the outlier threshold is unwarranted, and have prepared alternate, more supportable calculations that project a much lower threshold. **We urge CMS to maintain the outlier threshold at the current level of $23,600.**

GRADUATE MEDICAL EDUCATION

UMHS believes that Congress and the Courts have instructed CMS to acknowledge that educational activities within the scope of a graduate medical education program are considered to be "patient care activities". (47 Fed Reg. 43296, 43310 Sept 30, 1982 and Sixth and Seventh circuit decisions Univ. of Cincinnati v. Bowen 1989 & Loyola Univ. of Chicago v. Bowen 1990), and subsequent amendments to the statute have imposed various limits on the amount of graduate medical education reimbursement providers receive.

In the proposed rule preamble CMS acknowledges that didactic teaching activities such as educational conferences, journal clubs and seminars are a necessary part of an approved medical residency program and that some of these activities may take place outside the hospital complex. CMS concludes that such didactic or "scholarly" activities which occur in a non-hospital site, are not allowable for direct graduate medical education (DGME) and indirect medical education (IME) payment purposes. The stated rationale for the exclusion of time devoted to these activities is that they are not "related to patient care". The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full time

equivalent (FTE) resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a non-hospital setting.

The proposed rule position is in stark contrast to the CMS' position as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include "scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty." [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. UMHS agrees with the CMS 1999 position. The activities cited are an integral component of the patient care activities engaged in by residents during their residency programs. In addition, UMHS requests the following effects of the "clarification" be considered:

- Requiring GME programs to maintain records to document the frequency and location of these didactic activities creates an undue and unnecessary administrative burden on hospitals.

- For DGME purposes, it is critical that the calculation of FTE be consistent with the calculation used in the 1985 base year, which was used to establish the hospital-specific cost per resident. At that time, there were no discussions about excluding didactic teaching activities.

- The didactic teaching time spent, on average, is a small percentage of the total time spent by residents, who generally work far in excess of the 40 hour average that CMS uses to determine FTEs.

Determining FTE interns and residents is already one of the most complex parts of the Medicare hospital payment regulations. UMHS recommends **CMS rescind this "clarification", to retain a more reasonable and logical calculation of FTEs and avoid another layer of complexity and administrative burden.**

Once again UMHS would like to thank you for the opportunity to comment on the proposed rule to update the Inpatient Prospective Payment System for FY 2007. If you have any questions or would like clarifications please contact me at (734) 647-3322.

Sincerely,

Casey Crimmins, Manager
Accounting and Reimbursement Services
University of Michigan Hospitals and Health Centers

Submitter : Mr. James Harris **Date:** 06/12/2006

Organization : MedCath Corporation

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment.

CMS-1488-P-1487-Attach-1.DOC

#1487

MedCath®
CORPORATION

June 12, 2006

VIA ELECTRONIC SUBMISSION

Hon. Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1488-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Re: Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates; Proposed Rule, 71 Fed. Reg. 23,996 (Apr. 25, 2006)

Dear Dr. McClellan:

This letter provides the comments and recommendations of MedCath Corporation ("MedCath") in response to the proposed changes to the hospital inpatient prospective payment system ("IPPS") and rates for fiscal year ("FY") 2007 published in the Federal Register by the Centers for Medicare & Medicaid Services ("CMS") on April 25, 2006. We appreciate the opportunity to provide these comments and recommendations.

Based in Charlotte, North Carolina, MedCath is a national provider of cardiovascular services. We build and operate fully-licensed acute care hospitals, and other clinics and centers focusing on cardiovascular care. All of our twelve hospitals are owned in partnership with physicians and, in certain instances, local community hospitals. We also have entered into alliances and joint ventures with community hospitals to enhance the provision of cardiovascular services in their communities. We have established an outstanding reputation for innovation and for our focus on providing high-quality cardiovascular care.

I. INTRODUCTION

As discussed in detail below, MedCath opposes many of the changes in the IPPS as outlined in the proposed rule. With the proposed rule, CMS seeks the most significant changes to CMS's "flag-ship" diagnosis-related group ("DRG") system since the inception of the IPPS – a period of over twenty years. While we support reform of the current system to more accurately reflect the cost of health care services provided by all hospitals, the proposed rule in its current form does more harm than good.

MedCath engaged The Lewin Group ("Lewin") to analyze the proposed rule and assist MedCath with making its recommendations. This analysis found, and we respectfully submit, that CMS both incorrectly calculated the cost-to-charge ratios ("CCRs") and improperly utilized Medicare Cost Report ("MCR") CCRs for estimating DRG-level costs given inconsistencies in

how costs are assigned to cost centers within the MCR. In other words, we believe that CMS, in its good faith effort to improve the IPPS, computed cost-based weights in a manner that is not accurate and the MCR data on which the CCRs are based on are structurally flawed.

CMS proposes two major changes to the DRG weighting system – the utilization of hospital-specific relative values ("HSRVs") and a modified version of cost-based weights rather than charge-based weights (collectively, the hospital-specific relative value cost center ("HSRVcc") methodology). While the use of "cost" weights, as opposed to charge weights, is generally preferable as actual costs would better reflect resource use, the use of cost weights, based upon cost-to-charge ratio step-down formulations, poses a variety of practical, theoretical, and computational issues. We believe the HSRVcc methodology developed by CMS and calculation of the ten cost center CCRs is invalid in that hospital-level weighted geometric means instead of charge-weighted averages were utilized. This practice has an unwarranted impact upon IPPS payment distributions. CMS's method of estimating CCRs produces vastly different results at the DRG and service line level as compared to a more technically appropriate charge-based weighting scheme.

Beyond the issue of utilizing the "correct" weighting scheme to calculate CCRs, the proposed rule fails to recognize that careful care must be employed in calculating cost-based weights. The fundamental assumption that cost-based weights represent a "truth set" is incorrect. In its extensive work in the industry, Lewin has determined that hospitals often report identical costs in widely different cost centers. Moreover, MCRs are not uniformly compiled, are not extensively audited, and hospitals typically are inconsistent in the reporting of costs. Thus, the use of calculated CCRs may not produce cost estimates reflective of the true underlying cost structure for any given service or case type. Ultimately, any comparison of costs calculated from MCRs utilizing various CCR methods produces wide ranging results, none of which necessarily reflect actual costs.

Of comparable importance is the well known fact of charge compression whereby high-cost devices show a lower markup than lower-cost devices. Thus, an overall "supplies" CCR will drastically underestimate the true costs of high-cost devices. We provide examples of the MCR and charge compression issues in our comments below.

Finally, the utilization of CCR derived costs should be externally verified. At a minimum, the cost weights for procedures with high-cost devices should be verified with external cost data – preferably invoices. We believe, the entire range of CMS cost weights should be cross-checked with the results of state-of-the-art hospital accounting systems. Such systems typically utilize an internal "costing" process, which likely produce more accurate costs than the CMS MCR-based costing system which averages costs across all types of cases and hospitals.

Given these inadequacies and the failure of the proposed rule to adhere to threshold legal requirements as explained further below, CMS should: (1) withdraw the proposed rule; (2) delay implementation of the changes outlined in the proposed rule for one year to ensure that changes to the IPPS actually create a better, more accurate payment system; (3) revise the methodology utilized to calculate cost-based weights and rely upon data more accurate than MCR data to reflect actual costs; and (4) phase-in any changes to the IPPS over a period of three to five years.

II. BACKGROUND

A. The Social Security Act

Pursuant to section 1886(g) of the Social Security Act (the "Act"), payment for the capital-related costs of hospital inpatient stays is based upon the IPPS. Specifically, payment

under the IPPS is based upon the assignment of a hospital's discharge in a particular DRG and the relative payment weight of that DRG. The relative weight represents the resources required by hospitals, on average, to provide care to patients in that DRG compared to the resources required in other DRGs.

In FYs 1984 and 1985, these DRG weights were based upon hospitals' costs as reported on MCRs. Beginning with FY 1996 and through the present, CMS calculates the relative weights based upon hospitals' charges as reported on the bills submitted to the Medicare program. Hospitals, however, are still required to submit MCRs which are utilized for policy analysis and research.

Currently, the most significant use of the MCR is to calculate the total aggregate cost of care to all Medicare patients for comparison to the Medicare program's payments and the calculation of profit margins. This information is used, for example, in MedPAC's annual update recommendations to the Congress. Use of MCRs for aggregate calculations is dramatically different than use of MCRs for DRG-level analysis.

B. Medicare Payment Advisory Commission Recommendations

In March 2005, the Medicare Payment Advisory Commission ("MedPAC") submitted its Report to the Congress: Physician-Owned Specialty Hospitals. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ("MMA") directed MedPAC to report to the Congress on certain issues concerning physician-owned cardiac, orthopedic, and surgical specialty hospitals. In preparing its report, MedPAC analyzed hospitals' MCRs and inpatient claims from FY 2002. Importantly, MedPAC acknowledged that its findings were based upon the small number of physician-owned specialty hospitals having been in operation long enough to generate Medicare data.

In its report, MedPAC made several recommendations regarding the DRG system. These recommendations included: (1) refining the current DRGs to more fully capture differences in severity of illness among patients; (2) basing the DRG relative weights on the estimated cost of providing care rather than on charge; (3) basing the weights on the national average of hospitals' relative values in each DRG; (4) adjusting the DRG relative weights to account for differences in the prevalence of high-cost outliers; and (5) implementing the case-mix measurement and outlier policies over a transitional period.

C. The Proposed Rule

In the proposed rule, CMS focused on four of the five recommendations in the MedPAC report. First, CMS examined refining the current DRG system to better recognize severity of illness. Based upon its analysis of Medicare claims data, CMS developed a consolidated severity group that could be an alternative to the current DRG system. CMS proposes to adopt its consolidated severity DRG system in FY 2008, if not earlier. This delay in implementation is based upon CMS's recognition that revising the DRGs to better recognize severity of illness may have ancillary implications for the outlier threshold, the measurement of real case-mix versus apparent case-mix, and indirect medical education and disproportionate share hospital adjustments.

With respect to the HSRVs, CMS analyzed MCRs, departmental CCRs, Medicare Provider Analysis and Review ("MedPAR") claims data, and MedPAC's suggested methodology for adopting hospital-specific cost relative weights. With the proposed rule, CMS made several changes to MedPAC's recommendation in an effort to propose an administratively feasible methodology for improving the accuracy of DRG weights. CMS proposes to implement the HSRVcc methodology in FY 2007.

In the proposed rule, CMS stated its belief that it does not have the authority to adopt MedPAC's outlier recommendation. Nonetheless, CMS intends to examine this issue in greater detail in the future.

Finally, while CMS proposes to implement the HSRVcc methodology in FY 2007, the agency acknowledges that the proposed changes could result in significant changes to hospital payments. As such, CMS seeks public comment as to whether a transition period to the HSRVcc methodology should be provided.

III. DEFICIENCIES WITH THE DRG RECLASSIFICATIONS IN THE PROPOSED RULE

A. The HSRVcc Has an Unwarranted Adverse Impact Upon Cardiology

The HSRVcc methodology developed by CMS has an adverse and unwarranted impact upon cardiology services. We believe that Medicare payments for all cardiology DRGs, as defined by major diagnostic category for diseases and disorders of the circulatory system (MDC 5), would be reduced by 7.5 percent from FY 2006 to FY 2007 – primarily due to the HSRVcc DRG weight methodology (***Figure 1***). This is the only major diagnostic category that would experience aggregate payment reductions under the proposed rule. Cardiology, however, is one of the most important services for Medicare beneficiaries and accounted for over 30 percent of total Medicare inpatient payments in FY 2006.

Figure 1

Change in Medicare Payments[1] FY 2006 – FY 2007 by MDC Category

MDC	Description	Percent of Medicare Payments in FY 2006	Percent Change in Medicare Payments FY 2006-07	Change in Medicare Payments For Surgical DRGs
	Transplants and tracheostomy	6.1%	2.8%	3.9%
1	Diseases and disorders of the nervous system	6.2%	3.8%	1.5%
2	Diseases and disorders of the eye	0.1%	9.6%	12.6%
3	Diseases and disorders of the ear, nose, mouth and throat	0.5%	8.2%	5.2%
4	Diseases and disorders of the respiratory system	13.2%	10.1%	0.6%
5	**Diseases and disorders of the circulatory system**	**31.0%**	**-7.5%**	**-13.5%**
6	Diseases and disorders of the digestive system	9.6%	9.4%	6.9%
7	Diseases and disorders of the hepatobiliary system and pancreas	2.8%	4.8%	2.2%
8	Diseases and disorders of the musculoskeletal system and connective	12.6%	2.5%	0.5%
9	Diseases and disorders of the skin, subcutaneous tissue and breast	1.6%	15.6%	7.7%
10	Endocrine, nutritional and metabolic diseases and disorders	2.3%	11.2%	-0.5%
11	Diseases and disorders of the kidney and urinary tract	4.5%	11.7%	12.3%
12	Diseases and disorders of the male reproductive system	0.5%	6.4%	4.7%
13	Diseases and disorders of the female reproductive system	0.7%	5.8%	5.5%
14	Pregnancy, childbirth and the puerperium	0.0%	36.8%	26.6%

1 Payments are weighted by number of Medicare discharges by DRG in FY 2005. Source: Lewin analysis using the AORBOR data.

