Submitter : **Dr. Rodney Young** **Date: 06/07/2006**

Organization : **Texas Tech University Health Sciences Center**

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, it would be very difficult 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,

Rodney Young, MD

Submitter : Dr. Marion Sims **Date:** 06/07/2006

Organization : Medical Center East Family Medicine Residency

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

As a family medicine residency program director, 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.

Submitter : **Dr. Willaim Bardsley** **Date: 06/07/2006**

Organization : **Dr. Willaim Bardsley**

Category : **Physician**

Issue Areas/Comments

HSRV Weights

HSRV Weights

Re: File Code pportunity to comment on this proposed rule and for consideration of my comments. I may be contacted CMS-1488-P Comments to Proposed Rule 71 FR 23995, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates; Proposed Rule The purpose of this letter is to provide comments on the proposed changes to the Inpatient Prospective Payment System (IPPS) published in the April 25, 2006 Federal Register. HSRV Weights I agree with the intention of increasing payment accuracy of claims, but disagree strongly with the timing of the implementation of the DRG weight calculation changes that are proposed for FY 2007. The following should be considered for postponing the implementation of the DRG weight changes proposed for FY 2007 until at least FY 2008: The proposal to move to a hospital specific relative value (HSRV) weighting method will have significant impacts to tertiary hospitals, and more significant impacts to the cardiology departments of these hospitals. CMS should ensure that the new methodology is correct and improves payment accuracy. Several professional associations and analysts have reported errors in the methodology, including the following: non-inclusion of several hundred hospitals in the analysis, using unweighted cost to charge ratios rather than weighted cost to charge ratios, and pre-transplant costs were included in the calculation of the transplant DRGs. Postponing implementation will allow CMS and stakeholders time to analyze the proposal and revise potential inadequacies in the proposed methodology. The implementation of the DRG weight calculation to the proposed HSRVs is inappropriate without implementation of corrections to all identified payment inaccuracies. MedPAC, the American Hospital Association, and others have all suggested implementing all proposed changes simultaneously to avoid payment swings. Implementation of only HSRVs will decrease the overall payment accuracy of the DRG system at a facility level for most hospitals. Table K of the Proposed Rule (72 FR 24024) reports that implementation of only the HSRVs for FY 2007 will result in larger payment inaccuracies across hospitals than not implementing the correction. Since the implementation of the consolidated severity adjusted DRGs is not possible by the beginning of FY 2007, I respectfully request postponing the implementation of HSRVs until all proposed changes can be implemented. In the FY 2006 final rule, CMS discussed that several cardiovascular DRGs requiring stent insertion were not paid appropriately because the DRGs reflect charges for only one stent. Practically, it is recognized that on average, multiple stents are used during procedures. However, those costs are not recognized by the current DRG weight calculation process. The FY 2006 Final Rule described that data would be available for the FY 2008 rule that would adequately reflect the charges/costs of the DRGs. Postponing the implementation of the HSRVs will allow time for CMS to adequately determine the costs of the DRGs that are most impacted by this proposal. This proposal has been described as the most significant to the inpatient payment system since DRGs were implemented. These proposed complex changes require adequate time for all stakeholders to analyze the rule, and ensure potential inadequacies of the proposed methodology are corrected before implementation. I recommend postponing the implementation of the HSRV weighting method, proposing the changes in a separate Federal Register issuance, and providing an extended period of time for comments. I further recommend that CMS implement all proposed payment corrections simultaneously. The impact on CV departments and hospitals are significant. Consider a phase-in of the proposals to limit the negative impact, and provide time to adjust to the new reimbursement environment. Thank you for the oat 507-284-4072.

Submitter : Dr. David Harsha **Date:** 06/07/2006

Organization : St.Vincent Hospital, Indianapolis, IN

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

As a family medicine residency program director, 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, 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,

David M. Harsha, MD

Submitter : **Dr. Paul James** **Date: 06/07/2006**

Organization : **Family Medicine Residency Program: U of Iowa**

Category : **Physician**

Issue Areas/Comments

GME Payments

GME Payments

As the Head of the Department of Family Medicine at the University of Iowa, 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, 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,

Paul James MD
Head and Professor of Family Medicine
Roy J and Lucille A Carver College of Medicine
University of Iowa
Iowa City, Iowa 52242

Submitter : Neal Clemenson **Date:** 06/07/2006

Organization : Great Plains Family Practice Residency Program

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

As a family medicine residency program director, 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, 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,

Neal Clemenson MD

Submitter : **Dr. Jeffrey Tiemstra** **Date: 06/07/2006**

Organization : **U. of Illinois at Chicago College of Medicine**

Category : **Physician**

Issue Areas/Comments

GME Payments

GME Payments

As a faculty member in a family medicine residency, 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 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 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 physicians 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. 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,

Jeffrey D. Tiemstra, MD, FAAFP
Assistant Professor of Clinical Family Medicine
University of Illinois at Chicago College of Medicine
jtiemstr@uic.edu

Submitter : Dr. Otis Baughman III **Date:** 06/07/2006

Organization : Spartanburg Family Medicine Residency Program

Category : Academic

Issue Areas/Comments

GME Payments

GME Payments

As a family medicine residency program director, 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, 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.

Otis L Baughman III, MD
Family Medicine Residency Program Director
Director of Medical Education
Spartanburg Regional Medicine Center

Submitter : Dr. J. Michael Niehoff **Date:** 06/07/2006

Organization : Dr. J. Michael Niehoff

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

As a family medicine residency faculty member, I appreciate the opportunity to comment on the Centers for Medicare & 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 (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.

To explain some of the 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 a faculty member 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 are we 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 yours,
J. Michael Niehoff, MD

Submitter : **Dr. William Markle** **Date: 06/07/2006**

Organization : **Latterman Family Health Center**

Category : **Academic**

Issue Areas/Comments

GME Payments

GME Payments

As a family medicine residency program director, 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, 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,
William H. Markle, MD
UPMC McKeesport

Submitter : **Dr. raja jaber** **Date: 06/07/2006**

Organization : **Dr. raja jaber**

Category : **Physician**

Issue Areas/Comments

GME Payments

GME Payments

As a family medicine teacher, 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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In addition, 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,
Raja Jaber MD
Department of Family Medicine
SUNY AT Stony Brook
NY 11794-8461
631 4442300
631 4447552 FAX

Submitter : **Dr. Bruce Britton** **Date: 06/07/2006**

Organization : **Portsmouth Family Medicine**

Category : **Physician**

Issue Areas/Comments

GME Payments

GME Payments

As a clinical faculty member of a family medicine residency, 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.

Sincerely,

Bruce S. Britton M.D.
Assoc. Professor of Family and Community Medicine
Portsmouth Family Medicine
Eastern Virginia Medical School

Submitter : **Dr. Stephen Flynn** **Date: 06/07/2006**

Organization : **Fairview Hospital**

Category : **Physician**

Issue Areas/Comments

GME Payments

GME Payments

As a family medicine residency program director, 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. 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 "scholarlyactivities, 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 1999letter and cited again in this proposal 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 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. 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 tothe patient care experiences of residents during their residency programs.

Sincerely,
Stephen Flynn, MD
Program Director
Fairview Hospital/Cleveland Clinic
Family Medicine Residency Program

Submitter : **Dr. Lawrence Rosenthal** **Date: 06/07/2006**

Organization : **UMassMemorial Medical Center**

Category : **Physician**

Issue Areas/Comments

DRG Weights

DRG Weights

June 7, 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 a cardiac electrophysiologist and the Director of Cardiac Electrophysiology at the UMassMemorial Medical Center in Worcester, MA. We provide a complete medical and surgical program including a cardiovascular care center. We all agree the women should undergo annual mammography after the age of 40. However, one needs to screen 1500 women every 2 years for 10 years to save one life. Despite the costs associated with screening and prevention, no one would dare characterize screening for breast cancer as cost inefficient. It would strike me that sudden cardiac death, a far more potent killer amidst our population, should not be trivialized.

Unfortunately, much of the costs associated with ICD implantation is fixed and thus should not be considered as re-imbursement to the hospital. As an urban medical center we treat many with Medicare/Medicaid and free care. Lowering re-imbursement will only hurt institutions. Our institution finished the fiscal year even. Last year we implanted 300 ICD s for secondary prevention. Over a 12 month period, 45 patients experienced an ICD shock thus saving their life. That means 45 patients alive at this writing because of their device.

Thus I would urge CMS to consider the impact at reducing re-imbursement for such devices.

Sincerely,

Lawrence Rosenthal, MD, PhD, FACC
Director, Section Cardiac Electrophysiology and Pacing
Associate Professor of Medicine
UMassMemorial Medical Center
Worcester, MA 01655
Rosenthl@ummhc.org

Submitter : **Dr. Janet Cunningham** **Date: 06/07/2006**

Organization : **Glendale Adventist Family Practice Residency**

Category : **Physician**

Issue Areas/Comments

GME Payments

GME Payments

As a family medicine residency program director, 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.

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 Carel 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,

Janet Cunningham, MD, MPH
Program Director
Glendale Adventist Family Practice residency
Glendale CA

Submitter : Dr. Gary Silko **Date:** 06/07/2006

Organization : Saint Vincent Family Medicine Residency

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

Thank you for the opportunity to comment about CMS's proposed rule change entitled "Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates." As a family medicine residency director I feel these changes could cause serious jeopardy to the already tenuous status of family medicine training in this country. The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare DGME and 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 residents counts for all IME payments(regardless of setting) and for DGME payments when the activities occur in a nonhospital setting. The stated rationale for the exclusion of this time is that the time is not "related to patient care". This position reverses tyhe Agency's position expressed as recently as 7 years ago when the Director of Acute Care wrote that patient care activities should be interpreted broadly to include "scholarly activites, such as seminars, classroom lectures, etc. The activities cited in the 1999 letter and cited again in this proposal are an integral component of patient care activities engaged in by residents during their training. It is in fact at many of these lectures and discussions where major evaluation and therapy decisions are made about patient with whom the residents are caring in the hospital or outpatient clinic.
The issue goes deeper in terms of very burdensome documentation requirements that will impact administrative overhead. The net effect of all of this will be continued closure of residency programs principally in primary care, especially family medicine. This specialty is already anticipating major shortages in supply in coming years which will further limit access to care of millions of Americans, especially those who rely on Medicaid or Medicare for their insurance coverage. A loss of family medicine residencies will further tilt patients to rely on specialist care for noncomplex problems further raising the overall cost of care. This will have far greater negative fincancial implications for CMS than this proposed rule change. I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposed of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency training. The unintended consequences could be yet another blow to patients who are struggling for access to healthcare at all, let alone the compassionate, quality primary care delivered by family physicians.
Sincerely,
Gary J. Silko, M.D.
Program Director, Saint Vincent Family Medicine Residency
2314 Sassafras St. Erie, PA 16502

Submitter : Dr. Grant Greenberg **Date:** 06/07/2006

Organization : University of Michigan Chelsea Health Center

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

As a Medical Director of an Academic Health Center with a residency program at the University of Michigan, 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,
Grant M. Greenberg MD, MA
Assistant Professor
Department of Family Medicine
University of Michigan Medical School

Submitter : **Dr. Frederick Edwards** **Date: 06/07/2006**

Organization : **Mayo Arizona**

Category : **Physician**

Issue Areas/Comments

GME Payments

GME Payments

As a family medicine residency program director, 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, 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,

Fred Edwards MD
Program Director
Mayo Clinic Arizona
Family Medicine Residency

Submitter : **Dr. David Euans** **Date: 06/07/2006**

Organization : **East Jefferson General Hospital Fam Med Residency**

Category : **Physician**

Issue Areas/Comments

GME Payments

GME Payments

As a family medicine residency program director, 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 journalclubs, classroom lectures, and seminars as examples of didacticactivities that must be excluded when determining the full-timeequivalent resident counts for all IME payments (regardless of setting),and for DGME payments when the activities occur in a nonhospitalsetting, 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 careactivities 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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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. Richard Neill **Date:** 06/07/2006

Organization : Univ of Pennsylvania Family Medicine Residency

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

As a family medicine residency program director, 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. 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.

Submitter : Dr. Leslie Knight **Date:** 06/07/2006

Organization : University of Nebraska Medical Center

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

As a faculty member in 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.

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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,
Leslie A. Knight, MD, FAAFP

Submitter : **Mr. Richard Sadja** **Date: 06/07/2006**

Organization : **Family Practice Residency Program**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

As a family medicine residency program administrator, 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, 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,
Richard Sadja

Submitter : **Dr. Allen Perkins** **Date: 06/07/2006**

Organization : **University of South Alabama**

Category : **Physician**

Issue Areas/Comments

GME Payments

GME Payments

As a chair of the Department of Family Medicine at the University of South Alabama, I wish 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 CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in formal teaching activities such as lecturing 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 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]. 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 exception of time for "bench research" of one month or more in length, 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 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.

In summary, 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,

Allen Perkins, MD, MPH
Professor and Chair
Department of Family Medicine
University of South Alabama
aperkins@jaguar1.usouthal.edu

Submitter : **Dr. Frank Dennehy** **Date: 06/07/2006**

Organization : **VCU/Shenandoah Valley Family Practice Residency**

Category : **Physician**

Issue Areas/Comments

GME Payments

GME Payments

As a family medicine residency program director, 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 Carel firmly

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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,
Frank Dennehy, MD

Submitter : **Dr. Charles Koo** **Date: 06/07/2006**

Organization : **Brown Medical School**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

As a practicing heart rhythm specialist, also known as an electrophysiologist, at a 400 bed hospital located in RI, I am quite concerned Medicare beneficiaries will have limited access to life-saving and life-enhancing cardiac care due to the recently proposed inpatient rule. Technologies such as implantable cardioverter defibrillators are used to prevent sudden cardiac arrest, the nation s number one cause of mortality. Cardiac ablations are used to treat debilitating and life threatening cardiac arrhythmias such as ones that lead to stroke.

The full implementation of the CMS proposed Inpatient Prospective Payment System would have a devastating impact on my hospital s ability to serve patients in my community. These proposed reductions will impact hospital staffing for these critical procedures which will ultimately be translated into reduced patient access and care. CMS and Congress have emphasized the development of quality measures and activities. For example, the recent CMS mandate for hospitals to enroll in the ICD Registry represents personnel the hospital has to dedicate for this important initiative. Without accurate and appropriate reimbursement for these critical services, hospitals will not be able to dedicate resources to important quality improvement initiatives such as this.

I support an accurate hospital payment system and the goal of improving payment accuracy in the DRG system. However, the implementation of these sweeping changes will replace one system with another that has inherent flaws and miscalculations. I am concerned that CMS has used old data that is not reflective of current practice and that the data used from cost reports is not accurate. Additionally, it is troubling to me that significant errors and technical decisions have been made by CMS that exacerbate the problem. It is my understanding that over 200 hospitals were thrown out of the data set including large numbers of academic health centers. This will distort any analysis that CMS conducts. Additionally, CMS failed to adjust for hospital volume of care. The result of this flawed approach is that a small hospital of 50 beds has as much weight in the calculation as a large tertiary care center/academic health center.

Furthermore, CMS has failed to address issues related to charge compression. The rule fails to fix the charge compression problem that has penalized technology-intensive procedures for years. In fact, it makes the situation worse. Instead of increasing specificity to identify actual device costs, the rule lumps costs together into just 10 national cost centers to derive cost-to-charge ratios. Most devices and supplies are in a single cost center. Under this rule, distinctions between procedures - and even hospital departments - are lost.

The goal of the proposal is to improve the accuracy of the current payment system by designing a more refined system than the existing DRGs for grouping patients. CMS proposes to implement a new system based on the severity of the patient s illness in 2008 or earlier. The new CMS-DRG system does not make distinctions based on complexity, so a move in this direction is a good one. However, technologies that represent increased complexity, but not greater severity of illness, also need to be recognized. The payment methodology changes and the DRG severity changes should be implemented together, but there is no way to fairly identify and respond to their joint impact this year.

Thank you very much for your consideration of these comments. On behalf of my patients and the community in which I serve, I thank you and recommend that these changes be deferred so that all stakeholders can better understand the impacts and that CMS devotes the time necessary to get this right.

Sincerely,
Charles Koo, MD

Submitter : **Dr. Gary Gropper** **Date: 06/07/2006**

Organization : **Dr. Gary Gropper**

Category : **Physician**

Issue Areas/Comments

New Technology

New Technology

I have used X STOP interspinous process decompression device to treat lumbar spinal stenosis. It is useful in those patients that do not have a neurologial deficit but have significant neurogenic claudication. It can be placed under local or general anesthesia. Patients can be admitted for overnite observation and generally allowed home the next day. I have implanted 5 of the devices thus far and have had excellent alleviation of neurogenic claudication symptoms reported in those patients, thus far. I plan on continuing my efforts to implant the device in appropriate patients. I strongly urge reimbursement to hospitals be increased to defray costs of the device and make it reasonable to offer this option to appropriate surgical patients.