MDC	Description	Percent of Medicare Payments in FY 2006	Percent Change in Medicare Payments FY 2006-07	Change in Medicare Payments For Surgical DRGs
15	Newborns and other neonates	0.0%	4.3%	n/a
16	Diseases and disorders of the blood and blood forming organs	0.8%	13.3%	3.5%
17	Myeloproliferative diseases and disorders, and poorly differentiate	1.1%	2.3%	-0.5%
18	Infectious and parasitic diseases	4.3%	10.8%	6.9%
19	Mental diseases and disorders	0.4%	67.7%	8.5%
20	Alcohol/drug use and alcohol/drug induced organic mental disorders	0.2%	46.6%	n/a
21	Injuries, poisonings and toxic effects of drugs	0.8%	12.2%	6.3%
22	Burns	0.1%	22.4%	19.2%
23	Factors influencing health status	0.2%	26.4%	13.4%
24	HIV Infections	0.2%	9.5%	8.5%
25	Multiple significant trauma	0.2%	3.0%	11.9%
	Total	100.0%	3.4%	-3.0%

As described in the Federal Register, the HSRVcc methodology reduces payments for surgical DRGs and increases payments for medical DRGs. Importantly, as depicted by ***Figure 1***, the majority of the payment reduction for surgical DRGs is accounted for by the large reductions in the cardiac surgery DRGs. We estimate that the aggregate Medicare payments for cardiac surgery would be reduced by 13.5 percent due to the HSRVcc methodology. In aggregate, all other surgical MDCs would receive increases in aggregate Medicare payments except for relatively small aggregate reduction in payments for MDCs 10 and 17. As such, the proposed changes in the DRG weights have an adverse and unwarranted impact upon inpatient cardiology services relative to other major diagnostic categories. Ultimately, given the prevalence and importance of cardiology services, Medicare beneficiaries are at risk for harm when proposed reimbursement changes potentially limit the availability of life-saving and life-enhancing treatments.

B. Flawed Calculation and Application of Cost-to-Charge Ratios

We next determined whether there were systematic flaws in the HSRVcc methodology adversely impacting cardiology services relative to other major diagnostic categories. Based upon this review, we believe there are indeed flaws in the calculation and application of the CCRs utilized to develop the cost scaling factors.

For this analysis, Lewin identified the cardiology DRGs with the largest reduction in DRG weights from FY 2006 to FY 2007 (***Figure 2***), and examined their commonalities. This analysis determined that these DRGs have a high portion of their charges attributed to either the supplies and equipment cost center (pacemakers and defibrillators), cardiology cost center (catheter laboratory), or both. Given this result, Lewin examined problems with the CCR calculation and application for these cost centers as discussed below.

Figure 2
Change in Medicare Payments FY 2006 – FY 2007 by MDC Category[2]

DRG	Description	Change in DRG Weight 2006-07	Supply & Equipment Charges as a Percent of Total Charges	Cardiology Charges as a Percent of Total Charges
118	CARDIAC PACEMAKER DEVICE REPLACEMENT	-15.3%	48.9%	5.7%
124	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG	-19.1%	7.6%	33.4%
125	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG	-28.2%	8.1%	41.5%
515	CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH	-24.9%	67.4%	8.0%
518	PERC CARDIO PROC W/O CORONARY ARTERY STENT OR AMI	-30.9%	23.5%	46.5%
535	CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK	-26.1%	51.5%	12.7%
536	CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK	-24.5%	54.8%	14.3%
551	PERMANENT CARDIAC PACEMAKER IMPL W MAJ CV DX OR AICD LEAD OR GNRTR	-15.1%	43.9%	8.4%
552	OTHER PERMANENT CARDIAC PACEMAKER IMPLANT W/O MAJOR CV DX	-15.8%	50.0%	7.7%
555	PERCUTANEOUS CARDIOVASCULAR PROC W MAJOR CV DX	-23.3%	22.3%	35.0%
556	PERCUTANEOUS CARDIO PROC W NON-DRUG-ELUTING STENT W/O MAJ CV DX	-36.0%	29.6%	43.5%
557	PERCUTANEOUS CARDIO PROC W DRUG-ELUTING STENT W MAJOR CV DX	-25.7%	32.8%	33.1%
558	PERCUTANEOUS CARDIO PROC W DRUG-ELUTING STENT W/O MAJ CV DX	-35.3%	38.7%	38.8%

1. Cardiology Cost Center CCR Calculation

Lewin attempted to recreate CMS's CCR calculation utilizing the methodology described in the Federal Register to compute national geometric mean CCRs. Although, Lewin did not have the information to include exactly the same hospital cost reports as used by CMS, its recalculation of the national CMS geometric means were relatively similar except for the cardiology cost center, which was somewhat different (***Figure 3***). We suspect this difference likely is attributable to data cleaning protocols.

2 Source: Lewin analysis of FY 204 MedPAR datafile.

Figure 3
Geometric Mean CCRs Computed by CMS and Lewin

Cost Center	CMS Computed Geometric Mean CCR[3]	Lewin Computed Geometric Mean CCR[4]
Routine Days	0.836	0.835
Intensive Days	0.714	0.716
Supplies & Equipment	0.334	0.335
Therapeutic Services	0.345	0.345
Laboratory	0.251	0.244
Radiology	0.239	0.239
Other Services	0.499	0.479
Drugs	0.254	0.253
Operating Room	0.363	0.365
Cardiology	0.175	0.199

2. *CMS Should Utilize Charge Weighting Rather Than Hospital Weighting for its CCR Calculation*

We believe that the method utilized by CMS to compute the national average CCR is fundamentally flawed. The national average CCRs for each of the ten cost centers are based upon the geometric mean CCR, which is weighted at the hospital level. In order to estimate costs from MedPAR charge data using a CCR approach, CCRs are inherently computed in such a way that larger hospitals carry more weight than smaller hospitals. This is because larger hospitals simply account for more of the MedPAR charges than the smaller hospitals.

Figure 4 presents a simplified example of this fundamental flaw for three hypothetical hospitals. Specifically, ***Figure 4*** demonstrates that use of the geometric mean CCR would inaccurately estimate total costs when applied to the MedPAR charge data.

Figure 4
Example of Charge Weighted versus Geometric Mean CCR

Hospital	Discharges	Charges	CCR	Costs
Hospital A	10	$12,500	0.80	$10,000
Hospital B	100	$200,000	0.50	$100,000
Hospital C	1,000	$5,000,000	0.20	$1,000,000
Total	1,110	$5,212,500		$1,110,000
Estimated Costs using Charge Weighted versus Geometric Mean CCR				
Hospital-Weighted Geometric Mean CCR		$5,212,500	0.43	$2,241,375
Charge-Weighted Mean CCR		$5,212,500	0.21	$1,110,000

On the other hand, computing CCRs on a charge weighted basis dramatically changes the CCRs across the cost centers. ***Figure 5*** illustrates that utilizing a more appropriate charge

3 CCR weight factors available on CMS website.

4 Lewin calculations using FY 2003 cost reports from December 2005 update.

weighted CCR method reduces the CCRs for accommodation cost centers and increases the CCR for cardiology.

Figure 5
Charge Weighted versus Geometric Mean CCR by Cost Center

Cost Center	CMS Computed Geometric Mean CCR[5]	Lewin Computed Geometric Mean CCR[6]	Charge Weighted CCR[7]
Routine Days	0.836	0.835	0.659
Intensive Days	0.714	0.716	0.537
Supplies & Equipment	0.334	0.335	0.331
Therapeutic Services	0.345	0.345	0.298
Laboratory	0.251	0.244	0.215
Radiology	0.239	0.239	0.219
Other Services	0.499	0.479	0.470
Drugs	0.254	0.253	0.233
Operating Room	0.363	0.365	0.330
Cardiology	0.175	0.199	0.219

3. *The Proposed Rule Improperly Allocates Costs to DRGs*

As discussed above, the proposed rule attempts to estimate costs at the DRG level using cost center level CCRs derived from MCRs. There are two threshold problems with the utilization of MCRs in determining DRG relative weights – MCRs are old, and the data in MCRs are not detailed enough and consistently reported to accurately determine costs at the DRG level.

With respect to aging, there currently is a two-year lag between review of the hospital claims that are used to calculate charge-based DRG weights and their year of application. A system based upon MCRs would increase this lag by up to an additional year and a half, if not longer. This is because of several factors including: (1) hospitals do not have uniform FYs; (2) hospitals file their MCRs up to five months after the end of their FY; (3) cost-based DRG weights require comparing MCRs (over 4,000) with hospitals' charges (over 13 million hospital claims); and (4) CMS is required by the Act to publish its final regulation two months prior to its effective date to allow hospitals sufficient time to adjust their operating systems. Given that the primary goal of a new IPPS is to more accurately reflect costs, reliance upon outdated MCR data would be counter-productive.

Second, MCRs do not provide cost data at the level of individual items and services necessary for determining costs at the DRG level. Instead, costs are reported in the aggregate by cost center. In order to develop the estimated cost of individual items and services, as well as individual DRGs, an allocation process must be utilized. There are several cost allocation issues which substantially impact the reliability of this methodology for determining costs at the DRG

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5 CCR weight factors available on CMS website.

6 Lewin calculations using FY 2003 cost reports from December 2005 update.

7 See id.

level. These issues include: (1) routine versus ancillary costs; (2) revenue centers and cost centers; (3) compression of weights across cost centers; (4) compression of charges within cost centers; (5) accuracy of reporting; and (6) limited auditing. More specifically, there are inherent inadequacies of:

- Differential markups across supplies, but only a single CCR;
- Single per diem rates for routine and intensive days used across DRGs;
- Inconsistent cost accounting practices by hospitals; and
- Allocation of equipment costs across cost centers is often based on department square footage rather than actual utilization, which may explain low CCRs for cardiology and radiology cost centers that use expensive equipment.

Instead of relying upon inherently suspect MCR data, we believe a proxy more reflective of actual costs should be utilized. Many hospitals, including MedCath, use more sophisticated cost accounting tools that provide more accurate allocation of costs at the DRG level. One material advantage of our cost allocation method is that we mainly provide cardiac care so we primarily perform only a limited the number of DRGs. Thus, we are able to accurately allocate costs to these DRGs. CMS might obtain cost information for other sophisticated hospitals that similarly perform certain limited number of DRGs.

In order to benchmark payment accuracy, we used our cost allocation method noted above to compute costs across our twelve hospitals for the thirteen DRGs that had the largest reduction in relative weights under the proposed HSRVcc methodology. A review of MedCath's payments for DRGs with the largest DRG weight reductions in comparison to MedCath's estimated costs for those DRGs shows that, in many cases, proposed payments are below actual costs. Given that MedCath focuses on MDC 5 cases, its cost allocations are likely to be materially more accurate for cardiology cases and can serve as a reasonable benchmark for cardiology costs as compared to CMS's payments for these DRGs which is not reflective of true costs.

4. *Supplies and Equipment Charges*

A study performed by Lewin for MedPAC found that most hospitals reported that higher cost procedures and items generally are assigned a lower mark-up.[8] In this study, hospitals reported charges for supplies being set at a flat percentage or a sliding scale table based upon the ranges of the costs for each item. For example, any supply costing less than $100 might be marked up by a certain percentage, while supplies costing over $5,000 would be marked up at a lower percentage as provided in the supply cost table. All but one hospital indicated it marked up lower cost supplies at a higher rate than more expensive supplies.

Another Lewin study compared percentage mark-ups for cardiac pacemaker devices and cardiac defibrillator devices to hospitals' average mark-ups for supplies and equipment charged to patients and hospitals' overall average markups for all services.[9] As illustrated in ***Figure 6***, hospitals apply a much lower mark-up on pacemakers and defibrillator devices than they do for all their supplies and services on average.

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8 Lewin for MedPAC, "A Study of Hospital Charge Setting Practices" (Dec. 2005).

9 Lewin, "Hospital Charges and Medicare Payments for Implanted Permanent Pacemakers and Implanted Cardioverter Defibrillators" (Sept. 2003). Lewin also presented this study to CMS.

Figure 6
Average Hospital Mark-ups and CCRs[10]

Device Type	Average Percentage Mark-up (CCR)
Internal Cardiac Defibrillator Devices	37% (0.73)
Cardiac Pacemaker Devices	57% (0.64)
Overall Hospital	120% (0.45)
Supplies and Equipment Cost Center	201% (0.35)

The HSRVcc method estimates costs for all supplies and equipment using a CCR. Most hospitals, however, use a differential markup for supplies and equipment depending upon its costs. Thus, the estimated cost for high cost devices, such as pacemakers and defibrillators, will be inaccurate. For example:

- Actual cost to hospital for a cardiac defibrillator $20,000
- Hospital's charge ($20,000 + 37% markup) $27,400
- Estimated cost using average CCR ($27,000 * 0.35) $ 9,590

Under this example, the estimated cost for the defibrillator that would be used in the DRG weight calculation is substantially less than its actual cost. As such, we urge CMS to check its cost estimates with external benchmarks. To utilize MCR-based cost estimates as the "truth set" without external verification inevitably leads to serious errors in CMS rate setting.

IV. GIVEN THE DEFICIENCIES WITH THE DRG RECLASSIFICATIONS, THE PROPOSED RULE FAILS TO COMPLY WITH THE DATA QUALITY ACT AND AGENCY GUIDELINES

As discussed above, we believe there are several deficiencies with the DRG reclassifications in the proposed rule including the HSRVcc's unwarranted adverse impact upon cardiology, and the flawed calculation and application of CCRs. As such, MedCath seeks the correction of the deficient information published by CMS concerning the accuracy of the HSRVcc methodology, its impact upon hospitals, and the underlying data utilized in developing the proposed rule. The erroneous information violates the Federal Data Quality Act (the "DQA"),[11] the implementing guidelines issued by the Office of Management and Budget ("OMB Guidelines"),[12] HHS ("HHS Guidelines"),[13] and CMS ("CMS Guidelines").[14]

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10 Source: Lewin Group analysis.

11 Public Law 106-554, amending Paperwork Reduction Act, 44 U.S.C. §§ 3501 et seq.

12 Guidelines for Ensuring and Maximizing the Quality, Objectivity, Utility, and Integrity of Information Disseminated by Federal Agencies; Notice; Republication, 67 Fed. Reg. 8,452 (Feb. 22, 2002), available at www.whitehouse.gov/omb/fedreg/reproducible2.pdf.

13 HHS Guidelines for Ensuring and Maximizing the Quality, Objectivity, Utility, and Integrity of Information Disseminated to the Public, available at www.hhs.gov/infoquality.

14 Guidelines for Ensuring the Quality of Information Disseminated to the Public, *available at* www.hhs.gov/infoquality.

Section 515 of Public Law 106-554 directs the OMB to "issue guidelines that provide policy and procedural guidance to Federal agencies for ensuring and maximizing the quality, objectivity, utility, and integrity of information (including statistical information) disseminated by Federal agencies in fulfillment of . . . the Paperwork Reduction Act." The DQA requires the OMB to issue guidelines that comply with the certain specifications.

Pursuant to the DQA, the OMB published the OMB Guidelines in the Federal Register on February 22, 2002. In the Final Guidelines, the OMB called on agencies to issue their own implementing guidelines by October 1, 2002. The OMB Guidelines state that agencies must "adopt a basic standard of quality (including objectivity, utility, and integrity) as a performance goal and should take appropriate steps to incorporate information quality criteria into agency information dissemination practices."[15]

On September 30, 2002, HHS announced that its guidelines implementing the OMB Guidelines would be available on the Internet at www.hhs.gov/infoquality. As directed by the HHS Guidelines, CMS issued agency-specific guidelines. Information subject to the CMS Guidelines includes the following:

(1) Statistics and information designed for public dissemination to help CMS program beneficiaries make informed choices;

(2) Statistical or actuarial information;

(3) Studies and summaries prepared for public dissemination to inform the public about the impact of CMS programs; and

(4) Studies and summaries prepared for use in formulating broad program policy.

More specifically, the information subject to the CMS Guidelines includes program information, statistical data sets, research and evaluation reports, technical reports, and payment updates. A number of these types of program information were used by CMS in developing the proposed rule.

The CMS Guidelines require that any information released by CMS is to have been "developed from reliable data sources using accepted methods for data collection and analysis" and "based on thoroughly reviewed analyses and models."[16] The CMS Guidelines also state that "CMS reviews the quality (including the objectivity, utility, and integrity) of information before it is disseminated and treats information quality as integral to every step of the development of information, including the creation, collection, maintenance and dissemination."[17]

We believe that CMS has not thoroughly reviewed the data it cites as support for the changes to IPPS in the proposed rule, nor has CMS ensured the quality of that data, for the reasons discussed above. Before CMS can issue a proposed rule that can be a basis for meaningful comment, the agency must utilize more complete data sets (to include the data presented herein), conduct a proper and thorough analysis of that data, and reach supportable conclusions for its proposed changes to the IPPS that are not the product of incorrect

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15 67 Fed. Reg. at 8,458.

16 CMS Guidelines, § V.

17 Id.

assumptions. Only then will CMS's proposals on the IPPS be based upon quality information. Currently, CMS has failed to show that its data meets the standards established by the CMS Guidelines of utility, objectivity, integrity, transparency, and reproducibility.

V. GIVEN THE DEFICIENCIES WITH THE DRG RECLASSIFICATIONS, CMS SHOULD WITHDRAW THE PROPOSED RULE AS REQUIRED UNDER THE ADMINISTRATIVE PROCEDURES ACT

Given the deficiencies with the DRG reclassifications discussed above, we believe that interested parties cannot offer meaningful comments to the proposed rule. This defect in the notice-and-comment rulemaking process requires that CMS withdraw its proposed rule until more comprehensive, statistically-sound, and appropriate data are evaluated by the agency and shared with the public. Should CMS choose not withdraw the proposed rule, we believe grounds exist for a court to invalidate the final regulation due to the agency's failure to provide the public with a viable opportunity to offer meaningful comments.

Pursuant to the Administrative Procedures Act (the "APA"), federal agencies must "give interested persons an opportunity to participate in the rule making through submission of written data, views, or arguments."[18] Courts have consistently held that the public's right to participate in the rulemaking process requires an agency to "provide sufficient factual detail and rationale for the rule to permit interested parties to comment meaningfully."[19]

The controlling law in the D.C. Circuit is well established and clear. In order for parties to offer meaningful support or criticism under the APA's notice-and-comment rulemaking process, "it is especially important for the agency to identify and make available technical studies and data that it has employed in reaching the decisions to propose particular rules."[20] If the federal agency relies upon an outside study in promulgating a rule, the agency itself must first examine the methodology used to conduct the study.[21] Furthermore, the technical complexity of the analysis does not relieve the agency of the burden to consider all relevant factors and there "must be a rational connection between the factual inputs, modeling assumptions, modeling results and conclusions drawn from these results."[22]

In Portland Cement Ass'n v. Ruckelshaus,[23] the D.C. Circuit invalidated a final Environmental Protection Agency regulation because the agency's failure to utilize sufficient research data in the proposed rule hindered the opportunity for meaningful public comment. The court held that it "is not consonant with the purpose of a rule-making proceeding to promulgate rules on the basis of inadequate data." Instead, the issuing agency "must disclose in detail the thinking that has animated the form of a proposed rule" and provide a reasoned analysis of the data.

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18 5 U.S.C. § 553(c).

19 Florida Power & Light Co. v. United States, 846 F.2d 765, 771 (D.C. Cir. 1988); see also Home Box Office, Inc. v. FCC, 567 F.2d 9, 35 (D.C. Cir. 1977); United States v. Nova Scotia Food Products Corp., 568 F.2d 240, 251-52 (2d Cir. 1977).

20 Connecticut Light & Power Co. v. Nuclear Regulatory Com., 673 F.2d 525, 530-31 (D.C. Cir. 1982); see also Sierra Club v. Costle, 657 F.2d 298 (D.C. Cir. 1981).

21 See City of New Orleans v. SEC, 969 F.2d 1163, 1167 (D.C. Cir. 1992).

22 Sierra Club, 657 F.2d at 333.

23 486 F.2d 375 (D.C. Cir. 1973).

Similar to Portland Cement, CMS's reliance on deficient data provides no opportunity for the public to offer meaningful support or criticism of the proposed rule. Consequently, CMS should withdraw the proposed rule until such time that the agency can obtain more inclusive data and provide a reasonable analysis thereof.[24] In doing so, CMS should consider the data submitted herein, revise its assumptions and conclusions accordingly, and publish a new proposed rule.

VI. RECOMMENDATIONS

As detailed above, we believe that the cost-based weights as calculated by CMS in the proposed rule are materially flawed, and rely upon incomplete and inappropriate data. We contend that CCRs calculated using charge weighted rather than geometric means weights is inherent more accurate and appropriate. More generally, we believe comparing cost-based weights to payments, as done by MedPAC, is misleading to the extent that costs based upon CCR calculations are not reflective of actual, or true, hospital costs.

Further, CMS has failed to recognize that CCR-based weights may be more compressed and, hence, less accurate as indicators of resource use than charge-based weights. Ultimately, the result of the CMS approach is that the cost-based weights in the proposed rule are not reflective of underlying costs. This result has recently been confirmed in other analyses: "If, however, by basing the DRG relative weights on the estimated costs ... MedPAC intends to employ cost-to-charge ratios to estimate costs, the resultant cost weights will likely be less, not more, accurate than current charge-based weights."[25]

As noted above, CMS's HSRVcc methodology would reduce by 7.5 percent payment for all cardiology DRGs and would reduce by 13.5 percent Medicare payment for all cardiac surgery. As such, it is absolutely imperative that CMS obtain external cost information – there are numerous hospitals that use carefully developed cost accounting systems – to validate its CCR-based cost weight results system. Otherwise, the "flag-ship" IPPS would be jeopardized. For example, millions of future cardiology patients may not receive the future high levels of clinical care that might be afforded by continuance of the current charge-based system. Much is at stake. CMS needs to proceed with caution.

Given these factors, we recommend that CMS withdraw the proposed rule and institute a one year delay in the use of cost-based weights. Such a delay has two decided advantages. First, a delay allows CMS to refine and validate its CCR cost estimation methodology. Given that the stated goal of the proposed rule is to develop a more accurate Medicare payment system, CMS should strive to obtain appropriate data reflective of actual costs.

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[24] Federal agencies have recognized the obligation to withdraw proposed rules because the underlying data or analyses are insufficient to provide an opportunity for meaningful public input. See e.g., 70 Fed. Reg. 70,166 (CMS withdrawing entire practice expense methodology proposed in its Physician Fee Schedule for fiscal year 2006 due to incorrect and insufficient data); 69 Fed. Reg. 64,266 (FDA withdrawing proposed physical medicine devices rule due to incorrect and conflicting data); 69 Fed. Reg. 39,874 (Small Business Administration withdrawing proposed small business size rule because of public concerns over the ageney's methodology in analyzing data); 67 Fed. Reg. 16,668 (Department of Labor withdrawing proposed rule due to failure to adequately consider underlying economic data); 63 Fed. Reg. 54,972 (Fish & Wildlife Service withdrawing proposed rule because of failure to incorporate the best scientific and commercial endangered species data in its analysis).

[25] Botz, C., Sutherland, J., Lawrenson, J., "Cost Weight Compression: Impact of Cost Data Precision and Completeness," Health Care Financing Review, v 27, no. 3, Spring 2006.

Second, a delay allows for a single transition to cost-based weights and the use of severity-adjusted DRGs. The current proposed rule calls for the use of cost-based weights in FY 2007 and severity-adjusted DRGs in FY 2008. Each step will have a dramatic impact upon differing hospitals. Certain hospitals receiving payment increases in FY 2007, may find new financial pressures in FY 2008. This financial uncertainty is unwarranted, both for technical reasons (a flawed CCR calculation system), and policy reasons (exaggerated uncertainty related to IPPS payment impact due to an erratic flow of "winners" and "losers").

As such, our recommendation is for a single set of regulations encompassing both cost-based weights and severity-adjusted DRGs to be phased-in over a three to five year period beginning in FY 2008. The degree of financial uncertainty associated with the proposed payment weights to hospitals heavily invested in cardiology care is unwarranted and unacceptable from both a business and clinical perspective. A lengthy transition process would also provide CMS with time to reconsider Medicare cost accounting principles.

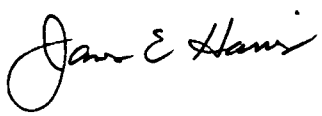
VII. CONCLUSION

A large amount of capital has been devoted to technological innovation and clinical enhancement of cardiology services over the last several decades. The HSRVcc methodology outlined in the proposed rule likely would have severe financial consequences throughout the industry, including harm to typical community and teaching hospitals which have decided to invest in cardiology services given prior Medicare IPPS schedules. The magnitude of these consequences is unwarranted on technical grounds given the flawed weighting structure employed by CMS as it develops CCRs and resultant cost weights.

Further, this degree of financial impact is also unjustified on policy grounds as the hospital industry requires confidence that investments made in clinical endeavors will not be undercut by precipitous changes in Medicare payment practices. The return of the nation's investment in cardiology technology appears to be high given David Culter's,[26] as well as others', work in this area. Ultimately, an abrupt decline in support for cardiology infrastructure is not in the best interest of Medicare beneficiaries.

MedCath appreciates the opportunity to submit these comments and recommendations. We are available and would be pleased to discuss these issues further with CMS.

Sincerely,



James E. Harris
Executive Vice President and Chief Financial Officer

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26 See, e.g., Culter, David M., Newhouse, J.P., Remler D. "Are Medical Prices Declining? Evidence from Heart Attack Treatments," Q. J. Econ. 1998, 113:4; Culter et al. "Pricing Heart Attack Treatments" in David M. Cutler and Ernst Berndt, eds. Medical Care Output and Productivity (Chicago: Univ. of Chicago Press, 2001); Culter, David M., McClellan M. "Is Technological Change in Medicine Worth it?" Health Affairs 2001, 20(5):11-29.

Submitter : **Date: 06/12/2006**

Organization :

Category : **Physician**

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS or the Agency) proposed rule entitled "Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates." 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in "patient care activities." The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

Background
The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a nonhospital setting, such as a physician's office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not "related to patient care".

This position reverses the Agency's position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include "scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty." [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency's 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs.

Residency Program Activities and Patient Care
I firmly believe that with the possible exception of extended time for "bench research," there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician's educational development into an autonomous practitioner.

To separate out CMS's newly defined "patient care time" from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,
Christine Rooney, MD

Submitter : Mr. Arthur Maples **Date:** 06/12/2006

Organization : Baptist Memorial Health Care Corporation

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1489-Attach-1.DOC

#1489

BAPTIST | MEMORIAL HEALTH CARE

June 9, 2006

Mark B. McClellan, MD, PhD
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1488-P
P.O. Box 8010
Baltimore, MD 21244-1850

Re: Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates
Docket Number CMS-1488-P

Dear Dr. McClellan:

Baptist Memorial Health Care Corporation (BMHCC) appreciates the opportunity to comment on the rules published on April 25, 2006 in the Federal Register. BMHCC has 14 acute care hospitals in its Mid South system and 12 of them are reimbursed for services under the Inpatient Prospective Payment System (IPPS). BMHCC includes one Critical Access Hospital, one Long term Acute Care Hospital and one hospital primarily for Rehabilitation Services for residents in the Memphis, Tennessee area.

As a regional provider of care, with tertiary referral hospitals in urban and community hospitals in rural locations, BMHCC participates in the state hospital associations in Tennessee (THA) and Mississippi (MHA) and in national associations including the American Hospital Association (AHA) and National Association of Long Term Hospitals (NALTH). BMHCC participated with these groups in developing comments regarding this rule and we are not only writing to support the comments provided to the Administrator by THA, AHA and NALTH, but also to contribute our system's perspective of elements that CMS had available in developing its proposed changes. From the BMHCC experience with large and small hospitals we urge that CMS ensure the adequacy of information by verifying and studying the impact before making such significant changes that are proposed to the payment system.

First, BMHCC believes that more time is essential to determine that adequate and appropriate data are used to form the improvements. A tertiary care hospital such as Baptist Memorial Hospital-Memphis (706 beds) is a primary provider of cardiovascular surgery for a large geographic area. Other hospitals within the BMHCC also provide complicated surgery but have more patients with medical needs. The charges for high-cost, hands-on surgical services may not be equal in mark-up to the ancillary services in non-surgical cases which can distort the basis for the proposed improvements. Also, an important issue presented by the proposed methodology is that providers may not report

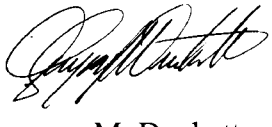
surgical devices and supplies, among other costs, within the same cost centers on the Medicare cost reports. For example, operating room supplies could be reported in an Operating Room line item or in a Medical and Surgical Supply line item. Cost center reporting requires a process for consistency across providers. As referenced in the comment from the AHA, if CMS is going to move to cost based weights, hospitals must have time to align cost reporting with claims reporting. While it may be appropriate for CMS to implement the HSRVcc proposal for specialty hospitals, BMHCC recognizes the complications involved for full-service hospitals and, suggests that more time for studying the HSRVcc is necessary.