Submitter : **Dr. Michael Friedman** **Date: 06/07/2006**

Organization : **Saints Mary and Elizabeth 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 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.

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Sincerely,

Michael H. Friedman, MD
Director, Saint Elizabeth Family Practice Residency Program
Chicago, IL 60622

Submitter : **Dr. Mark Potter MD** **Date: 06/07/2006**

Organization : **University of Illinois at Chicago**

Category : **Physician**

Issue Areas/Comments

GME Payments

GME Payments

As a residency program Director in a family medicine residency, 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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Sincerely,
Mark C. Potter MD
Program Director
Family Medicine Residency program
Department of Family medicine
University of Illinois
1919 W. Taylor St
Chicago Illinois 60612

Submitter : **Dr. Abraham Kocheril** **Date: 06/07/2006**

Organization : **Carle Heart Center**

Category : **Physician**

Issue Areas/Comments

DRGs: MCVs and Defibrillators

DRGs: MCVs and Defibrillators

As a practicing heart rhythm specialist in Urbana, IL, I am quite concerned Medicare beneficiaries will have limited access to life-saving and life-enhancing cardiac care due to the recently proposed inpatient rule. Technologies such as implantable cardioverter defibrillators are used to prevent sudden cardiac arrest, the nation s number one cause of mortality. Cardiac ablations are used to treat debilitating and life threatening cardiac arrhythmias such as ones that lead to stroke.

The full implementation of the CMS proposed Inpatient Prospective Payment System would have a devastating impact on my hospital s ability to serve patients in my community. These proposed reductions will impact hospital staffing for these critical procedures which will ultimately be translated into reduced patient access and care. CMS and Congress have emphasized the development of quality measures and activities. For example, the recent CMS mandate for hospitals to enroll in the ICD Registry represents personnel the hospital has to dedicate for this important initiative. Without accurate and appropriate reimbursement for these critical services, hospitals will not be able to dedicate resources to important quality improvement initiatives such as this.

I support an accurate hospital payment system and the goal of improving payment accuracy in the DRG system. However, the implementation of these sweeping changes will replace one system with another that has inherent flaws and miscalculations. I am concerned that CMS has used old data that is not reflective of current practice and that the data used from cost reports is not accurate. Additionally, it is troubling to me that significant errors and technical decisions have been made by CMS that exacerbate the problem. It is my understanding that over 200 hospitals were thrown out of the data set including large numbers of academic health centers. This will distort any analysis that CMS conducts. Additionally, CMS failed to adjust for hospital volume of care. The result of this flawed approach is that a small hospital of 50 beds has as much weight in the calculation as a large tertiary care center/academic health center.

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Thank you very much for your consideration of these comments. On behalf of my patients and the community in which I serve, I thank you and recommend that these changes be deferred so that all stakeholders can better understand the impacts and that CMS devotes the time necessary to get this right.

Submitter : Dr. Lee Hargraves **Date:** 06/07/2006

Organization : University of Massachusetts Medical School

Category : Academic

Issue Areas/Comments

GME Payments

GME Payments

As a family medicine residency faculty member, 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.

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.

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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,

Lee Hargraves

Submitter : Dr. Greg Dahlquist **Date:** 06/07/2006

Organization : Pomona Valley Hospital Medical Center FMRP

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

As a family medicine residency program director, 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, 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.

Submitter : Dr. Carole Upshur **Date:** 06/07/2006

Organization : Univ. of Massachusetts Medical School

Category : Other Health Care Professional

Issue Areas/Comments

GME Payments

GME Payments

As a family medicine residency faculty member, 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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Sincerely,

Carole Upshur, Ed.D., Professor, Dept. of Family Medicine

Submitter : **Dr. Mary Lindholm** **Date: 06/07/2006**

Organization : **UMass Memorial Medical Center**

Category : **Physician**

Issue Areas/Comments

GME Payments

GME Payments

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Sincerely,

Mary Lindholm, MD
Asst. Professor Dept. of Family and Community Medicine
UMass Memorial Health Care

Submitter : **Dr. Gerald Gleich** **Date: 06/07/2006**

Organization : **University of Massachusetts Medical School**

Category : **Physician**

Issue Areas/Comments

GME Payments

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Sincerely,
Gerald Gleich, M.D.
University of Massachusetts Worcester
Family Medicine Residency Director

Submitter : Becky Ruhnau-Gee **Date:** 06/07/2006

Organization : Becky Ruhnau-Gee

Category : Other Health Care Professional

Issue Areas/Comments

DRGs: Severity of Illness

DRGs: Severity of Illness

CMS needs reconsider its proposed rule change by evaluating the available alternatives for refining the DRG system.

The APR-DRGs are a proprietary system that limits full disclosure and the transparency of its casemix grouping and severity adjustment rules. The proprietary logic of this system may be disclosed to government, but it is not likely the same level of transparency will be provided to hospitals and payers. Reliance on a proprietary system is diametrically opposed to the open DRG architecture CMS has fully supported for the past 23 years, and which has served well as a model open to public discussion and scrutiny. It is crucial that the classification system used by CMS meets the standards for public review, discussion, adaptation and transparency.

Submitter : Mrs. Sheryl Murphy **Date:** 06/07/2006

Organization : UT Houston Medical School / Memorial Hermann Hosp.

Category : Nurse Practitioner

Issue Areas/Comments

Impact Analysis

Impact Analysis

Re: Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates

As a practicing heart rhythm specialist, also known as an electrophysiologist, at a 500+ bed hospital located in Houston, I am quite concerned Medicare beneficiaries will have limited access to life-saving and life-enhancing cardiac care due to the recently proposed inpatient rule. Technologies such as implantable cardioverter defibrillators are used to prevent sudden cardiac arrest, the nation s number one cause of mortality. Cardiac ablations are used to treat debilitating and life threatening cardiac arrhythmias such as ones that lead to stroke.

The full implementation of the CMS proposed Inpatient Prospective Payment System would have a devastating impact on my hospital s ability to serve patients in my community. These proposed reductions will impact hospital staffing for these critical procedures which will ultimately be translated into reduced patient access and care. CMS and Congress have emphasized the development of quality measures and activities. For example, the recent CMS mandate for hospitals to enroll in the ICD Registry represents personnel the hospital has to dedicate for this important initiative. Without accurate and appropriate reimbursement for these critical services, hospitals will not be able to dedicate resources to important quality improvement initiatives such as this.

I support an accurate hospital payment system and the goal of improving payment accuracy in the DRG system. However, the implementation of these sweeping changes will replace one system with another that has inherent flaws and miscalculations. I am concerned that CMS has used old data that is not reflective of current practice and that the data used from cost reports is not accurate. Additionally, it is troubling to me that significant errors and technical decisions have been made by CMS that exacerbate the problem. It is my understanding that over 200 hospitals were thrown out of the data set including large numbers of academic health centers. This will distort any analysis that CMS conducts. Additionally, CMS failed to adjust for hospital volume of care. The result of this flawed approach is that a small hospital of 50 beds has as much weight in the calculation as a large tertiary care center/academic health center.

Furthermore, CMS has failed to address issues related to charge compression. The rule fails to fix the charge compression problem that has penalized technology-intensive procedures for years. In fact, it makes the situation worse. Instead of increasing specificity to identify actual device costs, the rule lumps costs together into just 10 national cost centers to derive cost-to-charge ratios. Most devices and supplies are in a single cost center. Under this rule, distinctions between procedures - and even hospital departments - are lost.

The goal of the proposal is to improve the accuracy of the current payment system by designing a more refined system than the existing DRGs for grouping patients. CMS proposes to implement a new system based on the severity of the patient s illness in 2008 or earlier. The new CMS-DRG system does not make distinctions based on complexity, so a move in this direction is a good one. However, technologies that represent increased complexity, but not greater severity of illness, also need to be recognized. The payment methodology changes and the DRG severity changes should be implemented together, but there is no way to fairly identify and respond to their joint impact this year.

Thank you very much for your consideration of these comments. On behalf of my patients and the community in which I serve, I thank you and recommend that these changes be deferred so that all stakeholders can better understand the impacts and that CMS devotes the time necessary to get this right.

Sincerely,

_____

Sheryl W. Murphy R.N., M.S.N.

Submitter : **Dr. Stephen Griffith** **Date: 06/07/2006**

Organization : **University of Missouri-Kansas City School of Medic**

Category : **Physician**

Issue Areas/Comments

GME Payments

GME Payments

As a Chair of the Department of Community and Family Medicine at University of Missouri-Kansas City School of 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, as Chair of this program, I cannot conceive of how we 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,

R. Stephen Griffith, MD
Chair, Department of Community and Family Medicine
University of Missouri-Kansas City School of Medicine

Submitter : Dr. Allan Wilke **Date:** 06/07/2006

Organization : UASOM-Huntsville Family Medicine Residency

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

See attachment.

CMS-1488-P-288-Attach-1.DOC

June 7, 2006

Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services

Attention: **CMS-1488—P "Resident Time in Patient-Related Activities"**

Dear Administrator McClellan:

On behalf of the University of Alabama School of Medicine-Huntsville Family Medicine Residency, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS or the Agency) p roposed rule entitled *"Medicare P rogram; 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 c omponent of t he patient c are activities e ngaged in by r esidents d uring t heir r esidency 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,

Allan J. Wilke, MD
Residency Program Director
Associate Professor, Family Medicine

Submitter : Dr. Philip Diller **Date:** 06/07/2006

Organization : The Christ Hospital/UC Family Medicine Residency

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

To Whom it May Concern:
As a family medicine residency program director, 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.

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,
Philip M. Diller, MD-PHD
Program Director
The Christ Hospital/University of Cincinnati Fmily Medicine Residency Training Program

Submitter : Dr. Jasen Gundersen **Date:** 06/07/2006

Organization : UMASS Memorial Healthcare

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

As a family medicine residency faculty member, 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 a residency program 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. The documentation requirements that this 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,

Jasen W. Gundersen, MD
Director, Family Medicine Hospitalist Service
UMASS Medical Center

Submitter : Dr. Carolyn Lopez **Date:** 06/07/2006

Organization : Dr. Carolyn Lopez

Category : Physician

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.

Rules such as this make it difficult to train residents in office settings. Yet, this is exactly where residents should be trained if they are to effectively meet the needs of the populations served by CMS.

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,

Carolyn C. Lopez, MD
Chair, Department of Family and Community Medicine
John H. Stroger, Jr. Hospital of Cook County

Submitter : **Dr. Linda Clark** **Date: 06/07/2006**

Organization : **University of Massachusetts Medical SChool**

Category : **Physician**

Issue Areas/Comments

GME Payments

GME Payments

As a family medicine residency faculty member, 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 a residency program 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. The documentation requirements that this 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,

Linda Garufi Clark, MD
Assistant Professor of Clinical Family Medicine and Community Health, University of Massachusetts
Family Health Center of Worcester

26 Queen St.
Worcester, MA 01610
508-860-7700

Submitter : **Dr. richard wender** **Date: 06/07/2006**

Organization : **Thomas Jefferson University**

Category : **Physician**

Issue Areas/Comments

GME Payments

GME Payments

As a Chair of a large Department of Family and Community Medicine in Philadelphia, I welcome the opportunity to comment on the CMS proposed rule entitled, "medicare Program: Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 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 in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

Background: The proposed rule lists journal clubs, lectures and seminars as examples of didactic activities that must be excluded when determining the full time equivalent number of residents in a non-hospital setting, such as a physician's office or affiliated medical school. The rationale is that this is , supposedly, unrelated to patient care.
This new position reverses the Agency's position expressed as recently as 1999, at which time the Director of Acute Care wrote that patient care activities include "scholarly activities such as educational seminars, classroom lectures... and presentation of papers and research results to fellow residents, medical students, and faculty. This was published in a letter written by Tzvi Hefter to support the 1999 position. These activities as described in the letter are, without question, integral to patient care activities. As we strive to create high quality, safe patient care environments and future physicians to practice in those environments, who follow evidence with minimal unexplained variation in care, to NOT consider these "didactic" activities a part of patient care is dangerous and inappropriate. These are exactly the type of patient care activities that should be encouraged and supported.

Resiidency programs and Patient Care: With the possible exception of extended research time, I cannot envision any residency experience that is not related in a fundamental way to providing high quality patient care. I can also state, from the perspective of a Department Chair and former residency director, that the administrative task of figuring out which components of conferences are directly related to the care of a specific patient and which are related to principles of patient care in general would simply be impossible. Not only would the cost of monitoring be a huge burden, particularly for a primary care residency such as we run, but the task would ultimately be impossible to accurately perform.

In summary, I urge CME to rescind its clarification in teh 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, RIchard Wender ALumni Professor and Chair
Department of Family and Community Medicine
Thomas Jefferson University
Philadelphia, Pa.

Submitter : **Dr. Steven Staugaitis** **Date: 06/07/2006**

Organization : **University of Massachusetts Medical School**

Category : **Other Health Care Professional**

Issue Areas/Comments

GME Payments

GME Payments

I am a member of the faculty at the UMASS Medical Schools Family Medicine department, specializing in services to persons with developmental disabilities. I appreciate the opportunity to share concerns re: 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 differentiates 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.

CONCERN

The proposed rule indicates that 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 will have a deleterious effect on efforts to train and orient physicians to the special needs of disabled populations, a critical care area recognized by the federal government. It will set the field back immensely and deprive a very vulnerable population of care from health care providers that is sensitive to and knowledgable about their special needs.

In summary, 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. Of particular concern to me is the negative impact the proposed change will have on special needs populations.

Sincerely,

Steven D. Staugaitis, PH.D.
Asst Prof, FMCH
UMASS Medical School
E.K. Shriver Center

Submitter : Dr. Patrick McManus **Date:** 06/07/2006

Organization : Thomas Jefferson University Hospital

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

As a family medicine residency program director, 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.

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 . It is impossible to seperate this "teaching" from direct patient care as they are intrexicably linked in our superb medical education system.

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,
Patrick McManus, MD
Thomas Jefferson Univeristy Hospital
Residency Director Family Medicine

Submitter : Dr. Carlos Moreno **Date:** 06/07/2006

Organization : University of Texas Health Science Center Houston

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

As a Chairman of a family medicine academic department involved in Family Medicine 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.

In addition, as Chair of this department, I or my Residency Program Director, cannot conceive of how we 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,

Carlos A. Moreno, MD, MSPH
Professor and Chairman
C. Frank Webber Chair in Family Medicine

Submitter : Mr. William Bro **Date:** 06/07/2006

Organization : Kidney Cancer Association

Category : Other Association

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 : **Date: 06/07/2006**

Organization :

Category : **Individual**

Issue Areas/Comments

DRGs: Severity of Illness

DRGs: Severity of Illness

CMS needs reconsider its proposed rule change by evaluating the available alternatives for refining the DRG system.

1. Proprietary System The APR-DRGs are a proprietary system that limits full disclosure and the transparency of its casemix grouping and severity adjustment rules. The proprietary logic of this system may be disclosed to government, but it is not likely the same level of transparency will be provided to hospitals and payers. Reliance on a proprietary system is diametrically opposed to the open DRG architecture CMS has fully supported for the past 23 years, and which has served well as a model open to public discussion and scrutiny. It is crucial that the classification system used by CMS meets the standards for public review, discussion, adaptation and tansparency.

2. Methodology Due to its inherent complexity, the proposed methodology will cause an immediate and sustained decrease in coder productivity. The consequence is a longer revenue cycle. For the past 23 years, coders have worked in a consistent framework. If CMS adopts the proposed system, all inpatient coders will require retraining.

3. Selection Process CMS did not conduct an objective study to severity-adjust the DRG system. In spite of the fact that alternatives for the APR-DRG system are eadily available, there is nothing to indicate that CMS considered any of them for its IPPS. Further, CMS did not conduct a single independent study to determine the impact the implementation of this methodology will have on coding and billing productivity or hospital cash flow.

4. Timeframe Should the proposed rule be enacted, the aggressive implementation timeframe CMS has established would not allow provider organizations to effectively prepare for the changes, including database and information systems modifications, and the required retraining of coders and billing personnel. In addition, shortly after the proposed transition to APR-DRGs will be the prospect of migration to ICD-10, a huge change in billing practices that appears likely to be mandated within the next four years.

Adopting a proprietary system that will, without doubt, increase costs for software acquisition, training and services, and a system that is not fully transparent and accessible to all its constituents is imprudent and irresponsible. The content and methodology that enables hospital coding and casemix classification must be accessible, at no cost, to all in our nation s health care industry. Transparency is imperative if we are to advance health care affordability.

I strongly encourage CMS to reconsider this proposed rule change. It is not in the best interest of healthcare in the U.S. Thank you!

Submitter : **Date: 06/07/2006**

Organization :

Category : **Occupational Therapist**

Issue Areas/Comments

GENERAL

GENERAL

As a faculty member at a major university medical center, I oppose the proposed changes that would reduce funding for non-direct patient time for residents. Conference and indirect time is essential to ensure that quality, integrated care is performed.

Submitter : **Dr. Laura Forlano** **Date: 06/07/2006**

Organization : **University of Massachusetts**

Category : **Physician**

Issue Areas/Comments

GME Payments

GME Payments

As a Preventive Medicine Resident in the Department of family Medicine and Community Health at University of Massachusetts, 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.

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.

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 a residency program 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. The documentation requirements that this 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,
Laura G. Forlano, DO

Submitter : Dr. Birgit Kantor **Date:** 06/07/2006

Organization : Mayo Clinic

Category : Physician

Issue Areas/Comments

HSRV Weights

HSRV Weights

Comments to Proposed Rule 71 FR 23995, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates; Proposed Rule

I appreciate the opportunity to provide comments on the proposed changes to the Inpatient Prospective Payment System (IPPS) that were published in the April 25, 2006 Federal Register.

HSRV Weights

I fully support the plan of increasing payment accuracy of claims. However, I strongly disagree with the timing of the implementation of the DRG weight calculation changes proposed for FY 2007 for the following reasons:

Switching to a hospital specific relative value (HSRV) weighting method will have crucial impacts to tertiary hospitals, and more significant impacts to the cardiology departments of these hospitals. Because of the significant impact to hospitals, CMS should ensure that the new methodology is valid, reliable, and that it improves payment accuracy. There is concern because of reported errors in the methodology such as: non-inclusion of several hundred hospitals in the analysis, using unweighted cost to charge ratios rather than weighted cost, and including pre-transplant costs in the calculation of the transplant DRGs. Postponing the implementation will allow CMS and stakeholders adequate time to analyze the proposal and revise any potential inadequacies in the proposed methodology.

I strongly believe that the DRG weight calculation of the proposed HSRVs is inappropriate without correcting to all identified payment inaccuracies. MedPAC, the American Hospital Association, and others have all suggested implementing all proposed changes simultaneously to avoid payment swings because implementation of only HSRVs will actually decrease the overall payment accuracy of the DRG system for most hospitals. Table K of the Proposed Rule (72 FR 24024) reports that implementation of only the HSRVs for FY 2007 will result in larger payment inaccuracies across hospitals than not implementing the correction. Since the implementation of the consolidated severity adjusted DRGs is not possible by the beginning of FY 2007, I respectfully request postponing the implementation of HSRVs until all proposed changes can be implemented and corrected.

In the FY 2006 final rule, CMS discussed that several cardiovascular DRGs requiring stent insertion were not paid appropriately because the DRGs reflect charges for only one stent. Practically, it is recognized that on average, multiple stents are used during procedures. However, those costs are not recognized by the current DRG weight calculation process. The FY 2006 Final Rule described that data would be available for the FY 2008 rule that would adequately reflect the charges/costs of the DRGs. Postponing the implementation of the HSRVs will allow time for CMS to adequately determine the costs of the DRGs that are most impacted by this proposal.

The change in proposed calculations of DRG payments are described as the most significant to the inpatient payment system since DRGs were implemented. I propose changes in a separate Federal Register issuance and an extended period of time for comment period. I further recommend that CMS implement all proposed payment corrections simultaneously.

Finally, the impacts on cardiovascular departments and hospitals are significant. I suggest a phase-in of the proposals to limit these negative consequences to hospitals, and provide time to adjust their practice to the new reimbursement environment.

Thank you for the opportunity to comment on this proposed rule and for consideration of my comments. If you have any questions, please contact me ant time at 507-255-6092

Submitter : **Dr. jamie weinstein** **Date: 06/07/2006**

Organization : **university of michigan dept family medicine**

Category : **Physician**

Issue Areas/Comments

GME Payments

GME Payments

As a clinical faculty member in 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. 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 yours, Jamie Weinstein MD Clical Instructor Departmen of Family Medicine University of Michigan

Submitter : **Dr. Veronique Roger** **Date: 06/07/2006**

Organization : **Mayo Clinic**

Category : **Physician**

Issue Areas/Comments

HSRV Weights

HSRV Weights

I appreciate the opportunity to provide comments on the proposed changes to the Inpatient Prospective Payment System (IPPS) that were published in the April 25, 2006 Federal Register.

HSRV Weights

I agree with the intention of increasing payment accuracy of claims. However, I disagree with the timing of the implementation of the DRG weight calculation changes that are proposed for FY 2007. Please consider the following reasons for postponing the implementation of the DRG weight changes proposed for FY 2007 until at least FY 2008:

The proposal to move to a hospital specific relative value (HSRV) weighting method will have enourmous impacts to tertiary hospitals, and will particularly affect the cardiology departments of these hospitals. Thus, CMS should ensure that the new methodology is correct and improves payment accuracy. Errors in the methodology have been reported, these include in particular: non-inclusion of several hundred hospitals in the analysis, using unweighted cost to charge ratios rather than weighted cost to charge ratios, and pre-transplant costs were included in the calculation of the transplant DRGs. Postponing the implementation will allow CMS the required time to analyze the proposal and revise it as needed.

The implementation of the DRG weight calculation to the proposed HSRVs is inappropriate without implementation of corrections to all identified payment inaccuracies. MedPAC, the American Hospital Association, and others have suggested implementing the proposed changes simultaneously to avoid payment swings. Implementation of only HSRVs will actually decrease the overall payment accuracy of the DRG system at a facility level for most hospitals. Table K of the Proposed Rule (72 FR 24024) reports that implementation of only the HSRVs for FY 2007 will result in larger payment inaccuracies across hospitals than not implementing the correction. Since the implementation of the consolidated severity adjusted DRGs is not possible by the beginning of FY 2007, I respectfully request postponing the implementation of HSRVs until all proposed changes can be implemented.

In the FY 2006 final rule, CMS discussed that several cardiovascular DRGs requiring stent insertion were not paid appropriately because the DRGs reflect charges for only one stent. Practically, it is recognized that on average, multiple stents are used during procedures. However, those costs are not recognized by the current DRG weight calculation process. The FY 2006 Final Rule described that data would be available for the FY 2008 rule that would adequately reflect the charges/costs of the DRGs. Postponing the implementation of the HSRVs will allow time for CMS to adequately determine the costs of the DRGs that are most impacted by this proposal.

The change in proposed calculations of DRG payments are described as the most significant to the inpatient payment system since DRGs were implemented. The significance and complexity of the proposed changes require adequate time for all stakeholders to analyze the rule, and ensure potential inadequacies of the proposed methodology are corrected before implementation. I recommend postponing the implementation of the HSRV weighting method, proposing the changes in a separate Federal Register issuance, and providing an extended period of time for comment period. I further recommend that CMS implement all proposed payment corrections simultaneously.

Finally, the impacts on cardiovascular departments and hospitals are huge. I suggest a phase-in of the proposals to limit the negative impact to hospitals, and provide time to adjust their practice to the new reimbursement environment.

Thank you for the opportunity to comment on this proposed rule and for consideration of my comments.
Very truly yours,

Veronique L Roger

Submitter : Dr. Sirvard Khanoyan **Date:** 06/08/2006

Organization : Glendale Adventist Family Practice Residency

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

As a family medicine residency faculty member, 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 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, 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,

Sirvard Khanoyan, MD
Clinical Faculty, Glendale Adventist FPRP
residency program office 818-500-5594
voice mail/direct phone- 818-500-5576

Submitter :

Date: 06/08/2006

Organization :

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

As a family medicine residency faculty member, 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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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 a residency program 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. The documentation requirements that this 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,

kibibi Gaughan

Submitter : **Dr. Randall Longenecker** **Date: 06/08/2006**

Organization : **The Ohio State University Rural Program**

Category : **Physician**

Issue Areas/Comments

GME Payments

GME Payments

As a family medicine residency program director of a rural residency program, 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. In reality our residents spend 60-80 hours weekly, and spend many more than 40 hours per week (1 FTE) in patient care, even if such "educational activities" were excluded.

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 Carel 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.

Submitter : **Dr. David Gunther** **Date: 06/08/2006**

Organization : **Boston University**

Category : **Physician**

Issue Areas/Comments

GME Payments

GME Payments

As an Assistant Professor of Clinical Medicine of Boston University's Family Medicine Department 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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Residency Program Activities and Patient Care
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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,

David Gunther, MD
Assistant Professor of Clinical Medicine
Department of Family Medicine
Boston University

Submitter : **Dr. Brian Crownover** **Date: 06/08/2006**

Organization : **Dr. Brian Crownover**

Category : **Physician**

Issue Areas/Comments

GME Payments

GME Payments

As a family medicine residency program director, 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, 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,

Brian Crownover, MD, FAAFP
Program Director HQAAC
800 Coldwater Creek Circle
Niceville FL 32578
850-883-9360
bkcrown@hotmail.com

Submitter : **Dr. Robert Baldor** **Date: 06/08/2006**

Organization : **Dr. Robert Baldor**

Category : **Physician**

Issue Areas/Comments

GME Payments

GME Payments

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.

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 a residency program 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. The documentation requirements that this 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,

Robert A. Baldor, MD

Submitter : **Dr. Suzanne Cashman** **Date: 06/08/2006**

Organization : **University of Massachusetts Medical School**

Category : **Academic**

Issue Areas/Comments

GME Payments

GME Payments

As a family medicine residency faculty member, 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 a residency program 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. The documentation requirements that this 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,
Suzanne B Cashman, ScD

Submitter : Dr. Lee Green **Date:** 06/08/2006

Organization : University of Michigan

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

As a professor of family medicine, I appreciate the opportunity to comment on the Centers for Medicare & 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' (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 this rule would be to obstruct the very changes most needed in American health care, as identified in the Institute of Medicine's recent reports. Journal clubs and other activities aimed at translation of research into practice are not 'unrelated to patient care', they are an integral part of the patient care activities we must encourage and extend if we are to address the medical errors and quality issues that Congress, the IoM, and the American people expect us to remedy.

These rules would be a great leap backward in quality of care. Again I urge CMS to consider its goals in effectiveness, quality, and safety, and rescind this regressive change.

#312

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

CMS-1488-P-312 **Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates**

Please note that electronic comment CMS-1488-P-312 is a duplicate of CMS-1488-P-313. To view this comment, please see CMS-1488-P-313.

Submitter : **Dr. Jeff Markuns** **Date: 06/08/2006**

Organization : **Boston University**

Category : **Physician**

Issue Areas/Comments

GME Payments

GME Payments

As a physician from 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 an institution 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 would an institution 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,

Jeff Markuns, M.D.
Assistant Residency Director
Department of Family Medicine
Boston University Medical Center
1 Boston Medical Center Place
Boston, MA 02118
617-464-7529

#314

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

CMS-1488-P-314 **Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates**

Please note that electronic comment CMS-1488-P-314 is a duplicate of CMS-1488-P-316. To view this comment, please see CMS-1488-P-316.

Submitter : **Dr. Douglas Zipes** **Date: 06/08/2006**

Organization : **Indiana University School of Medicine**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Re: Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates

As a practicing heart rhythm specialist, also known as an electrophysiologist, at a 250 bed hospital located in Indianapolis. I am quite concerned Medicare beneficiaries will have limited access to life-saving and life-enhancing cardiac care due to the recently proposed inpatient rule. Technologies such as implantable cardioverter defibrillators are used to prevent sudden cardiac arrest, the nation s number one cause of mortality. Cardiac ablations are used to treat debilitating and life threatening cardiac arrhythmias such as ones that lead to stroke.

The full implementation of the CMS proposed Inpatient Prospective Payment System would have a devastating impact on my hospital s ability to serve patients in my community. These proposed reductions will impact hospital staffing for these critical procedures which will ultimately be translated into reduced patient access and care. CMS and Congress have emphasized the development of quality measures and activities. For example, the recent CMS mandate for hospitals to enroll in the ICD Registry represents personnel the hospital has to dedicate for this important initiative. Without accurate and appropriate reimbursement for these critical services, hospitals will not be able to dedicate resources to important quality improvement initiatives such as this.

I support an accurate hospital payment system and the goal of improving payment accuracy in the DRG system. However, the implementation of these sweeping changes will replace one system with another that has inherent flaws and miscalculations. I am concerned that CMS has used old data that is not reflective of current practice and that the data used from cost reports is not accurate. Additionally, it is troubling to me that significant errors and technical decisions have been made by CMS that exacerbate the problem. It is my understanding that over 200 hospitals were thrown out of the data set including large numbers of academic health centers. This will distort any analysis that CMS conducts. Additionally, CMS failed to adjust for hospital volume of care. The result of this flawed approach is that a small hospital of 50 beds has as much weight in the calculation as a large tertiary care center/academic health center.

Furthermore, CMS has failed to address issues related to charge compression. The rule fails to fix the charge compression problem that has penalized technology-intensive procedures for years. In fact, it makes the situation worse. Instead of increasing specificity to identify actual device costs, the rule lumps costs together into just 10 national cost centers to derive cost-to-charge ratios. Most devices and supplies are in a single cost center. Under this rule, distinctions between procedures - and even hospital departments - are lost.

The goal of the proposal is to improve the accuracy of the current payment system by designing a more refined system than the existing DRGs for grouping patients. CMS proposes to implement a new system based on the severity of the patient s illness in 2008 or earlier. The new CMS-DRG system does not make distinctions based on complexity, so a move in this direction is a good one. However, technologies that represent increased complexity, but not greater severity of illness, also need to be recognized. The payment methodology changes and the DRG severity changes should be implemented together, but there is no way to fairly identify and respond to their joint impact this year.

Thank you very much for your consideration of these comments. On behalf of my patients and the community in which I serve, I thank you and recommend that these changes be deferred so that all stakeholders can better understand the impacts and that CMS devotes the time necessary to get this right.

Sincerely,

___Douglas P. Zipes, MD_____

Submitter : **Dr. Tahir Yaqub** **Date: 06/08/2006**

Organization : **U of I, Chicago DFM**

Category : **Physician**

Issue Areas/Comments

IME Adjustment

IME Adjustment

As a faculty member in a family medicine residency, 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 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 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 physicians 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,

Tahir Yaqub, MD

Submitter : **Dr. Brett Baker** **Date: 06/08/2006**

Organization : **Carolina Arrhythmia Consultants, PA**

Category : **Physician**

Issue Areas/Comments

DRGs: MCVs and Defibrillators

DRGs: MCVs and Defibrillators

June 7, 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 a practicing cardiovascular specialist in Charleston, South Carolina. I care for a large number of patients with life-threatening arrhythmias. Many of these patients are treated with implantable cardioverter defibrillators and pacemakers. These devices save lives and increase the quality of life in many patients. The proposed change in hospital inpatient payment for 2007, if pursued, will reduce access to these therapies.

The proposed changes suggest reductions that would placed reimbursement for these devices below their costs. The degree of reduction of the related DRGs is among the largest of any DRG. The data and assumptions used to calculation the proposed reductions appear to be flawed.

Sweeping decisions of this nature need thorough analysis, 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. I request that CMS allow time for further study of the proposals but in the mean time continue with the current charge-based system. I appreciate your consideration on this issue.

Sincerely,

Brett Baker MD, FACC
Carolina Arrhythmia Consultants, PA
Charleston, South Carolina 29403
843-534-1770
843-534-1767 (fax)

Submitter : **Dr. Richard Hines** **Date: 06/08/2006**

Organization : **Summa Health System**

Category : **Physician**

Issue Areas/Comments

GME Payments

GME Payments

As a family medicine residency program director, 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.

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.

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.

I would most certainly NOT wish to be a patient cared for by a resident whose training was devoid of didactic activities such as classroom lectures, seminars, journal clubs, or nonhospital educational experiences. It is, indeed, these activities that provide the infrastructure and framework upon which appropriate medical judgment is founded!

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

Sincerely,

Richard M. Hines, MD

Director of Family Medicine Education
Summa Health System
Akron, Ohio

Submitter : **Dr. Brian Jaffe** **Date: 06/08/2006**

Organization : **Grand Traverse Heart Associates**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-319-Attach-1.DOC

June 7, 2006

As a practicing heart rhythm specialist, also known as an electrophysiologist, at a 400+ bed hospital located in Traverse City, MI, I am quite concerned Medicare beneficiaries will have limited access to life-saving and life-enhancing cardiac care due to the recently proposed inpatient rule. Technologies such as implantable cardioverter defibrillators are used to prevent sudden cardiac arrest, the nation's number one cause of mortality. Cardiac ablations are used to treat debilitating and life threatening cardiac arrhythmias such as ones that lead to stroke.