Second, a major consideration is the timeliness of the data used to establish the basis for improving the IPPS. Baptist Heart Institute is a part of BMHCC serving parts of Tennessee, Mississippi, Arkansas and Missouri that include areas with the nation's highest incidence of heart disease. It is of grave concern that the proposed changes for payment for cardiac services fails to account for current technology costs associated with drug-eluting stents and bi-ventricular pacemakers/defibrillators. Countless studies have demonstrated the medical value of implantable cardioverter defibrillators, cardiac resynchronization therapy has been shown to reduce hospitalizations and hospital days, and drug eluting stents are commonly used because of their ability to reduce return visits to the cath lab or surgery for repeat intervention. Payment determinations based on data from hospital cost reports from fiscal year 2003 cannot accurately reflect the cost for technology that was not available for use during that time period.

Third, the CMS outlier payment threshold proposal recognizes the problematic impact of older data and avoids using data from 2003. BMHCC supports the AHA proposal, based on analysis and current data from March 2006 HCRIS release that CMS lower the outlier threshold and avoid a real payment cut to hospitals that cannot be recouped. In response to the rules presentation that, CMS "supports the adoption of health IT as a normal cost of doing business to ensure patients receive high quality care, " and request for comment, BMHCC is committed to providing the highest quality care and supports the AHA's statement that decreasing payments to those that have not been able to afford IT further limits their ability to invest. CMS should support adoption of health IT through a payment adjustment funded with new money since the entire system can benefit from the improvement in technology.

BMHCC appreciates the opportunity to submit these comments. If you have any questions about them, please contact me at (901) 227-4137.

Sincerely,



Gregory M. Duckett
Sr. VP/Corp Counsel

Submitter : **Mr. Ronald Ashworth** **Date: 06/12/2006**

Organization : **Sisters of Mercy Health System**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1490-Attach-1.PDF

#1490

SISTERS OF MERCY
HEALTH SYSTEM

June 12, 2006

Mark B. McClellan, M.D., Ph.D, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS – 1488 – P - *Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates*
P. O. Box 8011
Baltimore, MD 21244-1850

Attention: **CMS-1488-P**

Dear Administrator McClellan:

The Sisters of Mercy Health System (Mercy) is a 19-hospital system operating in Missouri, Kansas, Oklahoma, and Arkansas. We perform a significant number of procedures in the inpatient setting and rely heavily on Medicare as a major payor for those services. Mercy welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule entitled *"Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates"* (IPPS), 71 Fed. Reg. No. 79 (April 25, 2005).

Thank you for considering our comments as listed below:

I. DRGs: Reclassifications

As a major health care provider in our communities, we implant medical devices and perform other cardiac procedures on a significant number of Medicare beneficiaries in the inpatient setting. The impact of the CMS proposed rule will reduce reimbursement in all cardiac services by approximately 10%. As a result of these proposed changes the reimbursement for stent placement, ICD implants and pacemakers will be severely impacted. We have estimated a decrease in reimbursement of over 22 million dollars for our organization based on the revised DRG classifications pertaining to our cardiology service line alone. The 22 million dollar decrease estimated for the cardiology service line is offset by approximately 12

million dollars for all other service lines combined. This results in a 10 million dollar negative impact to Mercy from the DRG recalibration. When taking into account all proposed changes (market basket update, wage index updates, etc), Mercy receives no additional Medicare funding for FY 2007. Therefore Mercy will not receive funding to cover even the basic inflationary factor of 3.4 percent, which we do not feel is the intent of CMS' budget neutral proposed rule. In addition, we are concerned the drastic change in cardiology reimbursement will have a negative impact on Medicare beneficiaries' access to these necessary and life saving procedures. Given the consequences of the proposed changes combined with the concerns regarding the transition from "charge-based" DRGs to "cost-based" HSRV DRG weights (outlined below), Mercy respectfully requests CMS delay the inpatient payment revisions until the methodology and underlying cost data are improved (see comments below) to ensure the accuracy of all Medicare payments.

II. HSRV Weights

Concerns with DRG Cost Based Methodology

Moving to an estimated "cost-based" system for determining payment weights does not truly reflect the actual price hospitals pay for the items and services they provide, but more of a rough approximation of costs. CMS will use hospital claims data from fiscal year 2004 and hospital cost reports from fiscal year 2003 to establish these weights for 2007. The proposed change would distort the estimation of accurate costs by combining multiple costs centers on the hospital cost reports into 10 CMS designated cost centers. When CMS established a single DRG weight (by combining the 10 cost center weights for each DRG), CMS applied a scaling factor which represented the percentage of total "national" costs for each cost center. In making the national calculations, the ratios are not weighted by each hospital's Medicare charges. They were instead converted using "national" cost center charge ratios developed from the FY 2003 cost report data. Hospital cost-to-charge ratios and charge mark-ups vary significantly among facilities and cost centers. For all hospitals, the proposal to use estimated cost based weights would significantly shift dollars from surgical DRGs to medical DRGs. Therefore, payment for certain high-volume, high-technology surgical procedures such as stent and ICD implants, along with pacemakers, would be reduced significantly. For example, DRG 558, drug-eluting stent, reduction in reimbursement will result in a payment of only 8% above the average procedure implant cost. The remaining costs of this procedure will not be covered by the residual reimbursement projected with the change in DRG weights. This is primarily due to the methodology CMS uses which is designed to remove the impact of hospital characteristics and varying charge mark-ups.

Medical Supplies is one of the 10 cost centers utilized in the Cost Center Charge Group for analysis, however, many hospitals include their medical supplies in each applicable line of the cost report (i.e. medical supplies specific to the Emergency Room are included in line 61 of the cost report). We do not believe that CMS has

appropriately considered the potential impact this may have on the revised/proposed DRG weights. As we move to a cost-based system, there should be mechanisms in place to ensure accuracy of this new system. We believe CMS could identify which provider reports were filed using this approach in order to properly include Medical supply costs in the appropriate cost center grouping(s).

Cardiology is also one of the 10 cost centers utilized in the Cost Center Charge Group for analysis. Per Table A in the April 25th proposed federal register, page number 24009, cost center lines 53 and 54 were used for this piece of the "analysis". Again, many complex hospitals (primarily facilities with significant cardiac cases) may utilize other cost center lines (for example lines 58 or 59) of the cost report. Per Table A, cost center lines 58 and 59 were grouped in the "other services and charges" category. CMS needs to consider these potential "mis-groupings" as they could negatively impact the cardiology DRG weights unjustifiably.

Concerns with high-cost cases

The severity of a patient's condition is not a sole indicator of the amount of resources necessary to adequately and successfully treat all patients. There are certain procedures that require very costly devices that will not be adequately reimbursed based on the proposed system. Due to the low volume of these types of cases, costs for these items could be "averaged" out of the proposed system. One example would be a patient that receives an ICD dual chamber generator which costs our system $19,500 on average for the device alone. Under the current DRG payment system, DRG 515 would pay Mercy facilities approximately $29,300 for the entire encounter (which would include the inpatient procedures and the implanted device). Under the proposed cost based DRG system CMS is proposing, our Medicare payment would fall to less than $23,000, which barely covers the cost of the device. While the cost of this device is included in our overall cost center expenses, we believe the newly proposed payment for DRG 515 would not be adequate for those patients that receive this costly device. In those instances where we have costly devices and low volumes, we feel the methodology used to calculate the cost based DRG system can have a continued negative payment impact on those encounters.

Need for additional information relating to CMS methodology

We do not feel (at this time) that CMS has supplied the provider community with adequate data to perform proper analysis necessary to assist CMS with recommendations on how to proceed with implementation of this newly proposed system. While CMS has requested the provider's insight on how to move forward toward a more "equitable" payment system, we believe additional time and resources will be required to make necessary recommendations on best approaches for moving forward for both FY 2007 and FY 2008 proposed changes. In order to make informed recommendations regarding the future of our Medicare payment system, we

believe additional information regarding the consolidated severity adjusted DRG system should be made available.

Recommendations

Mercy believes significant considerations must be made regarding the proposed DRG cost based methodology. Mercy struggles to understand how a cost-based DRG methodology (considered to be "budget neutral") has specifically placed cardiac service lines at risk nationally, while reimbursement to all other service lines are increasing. Mercy increases (experienced by all "other" service lines) will only be able to offset approximately 55% of the negative impact to one service line, cardiology. We believe this raises significant questions and concerns regarding the methodology being adopted by CMS. Additional payment considerations must also be made for those high-cost, low volume procedures that are not adequately being reimbursed under the proposed system. With these concerns, Mercy respectfully requests CMS delay the implementation of any cost-based DRG or CSA (consolidated severity adjusted) DRG system until all factors and methodology concerns are adequately addressed. Review of this proposed rule could be facilitated at the provider level, with release of additional details regarding the CSA DRG system as well as release of the files used to calculate the cost-based DRG weights.

III. DRGs: Severity of Illness

We agree with CMS that refining the current DRG system to account for severity of illness is appropriate. However, CMS has not conducted an objective study to adjust the current DRG system to any type of severity based system. Consolidated Severity Adjusted DRG's do recognize the "severity" of the patient; they do not however recognize specific "procedures" performed on the patient. We believe CMS agrees with these concerns stating that "a method of recognizing technologies that represent increased complexity should be included in the system." (71 Fed. Reg. 24014). We therefore respectfully request additional time and the necessary information to perform an in-depth financial impact analysis on the consolidated severity of illness proposed regulations. If the proposal is enacted, CMS's aggressive implementation time frame, does not allow provider organizations to properly prepare for the changes, in terms of modifying data bases and information systems, as well as training essential billing and coding personnel. In addition, it is important to note that shortly following the transition to this proposed rule, the health care industry is likely to undergo another seismic shift in billing practices with the migration to UB-04 and ICD-10 implementation.

IV. GME Payment

In the proposed FY 2007 Inpatient PPS Rule, CMS seeks to "clarify" its policy to exclude the time residents spend in "nonpatient care activities" for purposes of

calculating Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

According to CMS these "nonpatient care activities" include didactic activities, such as journal clubs, classroom lectures, and seminars. In determining whether the time can be counted, CMS distinguishes between whether the activity is occurring in a nonhospital or hospital site and applies different rules:

Nonhospital Sites

CMS states that resident time spent in didactic activities cannot be included in either a hospital's DGME or IME resident count if it occurs in a nonhospital site (such as a physician's office, medical school, etc.).

CMS asserts that this time is not allowable because the Medicare statute states that in order for the hospital to count resident time in nonhospital settings, it must be "spent in activities related to patient care" (DGME statute) or "in patient care" (IME statute).

Hospital Sites

For DGME purposes, resident time in "all areas of the hospital complex" may be counted so long as the resident is in an approved program, regardless of whether or not the resident is engaged in patient care activities. CMS states the hospital complex consists of the hospital and hospital-based providers and subproviders.

This is in contrast to IME's position which only allows time spent in patient care activities to be counted.

CMS states that while they have not explicitly defined "patient care activities" they have applied the "plain meaning of that term" which according to CMS refers to "care and treatment of particular patients, or to services for which a physician or other practitioner may bill" and "would certainly not encompass didactic activities."

Unlike the nonhospital site statute, there is no legislative requirement that the resident be engaged in "patient care activities" for purposes of counting residents within the hospital setting for DGME payments. Thus, all resident time in the hospital complex may be counted for DGME payments, so long as the resident is in an approved program.

There also is no specific reference to patient care activities in the IME legislation. CMS's position excluding resident didactic time in hospital settings for IME payments rests solely on a presumption that because IME payments reflect an adjustment to the DRG payment, these payments inherently are related to patient care and therefore the residents must be engaged in patient care to be counted.

The result of CMS' statements is that no didactic time may be counted for IME payment calculations, regardless of whether it occurs in a hospital or nonhospital site.

The AAMC disagrees, as do we, with CMS' position in this year's proposed rule. Clean wording Didactic activities engaged in which residents participate are an integral part of the patient care experience and therefore such resident time should be counted for both IME and DGME payment purposes regardless of the setting. In addition, the rule raises a myriad of questions concerning how such time would be adequately documented in addition to increasing the administrative burden on hospitals associated with the documentation.

V. Outlier Payment Threshold

If the costs of a particular Medicare case exceed the relevant DRG operating and capital payment (including DSH, indirect medical education (IME), or new technology add-on payments) plus a fixed-loss cost threshold, the hospital will receive an outlier payment. This payment equals 80% of the case's cost above the threshold calculation.

CMS proposes to increase the fixed-loss cost threshold for outlier payments from $23,600 to $25,530. This represents an 8.18% increase from the FFY 06 level. Outlier payments are funded through a reduction in the PPS standardized payment amount, equal to the projected outlier percentage. Section 1886(d)(5)(A)(iv) of the Act requires CMS to set the outlier cost threshold at a level it believes will result in outlier payments that are not less than 5% nor more than 6% of total DRG payments. However, CMS estimates that outlier payments will represent only 4.71% of total DRG payments in FFY 06, and that in FFY 05 outlier payments represented only 4.10% of total DRG payments. CMS further believes that FFY 07 outlier payments will be approximately 5.1% of actual total DRG payments. This is .9 percentage points lower than the 6% allowed by the act. The higher Outlier Payment Threshold translates to lower total Medicare payments to hospitals.

Based on CMS's estimates for FFY 06 and 07, and the fact that CMS has underpaid the outlier pool for a number of years, we urge CMS to reconsider the proposed increase in the Outlier Payment Threshold, and recommend that it be reduced from the FFY 2006 level of $23,600 or at least held constant at the FFY 06 level.