The full implementation of the CMS proposed Inpatient Prospective Payment System would have a devastating impact on my hospital's ability to serve patients in my community. These proposed reductions will impact hospital staffing for these critical procedures which will ultimately be translated into reduced patient access and care. CMS and Congress have emphasized the development of quality measures and activities. For example, the recent CMS mandate for hospitals to enroll in the ICD Registry represents personnel the hospital has to dedicate for this important initiative. Without accurate and appropriate reimbursement for these critical services, hospitals will not be able to dedicate resources to important quality improvement initiatives such as this.

I support an accurate hospital payment system and the goal of improving payment accuracy in the DRG system. However, the implementation of these sweeping changes will replace one system with another that has inherent flaws and miscalculations. I am concerned that CMS has used old data that is not reflective of current practice and that the data used from cost reports is not accurate. Additionally, it is troubling to me that significant errors and technical decisions have been made by CMS that exacerbate the problem. It is my understanding that over 200 hospitals were "thrown out" of the data set including large numbers of academic health centers. This will distort any analysis that CMS conducts. Additionally, CMS failed to adjust for hospital volume of care. The result of this flawed approach is that a small hospital of 50 beds has as much weight in the calculation as a large tertiary care center/academic health center.

Furthermore, CMS has failed to address issues related to "charge compression." The rule fails to fix the charge compression problem that has penalized technology-intensive procedures for years. In fact,

it makes the situation worse. Instead of increasing specificity to identify actual device costs, the rule lumps costs together into just 10 national cost centers to derive cost-to-charge ratios. Most devices and supplies are in a single cost center. Under this rule, distinctions between procedures - and even hospital departments - are lost.

The goal of the proposal is to improve the accuracy of the current payment system by designing a more refined system than the existing DRGs for grouping patients. CMS proposes to implement a new system based on the severity of the patient's illness in 2008 or earlier. The new CMS-DRG system does not make distinctions based on complexity, so a move in this direction is a good one. However, technologies that represent increased complexity, but not greater severity of illness, also need to be recognized. The payment methodology changes and the DRG severity changes should be implemented together, but there is no way to fairly identify and respond to their joint impact this year.

Thank you very much for your consideration of these comments. On behalf of my patients and the community in which I serve, I thank you and recommend that these changes be deferred so that all stakeholders can better understand the impacts and that CMS devotes the time necessary to get this right.

Sincerely,

Brian D. Jaffe, MD

Submitter : Dr. Judith Pauwels **Date:** 06/08/2006

Organization : University of Washington

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

As a family medicine residency program director, 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. 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 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, 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,
Judith Pauwels, MD
University of Washington

Submitter : **Dr. Paresh Shah** **Date: 06/08/2006**

Organization : **Mid-Atlantic Cardiovascular Associates**

Category : **Physician**

Issue Areas/Comments

DRGs: MCVs and Defibrillators

DRGs: MCVs and Defibrillators

Re: Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates

As a practicing heart rhythm specialist, also known as an electrophysiologist, at a 500 bed hospital located in Baltimore, I am quite concerned Medicare beneficiaries will have limited access to life-saving and life-enhancing cardiac care due to the recently proposed inpatient rule. Technologies such as implantable cardioverter defibrillators are used to prevent sudden cardiac arrest, the nation s number one cause of mortality. Cardiac ablations are used to treat debilitating and life threatening cardiac arrhythmias such as ones that lead to stroke.

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Furthermore, CMS has failed to address issues related to charge compression. The rule fails to fix the charge compression problem that has penalized technology-intensive procedures for years. In fact, it makes the situation worse. Instead of increasing specificity to identify actual device costs, the rule lumps costs together into just 10 national cost centers to derive cost-to-charge ratios. Most devices and supplies are in a single cost center. Under this rule, distinctions between procedures - and even hospital departments - are lost.

The goal of the proposal is to improve the accuracy of the current payment system by designing a more refined system than the existing DRGs for grouping patients. CMS proposes to implement a new system based on the severity of the patient s illness in 2008 or earlier. The new CMS-DRG system does not make distinctions based on complexity, so a move in this direction is a good one. However, technologies that represent increased complexity, but not greater severity of illness, also need to be recognized. The payment methodology changes and the DRG severity changes should be implemented together, but there is no way to fairly identify and respond to their joint impact this year.

Thank you very much for your consideration of these comments. On behalf of my patients and the community in which I serve, I thank you and recommend that these changes be deferred so that all stakeholders can better understand the impacts and that CMS devotes the time necessary to get this right.

Sincerely,

Paresh Shah, MD
Cardiac Electrophysiologist

Submitter : **Dr. Michael Tuggy** **Date: 06/08/2006**

Organization : **Swedish Family Medicine Residency**

Category : **Physician**

Issue Areas/Comments

GME Payments

GME Payments

As a family medicine residency program director, 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.

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.

Michael Tuggy, MD
Director, Swedish Family Medicine-FH
Seattle, WA.

Submitter : Dr. Kathryn Horn **Date:** 06/08/2006

Organization : Texas Tech University HSC - El Paso

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

As a family medicine faculty member at Texas Tech University HSC El Paso, Texas, 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.

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.

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 a faculty member of this program, I cannot conceive of how we 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. Malcolm Bersohn** **Date: 06/08/2006**

Organization : **David Geffen School of Medicine at UCLA**

Category : **Physician**

Issue Areas/Comments

DRGs: MCVs and Defibrillators

DRGs: MCVs and Defibrillators

Re: Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates

As a practicing heart rhythm specialist, also known as an electrophysiologist, at a 700 bed hospital located in Los Angeles, I am quite concerned Medicare beneficiaries will have limited access to life-saving and life-enhancing cardiac care due to the recently proposed inpatient rule. Technologies such as implantable cardioverter defibrillators are used to prevent sudden cardiac arrest, the nation s number one cause of mortality. Cardiac ablations are used to treat debilitating and life threatening cardiac arrhythmias such as ones that lead to stroke.

The full implementation of the CMS proposed Inpatient Prospective Payment System would have a devastating impact on my hospital s ability to serve patients in my community. These proposed reductions will impact hospital staffing for these critical procedures which will ultimately be translated into reduced patient access and care. CMS and Congress have emphasized the development of quality measures and activities. For example, the recent CMS mandate for hospitals to enroll in the ICD Registry represents personnel the hospital has to dedicate for this important initiative. Without accurate and appropriate reimbursement for these critical services, hospitals will not be able to dedicate resources to important quality improvement initiatives such as this.

I support an accurate hospital payment system and the goal of improving payment accuracy in the DRG system. However, the implementation of these sweeping changes will replace one system with another that has inherent flaws and miscalculations. I am concerned that CMS has used old data that is not reflective of current practice and that the data used from cost reports is not accurate. Additionally, it is troubling to me that significant errors and technical decisions have been made by CMS that exacerbate the problem. It is my understanding that over 200 hospitals were thrown out of the data set including large numbers of academic health centers. This will distort any analysis that CMS conducts. Additionally, CMS failed to adjust for hospital volume of care. The result of this flawed approach is that a small hospital of 50 beds has as much weight in the calculation as a large tertiary care center/academic health center.

Furthermore, CMS has failed to address issues related to charge compression. The rule fails to fix the charge compression problem that has penalized technology-intensive procedures for years. In fact, it makes the situation worse. Instead of increasing specificity to identify actual device costs, the rule lumps costs together into just 10 national cost centers to derive cost-to-charge ratios. Most devices and supplies are in a single cost center. Under this rule, distinctions between procedures - and even hospital departments - are lost.

The goal of the proposal is to improve the accuracy of the current payment system by designing a more refined system than the existing DRGs for grouping patients. CMS proposes to implement a new system based on the severity of the patient s illness in 2008 or earlier. The new CMS-DRG system does not make distinctions based on complexity, so a move in this direction is a good one. However, technologies that represent increased complexity, but not greater severity of illness, also need to be recognized. The payment methodology changes and the DRG severity changes should be implemented together, but there is no way to fairly identify and respond to their joint impact this year.

Thank you very much for your consideration of these comments. On behalf of my patients and the community in which I serve, I thank you and recommend that these changes be deferred so that all stakeholders can better understand the impacts and that CMS devotes the time necessary to get this right.

Sincerely,

Malcolm M. Bersohn

Submitter : Dr. Linda Weinreb **Date:** 06/08/2006

Organization : Dr. Linda Weinreb

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

As a family medicine residency faculty member, 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. christian machado** **Date: 06/08/2006**

Organization : **Providence Hospital**

Category : **Physician**

Issue Areas/Comments

Excluded Hospitals Rate of Increase

Excluded Hospitals Rate of Increase

Re: Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates

As a practicing heart rhythm specialist, also known as an electrophysiologist, at a 500 bed hospital located inSouthfield ,Micigan, I am quite concerned Medicare beneficiaries will have limited access to life-saving and life-enhancing cardiac care due to the recently proposed inpatient rule. Technologies such as implantable cardioverter defibrillators are used to prevent sudden cardiac arrest, the nation s number one cause of mortality. Cardiac ablations are used to treat debilitating and life threatening cardiac arrhythmias such as ones that lead to stroke.

The full implementation of the CMS proposed Inpatient Prospective Payment System would have a devastating impact on my hospital s ability to serve patients in my community. These proposed reductions will impact hospital staffing for these critical procedures which will ultimately be translated into reduced patient access and care. CMS and Congress have emphasized the development of quality measures and activities. For example, the recent CMS mandate for hospitals to enroll in the ICD Registry represents personnel the hospital has to dedicate for this important initiative. Without accurate and appropriate reimbursement for these critical services, hospitals will not be able to dedicate resources to important quality improvement initiatives such as this.

I support an accurate hospital payment system and the goal of improving payment accuracy in the DRG system. However, the implementation of these sweeping changes will replace one system with another that has inherent flaws and miscalculations. I am concerned that CMS has used old data that is not reflective of current practice and that the data used from cost reports is not accurate. Additionally, it is troubling to me that significant errors and technical decisions have been made by CMS that exacerbate the problem. It is my understanding that over 200 hospitals were thrown out of the data set including large numbers of academic health centers. This will distort any analysis that CMS conducts. Additionally, CMS failed to adjust for hospital volume of care. The result of this flawed approach is that a small hospital of 50 beds has as much weight in the calculation as a large tertiary care center/academic health centerThank you very much for your consideration of these comments. On behalf of my patients and the community in which I serve, I thank you and recommend that these changes be deferred so that all stakeholders can better understand the impacts and that CMS devotes the time necessary to get this right

Submitter : Dr. Gregory Fazio **Date:** 06/08/2006

Organization : Dr. Gregory Fazio

Category : Physician

Issue Areas/Comments

Operating Payment Rates

Operating Payment Rates

Re: Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates

As a practicing heart rhythm specialist, also known as an electrophysiologist, at a 400 bed hospital located in York PA, I am quite concerned Medicare beneficiaries will have limited access to life-saving and life-enhancing cardiac care due to the recently proposed inpatient rule. Technologies such as implantable cardioverter defibrillators are used to prevent sudden cardiac arrest, the nation s number one cause of mortality. Cardiac ablations are used to treat debilitating and life threatening cardiac arrhythmias such as ones that lead to stroke.

The full implementation of the CMS proposed Inpatient Prospective Payment System would have a devastating impact on my hospital s ability to serve patients in my community. These proposed reductions will impact hospital staffing for these critical procedures which will ultimately be translated into reduced patient access and care. CMS and Congress have emphasized the development of quality measures and activities. For example, the recent CMS mandate for hospitals to enroll in the ICD Registry represents personnel the hospital has to dedicate for this important initiative. Without accurate and appropriate reimbursement for these critical services, hospitals will not be able to dedicate resources to important quality improvement initiatives such as this.

I support an accurate hospital payment system and the goal of improving payment accuracy in the DRG system. However, the implementation of these sweeping changes will replace one system with another that has inherent flaws and miscalculations. I am concerned that CMS has used old data that is not reflective of current practice and that the data used from cost reports is not accurate. Additionally, it is troubling to me that significant errors and technical decisions have been made by CMS that exacerbate the problem. It is my understanding that over 200 hospitals were thrown out of the data set including large numbers of academic health centers. This will distort any analysis that CMS conducts. Additionally, CMS failed to adjust for hospital volume of care. The result of this flawed approach is that a small hospital of 50 beds has as much weight in the calculation as a large tertiary care center/academic health center.

Furthermore, CMS has failed to address issues related to charge compression. The rule fails to fix the charge compression problem that has penalized technology-intensive procedures for years. In fact, it makes the situation worse. Instead of increasing specificity to identify actual device costs, the rule lumps costs together into just 10 national cost centers to derive cost-to-charge ratios. Most devices and supplies are in a single cost center. Under this rule, distinctions between procedures - and even hospital departments - are lost.

The goal of the proposal is to improve the accuracy of the current payment system by designing a more refined system than the existing DRGs for grouping patients. CMS proposes to implement a new system based on the severity of the patient s illness in 2008 or earlier. The new CMS-DRG system does not make distinctions based on complexity, so a move in this direction is a good one. However, technologies that represent increased complexity, but not greater severity of illness, also need to be recognized. The payment methodology changes and the DRG severity changes should be implemented together, but there is no way to fairly identify and respond to their joint impact this year.

Thank you very much for your consideration of these comments. On behalf of my patients and the community in which I serve, I thank you and recommend that these changes be deferred so that all stakeholders can better understand the impacts and that CMS devotes the time necessary to get this right.

Sincerely,

Gregory Fazio, MD

Submitter : Dr. Charles Hamad **Date:** 06/08/2006

Organization : UMASS Medical School

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

I am a member of the faculty at the UMASS Medical SchoolsDepartment of Pediatrics, specializing in services to persons with developmental disabilities. I appreciate the opportunity to share concerns re: 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 differentiates 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. CONCERN The proposed rule indicates that 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 will have a deleterious effect on efforts to train and orient physicians to the special needs of disabled populations, a critical care area recognized by the federal government. It will set the field back immensely and deprive a very vulnerable population of care from health care providers that is sensitive to and knowledgeable about their special needs. In summary, 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. Of particular concern to me is the negative impact the proposed change will have on special needs populations. Sincerely, Steven D. Staugaitis, PH.D. Asst Prof, FMCH UMASS Medical School E.K. Shriver Center

Charles Hamad, Ph.D.
Center for Developmental Disabilities Evaluation and Research
Commonwealth Medicine
University of Massachusetts Medical School

Submitter : **Mrs. Barbara Panek** **Date: 06/08/2006**

Organization : **Orlando Regional Heathcare**

Category : **Individual**

Issue Areas/Comments

DRGs: Severity of Illness

DRGs: Severity of Illness

CMS needs reconsider its proposed rule change by evaluating the available alternatives for refining the DRG system.

1. Proprietary System The APR-DRGs are a proprietary system that limits full disclosure and the transparency of its casemix grouping and severity adjustment rules. The proprietary logic of this system may be disclosed to government, but it is not likely the same level of transparency will be provided to hospitals and payers. Reliance on a proprietary system is diametrically opposed to the open DRG architecture CMS has fully supported for the past 23 years, and which has served well as a model open to public discussion and scrutiny. It is crucial that the classification system used by CMS meets the standards for public review, discussion, adaptation and transparency.

2. Methodology Due to its inherent complexity, the proposed methodology will cause an immediate and sustained decrease in coder productivity. The consequence is a longer revenue cycle. For the past 23 years, coders have worked in a consistent framework. If CMS adopts the proposed system, all inpatient coders will require retraining.

3. Selection Process CMS did not conduct an objective study to severity-adjust the DRG system. In spite of the fact that alternatives for the APR-DRG system are readily available, there is nothing to indicate that CMS considered any of them for its IPPS. Further, CMS did not conduct a single independent study to determine the impact the implementation of this methodology will have on coding and billing productivity or hospital cash flow.

4. Timeframe Should the proposed rule be enacted, the aggressive implementation timeframe CMS has established would not allow provider organizations to effectively prepare for the changes, including database and information systems modifications, and the required retraining of coders and billing personnel. In addition, shortly after the proposed transition to APR-DRGs will be the prospect of migration to ICD-10, a huge change in billing practices that appears likely to be mandated within the next four years.

Adopting a proprietary system that will, without doubt, increase costs for software acquisition, training and services, and a system that is not fully transparent and accessible to all its constituents is imprudent and irresponsible. The content and methodology that enables hospital coding and casemix classification must be accessible, at no cost, to all in our nation s health care industry. Transparency is imperative if we are to advance health care affordability.

Submitter : Dr. David Sperling **Date:** 06/08/2006

Organization : Summa Health System

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

As a family medicine residency program associate director, 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 associate 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,

David Sperling, M.D.
Associate director for Resident Education
Summa Health System
55 Arcb St #3
Akron Ohio 44304

Submitter : Dr. Cynthia Kelley **Date:** 06/08/2006

Organization : Summa Family Medicine Center

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

As a family medicine residency program associate director, 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.

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.

I would most certainly NOT wish to be a patient cared for by a resident whose training was devoid of didactic activities such as classroom lectures, seminars, journal clubs, or nonhospital educational experiences. It is, indeed, these activities that provide the infrastructure and framework upon which appropriate medical judgment is founded!

To reiterate, I strongly 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 correctly recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

-Cynthia Kelley, D.O.
kelleyc@summa-health.org

Submitter : Dr. William Smucker **Date:** 06/08/2006

Organization : Summa Health System

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

As a family medicine residency program director, 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.

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To reiterate, I STRONGLY 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 correctly recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,

William D. Smucker, MD
Associate Director, Family Medicine Residency Program
Summa Health System
Akron, Ohio
Ph:330-375-3144

Submitter : Dr. Rick Kellerman **Date:** 06/08/2006

Organization : University of Kansas School of Medicine

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

See attachment

CMS-1488-P-333-Attach-1.DOC

Thank you for 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). As Chair of the Department of Family and Community Medicine at the University of Kansas School of Medicine - Wichita, 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 family medicine 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 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 interpretation 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. In fact, we try to have our didactic sessions as case-based as possible. For example, Grand Rounds is based on a specific patient's problem.

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. This is "adult learning" at its best. This educational methodology leads to the production of physicians who can practice autonomously. This is critical in a rural state like Kansas where many of our graduates practice in small geographically isolated towns.

It will be extremely difficult 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. Do we hire additional staff people to sit in on each of the didactic sessions and keep count of patient care time? Do we burden the residents to keep additional time cards and paperwork? This isn't a good use of resident-physician time. The documentation requirements are unreasonable and would result in an extremely large administrative burden.

This new CMS position would have a significant financial impact on our community hospitals where so much of our resident education occurs. The hospitals have invested significant financial resources in building conference rooms and classrooms, and purchasing computers and audiovisual equipment in order to provide an excellent teaching environment for our resident physicians. Didactic sessions such as workshops and seminars are frequently the setting in which residents learn how to use the electronic medical record, digital imaging systems, the maternal-fetal monitoring systems and how to better manage patient care through the use of new technology.

In conclusion, 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,

Rick Kellerman MD

Submitter : Dr. Chris Dunlap **Date:** 06/08/2006

Organization : TMH Family Medicine Residency Program

Category : Academic

Issue Areas/Comments

GME Payments

GME Payments

As a family medicine residency faculty member, 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, as a faculty member 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,

Chris Dunlap, M.D.

Faculty
TMH Family Medicine Residency Program

Tallahassee, FL 32308

Submitter :

Date: 06/08/2006

Organization :

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-335-Attach-1.DOC

UNC
SCHOOL OF MEDICINE

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of NORTH CAROLINA
at CHAPEL HILL

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Campus Box 7039
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Marsha L. Davenport, M.D.
Frank S. French, M.D.
William H. Lagarde, M.D.
Karen J. Loechner, M.D./ Ph.D.
Mary Ann Morris, M.D.
Louis E. Underwood, M.D.

June 8, 2006

Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services

Attention: **CMS-1488—P "Resident Time in Patient-Related Activities"**

Dear Administrator McClellan:

The University of North Carolina at Chapel Hill 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.

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 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 concur with the Agency's 1999 position. The activities cited in the 1999 letter and cited again in the

purported clarification are an integral component of the patient care activities engaged in by residents during their residency programs.

Residency Program Activities and Patient Care

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.

The geographic location of teaching activities is ubiquitous and is often held at bedside, in conference rooms, and in physician offices, which are located in buildings near but not within the hospital complex. In the case of the Division of Pediatric Endocrinology, clinical discussions and conferences are held in the Medical Biomolecular Research Building. This building is across Manning Drive from the hospital within a 5 minute walk. The merger of Academic Health Centers and the size of the medical center precludes having all facilities for conferences in the hospital proper. Conferences, such as Journal Clubs, Case reviews, Morbidity and Mortality, are directed at specific patients or groups of patients. Health problems are presented in a variety of techniques, but never disconnected from the healthcare of the patient.

To reiterate, we 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,

A. Joseph D'Ercole, MD, Program Director
Harry S. Andrews Professor and
Chief, Div. of Pediatric Endocrinology

Submitter : Dr. john smith **Date:** 06/08/2006

Organization : University of Nebraska Medical Center

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

As a faculty member in 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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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.

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,
John L Smith MD

Submitter : Dr. Neil Mitnick **Date:** 06/08/2006

Organization : Albany Medical Center Hospital

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

As a family medicine residency program director, 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 timespent 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, 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,

Neil C. Mitnick, D.O.
Residency Program Director
Professor and Alice E. Fruehan Chair
Albany Medical Center
Department of Family & Community Medicine Education
2 Clara Barton Drive - Suite 110
Albany, NY 12208

Phone: 518-213-0345
Fax: 518-213-0334
E-mail: MitnicN@mail.amc.edu

Submitter : Dr. Sharonne Hayes **Date:** 06/08/2006

Organization : Mayo Clinic

Category : Physician

Issue Areas/Comments

HSRV Weights

HSRV Weights

Re: File Code CMS-1488-P Comments to Proposed Rule 71 FR 23995, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates; Proposed Rule I am writing this letter is to comment on the proposed changes to the Inpatient Prospective Payment System (IPPS) published in the April 25, 2006 Federal Register. While increasing payment accuracy of claims is important, I disagree strongly with the timing of the implementation of the DRG weight calculation changes that are proposed for FY 2007.
Please consider postponing the implementation of the DRG weight changes proposed for FY 2007 until at least FY 2008: The proposal to move to a hospital specific relative value (HSRV) weighting method will have significant negative impact on tertiary hospitals, and even more significant impacts to the cardiology departments of these hospitals. CMS should ensure that the new methodology is correct and improves payment accuracy.

Several professional associations and analysts have reported errors in the methodology, including the following: non-inclusion of several hundred hospitals in the analysis, using unweighted cost to charge ratios rather than weighted cost to charge ratios, and pre-transplant costs were included in the calculation of the transplant DRGs.

By postponing implementation, CMS and stakeholders will have the time to analyze the proposal and revise potential inadequacies in the proposed methodology. The implementation of the DRG weight calculation to the proposed HSRVs is inappropriate without implementation of corrections to all identified payment inaccuracies. MedPAC, the American Hospital Association, and others have all suggested implementing all proposed changes simultaneously to avoid payment swings. Implementation of only HSRVs will decrease the overall payment accuracy of the DRG system at a facility level for most hospitals.
Since the implementation of the consolidated severity adjusted DRGs is not possible by the beginning of FY 2007, I respectfully request postponing the implementation of HSRVs until all proposed changes can be implemented. In the FY 2006 final rule, CMS discussed that several cardiovascular DRGs requiring stent insertion were not paid appropriately because the DRGs reflect charges for only one stent. Practically, it is recognized that on average, multiple stents are used during procedures. However, those costs are not recognized by the current DRG weight calculation process. The FY 2006 Final Rule described that data would be available for the FY 2008 rule that would adequately reflect the charges/costs of the DRGs. Postponing the implementation of the HSRVs will allow time for CMS to adequately determine the costs of the DRGs that are most impacted by this proposal.

The proposed complex changes require more time for all stakeholders to analyze the rule, and ensure potential inadequacies of the proposed methodology are corrected before implementation. I recommend postponing the implementation of the HSRV weighting method, proposing the changes in a separate Federal Register issuance, and providing an extended period of time for comments. I further recommend that CMS implement all proposed payment corrections simultaneously. The impact on CV departments and hospitals are significant. Consider a phase-in of the proposals to limit the negative impact, and provide time to adjust to the new reimbursement environment. Thank you for the opportunity to comment on this proposed rule and for consideration of my comments. I may be contacted at 507-284-8612

Submitter : Dr. Lisa Jernigan **Date:** 06/08/2006

Organization : TMH 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.

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.

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 faculty in 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,

Lisa Jernigan, MD
Tallahassee Memorial Family Medicine Residency Program
1301 Hodges Drive
Tallahassee, FL 32308
850-431-5714

Submitter : Dr. Mark Robinson **Date:** 06/08/2006

Organization : Cabarrus Family Medicine Residency Progam

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

As a family medicine residency program director, 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
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programs.

Sincerely,
Mark D. Robinson, MD

Submitter : Lynn-Marie Wozniak **Date:** 06/08/2006

Organization : Next Wave

Category : Other Health Care Professional

Issue Areas/Comments

DRGs: Hip and Knee Replacements

DRGs: Hip and Knee Replacements

Your proposal to fix the grouper logic for DRG 471 Bilateral and Multiple Joint Procedures so that multiple component, single-sided procedures do not get assigned inappropriately, will result in certain combinations of legitimate bilateral or multiple joint procedures also not getting assigned to DRG 471. By removing codes 00.71-00.73, and 00.81-00.84 entirely you are preventing the following combinations of surgery from being assigned to DRG 471:
1) Bilateral revisions of the same or different components of both knees; and 2) Initial total knee replacement on one side with revision of a component on the same or other knee during the same stay.

Attached is a proposal for how to structure the grouper logic so that these types of cases will not be overlooked.

Please note, that I agree with you that codes 81.53 and 81.55 should be removed from DRG 471 to discourage their use.

CMS-1488-P-341-Attach-1.DOC

DRGs: Hip and Knee Replacements
Group Logic for DRG 471

Grouper Logic for: DRG 471 – Bilateral or Multiple Joint Procedures

ANY COMBINATION OF 2 OR MORE CODES FROM PROCEDURES ON LIST A:

LIST A
0070 – Revision of hip replacement, both acetabular and femoral components
0071 – Revision of hip replacement, acetabular component
0072 – Revision of hip replacement, femoral component
0073 – Revision of hip replacement, acetabular liner and /or femoral head only
0080 – Revision of knee replacement, total (all components)
8151 – Total hip replacement
8152 – Partial hip replacement
~~8153 – Revision of hip replacement, NOS~~ ***
8154 – Total knee replacement
~~8155 – Revise knee replacement, NOS~~ ****
8156 – Total ankle replacement

OR

ANY 2 IDENTICAL CODES FROM PROCEDURES ON LIST B:
LIST B
0081 – Revision of knee replacement, tibial component
0082 – Revision of knee replacement, femoral component
0083 – Revision of knee replacement, patellar component
0084 – Revision of knee replacement, tibial insert (liner)

OR

ANY COMBINATION OF AT LEAST ONE CODE FROM PROCEDURES ON LIST A ***AND*** AT LEAST ONE CODE FROM PROCEDURES ON LIST B

OR

ANY COMBINATION OF AT LEAST THREE CODES FROM PROCEDURES ON LIST B

**** These are unspecified codes. To discourage their use CMS/3M should remove them from the DRG 471 list and assign them to just DRGs 454 and 455.

L. Wozniak – NEXT WAVE, 24 Madison Ave. Ext. Albany, NY 12203 518-452-3351

Submitter : Dr. Ian Clements **Date:** 06/08/2006

Organization : Mayo Clinic

Category : Physician

Issue Areas/Comments

HSRV Weights

HSRV Weights

Re: File Code CMS-1488-P Comments to Proposed Rule 71 FR 23995, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates; Proposed Rule The purpose of this letter is to provide comments on the proposed changes to the Inpatient Prospective Payment System (IPPS) published in the April 25, 2006 Federal Register.
HSRV Weights The intention of increasing payment accuracy of claims is important, but I disagree strongly with the proposed implementation date of the DRG weight calculation changes for FY 2007. I would suggest postponing the implementation of the DRG weight changes until at least FY 2008: The proposal to move to a hospital specific relative value (HSRV) weighting method will have significant impacts to tertiary hospitals with magnified effects on cardiology departments. CMS should evaluate that the new methodology does in fact improve payment accuracy. Several professional associations and analysts report errors in the methodology related to the following factors: failure to include several hundred hospitals in the analysis, the use of unweighted cost to charge ratios rather than weighted cost to charge ratios, and the inclusion of pre-transplant costs in the calculation of the transplant DRGs. A postponement in the implementation will provide CMS and stakeholders with time to analyze the proposal and revise potential inadequacies in the proposed methodology. The implementation of the DRG weight calculation to the proposed HSRVs is inappropriate without implementation of corrections to all identified payment inaccuracies. MedPAC, the American Hospital Association, and others have all suggested implementing all proposed changes simultaneously to avoid payment swings. Implementation of only HSRVs will decrease the overall payment accuracy of the DRG system at a facility level for most hospitals. Table K of the Proposed Rule (72 FR 24024) reports that implementation of only the HSRVs for FY 2007 will result in larger payment inaccuracies across hospitals than not implementing the correction. Since the implementation of the consolidated severity adjusted DRGs is not possible by the beginning of FY 2007, I respectfully request postponing the implementation of HSRVs until all proposed changes can be implemented. In the FY 2006 final rule, CMS discussed that several cardiovascular DRGs requiring stent insertion were not paid appropriately because the DRGs reflect charges for only one stent. Practically, it is recognized that on average, multiple stents are used during procedures. However, those costs are not recognized by the current DRG weight calculation process. The FY 2006 Final Rule described that data would be available for the FY 2008 rule that would adequately reflect the charges/costs of the DRGs. Postponing the implementation of the HSRVs will allow time for CMS to adequately determine the costs of the DRGs that are most impacted by this proposal. This proposal has been described as the most significant to the inpatient payment system since DRGs were implemented. These proposed complex changes require adequate time for all stakeholders to analyze the rule, and ensure potential inadequacies of the proposed methodology are corrected before implementation. I recommend postponing the implementation of the HSRV weighting method, proposing the changes in a separate Federal Register issuance, and providing an extended period of time for comments. I further recommend that CMS implement all proposed payment corrections simultaneously. The impact on CV departments and hospitals are significant. I would suggest that a phase-in of the proposals be considered to limit the negative impact, and provide time to adjust to the new reimbursement environment. Thank you for the opportunity to comment on this proposed rule and for consideration of my comments. I may be contacted at 507-284-1648

Submitter : **Dr. Paul Paulman** **Date: 06/08/2006**

Organization : **Dr. Paul Paulman**

Category : **Physician**

Issue Areas/Comments

GME Payments

GME Payments

As a faculty member in 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.

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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.

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,

Paul Paulman, MD

Submitter : Dr. Michael Milano **Date:** 06/08/2006

Organization : University of North Carolina

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1488-P-344-Attach-1.DOC

June 8, 2006

Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services

Attention: **CMS-1488—P "Resident Time in Patient-Related Activities"**

Dear Administrator McClellan:

The University of North Carolina 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.

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

Residency Program Activities and Patient Care

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.

Medical and dental training requires didactic teaching in order to train residents to provide care of the highest quality. This didactic training may take many forms and can occur in various sites. However, they all include a discussion of the various aspects of patient care. It is during these didactic seminars that signs and symptoms are discussed, treatment options are considered, and a final plan of action is determined. Even though a patient may not be physically present, clearly these seminars should fall under the heading of "patient care." In discussing patient care prior to rendering it, the medical and dental training processes remains one centered on education and not experimentation.

To reiterate, we 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 Milano, DMD
Associate Professor and Graduate Program Director
University of North Carolina, School of Dentistry, Department of Pediatric Dentistry

Submitter : **Dr. Robert Curry** **Date: 06/08/2006**

Organization : **University of FLorida**

Category : **Physician**

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.

Sincerely,

R. W. Curry, Jr. MD
Professor and Chair
Dept of Community Health and Family Medicine
College of Medicine
University of Florida

CMS-1488-P-346 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates**

Submitter : Sue Littlewood **Date & Time:** 06/08/2006

Organization : Tallahassee Memorial HealthCare Family Medicine

Category : Other Health Care Professional

Issue Areas/Comments

GME Payments

GME Payments

As a family medicine residency administrator, 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 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 administrator

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,
Sue Littlewood
Administrator
TMH Family Medicine Residency
1301 Hodges Dr.
Tallahassee, FL 32308

CMS-1488-P-347 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates**

Submitter : Mr. Sean Donohue **Date & Time:** 06/08/2006

Organization : Eli Lilly and Company

Category : Drug Industry

Issue Areas/Comments

DRGs: Severe Sepsis

DRGs: Severe Sepsis

See attached document

CMS-1488-P-347-Attach-1.DOC

ATTACHMENT TO #347

www.lilly.com

Eli Lilly and Company
Lilly Corporate Center
Indianapolis, IN 46285
U.S.A.