VI. Occupational Mix Adjustment at 100% for FY 2007

We are concerned about the implications of the court-mandated application of the occupational mix adjustment to 100 percent of the wage index beginning FY 2007. Previously, CMS only applied the occupational mix adjustment using 10 percent of the adjustment factor in calculating the wage index values as they recognized the inaccuracies in the data collected in the past. We understand the restraint CMS is

under in light of the court order to utilize 100% of the occupational mix adjustment. However, the extremely tight timeframe provided to the hospital community to supply the new data for the occupational mix survey combined with the potential for large variances to occur when calculating the final wage index factor for FY 2007 is of great concern. At this point, there has been no projected impact made to determine what constraints this may have on the provider's ability to continue to provide care. Therefore, we respectfully request CMS implement a multi-year transition or the use of corridors in order to ensure hospitals will be able to handle all financial implications this revision could have.

In addition to the transition or use of corridors, Mercy would like to propose that the "wage index reviews" be bid out to one "national" fiscal intermediary as part of the Medicare Administrative Contract (MAC) bidding process scheduled to continue (for Jurisdictions 1, 2, 4, 5, 7, 12 and 13) in September 2006. A single "national" intermediary selection would provide both CMS and the provider community a "consistent" approach to the wage index process. Historically, providers located in the same state (or even the same MSA) have been subject to a wage index "review/approval" by different fiscal intermediaries. While the MAC bidding process should create consistency from an FI perspective going forward for those providers in a common geographic location (or jurisdiction), there will still be the ability for inconsistencies to occur among providers within varying jurisdictions. As Medicare continues to evolve, and the health care industry continues to operate within extremely tight financial constraints, we believe consistency in application of Medicare rules, regulations, and reviews is imperative. A one percent change in a provider's wage index can mean hundreds of thousands of dollars to one provider. This one percent change could be determined by what kind of documentation one fiscal intermediary either allowed or denied in one jurisdiction versus another. Wage index calculations are utilized for payment of every Medicare inpatient claim and variation among fiscal intermediaries (even across jurisdictions) could be detrimental to hospitals located within a certain geographic region.

We respectfully request CMS strongly consider using the MAC process to solicit a single "national" fiscal intermediary to ensure wage index reviews are handled consistently and accurately so that all providers are subject to the same Medicare interpretation. We believe the inclusion of 100% of the occupational mix wage index results intensifies the need for this approach going forward. The 100% inclusion of occupational mix data means additional scrutiny, education, and emphasis will be necessary from both a fiscal intermediary and provider prospective. Fluctuations in wage index percentages for any provider can prove to be extremely volatile and therefore must be handled with extreme care. We believe a national nomination for a single wage index intermediary would bring us closer to ensuring this process is handled effectively.

Thank you for considering our comments. Should you have additional comments please contact Ron Trulove at (314) 364-3561 or me at (314) 628-3685.

Sincerely,

Ron Ashworth
President/CEO
Sisters of Mercy Health System

Cc: Jim Jaacks
Randy Combs
Ron Trulove

Submitter : **Dr. Rachel Hall** **Date: 06/12/2006**

Organization : **University of South Carolina/Palmetto Health**

Category : **Individual**

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS or the Agency) proposed rule entitled Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates., 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in patient care activities. The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

Background
The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a nonhospital setting, such as a physician's office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not "related to patient care".

This position reverses the Agency's position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include "scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty." [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency's 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs.

Residency Program Activities and Patient Care
I firmly believe that with the possible exception of extended time for bench research, there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician's educational development into an autonomous practitioner.

To separate out CMS's newly defined "patient care time" from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,

Rachel E. Hall, M.D., F.A.A.F.P
Assistant Professor
University of South Carolina School of Medicine

Submitter : **Mr. Kevin Higdon** **Date: 06/12/2006**

Organization : **Elkhart General Hospital**

Category : **Hospital**

Issue Areas/Comments

HSRV Weights

HSRV Weights

" There has been a big push recently regarding Pay for Performance efforts in regards to reimbursing physicians and hospitals. This is a good effort to increase the quality of healthcare in the country. Yet, it appears that there is little or no discussion about matching quality improvements with reimbursement in this proposal. I would suggest that these efforts be continued and be part of the proposal.

As stated above, these are just a few of the concerns that EGH has with the proposed rules. Those, in combination with the concerns that AHA has expressed to you previously in their letter, necessitate a more formal review of the rules and, at minimum, a delay in the implementation of the rules.

If you have any questions, I would be more than willing to discuss these with you. I can be reached at khigdon@egh.org or (574) 523-3208.

Sincerely,

Kevin J. Higdon
Vice President of Finance

KJH/lt

cc: Elkhart General Hospital Board of Directors
Elkhart General Hospital Administrative Staff
Evan Bayh, U.S. House of Representatives
Richard Lugar , U.S. House of Representatives
Chris Chocola, U.S. House of Representatives
Mark Souder, U.S. House of Representatives
Fred Upton, U.S. House of Representatives
Senator Carl Levin, Michigan House of Representatives
Senator Debbie Stabenow, Michigan House of Representatives
Brent Richards, Manager of Reimbursement, Elkhart General Hospital

CMS-1488-P-1492-Attach-1.PDF

ATTACHMENT TO # 1492

Elkhart General Healthcare System

June 12, 2006

Mr. Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1488-P
Mailstop: C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Dr. McClellan:

As the Vice President of Finance at Elkhart General Hospital (EGH) in Elkhart, Indiana, I would like the Centers for Medicare and Medical Services (CMS) to consider our comments on the fiscal year (FY) 2007 inpatient prospective payment system (IPPS) and occupational mix adjustment proposed rules.

For background purposes, Elkhart General Hospital (EGH) is an Indiana non-profit corporation offering a broad spectrum of health related services to Elkhart County and other parts of north central Indiana and southwestern Michigan. The Hospital was established in 1909 and with 365 licensed beds, a medical staff of over 300 physicians, a complement of more than 2,500 full-time and part-time employees and a volunteer auxiliary of 450 members. EGH is the largest hospital in Elkhart County.

The rule proposes the most significant changes in the calculation of diagnosis-related group (DRG) relative weights since 1983 by creating a version of cost-based weights using the newly developed hospital-specific relative values cost center methodology. It also proposes refining the DRGs to account for patient severity, with implementation likely in FY 2008. In addition, the rule would update the payment rates, outlier threshold, hospital wage index, quality reporting requirements, and payments for rural hospitals and medical education, among other policies.

EGH is a full-pledged member of the American Hospital Association (AHA). In fact, the President of EGH, Greg Lintjer, is a member of the Board of Directors. We are aware of a letter sent to you by AHA leadership regarding their thoughts and suggestions about the proposed rules.

EGH, along with AHA, fully supports many of the proposed rules provision. We, like them, have serious concerns about certain proposed changes to DRG weights and classifications. Instead of rewriting all their comments and concerns, please refer to that letter and be assured that the AHA letter has our 100% support. We would like to also consider the following:

- We definitely support moving to a DRG-weighing methodology based upon hospital costs. But to expand from 526 DRGs to 1,258 goes against the mentality of trying to simplify healthcare. It seems that daily one of our congressman bring up this point. It already takes mammoth effort in

Elkhart General Healthcare System
600 East Boulevard
Elkhart, IN 46514
Phone: 574/294-2621
www.egh.org

- staffing and training costs to ensure to current system is working properly. Now the plan is to more than double it!!! This will just add to more confusion to an already over complicated system.

- Under the proposed rules changes many of the cost DRG's are being reduced significantly. These are the same DRGs that technology advancements have had a very positive impact on saving lives. An example of this are procedures that utilize a cardiac implantable Defibulator (DRG 5635 and 536). The cost of these generally run between $25,000 to $29,000 just for the device alone, let alone the other services and supplies related to that surgery. Currently, our payment for that does not even came close to covering the direct cost, yet CMS is proposing to cut the reimbursement greater than 10%. EGH and others will not be able to sustain any type of profitability if this continues and more than likely, the self insured or insurance patient will end up footing the cost, a cost shift to local employers and individuals that no one can afford.

- There has been a big push recently regarding Pay for Performance efforts in regards to reimbursing physicians and hospitals. This is a good effort to increase the quality of healthcare in the country. Yet, it appears that there is little or no discussion about matching quality improvements with reimbursement in this proposal. I would suggest that these efforts be continued and be part of the proposal.

As stated above, these are just a few of the concerns that EGH has with the proposed rules. Those, in combination with the concerns that AHA has expressed to you previously in their letter, necessitate a more formal review of the rules and, at minimum, a delay in the implementation of the rules.

If you have any questions, I would be more than willing to discuss these with you. I can be reached at khigdon@egh.org or (574) 523-3208.

Sincerely,

Kevin J. Higdon
Vice President of Finance

KJH/lt

cc: Elkhart General Hospital Board of Directors
Elkhart General Hospital Administrative Staff
Evan Bayh, U.S. House of Representatives
Richard Lugar, U.S. House of Representatives
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Fred Upton, U.S. House of Representatives
Senator Carl Levin, Michigan House of Representatives
Senator Debbie Stabenow, Michigan House of Representatives
Brent Richards, Manager of Reimbursement, Elkhart General Hospital

Submitter : Dr. Glynda Moorer **Date:** 06/12/2006

Organization : Dr. Glynda Moorer

Category : Individual

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS or the Agency) proposed rule entitled Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates. 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in patient care activities. The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

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This position reverses the Agency s position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty. [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency s 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs.

Residency Program Activities and Patient Care
I firmly believe that with the possible exception of extended time for bench research, there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician s educational development into an autonomous practitioner.

To separate out CMS s newly defined patient care time from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,

Submitter : **Ms. Mary Whitbread** **Date: 06/12/2006**

Organization : **Henry Ford Health System**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1494-Attach-1.DOC

#1494

Mary Whitbread, Vice President
Reimbursement and Contracting
One Ford Place
Detroit, Michigan 48202

Ph: (313) 874-9533
Fax: (313) 876-9229

June 12, 2006

Centers for Medicare and Medicaid Services
Attn: CMS 1488-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-1488-P
Hospital Inpatient PPS Proposed Rule for FY 2007
HSRV Weights, DRGs – Severity of Illness, Hospital Quality Data, Transparency of Health Care Information, GME Payments, Operating Payment Rates - Outliers

Dear Sir or Madam:

The Henry Ford Health System welcomes this opportunity to comment on the proposed rule (the "NPRM") promulgated by the Centers for Medicare and Medicaid Services ("CMS") entitled *Medicare Program: Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates* (71 Fed. Reg. 23996 (April 25, 2006)). As a multi-hospital, not-for profit, academic healthcare system, with both community and tertiary hospitals, the issues in this rule have broad and significant import for us.

HSRV Weights

We support the adoption of the hospital-specific relative value ("HSRV") based payment system. This methodology results in a more accurate and equitable payment system. A comparison of our cost estimates and case margins showed an overall improvement in the distribution of payments. Where we did note large disparities between our costs and the CMS cost based weights, we found the variance was often corrected when the cases were regrouped using the severity adjusted DRGs. We were disappointed that the new weights did not always correct underpayment issues for the high costs of some new technology items. We hope CMS will continue efforts to refine the system to accurately capture these costs.

DRGs – Severity of Illness

We have long contended the current DRGs fail to take into account the severity of illness and we are very pleased CMS is addressing this problem. From our preliminary review, the consolidated severity-adjusted DRGs significantly reduce the cost variation between DRGs. The

one consistent shortcoming we noted, and that was acknowledged by CMS, is the failure to take into account new or complex technology.

One example that was clear in the limited time we had to review our data (and without detail on the grouper logic) was robotic surgery. We do a high volume of robotic prostatectomies. Virtually all of these cases fell into a severity level 1 under the CS-DRGs. We suspect that the low severity was due, in large part, to the fact that this expensive alternative method reduces length of stay and complications. What the new system fails to measure is the significant additional supply and capital expense this technology requires. We are penalized for investing in and achieving the best outcomes for our patients. We urge CMS to explore ways in which the grouper/severity levels could be used to recognize certain approved technologies until they acquire widespread use.

Hospital Quality Data

We understand that many of CMS' proposed changes to its hospital quality data reporting system are mandated by statute, and we are generally supportive of CMS' initiatives in tying reimbursement to quality data disclosure. However, we believe that certain modifications are necessary to CMS' policies, as proposed. One such modification relates to CMS' proposal that the expanded disclosure obligations are to apply to data to be submitted on August 15, 2006. Pursuant to the Administrative Procedure Act and Section 1871(e)(1)(B)(i) of the Social Security Act, a rule cannot go into effect prior to the expiration of 30 days from the date it is published. Since the Final Rulemaking will likely not be issued by July 15, it would be in contravention of these statutes to apply these new reporting requirements to the August 15 submission. Indeed, it is possible that, in light of comments received on the 21 measures proposed in the NPRM, CMS may change some of the data elements required. It would be inequitable to give hospitals only a couple of weeks to respond to any such changes in compiling the data to be submitted on August 15.

We also ask that CMS clarify whether the 2.0 percent reduction in the market basket update would ever apply retroactively. For instance, what happens if a hospital were to furnish all pertinent quality data for the first two quarters of the Federal fiscal year but then fails to meet CMS standards for the third quarter? The applicable statute and the regulation both limit the application to a period *no greater than* the current fiscal year. Social Security Act, 1886(b)(3)(B)(viii)(I); 42 C.F.R. § 412.64(d)(2). However, neither provision requires that the update factor be reduced for all claims submitted during the *entire* fiscal year, including those that have already been submitted. Given the significant increase in data elements to be collected, there is an increased possibility that a hospital will be found non-compliant despite reasonable diligence in gathering and submitting data.

Transparency of Health Care Information

We agree with CMS that there is a national healthcare crisis and laud CMS' efforts to address the issue. We think it would be more beneficial to focus on working with Congress to expand Medicaid and other safety net programs to ensure meaningful health care coverage for the uninsured. While achieving transparency in price information is a worthwhile objective, it is of limited value to a limited population.

As CMS is aware, most hospital charges are listed on charge description masters that contain tens of thousands of items. Further, each hospital has its own unique system for

establishing charges. For example, whereas one hospital might set its charges for emergency room visits based on patient acuity, another hospital in the same city could set its charges based on the items and services utilized by the patient during the visit. Given the complexity and differentiation between hospital charge structures, price comparisons among hospitals on the basis of charges would be virtually impossible. Disclosure, therefore, of hospital-specific charges will not accomplish CMS' transparency goals.