Phone 317 276 2000

June 8, 2006

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

Dear Dr. McClellan:

File Code: CMS-1488-P

Eli Lilly and Company appreciates this opportunity to comment on the Centers for Medicare and Medicaid Services Notice of Proposed Rulemaking. Lilly is a leading, innovation-driven corporation committed to developing a growing portfolio of best-in-class and first-in-class pharmaceutical products that help people live longer, healthier and more active lives.

DRGs: Severe Sepsis

Lilly commends CMS for its efforts to incorporate recognition of severity of illness by changing to a consolidated version of 3M Company's APR-DRGs. The current DRG system does not accommodate severity of illness, but instead focuses only the presence or absence of complicating or co morbid conditions; a system where having asthma carries the same weight as acute organ failure. Poor reimbursement for severe sepsis is related, in part, to this shortcoming in the current system. The move to severity-based DRG system would better reflect the increased cost of care across all severe sepsis cases, lead to more appropriate reimbursements and ultimately, to better patient care and patient outcomes.

While better incorporation of severity of illness is long overdue, the proposed changes have a number of limitations, which have been outlined in the proposed rule. While changes to better account for complexity as well as severity would further improve payments for severe sepsis cases, those changes would likely cause additional delays in implementation. For severe sepsis cases, an alternative solution exists today in the creation of severe sepsis DRGs.

Evidence is currently available to validate that severe sepsis cases are clinically coherent. They are not simply the most expensive cases in a DRG, but are cases with common acute illness, managed in the same fashion, with a differentiated and greater use of ICU, pharmacy, and respiratory care services. CMS expressed hope that another year of data with better coding guidance could help clarify the matter of clinical coherence. We would argue, however, that the coding confusion that CMS reports is limited to the other codes under the SIRS heading, not with severe sepsis itself (995.92). In fact, we believe that greater adoption of the

severe sepsis code (995.92) without large shifts in the characteristics of those being coded actually provides evidence that a coherent population is being better recognized.

Delaying implementation of the severity-adjusted DRG system would perpetuate the inadequate coverage for severe sepsis cases. **To that end, we recommend that CMS create severe sepsis DRGs for FY2007. Creating those DRGs would not only provide for appropriate reimbursement, but would also encourage advances in disease identification and quality improvement initiatives.** In our experience, quality improvement projects are often prioritized for high-impact DRGs. Severe sepsis DRGs would allow for national benchmarks and would encourage hospitals to understand performance improvement opportunities better.

Creating severe sepsis DRGs now will aid in the quality improvement efforts promoted by the Surviving Sepsis Campaign, the VHA, the Society of Critical Care Medicine, Leap Frog, and others. Improving severe sepsis care could lead to significant reductions in mortality and spare the lives of many Medicare beneficiaries.

Lilly appreciates the opportunity to comment on the important issues raised in the Notice of Proposed Rulemaking. We value CMS' consideration of our comments and welcome the opportunity to discuss any of these issues.

Sincerely,

ELI LILLY AND COMPANY

Sean Donohue, Director
Federal Health Affairs

By electronic submission

Submitter : Mr. David Robertson **Date:** 06/08/2006

Organization : Monongalia General Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

Attachment

CMS-1488-P-348-Attach-1.PDF

Attachment #348

Monongalia Health System

May 30, 2006

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

Dear Sirs:

On April 12, 2006 the Centers for Medicare and Medicaid Services released its Notice of Proposed Rule Making for FY2007 changes to Medicare's hospital inpatient prospective payment system. These proposed changes are scheduled to take effect on October 1, 2006. As President and Chief Executive Officer of Monongalia General Hospital in Morgantown, West Virginia, I am writing to you to discuss my very serious concerns about the impact that these changes will have on Monongalia General Hospital, and other community hospitals performing large volumes of procedures involving cardiac and orthopedic implanted devices.

It is my understanding that some of the basis for the proposed changes stem from the desire to more accurately align the payment of inpatient hospital services to the costs of providing the services and to limit the ability of for-profit limited service hospitals to select services and patients based on profitability considerations. I strongly endorse and support the need to correct this major failing of the existing system. However, Monongalia General Hospital (MGH) is an example of an institution that is unintentionally adversely impacted by these changes. MGH is a not-for-profit community hospital serving the needs of the citizens of Monongalia, Marion, and Preston counties in West Virginia. Despite the fact that MGH is located in the same community as West Virginia University Hospital, MGH is the market leader in terms of orthopedic and interventional cardiac care for the communities that we serve. Over the years, MGH has developed an extraordinarily strong reputation in these service areas, and we accept all patients who present to us regardless of their ability to pay. However, interventional cardiology and orthopedics represent a significant portion of our total revenues, and as a result, while we are a relatively small hospital (average daily census of 105 patients) we are the 51st most heavily impacted hospital in the nation by these proposed changes, resulting in a reduction of $2.2 million annually in our reimbursement.

Monongalia General Hospital was originally constructed in 1977, and in the last 30 years very little has been done to our physical facilities. We are in significant need of expansion and modernization, and as a result, MGH has just initiated a $97 million modernization project. Without considering the impact of these proposed changes, MGH

is budgeted for an operating margin of $1.3 million for the fiscal year ending June 30, 2007. The reduction in reimbursement that the proposal to a cost-based DRG payment system will have on our facility will be nearly double our entire operating margin, and

this is before principal payments on $70 million of bonds will begin to take effect. In addition to the negative impact of the cost-based DRG system, we understand that the annual impact of the changes to the proposed severity adjusted DRG system will reduce our payments from Medicare by an additional $2.7 million per year. Clearly, these proposed changes have a very grave impact on MGH.

West Virginia is a rate regulated state, and therefore, MGH has no ability to recapture these reimbursement reductions through charges to other payers. At the present time, MGH is reimbursed 80.4% of our actual costs of providing care to Medicare patients, and this will significantly reduce this already alarmingly low figure. I would strongly encourage you to exempt community, not-for-profit hospitals from these reimbursement reductions as this is not the group of hospitals that were the intended target of these changes and there severe flaws in the proposed reimbursement system. In the case of MGH, without some regulatory relief, these changes will be devastating.

I would also like to point out a fundamental flaw which I believe exists in the method which has been used to calculate the actual costs of hospital services, particularly services that require costly implants. The approach used by CMS is to apply an overall ratio of costs to charges to individual devices. First, the data used by CMS to calculate the ratio of costs to charges uses data that is severely outdated and does not represent the current cost of technology. The data used by CMS does not reflect the current cost of the drug eluting stents which are significantly more expensive than the bare metal stents. In fact, the average cost of drug eluting stent is approximately three to four times the cost of the bare metal stent. An additional problem with the cost based methodology is that the typical patient is in the hospital for a shorter period of time than the typical patient. If the cost to charge ratio is applied to the total stay, the calculation of the payment rate applied to the total stay will be reduced since the ratio of costs to charges applied to ancillary services is typically less than the costs to charge ratio applied to routine services. It unclear whether the true costs of the cath lab or operating room equipment is completely reflected in the costs of the ancillary services for caths, angioplasties, open-heart surgery an orthopedic surgery. Another problem with this methodology is that the ratio of cost to charges varies widely on individual line items, with the levels of mark-up being significantly lower on high cost devices. Thus, the methodology does not recognize the fact that the cost of high charge devices as a percentage of charges is typically much less than the average cost to charge ratio for the overall organization. This results in reimbursement rates that are significantly understated and do not reflect our costs.

I greatly appreciate your consideration of our concerns, and would recommend that you refine the cost determination for procedures utilizing high cost devices, and consider exempting non-profit community hospitals from these reductions as they are not the intended target for corrective action as a result of documented abuses.

Sincerely,

David J. Robertson
President and CEO
Monongalia Health System

cc: Senator Robert Byrd
Senator John D. Rockefeller
Representative Alan B. Mollohan
Representative Nick J. Rahall II
Representative Shelly Moore Capito
Sonia D. Chambers, Chair WV Healthcare Authority
Sam G. Kapourales WV Healthcare Authority
Marilyn G. White WV Healthcare Authority

Submitter : Dr. Kathleen Braden **Date:** 06/08/2006

Organization : University Of Massachusetts Medical School

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

June 8, 2006

To Whom It May Concern:

I am a member of the faculty at the UMASS Medical Schools Pediatrics and Family Medicine departments, specializing in services to persons with developmental disabilities. I appreciate the opportunity to share concerns re: 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 differentiates 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. CONCERN The proposed rule indicates that 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 will have a deleterious effect on efforts to train and orient physicians to the special needs of disabled populations, a critical care area recognized by the federal government. It will set the field back immensely and deprive a very vulnerable population of care from health care providers that is sensitive to and knowledgeable about their special needs. In summary, 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. Of particular concern to me is the negative impact the proposed change will have on special needs populations.

Sincerely,

Kathleen Braden, MD
Developmental/Behavioral Pediatrician

Submitter : Dr. Penelope Tippy **Date:** 06/08/2006

Organization : Southern Illinois University School of Medicine

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

June 7, 2006
As a family medicine residency program director, 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, 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,
Penelope K. Tippy, M.D.

CMS-1488-P-350-Attach-1.DOC

Attachment #350

June 7, 2006

As a family medicine residency program director, 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, 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,

Penelope K. Tippy, MD
Professor, Family and Community Medicine
Southern Illinois University School of Medicine
Carbondale, IL

Submitter : Mr. Carlos A. Maceda **Date:** 06/08/2006

Organization : Englewood Hospital & Medical Center

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment.

CMS-1488-P-351-Attach-1.WPD

Attachment #351

June 12, 2006

Deleted: June 8, 2006

Deleted: May 10, 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

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Commenting on: General Comments; HSRV weights

Dear Dr. McClellan:

Deleted: READ and DELETE: This letter is an example only. As always, please ensure your comment letter reflects your own experiences and opinions. We strongly encourage you to write your letter on your own organization's letterhead. ¶

Deleted: This letter is an example; as always, please ensure your comment letter reflects your own experiences and opinions. ¶

My name is Carlos A. Maceda. I am the director of Materials Management at Englewood Hospital and Medical Center, in Englewood New Jersey. My role in the organization is of expense management. We look at price, utilization, and payer mix to make assumptions, and determinations about implants and new technology. We are a tertiary hospital in a highly competitive area and must always stay on the cutting edge to maintain our referring physicians.

Deleted: (Describe yourself and your hospital in this paragraph – your title and role; where your hospital is located, what areas you serve; how many beds you have, number of cases per year, etc.)

We appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services' Proposed Changes to the Hospital Inpatient Payment Systems and fiscal year 2007 Rates (CMS-1488-P). While we are supportive of making changes to the payment structure that will better distribute payments we feel that this rule puts further burden on the hospitals themselves.

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Misalignment between providers gives the medical device industry a tremendous advantage. As CMS makes cuts in certain areas the device companies are not interested in what this does to the hospitals and continue to raise prices as well as bring to market other 'me too' devices that cost more and add little or no value but as mentioned earlier hospitals must compete and offer the latest and greatest to their physician staff.

Deleted: of many of the provisions in the proposed rule, we are very concerned about the proposed methodologies resulting in inaccurate payment amounts, particularly for the cardiovascular services we provide our patients.

The medical device companies similar to the pharmaceutical companies have done an excellent job in creating relationships with the physicians and in many cases offering services to the physicians that we as a provider cannot offer legally. This makes negotiations extremely difficult. Compounded by the fact that physicians are insulated from the cost of the devices.

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My greatest fear would be if Medicare reduces costs based on data three years ago some of the payments would be less than the acquisition cost of some devices, especially in the cardiac rhythm management group where some of the steepest cuts are proposed. As individual hospitals we will not be able to negotiate price decreases commensurate with the decreases in payments.

This is why in my humble opinion CMS, similar to DMERC should take assignment for all implants. Use its volume for negotiating leverage with the manufactures and pay them directly. This will give CMS a clearer picture of cost and Hospitals would be able to give a more accurate report on cost. Hospitals would be paid for their costs alone.

CMS could create formularies and make recipients know that if they decide to receive an implant that is not in the formulary they will have to pay the difference. Similar to what CMS does right now with some items.

Currently when new products come to market is very difficult for a stand-alone hospital to make a determination whether the item will improve patient outcomes. The manufacturer conducts studies and independent data is not readily available. It takes several months sometimes a year to build up enough cases to determine what the true outcomes are and by this time the hospital has been paying the premium on the product due to the novelty or exclusivity. Conducting these studies also requires resources that most hospitals do not have to spare. Reducing these costs from hospital should also improve cash flow and reduce labor expenses in certain areas by not having to pay for the invoices.

Medicare could pull together outcome studies quicker and determine whether an item should be added to the formulary or not. Companies similar to the Pharmacy Benefit Management companies could monitor the program for CMS.

Sincerely,

Carlos A. Maceda, MBA, CHE
Director of Materials & Support Services
350 Engle Street
Englewood NJ. 07631
201-894-3649
carlos.maceda@ehmc.com

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Submitter : **Date: 06/08/2006**

Organization :

Category : **Health Plan or Association**

Issue Areas/Comments

DRG Reclassifications

DRG Reclassifications

See Attachment

DRGs: Severity of Illness

DRGs: Severity of Illness

See Attachment

GENERAL

GENERAL

See Attachment

CMS-1488-P-352-Attach-1.DOC

IPPS Comment Letter

Re: file code CMS-1488-P

Dear Sir or Madam:

Blue Cross Blue Shield of Minnesota (hereinafter Blue Cross) is pleased to provide comments to CMS on the proposed changes to the Medicare inpatient prospective payment system. We recognize that due to the significance of the proposed classification changes, the implications will extend far beyond the Medicare program.

Blue Cross provides coverage to over 2.1 million Minnesotans. In Medicare, we participate in the Medicare Advantage program as a member of the Northern Plains Alliance. In addition, Blue Cross participates in Medicare at the local plan level through its nonprofit HMO affiliate, Blue Plus. Blue Plus has two SNP plans. Blue Cross also offers a Medicare Cost Contract. In the two SNP plans, provider contracts include provisions that require Blue Plus to pay as Medicare pays. Consequently, the proposed rules have a direct implication for this organization. These comments are being submitted in our role as a local plan.

Blue Cross supports the A gency's desire to move toward a classification system that more accurately reflects severity of illness. Whether the APR-DRG methodology proposed is the appropriate modification is outside the scope of these comments. However, any modifications to the existing DRG classification system will require significant claims payment system changes. These modifications will affect not only CMS but also organizations like Blue Cross and Blue Plus that are contractually required to pay as Medicare pays. Therefore, we would urge CMS to not implement the new classification system any earlier than FY 2008. In addition, we would urge CMS to provide sufficient advance notice to allow organizations to make the claims system changes necessary to support the new methodology.

We also request that when the classification system is implemented it be done at one time with a single effective date. A phase-in similar to the initial DRG implementation that would combine some percent of the payments from the current DRG system with some percent from the new classification system, would necessitate an extensive cross-walk in the claims payment systems, thereby increasing administrative expense and burden. It has also been suggested that an implementation s trategy c ould be u sed t hat would c reate a " phantom" p hase-in. U nder t his scenario, payments would be made for a period of time under the existing DRG classification while simultaneously requiring that the hospital be shown what the payment would be under the new classification system. This necessitates processing the claim twice. Consequently, this would impose a significant administrative burden and expense for CMS as well as for an organization that is contractually required to pay as Medicare.

Blue Cross applauds the Agency's desire to move toward value-based purchasing. Due to the time constraints of the response period, we are unable to provide comment to CMS on how to best implement this strategy. However, we look forward to doing so as the Agency continues its work on this important initiative.

Thank you for the opportunity to provide these comments. If you have any questions, please contact me at 651-662-8429.

Sincerely,

Deborah Madson
Vice President
Government Programs

Submitter : Dr. Dennis Ruppel **Date:** 06/08/2006

Organization : Mount Carmel Health System

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

June 8, 2006

To Whom It May Concern:

As a family medicine residency program director, I appreciate the opportunity to comment on the Centers for Medicare & 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 (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 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.

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,

Dennis F. Ruppel, MD
Program Director
Mount Carmel Family Medicine Residency
2150 Marble Cliff Office Park
Columbus, Ohio 43215

Submitter : Dr. Kevin Kahn **Date:** 06/08/2006

Organization : UNC Hospitals Dept. of Neurology

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

The issues of residents attendance for morbidity & mortality conference, journal club, grand rounds, and other didactics have a direct impact on patient. Care what is learned in these venues is often applied immediately in both in and outpatient clinical settings. To exclude these activities from re-imbursed time would be equivalent to government sponsored lowering of the standard of care of medicine and education. Lowering the standards of care for medicare patients is discriminatory and this policy should be rescinded. Thank you.

CMS-1488-P-354-Attach-1.RTF

Attachment # 354

UNC
SCHOOL OF MEDICINE
DEPARTMENT OF
NEUROLOGY

June 8, 2006

Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services

Attention: CMS-1488—P "Resident Time in Patient-Related Activities"

Dear Dr. McClellan:

The University of North Carolina Health System 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.

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".

The activities cited in the 1999 position and cited again in the purported clarification are an integral component of the patient care activities engaged in by residents during their residency programs.

Residency Program Activities and Patient Care
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.

The proposed inpatient rule alteration exclusion, for purpose of DGME and IME payment activities held in medical school or physician's office, and other non-hospital settings, reflects a lack of understanding of the interconnectivity of graduate medical education.

The geographic location of teaching activities is ubiquitous and is often held at bedside, in conference rooms, in physician office, and other locations. The evolving merger of all of these facilities into Academic Health Centers precludes parsing out geographic sites. Conferences, such as Journal Clubs, are directed at specific patients or groups of patients. Health problems are presented in a variety of techniques, but never disconnected from the healthcare of the patient. Conferences, such as those of Morbidity and Mortality, have been major teaching activities for a century and focus on specific patients. Moreover, these conferences are sequencing into the basis of error reduction, a quality forum emphasized by CMS. Moreover, the country is badly served by capping the GME numbers for payment, as prescribed in the Balanced Budget Act of 1997.

The University of North Carolina at Chapel Hill, Campus Box 7025, Chapel Hill, NC 27599-7025
Phone (919) 966-3133 · Fax (919) 966-2922

To reiterate, we 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 Kahn

Kevin Kahn, MD
Director of Research
University Headache Clinic
Department of Neurology
3114 Bioinformatics Bldg.
CB 7025, UNC Hospitals
Chapel Hill, NC 27599-7025
(919) 966-2527
(919) 843-8245 (FAX)

KK/cb

Submitter : **Miss. Robert Rea** **Date: 06/08/2006**

Organization : **Mayo Clinic**

Category : **Physician**

Issue Areas/Comments

HSRV Weights

HSRV Weights

I appreciate the opportunity to provide comments on the proposed changes to the Inpatient Prospective Payment System (IPPS) that were published in the April 25, 2006 Federal Register.

HSRV Weights

The proposal to move to a hospital specific relative value (HSRV) weighting method will have material impacts to tertiary hospitals, and more significant impacts to the cardiology departments of these hospitals. Because of the significant impact to hospitals, CMS should ensure that the new methodology is correct and improves payment accuracy. Several professional associations and analysts have reported errors in the methodology, including the following: non-inclusion of several hundred hospitals in the analysis, using unweighted cost to charge ratios rather than weighted cost to charge ratios, and pre-transplant costs were included in the calculation of the transplant DRGs. Postponing the implementation will allow CMS and stakeholders adequate time to analyze the proposal and revise any potential inadequacies in the proposed methodology.

The implementation of the DRG weight calculation to the proposed HSRVs is inappropriate without implementation of corrections to all identified payment inaccuracies. MedPAC, the American Hospital Association, and others have all suggested implementing all proposed changes simultaneously to avoid payment swings. Implementation of only HSRVs will actually decrease the overall payment accuracy of the DRG system at a facility level for most hospitals. Table K of the Proposed Rule (72 FR 24024) reports that implementation of only the HSRVs for FY 2007 will result in larger payment inaccuracies across hospitals than not implementing the correction. Since the implementation of the consolidated severity adjusted DRGs is not possible by the beginning of FY 2007, I respectfully request postponing the implementation of HSRVs until all proposed changes can be implemented.

The change in proposed calculations of DRG payments are described as the most significant to the inpatient payment system since DRGs were implemented. The significance and complexity of the proposed changes require adequate time for all stakeholders to analyze the rule, and ensure potential inadequacies of the proposed methodology are corrected before implementation. I recommend postponing the implementation of the HSRV weighting method, proposing the changes in a separate Federal Register issuance, and providing an extended period of time for comment period. I further recommend that CMS implement all proposed payment corrections simultaneously.

Finally, the impacts on cardiovascular departments and hospitals are significant. I suggest a phase-in of the proposals to limit the negative impact to hospitals, and provide time to adjust their practice to the new reimbursement environment.

Thank you for the opportunity to comment on this proposed rule and for consideration of my comments. If you have any questions, please contact me at 507-255-4152

Sincerely,

Robert F. Rea, M.D.
Associate Professor of Medicine
Director Implantable Cardiac Electrical Device Service
Mayo Clinic
Rochester, MN

Submitter : Mr. WALTER WINKLER **Date:** 06/08/2006

Organization : KEOKUK AREA HOSPITAL

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

Whatever changes in reimbursement are made CMS needs to keep in mind those hospitals that end up with the lowest absolute payment because of whatever forumlas are implemented. Those of us who have been receiving the low payment for years are almost financially ruined and cannot continue providing care at payment rates below cost, even when our costs are below average. Special programs have been instituted for various groups of hospitals and have ended up causing much inequality in the medicare payment system. The one basic business premise CMS has forgotten is that no business can operate over the long term with payment lower than cost. It's that simple.

Wally Winkler, MBA, CHE
Chief Financial Officer
Keokuk Area Hospital
319 526 8661
wally@kah.kahnet.com

Submitter : Dr. Alexander Blount **Date:** 06/08/2006

Organization : University of Massachusetts Medical School

Category : Other Practitioner

Issue Areas/Comments

GME Payments

GME Payments

This year is the first that there is an increase in demand for primary care physicians. But according to the "Impending Collapse of Primary Care" report from the American College of Physicians, there is a crisis just around the corner. The workforce is aging and retirements will soon decimate the provider pool. Primary care is crucial, in Medicare's own numbers, the higher the ratio of primary care physicians to patients in a state, the lower the cost and the higher the quality of care. The loss of Title IV funds has made training of primary care physicians more difficult. Any further erosion could further reduce the supply of new physicians, costing much more and reducing quality of care in the long run.

Alexander Blount, EdD
Director of Behavioral Science
Department of Family Medicine and Community Health
University of Massachusetts Medical School

Submitter : Mr. Matthew Williams **Date:** 06/08/2006

Organization : Catholic Healthcare Partners

Category : Health Care Provider/Association

Issue Areas/Comments

Blood Clotting Factor Payment Rate

Blood Clotting Factor Payment Rate

Over the years, CMS has made payment policy changes impacting the coverage of blood clotting factors provided to inpatient hemophiliac patients. The blood clotting factors are necessary for patient health and healing. We support CMS in their quest for a uniform approach for drug payment. We recommend CMS continue to provide the additional Medicare Part B drug payment for blood clotting factors in the future even if severity-adjusted DRGs are implemented. This is a vitally important medical treatment for hemophiliacs.

CBSAs

CBSAs

See attachment.

Cost-Based Weights: Outlier Threshold

Cost-Based Weights: Outlier Threshold

According to the proposed rule, cases would qualify for outlier payments in FY 2007 if costs exceed the inpatient PPS rate for the DRG, including indirect medical education, disproportionate share hospital, and new technology payments and a fixed-loss threshold of $25,530. CMS has consistently budgeted a higher outlier payment amount for each fiscal year that has exceeded amounts actually paid (i.e. versus 5.1% budgeted for both years versus 4.1% and 4.7% paid in 2005 and 2006 respectively).

We are concerned that the increase in the fixed-loss threshold amount from $23,600 to $25,530 is unwarranted and would further reduce the payment to our associated hospitals for the medically necessary care provided. Presently our hospitals receive approximately $12 million dollars in inpatient outlier payments, which is a very small portion of our overall total revenue, but is vital payment especially to our smaller facilities. We would like to see an analysis of the proposed changes to the 2007 DRGs and rationale for the increased outlier threshold. In addition we recommend the following considerations for outlier payment as CMS moves forward with severity-adjusted DRGs:

1. Maintain current fixed-loss outlier threshold of $23,600 for FY 07 and at least FY08 to ensure payment stability during this transition period until the full impact and disclosure of severity-adjusted DRGs in provided. We are also concerned that the impact of severity-adjusted DRGs relative to outlier payment has not been fully analyzed and disclosed to hospitals in the proposed rule. Without more detail on how specific severity-DRGs would be adjusted to incorporate payment that normally would be paid as a separate outlier, hospitals are unable to determine if the higher severity of illness DRG payment will be sufficient to offset the need for a separate outlier payment in the future. Furthermore, the elimination of a separate outlier payment would require a legislative change which may not be accomplished by the FY07 Final Rule timeframe.

2. Continue to provide a separate outlier payment after the transition to severity-adjusted DRGs to provide a stop-gap for unusual cases that require intensive interventions. Outlier payments were designed to provide some financial protection for providers who treat extraordinary or intensive cases beyond the normal care protocol. Hospitals need the assurance that financial assistance will be available to serve all beneficiaries, not just beneficiaries that fall within the norm. Although severity-adjusted DRGs can account for some of the outlier cases, the fact remains that there will always be cases that do not fit the norm due to the individuality of patients. If outlier payments are eliminated altogether, Medicare beneficiaries could face unintended consequences like care rationing or withholding of needed services. We do not believe that Medicare desires this outcome for their beneficiaries or the public in general.

DRG Reclassifications

DRG Reclassifications

See attachment.

DRGs: Hip and Knee Replacements

DRGs: Hip and Knee Replacements

We support CMS in the movement of ICD-9 procedure codes 00.71, 00.72, 00.73, 00.81, 00.82, 00.83, 00.84, 81.53, 81.55 from DRG 471 to DRG 545 and the corresponding correction to the Medical Code Editor (MCE) for the Bilateral Procedure Edit.

EMTALA

EMTALA

Currently Physicians and Non-Physician Practitioners are authorized by hospital medical staff bylaws as qualified medical personnel and are able to determine when a woman is in labor under current EMTALA regulations. However, only a Physician is able to certify that a woman is in false labor and may be released from the Emergency Room without further EMTALA obligations. It is ironic that specially trained Non-Physician Practitioners can deliver a baby, but under current Conditions of Participation provisions for EMTALA are not able to determine that a woman is not in labor; particularly when the current requirement permits physicians to phone in their certification of false labor without physically viewing the patient. We support CMS proposal to amend the Conditions of

Participation for EMTALA which would allow Non-Physician Practitioners to certify false labor.

This privilege is a reasonable service to permit within State scope of practice and State law for the specially trained staff and can be easily accommodated in our affiliated hospitals medical staff bylaws.

Hospital Quality Data

Hospital Quality Data

CHP supports CMS drive toward achieving greater accuracy in the validation process and its requirement of hospitals to meet chart validation by combining samples proposed for federal fiscal year (FFY) 2007. The combining of 15 cases from the first, second, and third quarters into a single sample to determine whether or not the 80% reliability test is met is an improvement in current program procedures. However, CHP would be supportive of an even more statistical robust methodology. Moving beyond the proposed threshold to a higher level of hospital data validation by as many as 25 cases would foster Centralized Data Abstraction Center (CDAC) standards, increased statistical reliability, provide hospitals with needed flexibility, as well as mitigate the effect that a random error could place on a hospital from receiving its full update for FFY 2007. Moreover, CHP is supportive of the CMS proposal that hospitals would attest to the completeness and accuracy of the quarterly data submitted to the Quality Improvement Organization (QIO) clinical warehouse.

Occupational Mix Adjustment

Occupational Mix Adjustment

The acceleration of the due date for the data submission of the Occupational Mix Survey information to June 1, 2006 has caused undo hardship upon calendar year reporting facilities for which 2005 Medicare Cost Reports were due on May 31, 2006. Many facilities had planned on preparing the Occupational Mix Survey information during the month of May 2006. The announcement of the accelerated due date has not given hospitals adequate time to plan and budget for the required additional resources. The strain on resources could potentially impact the results reported by hospitals both for the submitted Cost Report as well as Occupational Mix Survey. Since the Cost Reports are the key to underlying proposed changes for 2007 IPPS proposal, hospitals should be allowed adequate time to focus on accuracy and compliance. Staff were not afforded sufficient time to review findings of either report as allowed in past years. We recognize that the change in due dates were the result of a Federal court decision beyond CMS control, however, we wanted to voice our disappointment in a decision that benefited a few hospitals but severely inconvenienced a greater number of hospitals across the nation. We appreciate CMS providing an alternative proposed rule to address the handling of the fully implemented Occupational Mix Survey and look forward to submitting comments. However we are concerned that the accelerated and constrained reporting period could result in the filling of inadequate reports which could impact national figures as well as individual facility rates.

CMS-1488-P-358-Attach-1.DOC

CMS-1488-P-358-Attach-2.DOC

DRG Reclassifications:

The proposed rule, if adopted, would result in the most significant change to the Inpatient Prospective Payment System (IPPS) since its implementation in the 1980s. Changes of this nature can not be taken lightly or rushed into without proper planning and analysis. We recognize that in order to expand care access to beneficiaries, provide equitable reimbursement for rendered services, and improve overall health care quality to Medicare beneficiaries and others, the current methodology of payment needs to be adjusted to account for changes in the healthcare delivery. Our overall concern, however, is that the proposed rule initiates so many policy changes that their "collective" impact is difficult to quantify from both a financial and operational perspective. Catholic Healthcare Partners (CHP) is willing to work toward implementing a refined DRG payment methodology, however our hospitals need sufficient time and information to understand DRG remapping, validate cost-based calculations, plan for financial changes to operations, train staff on coding policy and retool our hospital information systems in order to accurately and successfully transition to cost-based and severity-adjusted DRGs. Specifically we recommend the following considerations:

1. Delay the implementation of hospital specific relative values (HSRVs) and cost-based weights (HSRVcc) until at least FY 2008. The proposed rule offered two different methodologies for arriving at hospital specific relative values and cost-based weights. Upon review, the simplified CMS proposed methodology had the benefit of focusing costs into ten manageable cost centers for national cost-to-charge ratio development and supported an annual update process. Hospitals frequently encounter annual fluctuations in costs for drugs, supplies, and staff that are driven by market forces beyond their control. The annual update process provides some flexibility in adjusting for those unexpected costs particularly in markets prone to shortages and recalls that drive up costs. Unfortunately, the American Hospital Association notified its member hospitals that the CMS methodology had several serious calculation errors which could result in unintended financial consequences. **We recommend CMS work with the AHA to identify and address the areas of concern, and once resolved re-issue the respective cost-based calculation methodologies along with a comparative schematic of each calculation methodology and an example of how cost would be calculated under each methodology using a common set of same data. This information should be released in time for adequate analysis and comment for FY 2008.**

2. Amend the ten Cost Centers proposed under the CMS recommendation to include inpatient costs from Medicare Cost Report Worksheet C Part I Column 5 line 62 – Observation to fully capture clinical costs associated with direct patient care. In reviewing the services to be considered in cost-based DRG weighting, it appears CMS excluded line 62 – Observation costs. Although Observation services are typically considered an "outpatient" service, inpatients can legitimately spend up to 48 hours (i.e. 2 days) prior to their inpatient admission in Observation status. By excluding inpatient costs reported for line 62, CMS would be understating associated DRG costs for medically necessary nursing services. CMS has repeatedly instructed hospitals to appropriately prepare complete Cost Reports by separating routine and ancillary by inpatient and outpatient costs.

The CMS proposed cost-based methodology will finally recognize those hospitals which have been compliant in completing their Cost Reports as instructed. Worksheet C Part I Column 5 line 62 allows hospitals to distinguish between costs associated with "pure" outpatient Observation cases versus costs associated with patients who were placed in Observation prior to an inpatient admission. **As such, CMS should include the costs of care spent in Observation that ultimately results in an inpatient admission as reported in line 62 in the overall DRG cost-based weighting.**

3. Delay the implementation of the severity-adjusted DRG methodology until at least FY 2008. We understand and share CMS concern regarding charge-driven biases and "DRG complication-co morbidity creep" that has been occurring since the inception of DRGs. We also support the decision to move to DRGs that are more reflective of intensity of service and severity of illness as demonstrated by the presence of underlying complications, multiple co-morbidities and secondary diagnoses. However we are concerned that hospitals have not been given sufficient information and/or time to evaluate the impact of either proposed MedPAC APR-DRGs or CMS Consolidated DRGs. Specifically, hospitals have not been given sufficient cross-maps from the current 526 DRGs to each of the respective proposed 1258 APR-DRGs or 861 Consolidated DRGs. Without the cross-maps, a true financial impact analysis can not be completed. Many DRGs can be intuitively matched based on description, but there are a significant number of DRGs that can regroup to numerous severity-adjusted DRGs depending upon the reclassification of specific ICD-9 diagnosis and procedures codes under the severity-adjusted DRG grouper. We are also concerned that hospitals will not have sufficient time to purchase and implement a new DRG Grouper that will be required to generate the severity-adjusted DRGs on a daily basis to support hospital inpatient billing, effective October 1, 2006. According to the proposed rules, only one vendor, 3M, was identified as having access to the grouper. With over 4,000 hospitals requiring a new severity-adjusted DRG Grouper, it is not feasible or reasonable to expect that one vendor could service all the hospitals nationally in the few months between the posting of the final IPPS rule and an October 1, 2006 implementation. We are concerned that new coding requirements associated with the reporting of secondary diagnoses and hospital acquired infections will require additional coding staff training and some reprogramming of internal software and claims processing to allow for the additional codes to appear on hospital claims. **Hospitals need additional time to be able to verify that coders understand and implement crucial coding policy changes, new groupers are functioning, programming and claim processing functions are reporting necessary ICD-9 and DRG information properly to ensure financial and operational stability during the transition to severity-adjusted DRGs.**

4. Implement simultaneously, but not earlier than FY 2008, the proposed cost-based DRG relative weight determination policy and the proposed severity adjustment policy. The simultaneous implementation approach should help to smooth out the major redistributive effects on hospital payments.