As an alternative, CMS could expand upon its current efforts to report national average charges are for certain common procedures. Such an approach would be administratively simple to implement. CMS has all of the data regarding hospital charges for any given procedure in its MedPAR file. Therefore, there would be no additional obligations (or costs) imposed upon hospitals in making this data available to the public. Further, using national data as a benchmark, patients can identify whether charge information they receive from their local hospitals indicates that they live in a region with unusually high charges. Patients aware of such a disparity could encourage their local institutions to reduce their charges to better align with national averages. Thus, disclosure of national charge data could facilitate CMS' goal of reducing charges in regions with exceptionally high charges.

It has been our experience that hospital charge data is not relevant to the vast majority of insured consumers. For this population, the relevant financial information is the contractual amount agreed to between the provider and the insurer and the individual insurance policy terms. We have found it is impossible, as a provider, to supply this information to all of our patients because of the sheer number of policy options offered by insurance companies.

To summarize, CMS has our full support in improving access to affordable healthcare. Pricing transparency, while laudable, does little to address the problem of the uninsured and would have a marginal impact on costs. Hospital charge information should be made available to consumers but, in order to have useful, uniformly comparable data, it should be provided in a centralized system using claims data. Of more interest/importance to insured consumers is information that would provide policy specific information on patient financial liability. This is something that only the insurance companies have the ability to provide.

GME Payments

We consider CMS' changes to its graduate medical education ("GME") policies to be problematic. In particular, we disagree with CMS' proposed disallowance of resident time spent in nonpatient care activities for the purposes of counting resident time in non-hospital sites, as well as for the indirect medical education ("IME") calculation. This policy contravenes the plain meaning and manifest intent of the pertinent statutory provisions. Thus we request that the policy be modified or simply withdrawn.

Non-Hospital Site Training

Although the NPRM relies on language in the statute as support for the proposed disallowance of time spent in nonpatient care activities in non-hospital settings, the language of the cited provisions hardly compels CMS' interpretation. The direct GME provision states that CMS regulations must:

> provide that only time spent in activities relating to patient care shall be counted and that all the time so spent by a resident under an approved medical residency training program shall be counted towards the determination of full-time equivalency, without regard to the setting in

> which the activities are performed, if the hospital incurs all, or substantially all, of the costs for the training program in that setting.

Social Security Act, § 1886(h)(4)(E) (emphasis added).[1] Congress could have simply stated that only time spent in "patient care" would be included in the resident count. However, it chose instead to define the scope of permitted activities more expansively, and includes all activities that "relate to" patient care. *See, e.g.*, Morales v. Trans World Airlines, 504 U.S. 374, 383 (1992) (finding that, when used in a statute, the term "relating to" is intended to be interpreted broadly). Thus, Congress did not expect that a resident must engage exclusively in patient care. Rather, as long as there is some nexus between patient care and the resident's activities, the statutory conditions would be satisfied. *Cf. University of Cincinnati v. Bowen,* 875 F.2d 1207, 1211 (6th Cir. 1989) (stating that any activities required as part of a resident's training "*ipso facto* contribute to the quality of care received by the Hospital's Medicare patients"). Didactic activities, such as journal club and lectures on medical topics, demonstrate such a nexus. CMS' interpretation, which limits time includible in the resident count solely to direct patient care activities, thus does not square with the statute's plain meaning.

CMS itself has acknowledged that the statute may be fairly read as covering a wide range of undertakings within the scope of "patient care activities." As stated in a letter from Tzvi M. Hefter, Director, Division of Acute Care, to B. Scott McBride, Vinson & Elkins LLP, dated September 24, 1999:

> HCFA interprets the phrase "patient care activities" broadly to include any patient care oriented activities that are part of the residency program. As you stated in your letter, this can include resident participation in "1) the direct delivery of patient care, such as clinical rounds, discussions, and conferences, and 2) scholarly activities, such as educational seminars, classroom lectures, research conferences, patient care related research as part of the residency program, and presentations of papers and research results to fellow residents, medical students, and faculty." Therefore, as long as the residents are primarily involved in patient care oriented activities and other program requirements are met, a hospital may include other educational activities as part of the entire time spent by residents in non-hospital settings and include this time in its FTE count and GME/IME payment calculations.

The interpretation in the NPRM represents a complete reversal from this earlier interpretation. Although CMS has disavowed this letter in its NPRM, there has been no amendment to the statute or other legislative development which would account for the change in CMS' interpretation. This sudden shift, without further explanation, is arbitrary and capricious agency a ction. *See, e.g.*, Motor Vehicle Manufacturers Association of the United States, Inc., v. State Farm Mutual Automobile Insurance Company, 463 U.S. 29, 42 (1983). Absent a reasonable justification for this shift, CMS should uphold its test articulated in the letter, *i.e.*, deeming the patient care requirement met if a resident is "primarily involved in patient care oriented activities."

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[1] Similarly, for IME, Congress mandated that, as of October 1, 1997, "all the time spent by an intern or resident in patient care activities under an approved medical residency training program at an entity in a nonhospital setting shall be counted towards the determination of full-time equivalency if the hospital incurs all, or substantially all, of the costs for the training program in that setting." Social Security Act, § 1886(d)(5)(B)(iv) (emphasis added). Although worded slightly differently from the direct GME provision, there is no evidence that Congress intended that there be separate counting rules for direct GME and IME for time residents spend in non-hospital site rotations. Rather, IME payment merely acts as an additional incentive to hospitals to encourage these non-hospital site rotations.

This proposed change to CMS' non-hospital site resident counting rules also contravenes the manifest intent of the statute. By creating a mechanism for reimbursing hospitals for resident time in non-hospital site rotations, Congress clearly intended to encourage hospitals to place their residents in non-hospital settings. Yet, if CMS' current proposal is ultimately implemented, there will be a chilling effect on this type of training. Hospitals will be forced to demand that non-hospital sites closely monitor what portion of a resident's time is spent in patient care activities and what portion is spent in nonpatient care activities. In many instances, it may not even be clear when the patient care activities have ended and the nonpatient care activities have begun. In any event, most physician clinics and other non-hospital sites that have agreed to train residents do so out of a spirit of generosity and enjoyment of participating in the teaching process. If the documentation requirements associated with this training become too onerous, many physician clinics and other sites will likely refuse to participate going forward. Thus, CMS' policy will have frustrated Congress' intent both in initially enacting the direct GME payment provisions and in subsequently enacting the IME payment provisions.

If CMS nevertheless determines to implement this proposed policy, further clarification is needed. One matter requiring amplification relates to the scope of activities that are considered "part of the approved residency program." 71 Fed. Reg. at 24114. Many activities occur at non-hospital sites that are neither required by any accrediting body for the residency program, planned by the hospital, nor included on the hospital's rotation schedules. For instance, if a supervising physician meets a resident for lunch and happens to discuss a medical topic, CMS may interpret such an encounter as a nonpatient care activity. Yet, given the spontaneous nature of such an encounter, this exchange could hardly qualify as part of the approved program, any more so than, say, a weekend golf outing involving some tangential discussion of medical topics. CMS should clarify that only planned activities expressly undertaken to meet programmatic requirements should be included as part of the approved residency program.

Another ambiguity in CMS' policy relates to how the time associated with any such nonpatient activities is to be reported for cost reporting purposes. CMS has only stated that such time may not be "counted for the purpose of direct GME and IME payments." 71 Fed. Reg. at 24114. Yet, it is unclear whether CMS intends to exclude this time just from the time allowable as part of a hospital's resident count, or whether hospitals are also supposed to exclude this time from the total time worked by the resident. For a resident training in multiple locations, a hospital calculates its portion of the resident count by dividing time associated with such resident's rotations to the hospital by total time worked by the resident over the course of a year. 42 C.F.R. § 413.78(b). This total time serving as the "denominator" varies resident by resident, and is determined solely by how many hours a hospital deems to be necessary for the resident to complete the residency requirements for that year. 54 Fed. Reg. 40286, 40291 (Sept. 29, 1989). The statute cited by CMS in its NPRM states only that "time spent in activities relating to patient care shall be counted." Social Security Act, § 1886(h)(4)(E) (emphasis added). To be "counted", the time appears both in the allowable time claimed by the hospital and the total time worked by the resident in a given year. Conversely, if the activities do not relate to patient care, then the time should not be counted either as allowable time or as part of the total time worked. In other words, to be consistent in its interpretation of the statute, CMS should specify that time associated with nonpatient care activities should not be included at all in IRIS, either as allowable or unallowable. Thus, these activities would not result in any dilution of the total resident count that may be claimed by all of the hospitals training the resident.

Additionally, CMS should explain that its proposed rule is prospective in effect only. As is evidenced by the letter to Mr. McBride, CMS' stance in the NPRM represents a dramatic shift in policy. As such, the policy does not qualify as a mere "clarification." *See, e.g.*, Paralyzed Veterans of America v. D.C. Arena L.P., 117 F.3d 579, 586 (D.C.Cir.(1997), ("Once an agency

gives its regulation an interpretation, it can only change that interpretation as it would formally modify the regulation itself: through the process of notice and comment rulemaking."). Accordingly, if CMS does decide to implement this revised policy in some form (and we believe it shouldn't), it should clearly state that it applies only for rotations beginning on or after July 1, 2007.

Indirect Medical Education

CMS' position with respect to the impact of nonpatient activities on the calculation of IME is also at odds with the governing statute. According to the pertinent statute, "[t]he Secretary shall provide for an additional payment amount for subsection (d) hospitals with indirect costs of medical education, in an amount computed in the same manner as the adjustment for such costs under regulations (in effect as of January 1, 1983) [except as otherwise provided in the IME statutory provisions]." Accordingly, unless superseded by other statutory provisions, the IME payment system in effect on January 1, 1983 continues to remain in effect. In 1983, the determination of a hospital's resident count was subject to just two exclusions: residents who were not physically at the hospital, *e.g.*, residents who were on the hospital's payroll but furnished services at another location; and residents who were not in an approved program. 46 Fed. Reg. 21582, 21584 (Apr. 1, 1980). *See also* PRM CMS-Pub. 15-2, § 1208.2 (cost reporting instructions indicating same two exclusions). Significantly, time residents spend in nonpatient care activities was not excluded from the resident count. Thus, the regulatory system in effect on January 1, 1983 included time associated with nonpatient care activities in the resident count. Since there is no statutory provision superseding this calculation methodology, the plain meaning of the statute requires that this time continue to be included in the resident count.

Including all of a resident's time in the resident count, encompassing time associated with nonpatient care activities, is also consonant with the statute's manifest intent. Congress enacted the IME adjustment due to "serious concerns" about the ability of the inpatient prospective payment system to account for "a number of factors" that may legitimately increase the allowable operating costs incurred by teaching hospitals. H.R. Rep. No. 98-25, 140-41 (1983); *see also* S. Rep. No. 98-23, 52-53 (1983). Congress specifically enumerated three factors that may contribute to the higher costs of operating a teaching hospital:

1) patient severity of illness;

2) specialized services and treatment programs provided by teaching institutions; and

3) additional costs associated with the teaching of residents, including the costs of additional tests and procedures ordered by residents and additional staff resources required for participation in the education process. *Id.*

In large part, these factors relate to the institutional characteristics of a teaching hospital as a whole, rather than simply cost increases directly related to resident involvement in patient treatment. Therefore, an add-on payment based solely on the number of residents, or the costs associated with their role in patient care, would not suffice to capture all of the factors contributing to the teaching hospital's higher costs. Instead, Congress determined that the IME adjustment should be calculated based on the ratio of interns and residents to beds, which serves as a more accurate proxy measure for IME costs. *Id.*

The decision by Congress to enact the IME statutory provisions was based largely on recommendations it received from CMS (then HCFA). In a December 1982 report to Congress, the Secretary specifically addressed the need for the proposed payment system to account for

"indirect costs of graduate medical education."[2] In that report, the Secretary acknowledged that while these increased costs are clearly correlated with the intensity of teaching in an institution, the Secretary did not know which part of these increased costs is caused by residents' instruction and which part is due to other factors such as the types of patients treated by teaching hospitals:

> The indirect costs of graduate medical education are higher patient care costs incurred by hospitals with medical education programs. **Although it is not known precisely what part of these higher costs are due to teaching (more tests, more procedures, etc.) and what part is due to other factors (the particular types of patients which a teaching hospital may attract), the Medicare cost reports clearly demonstrate that costs per case are higher in teaching hospitals.**
>
> It is also clear that the mere presence of interns and residents puts extra demands on other staff and leads to the existence of higher staffing levels. The process of graduate medical education results in very intensive treatment regimens. Again, **the relative importance of the various reasons for the higher costs observed in teaching hospitals is difficult to identify precisely**. However, there is no question that hospitals with teaching programs have higher patient care costs than hospitals without. (Underscoring in original; emphasis in boldface type added.)

What is clear from CMS' report, which ultimately formed the basis of the IME legislation, is that resident involvement in patient care is only one reason for the increased costs of care in a teaching hospital. Moreover, it is impossible to determine how important a factor resident involvement in care may be, as compared with, for example, the type of patient ordinarily seen by a teaching institution. Therefore, disallowing time residents spend in nonpatient care activities from the IME resident count calculation improperly ignores the importance of all of the other factors that contribute to the increased costs of care for teaching hospitals. Since Congress meant to compensate for all of these factors, CMS' policy contravenes the manifest intent of the statute.

In one recent case, the court affirmed that Congress' intent in enacting the IME statutory provisions was to compensate teaching hospitals for more than just the direct costs of resident involvement in patient care. Rather, IME payments are based on a proxy because it is not possible to precisely identify or measure the higher operating costs incurred by teaching hospitals, due to their very nature as teaching institutions:

> It is precisely because the indirect costs cannot be adequately itemized and quantified that Congress devised a formula based on the degree of teaching intensity in a particular hospital, as a substitution for any other method of reimbursing such costs. If Congress had believed that the indirect medical education costs of a teaching hospital could be separately identified and quantified, and that higher direct patient care costs could be so determined from the hospital's records, then Congress could easily have qualified its formula for reimbursement to restrict the number of FTE residents to a number based only on hours that residents spent providing "patient care." It obviously did not do so.

Riverside Methodist Hospital, No. C2-02-94, 2003 U.S. Dist. LEXIS 15163 at *31 (S.D. Ohio, July 31, 2003). As thus recognized by the court, it is not in keeping with the statute or legislative

---

[2] *Report to Congress Required by the Tax Equity and Fiscal Responsibility Act of 1982,* December 1982, *reprinted in* CCH Report No. 374, Extra Edition, January 5, 1983, at pp. 48-49.

intent to limit a hospital's resident count to the time spent in patient care activities. CMS should revise its policy to properly reflect the directions Congress has given the agency in the statute.

Even if CMS believes that resident activities must be related to patient care in order to be included in the IME resident count, residents' research and other educational activities that are within the scope of an approved GME program must necessarily be considered to be related to patient care. To the extent that these activities are a necessary and proper component of a residency training program, the costs of the training must "*ipso facto* contribute to the quality of care received by the Hospital's Medicare patients" and, therefore, must be considered an allowable patient care related cost. University of Cincinnati v. Bowen, 875 F.2d 1207, 1211 (6th Cir. 1989); *see also,* Loyola Univ. of Chicago v. Bowen, 905 F.2d 1061, 1072 (7th Cir. 1990). To the extent that journal club and lectures are an integral part of the residency program, CMS should thus deem the time related to these activities as patient care-related and allow hospitals to include this time in their IME calculations.

Operating Payment Rates - Outliers

We request that CMS reconsider its proposed increase in the outlier threshold. Pursuant to statute, outlier payments "may not be less than 5 percent nor more than 6 percent of the total payments projected or estimated to be made based on DRG prospective payment rates for discharges in that year." Social Security Act, § 1886(d)(5)(A)(iv). As with FYs 2005 and 2006, CMS is seeking to comply with this statute by setting a targeted outlier payment amount of 5.1 percent of total DRG payments. Yet, CMS has acknowledged that, for the past two years, its modeling of claims data has resulted in materially inaccurate projections of outlier payments. For FY 2005, CMS' current data shows that outliers only accounted for 4.1 percent of total DRG payments, and for FY 2006, CMS currently anticipates that outliers will have accounted for 4.71 percent of total DRG payments. 71 Fed. Reg. at 24150. Given these differences between CMS projections and actual expenditures, it is a reasonable inference to conclude that CMS' model must be flawed in some respect. Yet, CMS has stated that it is continuing to apply the same methodology in its calculation of the FY 2007 outlier threshold. 71 Fed. Reg. at 24149. Based on this model, CMS will be *raising* the threshold to $25,350 to achieve the targeted 5.1 percent amount, even though last year CMS did not reach this target after *reducing* the threshold. Although it may be true that the governing statute only requires that CMS project outlier payments between 5 and 6 percent of total payments, there is an implicit requirement that CMS' projections be reasonable. After two years of faulty projections, CMS has an obligation to examine what accounts for the distortions to its model and correct for them in the current year.

* * *

Thank you for your review of this submission. Please contact me if you should have any questions regarding these comments.

Sincerely,

Submitter : **Dr. Hannah Phillips** **Date: 06/12/2006**

Organization : **Hallmark Health**

Category : **Physician**

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS or the Agency) proposed rule entitled "Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates." 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in "patient care activities." The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

Background
The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a nonhospital setting, such as a physician's office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not "related to patient care".

This position reverses the Agency's position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include "scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty." [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency's 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs.

Residency Program Activities and Patient Care
I firmly believe that with the possible exception of extended time for "bench research," there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician's educational development into an autonomous practitioner.

To separate out CMS's newly defined "patient care time" from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,

Dr. Hannah E. Phillips

Submitter : **Dr. jeffrey geller** **Date: 06/12/2006**

Organization : **greater Lawrence family health center**

Category : **Physician**

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS or the Agency) proposed rule entitled "Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates." 71 Fed. Reg. 23996 (April 25, 2006).

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Background
The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a nonhospital setting, such as a physician's office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not "related to patient care".

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To separate out CMS's newly defined "patient care time" from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,

jeffrey s. geller

Submitter : Mr. Arthur Tedesco **Date:** 06/12/2006

Organization : The Danbury Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attached

CMS-1488-P-1497-Attach-1.RTF

#1497

June 12, 2006

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Attention CMS-1488-P
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Re: CMS-1488-P; Medicare Program; Proposed Changes to Hospital Inpatient Prospective Payment System and Fiscal Year 2007 Rates

Dear Dr. McClellan:

Danbury Hospital appreciates the opportunity to provide these comments regarding the Centers for Medicare and Medicaid Services (CMS) proposed rule: Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates [CMS-1488-P]. The CMS proposed rule sets forth numerous and sweeping operational and policy changes to the hospital inpatient prospective payment system (IPPS). These comments outline strategies to more effectively meet the proposed rule's stated objective of creating incentives for hospitals to operate efficiently and minimize costs while at the same time ensuring that payments are sufficient to adequately compensate hospitals for their legitimate costs.

Danbury Hospital supports the following recommendations:

Increase in Base Payments and Minimum Rate Increase. The Connecticut Hospital Association has detailed in its comments the policies that have reduced funding to high wage states, penalized hospitals that appropriately care for transferred patients, and reduced funding of teaching programs. The detailed analyses provided by CHA shows how Connecticut hospitals like Danbury Hospital have consistently been disproportionately negatively affected by Medicare rate policies during the past decade. To bring Danbury Hospital up to the national average increase, an add on adjustment should be made to step up the basis of payment so that the 2007 year payment would be at a level equal to what it would have been had Danbury Hospital been receiving the national average increase during the past decade. The add on needed for Danbury Hospital is 8%. In addition, Danbury Hospital believes at a minimum CMS should provide as a basic matter of policy, that no hospital receive payments less in the current year than in the previous year. Optimally, CMS should provide a minimum payment increase of 2%.

Wage Index Budget Neutrality: CMS eliminated Critical Access Hospital (CAH) data from the wage index file it uses to compute the national average hourly wage (NAHW). Because CAHs have lower average hourly wages than the average PPS hospital, the elimination of

this data results in an overstated NAHW, which consequently reduces payment because of the budget neutrality adjustment. CMS should apply a positive budget neutrality adjustment in FY 2007 to compensate for the prior underpayments and should remove CAH data from all parts of the calculation.

DRG Changes: Danbury Hospital supports moving to a DRG-weighting methodology based on hospital costs rather than charges, but requests a one-year delay in the proposed DRG changes given the serious concerns with the HSRVcc and CS-DRG methodology. Danbury Hospital opposes the introduction of a new classification system at this time, as the need for a new system is still unclear.

Quality: When expanding quality data reporting requirements for hospitals to receive a full market basket update to include all 21 measures that are currently part of the Hospital Quality Alliance's (HQA's) public reporting, CMS should make the data collection prospective by requiring that hospitals pledge to submit data for patients discharged on or after July 1, 2006 rather than January 1, 2006. Danbury Hospital also urges CMS to continue to use HQA as the principal source of measures for hospital performance reporting and continue to align its efforts with those of HQA. Finally, it is critically important that CMS enhance its data submission, validation, and error correction processes, in order to ensure that hospitals are not inappropriately penalized for technical data issues.

Cost Outlier Threshold: Danbury Hospital urges CMS to adopt the AHA-recommended outlier threshold methodology, lowering the outlier threshold.

Value-Based Purchasing: The primary goal of value-based purchasing, also known as pay-for-performance systems, should be to facilitate the development of a healthcare system that is safe, effective, patient-centered, timely, efficient, and equitable, and the systems should be designed to support that goal. Pay-for-performance systems should: be practical for hospitals to implement; ameliorate, not exacerbate, the financial challenges already facing hospitals by providing and aligning physician and hospital incentives, not imposing penalties; be based on measures that accurately assess a hospital's performance in delivering quality care; and compensate a hospital based on its own performance, irrespective of the performance of other hospitals.

We appreciate your consideration of these comments.

Sincerely,

THE DANBURY HOSPITAL

Arthur N. Tedesco
Sr. Vice President & Treasurer

Submitter : **Mr. Jeffrey Heidt** **Date: 06/12/2006**

Organization : **Ropes**

Category : **Attorney/Law Firm**

Issue Areas/Comments

Wage Data

Wage Data

See Attachment

CMS-1488-P-1498-Attach-1.PDF

CMS-1488-P-1498-Attach-2.PDF

#1498

ROPES & GRAY LLP
ONE INTERNATIONAL PLACE BOSTON, MA 02110-2624 617-951-7000 F 617-951-7050
BOSTON NEW YORK PALO ALTO SAN FRANCISCO WASHINGTON, DC www.ropesgray.com

June 12, 2006

Submitter: Deborah Kantar Gardner and Jeffrey L. Heidt

Organization: Ropes & Gray LLP

Category: Health Care Provider Representative

Issue Areas/Comments: General re: CMS-1488-P-Wage Data

VIA ELECTRONIC MAIL
http://www.cms.hhs.gov/eRulemaking

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1488-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Comments on Medicare Program: Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates, Published at 71 F.R. 24,001 (April 25, 2006) CMS-1488-P- Wage Data

Dear Dr. McClellan:

We welcome the opportunity to submit these comments on proposed rules published on April 25, 2006 at 71 F.R. 24001 *et seq.* This firm provides legal services to numerous providers who may be adversely effected by implementation of that portion of the proposed rules that seeks to exclude the wage data of a critical access hospital (CAH) converting to rural hospital status from the computation of the wage index until the converting hospital is an IPPS hospital in both the year in which the survey data is collected (the "base year") and the current rate year (the "rate year"). This aspect of the proposed rule is contrary to the statutory mandate that requires inclusion of all subsection (d) hospitals (those hospitals subject to the prospective payment system) in the wage index calculation and frustrates the purpose of the wage index and the rural

floor. It also is inconsistent with the position the Secretary took in determining to remove the wage data of CAHs from the wage index calculation. It has no basis in law or in logic and is antagonistic to the interests of Massachusetts PPS hospitals, many of whom are suffering from a declining and non-representative wage index due to the exclusion of CAHs from the wage index and who would benefit from the immediate inclusion of any converting CAH in the wage index computation.

As you know, Congress mandated the creation of a wage index in 1983 by requiring the Secretary to adjust the proportion of hospitals' costs attributable to wages and wage-related costs of the DRG rates for area differences in hospital wage levels by a factor reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level. Pub. L. No. 98-21, § 601 (1983) (codified at 42 U.S.C. § 1395ww(d)(3)(E)). In 1987, Congress amended the statute to require the Secretary to update this factor on the basis of an annual survey of the wages and wage-related costs of subsection (d) hospitals. Pub. L. No. 100-203, § 4004. Generally, a hospital's PPS reimbursement is based on the wage index for the geographic area in which it is located. However, Congress also mandated that an urban area's wage index cannot be lower than the wage index applicable to rural areas in that state (the "rural floor"). Pub. L. No. 105-33, § 4410. Congress intended that the rural wage floor benefit urban providers by preventing the wage indexes of urban hospitals from falling below the wage index applicable to rural areas and thereby correct the anomaly of some urban providers being paid less than the average rural hospital in their states.

Prior to October 1, 2003, the Secretary included the wage data of CAHs in the computation of the wage index and the rural floor for various states. It did so because it had no reason to believe that these hospitals did not provide an accurate reflection of the labor market during the relevant period. However, effective October 1, 2003, the Secretary decided to exclude the wage data of CAH from the wage index based on data showing that a substantial negative impact of CAHs on the wage indexes of areas where they were located. Therefore, beginning with the FY 2004 wage index, the Secretary excluded from the wage index the wage data of CAHs "even if the hospital was paid under the IPPS during the cost reporting period used in calculating the wage index." 68 F.R. 45,398, Aug. 1, 2003. The sole reason the Secretary gave for his exclusion of CAHs from the wage index was that he "believe[d] that this change would improve the overall equity of the wage index." Id.

Without regard to the propriety of excluding CAHs from the wage index, the proposed rule preventing the inclusion of the wage data of CAHs in the wage index is inconsistent with the statute and the Secretary's prior practices. Pursuant to the statutory mandate, a CAH that converts to a PPS hospital is a subsection (d) hospital that must be included in the wage index because its wage data reflects the actual wages paid by the hospital and the conditions occurring in the labor market area in which it is located. A CAH that converts to IPPS status is not tantamount to a new hospital that has not filed any wages and hours data on a Medicare cost report; rather, it is a provider that participated in the Medicare program (albeit with a different status) previously and has developed, and in many cases submitted, wages and hours data for the

wage index. Because this data is available to the Secretary for the wage index survey and presents an accurate and objective picture of wage conditions in the area that the provider is located, it should be included in the wage index calculation. Indeed, in prior years, the Secretary has recognized the importance of including all available wage data in the wage index calculation:

> We have always maintained, subject to limited expectations [sic], that any hospital that is in operation during the data collection period used to calculate the wage index should be included in the database, since the hospital's data reflects conditions occurring in that labor market area during the period surveyed.

67 F.R. 49,982, 50,023 (Aug. 1, 2002). By excluding the wage data of a CAH that converts to IPPS status for the reason that the hospital was not an IPPS hospital in the year in which the wage survey was conducted, the Secretary arbitrarily creates a wage index that does not "reflect[] the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level" in violation of the statutory mandate. See 42 U.S.C. § 1395ww(d)(3)(E).

This aspect of the proposed rule also violates the statutory purpose of the wage index and the rural floor. Congress required the wage index to reflect real wage levels and selected a survey format to ensure that a group of providers were included in the wage index calculation. CAHs that have converted to IPPS hospitals are subsection (d) hospitals that Congress intended to be included in the calculation of the wage index. Where actual wage data is available, it defies the statutory purpose of the wage index survey not to use that data. Moreover, to the extent that CAHs form the rural floor in a given state, their wage data is all the more important in carrying out Congressional desire to protect urban hospitals from declining wage indexes. This is particularly true in states subject to an imputed rural floor which, in accordance with Medicare's principles of fairness and accuracy, should be able to avail themselves of a wage index based on the more accurate and representative wage data of a true subsection (d) rural hospital rather than an imputed rural index.

Immediately including converting CAHs in the wage index computation would be consistent with the Secretary's past practice in excluding CAHs from the wage index. As noted above, the Secretary excluded CAHs from the wage index based on their Medicare status in the current rate year. Even hospitals that were IPPS hospitals in the base year (the year the wage data was collected), were excluded from the wage index calculation simply by virtue of their Medicare status in the rate year. In choosing to focus on a provider's Medicare status in the rate year, the Secretary acknowledged the importance of actual conditions in the labor market, despite the time lag in the computation of the wage index.

The Secretary's proposed changes will have a significant adverse impact in Massachusetts should its CAHs choose to convert to IPPS status. In Massachusetts, the imputed rural floor for FY 2006 (1.075) is lower than the actual rural floor that existed prior to the Secretary's exclusion of CAHs from the wage index and lower than the rural floor would be if converting CAHs were

included in the wage index in the year of conversion. Massachusetts PPS hospitals would continue to suffer severe reductions in their Medicare payments if they are compelled to wait four years after a CAH converts to PPS status before the Secretary includes the wage data of the converting CAH in the wage index calculation. The proposed changes would, therefore, have a drastic and unwarranted impact on Massachusetts PPS hospitals and would undoubtedly have an injurious impact on their ability to deliver quality care and services.

Thank you for the opportunity to comment on the proposed rules. For the reasons set forth above, these proposed changes to the wage index calculation are arbitrary and should not be implemented. If you or your staff needs further clarification of the views expressed in this submission, please contact either of the undersigned at 617-951-7000.

Respectfully submitted,

Deborah Kantar Gardner and Jeffrey L. Heidt
Ropes & Gray LLP
One International Place
Boston, MA 02110-2624
617-951-7000

Submitter : **Date: 06/12/2006**

Organization :

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1499-Attach-1.DOC

#1499

June 12, 2006

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1488-P and P2
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Dr. McClellan:

On behalf of Centura Health's 10 acute hospitals, and related health care entities, we appreciate the opportunity to submit comments to the Centers for Medicare and Medicaid Services (CMS) on the fiscal year (FY) 2007 inpatient prospective payment system (PPS) and occupational mix adjustment proposed rules.

While Centura Health supports many of the proposed rule's provisions, we have serious concerns about the proposed changes to the DRG weights and classifications.

Centura Health supports meaningful improvement to Medicare's inpatient PPS. We believe we share a common goal with CMS in refining the system to create an equal opportunity for return across DRGs, which will provide an equal incentive to treat all types of patients and conditions. However, more time is needed to understand the significant proposed policy changes, which redistribute from $1.4 to $1.7 billion within the inpatient system. Analysis shows the impact of the proposed changes to be highly unstable, with small changes in method leading to large changes in hospital payment. And the validity of CMS' proposals versus potential alternatives to improve the DRG weights and classification system is uncertain. Moving forward requires thoughtful change.

Specifically, Centura Health supports the following:

- **One-year Delay**: Centura Health supports a one-year delay in the proposed DRG changes given the serious concerns with the HSRVcc and CS-DRG methodology. Centura Health is committed to working with CMS over the next year to address these concerns.

- **Collaborative Approach to Moving Forward:** Centura Health commits to working with CMS to develop and evaluate alternatives for new weights and classifications.

Centura Health appreciates the opportunity to submit these comments. If you have any questions about our remarks, please contact Pam Nicholson, SR VP External Affairs and Chief of Staff, or Doug Lemieux, Reimbursement AVP at 303-804-8112 or douglemieux@centura.org.

Sincerely,

Gregory H. Burfitt

Submitter : Mrs. Karen Hill **Date:** 06/12/2006

Organization : Central Baptist Hospital

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

See attached.

CMS-1488-P-1500-Attach-1.DOC

#1500

BAPTIST HEALTHCARE SYSTEM

Central Baptist Hospital
1740 Nicholasville Road
Lexington, Kentucky 40503
(859)260-6445

Electronically Submitted

June 12, 2006

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1488-P
7500 Security Boulevard
Baltimore, Maryland 21244-1850

RE: Provider Comments
Proposed Changes to Inpatient PPS
DRG Reclassifications and Severity of Illness

On behalf of the Central Baptist Hospital, a member of Baptist Healthcare System, Inc. (BHS), we appreciate the opportunity to comment on the fiscal year (FY) 2007 proposed changes to the hospital inpatient prospective payment system.

Central Baptist Hospital supports meaningful improvements to Medicare's inpatient prospective system and shares CMS's desire to develop a payment system that provides an equal financial incentive (margin) to treat all patients, regardless of diagnosis or severity of illness. Central Baptist further acknowledges that this payment system must be statistically robust, clinically meaningful and at the same time, administratively feasible.

Central Baptist Hospital submits the following recommendations to the current proposals:

1. The proposed changes to the DRG weights based upon Hospital Specific Relative Value cost center (HSRVcc) and introduction of Consolidated Severity Adjusted DRGs (CS-DRGs) should be implemented simultaneously.

2. The proposed changes to the DRG weights (HSRVcc) and introduction of CS-DRGs should be implemented on or after October 1, 2008.

3. Valid cost-based weights must be developed and utilized.

4. Further refinement of the proposed CS-DRG methodology needs to be done to ensure it promotes (rather than inhibits) the accomplishment of CMS's stated goals.

Discussion and rationale for recommendations:

Recommendation 1: Simultaneous Implementation

a. The proposed HSRVcc changes in FY2007 are projected to reduce reimbursement to BHS(our parent corporation) from the current FY2006 amount by nearly $8.5 million.

b. The proposed implementation of CS-DRGs in FY2008 is projected to increase reimbursement from the FY2007 amount by nearly $8.2 million (which represents a reduction of approximately $300,000 from the current FY2006 amount). This significant volatility in reimbursement has several implications.

   First, BHS will **permanently** lose $8.2 million in reimbursement in FY2007.

   Second, BHS will **potentially** receive an increase in reimbursement in FY2008. BHS has utilized the 3M APR-DRG grouper for many years, largely as part of internal quality initiatives and the Premier Hospital Quality Incentive Demonstration. As a result, BHS had the internal APR-DRG data to convert to CS-DRGs and calculate the impact of the FY2008 proposal.

   However, the underlying assumptions in the impact analysis are: (1) coding in the future is consistent with current coding practices, and (2) that Medicare will allow current coding in the future reimbursement model. Because these are assumptions and not givens, BHS has significant concerns regarding the ability to accurately forecast the proposals impact beyond FY2007, which is critical.

   Third, the increase in reimbursement in FY2008 under the CS-DRG system indicates that BHS hospitals treat more severe patients on average. This finding is consistent with the mission and values of its member hospitals.

   BHS is comprised of five hospitals within the state of Kentucky. It operates urban hospitals in Louisville, La Grange and Lexington, rural referral centers in Corbin and Paducah. Collectively, BHS has the largest number of inpatient admissions in Kentucky and is one of the largest providers of Medicaid services within the state. Central Baptist Hospital in Lexington, is the BHS facility with the largest number of cardiac admissions each year and the highest case mix of any hospital in the state. This reduction in reimbursement has the potential to impact us to a greater degree that most facilities because of the large number of cardiac referrals we get from the central and eastern parts of the state including other hospitals.

   The primary and secondary markets for BHS hospitals is comprised of 40 of the 120 counties in Kentucky and range across the central, western and southeastern parts of the state. Five of the poorest ten counties are located with the BHS service area.

   Medicaid, charity and uninsured patients represent over 17% of BHS inpatient business. As part of BHS's Christ-centered mission, each BHS hospital has not only expanded its

general acute care services, but also its highly specialized tertiary programs in an effort to provide a full range of surgical and medical services to all patients regardless of their ability to pay or severity of illness. Central Baptist Hospital, a disproportionate share facility, serves an even higher percentage of Medicaid, charity and uninsured patients than BHS as a whole, with this population accounting for over 18.5% of our inpatient business. As previously stated, Central Baptist Hospital offers a broad range of tertiary care services to all patients including cardiology services, regardless of ability to pay, including being a regional leader in the offering of high acuity services and new technologies in neonatology, oncology, neurology, cardiac surgery, medical and interventional cardiology, and orthopedics.

Given the mission of BHS and demographics of the communities it serves, it is clear that BHS hospitals are not specialty hospitals that target services that provide higher margins. However, given the high severity of illness for the patient population BHS hospitals serve, unless the HSRVcc and CS-DRG proposals are implemented simultaneously, unfair financial hardship will be experienced, threatening our ability to provide the same level of access to cutting edge technologies currently offered.

Fourth, CMS suggests that a budget neutrality factor may be applied to offset improvements in coding practices. This too, represents a significant unknown in the current proposal that needs to be accurately evaluated and communicated for which additional time is necessary.

Recommendation 2: Delay until October 1, 2008

a. It is imperative that the GROUPER technology be made available to hospitals and vendors. Without direct access to the GROUPER by hospitals, it will be virtually impossible to understand its logic. Without access by multiple vendors, it will be more difficult to purchase at a competitive price and will be more difficult to integrate into existing hospital systems.

b. In addition, many current hospital software programs will need to be modified to handle the new payment and billing system. An implementation date before October 1, 2008 will not allow adequate time to make all the necessary system changes and upgrades.

c. CMS stated that one option to the software issue is for hospitals to submit claims without being grouped and allow CMS to assign the CS-DRG. This raises several serious concerns.

   First, without the CS-DRG information, revenues and patient receivables cannot be recorded accurately. Statement of Position (SOP)-00-1(6) states, "Health care entities need to estimate amounts that ultimately will be realizable in order for revenues to be fairly stated in accordance with generally accepted accounting principles (GAAP)." Paragraph (9) states "Management is responsible for the fair presentation of its financial statements in conformity with GAAP".

   Currently, the DRG assignment is critical in making an accurate estimate of the net realizable value of accounts receivable. Given the significance of and the increased

uncertainty of the impact of the proposed changes for FY2007 and FY2008, it will be even more important for patient bills to be grouped prior to billing.

Second, the Medicare inpatient business represents over 41% of BHS total inpatient business. As such, changes to the Medicare payment system have a significant impact on BHS's ability to accurately estimate payments in evaluating strategic initiatives, business plans, budgets, marketing, staffing and other critical decisions. With the significance of the proposed changes, more time is required to understand and perform impact analysis.

d. Four of five BHS hospitals are disproportionate share hospitals (DSH). Last year these hospitals received approximately $14.7 million in DSH reimbursement. It is anticipated that the CS-DRGs will have a material impact on DSH payments and in order for hospitals to adequately plan and make appropriate adjustments in a timely manner, BHS recommends that further analysis be prepared and accurate impact estimates published prior to implementation of the proposed changes.

e. Additional time is required to determine the impact from other third party payers (including Medicaid) that have historically modeled reimbursement rules and methodologies from the Medicare payment system. It is anticipated that these third party payers will adopt the new Medicare payment system at some time in the near future following implementation by Medicare. However, given the complexity of the proposed changes, additional time is necessary for payers and hospitals to better understand these changes and make appropriate systematic changes.

Recommendation 3: Valid Cost Weights

a. Under the HSRV weight calculation method, the ten cost center categories were developed based on broad accounting definitions, where each cost center category represents at least five percent of the charges in the claims data. BHS acknowledges the need to remove bias introduced by individual hospital characteristics (i.e. unique cost centers reported on the cost report), but it appears that this resulted in incorrect cost center groupings in the CMS study that raises concerns regarding the accuracy of the cost-to-charge ratio (CCR) data.

For example, according to CMS-1488-P, Table-A (pp.66-67 and pp.186-187) the HSRV Cardiology cost center includes cost report lines 53 and 54. However, one BHS hospital includes its Catherization Lab revenues and expenses on cost report line 42.01, which according to the table appears to be incorrectly grouped with the HSRV Radiology cost center that includes cost report lines 41,42 and 43.

BHS is very concerned that grouping errors such as the one described here could materially impact the CCR used to calculate the DRG weights. Therefore, BHS recommends that CMS work through the Medicare intermediaries to audit the cost report line definitions for all hospitals to ensure groupings are accurate.

b. The weighting calculation used to determine the scaling factors gives equal weight to each hospital regardless of size or volume. This methodology results not only in an

inaccurate national cost-to-charge ratio, but is inconsistent with the method used when averaging the ten cost center DRG weights to which the scaling factors are applied. Therefore, BHS recommends that a consistent weighting methodology be utilized to calculate the scaling factors.

c. HSRVcc costs were based on the 2004 cost reports. Significant changes in medical technologies, products and services have been introduced, which have significantly impacted the CCR. Therefore, BHS recommends that a more recent audited cost report be used, after audit procedures have been performed as recommended in (a.) above.

d. Central Baptist Hospital is also concerned that partial data from a number of large hospitals whose cost to charge ratios were classified as outliers were excluded from the analysis. The exclusion of this data, which, because of the size of excluded facilities, collectively accounts for a large percentage of Medicare inpatient admissions nationally, materially impacts the resulting calculations, and, in particular, causes routine care cost to charge ratios to be much higher as used in the CMS calculations than the actual national averages reflect. Furthermore, this problem is compounded by the fact that CMS continues to use partial data from these same facilities

Recommendation 4: Consolidated Severity-Adjusted DRG Methodology

a. CS-DRGs are developed by grouping APR DRGs considering average length of stay and average charges. This grouping methodology is inconsistent with the cost-based intention of the proposed changes. Average cost, using the HSRVcc methodology (applying the recommended changes), for each APR DRG by severity level should be the determinant for grouping APR DRGs into CS DRGs.

b. CMS believes that the adoption of consolidated severity-adjusted DRGs would create a risk of increased aggregate levels of payment, similar to the 2% increase associated with the implementation of the current DRG system in 1983 and has recommended the application of a compensating budget neutrality factor. Because of the significance of even a 2% reduction in reimbursement, BHS recommends that this be further studied before implementation.

Thank you for your consideration of our recommendations. We certainly hope you can see and appreciate the legitimacy of the concerns raised. If you have any questions, please feel free to contact me at (859) 260-6445 or khill@bhsi.com.

Karen S. Hill, RN, MSN
Vice President /Nurse Executive
Central Baptist Hospital