5. Limit the severity-adjusted DRG methodology to a 3-digit DRG to minimize extra costs associated with reprogramming and retooling information systems to handle a 4-digit DRG. Under the MedPAC proposal, hospitals would have to reprogram existing health information, claims processing, and decision-support systems to accommodate a 4-digit DRG. A field length change is an extremely expensive customization to most existing information systems and the fact that the DRG number is such a key data element in most software systems only compounds the problem. Essentially moving to a 4-digit DRG could result in the same level of reprogramming and operational changes as Y2K. Hospitals do not have enough time to prepare by October 1, 2006 and may not be enough time by October 1, 2007 to make all the necessary software changes. **CHP supports the decision to use the consolidated DRGs as it would avoid 4-digit DRGs. Every provider or entity that collects or evaluates DRG information would have to make programming changes if a 4-digit DRG, as proposed by MedPAC APR-DRG, is adopted. Moving to a 4-digit DRG would add undue programming costs to health care and related healthcare markets and move limited financial resources away from initiatives focused on improving quality care and access to healthcare.**

6. Consider transitioning to severity-adjusted DRGs at the same time as implementation of ICD-10 potentially in FY 2009. Although this option was not presented in the proposed rule, it could reduce the overall cost in the long term for severity-adjusted DRG changes and provide a significant improvement to the current system. As hospitals move to severity-adjusted DRGs, coding and claims processing systems will need to be revised to factor expanded code ranges, new coding algorithms and revised code fields within system software and forms. Exactly the same type of coding and software changes would have to be adjusted for the implementation of ICD-10. Migrating to new severity-adjusted DRGs and to new ICD-10 codes simultaneously would allow hospitals to update their encoders, groupers, and internal software systems once and thereby reducing overall costs associated with reprogramming, retraining, and re-installations. A simultaneous transition would also consolidate staff downtime or unproductive training time. **The end result would include an updated ICD-10 coding structure that matches to the rest of the world and an updated DRG structure that accommodates severity of illness, multiple complications and co-morbidities. We recommend that CMS give serious consideration to finalizing all these changes no later than July 1, 2007, for an October 1, 2009 implementation, to provide adequate time for transition, training, systems re-design and testing.**

Submitter : Dr. Uche George-Nwogu **Date:** 06/08/2006

Organization : University of Michigan

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

As an assistant residency director of department of family medicine Residency program, 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. In addition, I cannot conceive of how our program could 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 would we 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. Phil Matthews **Date:** 06/08/2006

Organization : Arkansas Hospital Association

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-360-Attach-1.DOC

Attachment # 360

PHIL E. MATTHEWS
President and CEO

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:

On May 9, the Centers for Medicare & Medicaid Services (CMS) published its Proposed Rule covering the Medicare Inpatient Hospital Prospective Payment System (IPPS) for Fiscal Year 2007. The proposal includes two of the most consequential changes in the Medicare payment methodology since the implementation of the IPPS in 1983.

First, the rule would significantly alter the way in which CMS weights DRGs. Currently, the weights are charge-based. Under CMS' proposed rule, that would change in FY 2007 to a methodology which bases the weights on a newly developed hospital-specific relative value cost center (HSRVcc). We agree that basing DRGs on costs rather than charges may result in more appropriate payments; however CMS offers no compelling evidence that its approach to converting charges to costs using the national cost center cost-to-charge ratios (CCRs) rather than hospital specific data is anything more than the most expedient pathway.

CMS also proposes moving to an entirely new patient classification system beginning in FY 2008 *or earlier*. Currently, CMS uses 526 DRGs to classify all Medicare patients. Your agency considered use of 3M's all-patient refined DRGs (APR-DRGs) as an alternative to its current set of DRGs, which would increase the number of categories to 1,258. But, instead it chose to refine the APR-DRG system by consolidating those DRGs into a new DRG universe with 861 consolidated severity-adjusted DRGs, or CS-DRGs.

In our opinion, there is a need for more careful analysis of this reclassification, along with greater access to the specifics of CMS's methodology and the new GROUPER. The current DRG GROUPER logic has been in the public domain since the inception of the

419 Natural Resources Drive • Little Rock, Arkansas 72205 • 501-224-7878 • Facsimile 501-224-0519

IPPS. Without the new GROUPER logic, it is virtually impossible for AHA or anyone else to thoroughly analyze the system and comment. Without access to the new GROUPER, we have no understanding of how and why patients fall into certain CS-DRGs and cannot evaluate whether it represents policy improvement.

While the changes being proposed yield small shifts in the percentages of losses or gains by individual facilities, they lead to broad swings in total payments and absolute dollars due to the large sums involved. Because of that sensitivity, the changes create cause for serious concern among Arkansas' hospitals, which would see roughly $25 million in Medicare payments redistributed to facilities in other states under the budget neutral parameters of the rule. Those dollars are critical for supporting the healthcare infrastructure in a small rural state like Arkansas.

The Arkansas Hospital Association (AHA) agrees that meaningful improvements need to be incorporated into the Medicare IPPS. However, we also believe that CMS should work in cooperation with various hospital groups 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.

Specifically, the AHA supports the following:

- **One-year Delay:** The AHA supports a one-year delay in the proposed DRG changes given the serious concerns with the HSRVcc and CS-DRG methodology. The AHA 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:** The AHA 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**: The AHA commits to working with CMS to develop and evaluate alternatives for new weights and classifications.

We appreciate the opportunity to submit these comments. If you have any questions about our remarks, please feel free to contact me or Paul Cunningham, senior vice president, at (501) 224-7878 or pcunningham@arkhospitals.org.

Sincerely,

Phil E. Matthews

Submitter : Dr. Jeremy Golding **Date:** 06/08/2006

Organization : University of Massachusetts Medical School

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

I am a family medicine residency faculty member. 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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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 a residency program 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. The documentation requirements that this 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,
Jeremy Golding, MD, FAAFP
University of Massachusetts Medical School
Family Medicine Residency

Submitter : Dr. Roxanne Fahrenwald **Date:** 06/08/2006

Organization : YCCHD

Category : Academic

Issue Areas/Comments

GME Payments

GME Payments

As a family medicine residency program director, 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, 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,
Roxanne Fahrenwald MD
Montana Family Medicine Residency Program

Submitter : Dr. Karen Hall **Date:** 06/08/2006

Organization : UF

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

At a time when medicine is moving the focus from education in hospitals to an acknowledgment of the necessity to train new physicians in outpatient setting, I believe it short sighted to tie all GME payments to strict patient care time in hospitals. While it may be easier to track, the future of medicine lies in innovation and responding to the changes in medical care. Excluding lecture and discussion from reimbursed time for GME payments is also shortsighted in that patient care is intimately involved with learning on the part of every physician.

Submitter : Mr. William Reifer **Date:** 06/08/2006

Organization : Phelps Memorial Hospital

Category : Health Care Professional or Association

Issue Areas/Comments

Hospital Quality Data

Hospital Quality Data

While it is reasonable for the public to expect that hospitals provide validated objective evidence of quality care, some of the proposed changes to 'Reporting of Hospital Quality Data for Annual Hospital Payment Update' impose an unreasonable burden on hospitals providing that very care.

1. 'Hospitals will be required to submit data on the expanded measures to the QIO Clinical Warehouse beginning with discharges that occur in the first calendar quarter of 2006 (January through March discharges).' - It is not reasonable to ask hospitals to report data retrospecively (back to Jan 1 2006 - as of this writing of June 8, 2006). Data abstraction for these indicators is a staff intensive, labor intensive activity requiring not only review of charts, but also the time to clearly understand the indicators. Hospitals that have not previously chosen to study all 21 indicators (and there was no requirement to do so) face the prospect of finding and training (clinical) staff to abstract months of data. This proposed expansion of clinical indicators should be prospective, allowing reasonable time for hospitals to prepare. Furthermore, meaningful comparative public reporting of data is not well served by including retrospective (to Jan 1 2006) results for hospitals who are new to a given indicator set, with data of hospitals that have reported for some time.
2. There continues to be no formal process in this proposed changes for appeal/review of validation decisions where hospitals do indeed pass the 80% threshold, but where validators have disagreed with some number of a hospital's submitted data responses. It is important to have some formal mechanism for review so serve the purpose of ongoing refinement of understanding of subtle aspects of indicator results. Although a hospital might 'pass' current validation, future results might well depend on documenting clinical practices in areas where hospitals have legitimate disagreements with the opinions of the validation abstractors. Both for learning purposes, and to serve the needs of the public for valid data, hospitals should have some due process or at least formal feedback mechanism for instances of validation disagreements in the context of passing validation as well as failing.
3. It is reasonable for hospitals to receive more than 10 days time to file validation appeals. It is noted that CMS receives much more time. Given all of the priorities at busy hospitals, 10 days may be too short a time for a given hospital to respond fully to a validation decision, not offering hospitals (and the public) reasonable due process. 30 days is suggested as a reasonable time frame.

Thank you.

Submitter : **Ms. Carol Pulley** **Date: 06/08/2006**

Organization : **Southern Ocean County Hospital**

Category : **Hospital**

Issue Areas/Comments

Hospital Quality Data

Hospital Quality Data

To whom it may concern,
Please see attached file for comments

CMS-1488-P-365-Attach-1.DOC

#365

June 5, 2006

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

Public Comment: Hospital Quality Data re: Reporting of Hospital Quality Data for Annual Hospital Payment Update (S 412.64(d)(2)).

This following commentary is specifically in regards to:
Hospitals that fail RHQDAPU validation requirement due to failure to submit charts by the deadline.

It is proposed that for the FY 2007 payment update, hospitals must pass the validation requirement of a minimum of 80 percent reliability, based upon a chart-audit validation process, for the first three quarters of data from CY 2005.

This is a fair requirement, except that there are no options for a hospital to appeal in the event that charts miss a CDAC deadline, despite demonstrating diligence in following submission requirements with reliable data in all other quarters.

- Currently, failure due to late submission of charts is not an accepted reason to appeal and thus such appeals are not reviewed or accepted.
- Therefore, despite diligence in all other regards in meeting CMS requirements for data collection and reporting, and achieving successful validation rates in all other quarters, there is no opportunity for a hospital to pass validation if one quarter is missed.
- **Specifically in our situation, we have conscientiously participated in the validation process since 1st Q 2003 and have reported in good faith, yet as a result of unusual circumstances, a deadline was missed by one day in 1st Q 2005. We subsequently instituted a system of double checks to ensure timely submission of charts to CDAC.**
- **If CMS uses 3 quarters of data as proposed, it is impossible for us to pass this validation requirement.** (Validation rates: 4th Q 04 - **97%**; 1st Q 05 - **0%**; 2nd Q 05 - **97%**; and 3rd Q 05 - **92%**).

We recommend:
that there be a structured reconsideration process to precede the determination of whether RHQDAPU requirements have been met in the event that a hospital fails validation as a result of failing to meet the CDAC deadline.
This would involve a process which requires assessment of the hospital's timeliness and validation scores in the preceding and following quarters to determine whether a standard of diligence has been met; thus hospitals would not be penalized for such one-time events. It would be appropriate for the hospital to submit a plan of correction to avoid future occurrences.

Southern Ocean County Hospital appreciates the opportunity to comment on this proposed rule.

Sincerely,

Carol Pulley RN MSN
Outcomes Manager
Southern Ocean County Hospital
Manahawkin, N.J.
609-978-8900 ext 2056
cpulley@soch.com

Submitter : Dr. Tracy Kedian **Date:** 06/08/2006

Organization : University of Massachusetts Medical School

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

As a family medicine residency faculty member, 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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Sincerely,
Tracy Kedian, MD

Submitter : Ms. Glenda Van Roekel **Date:** 06/08/2006

Organization : Avera McKennan Hospital

Category : Hospital

Issue Areas/Comments

Hospital Quality Data

Hospital Quality Data

Avera McKennan Hospital & University Health Center in Sioux Falls, SD has participated in the Premier/CMS Hospital Quality Demonstration since October 2003. We submit total hip and knee arthroplasty data for Medicare patients as part of that project. We do not participate in SIP, but plan to submit data for the Surgical Care Improvement Project beginning with July 1, 2006 discharges. Our understanding is that a decision will be made in August regarding the requirement under CMS-1488-P that SIP data from January 1, 2006 be submitted in order to recieve the Annual Payment Update. This would require us to abstract and submit data retrospectively on the additional focus groups included in SIP, as well as non-Medicare total hips and knees. Should this change not pass as currently proposed, many hours of effort could go into data collection unnecessarily if we begin now. We do not agree that this would not place an additional burden on hospital resources, particularly in light of a short time frame before submission deadline. If our understanding of this issue is incorrect, we would appreciate clarification.

Submitter : Dr. Nancy Levine **Date:** 06/08/2006

Organization : West Penn Family Practice

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

As a family medicine residency program director, 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.

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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,
Nancy Levine MD

Submitter : Dr. Juan Carlos Martinez-Alvarado **Date:** 06/08/2006

Organization : Tallahassee Memorial Family Medicine Residency Pro

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

As a family medicine residency faculty member, 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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Sincerely,

Juan Carlos Martinez-Alvarado, M.D.
Faculty
Tallahassee Memorial Family Practice Residency Program
1301 Hodges Drive
Tallahassee, FL 32308

Submitter : Dr. Robert Morse **Date:** 06/08/2006

Organization : U. of Oklahoma

Category : Academic

Issue Areas/Comments

GME Payments

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Sincerely,

R. Michael Morse, M.D.
Professor and Chair
Department of Family Medicine
U. of Oklahoma College of Medicine, Tulsa

Submitter : Dr. J. William KErns **Date:** 06/08/2006

Organization : Shenandoah Valley Family Practice Residency Progra

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

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programs.

Sincerely,

J. William Kerns, MD
Shenandoah Valley Family Practice Residency
140 W 11th Street
Front Royal, VA. 22630
540-636-2028

Submitter : Peter McConarty **Date:** 06/08/2006

Organization : Community Health Conections

Category : Physician

Issue Areas/Comments

Capital Payment Rate

Capital Payment Rate

GENERAL

GENERAL

The CMS rule "Proposed Changes to the Hospital Inpatient Prospective Payment Systems..." would create a fallacious dichotomy between patient care and "education" in GME programs. Clearly, by design, GME prograams have been built on the model of patient care being thoroughly intermingled with the process of learning to take optimal care of patients. Only a residency which acts as a "mill" for churning out patient encounters could approve of the proposed rule. If CMS believes that teaching residents to take care of patients fast "and not think toomuch about it", the proposed rule would be appropriate. Otherwise the rule will be counterproductive.

I urge that the CMS proposed rule be withdrawn.

Submitter : Mr. John Matessino **Date:** 06/08/2006

Organization : Louisiana Hospital Association

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-373-Attach-1.PDF

#373

LOUISIANA HOSPITAL ASSOCIATION

JOHN A. MATESSINO
PRESIDENT & CEO

9521 BROOKLINE AVENUE ◆ BATON ROUGE, LOUISIANA 70809-1431
(225) 928-0026 ◆ FAX (225) 923-1004 ◆ www.lhaonline.org

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:

On behalf of the Louisiana Hospital Association's (LHA) 181 member hospitals, health care systems and other health care organizations, 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 the LHA supports many of the proposed rule's provisions, we have serious concerns about the proposed changes to the DRG weights and classifications.

Louisiana hospitals support meaningful improvements to Medicare's inpatient PPS. We believe the LHA 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, the LHA supports the following:

- **One-year Delay:** The LHA supports a one-year delay in the proposed DRG changes given the serious concerns with the HSRVcc and CS-DRG methodology. The AHA 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:** The LHA 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**: The LHA commits to working with CMS to develop and evaluate alternatives for new weights and classifications.

We have enclosed detailed comments 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.

The LHA appreciates the opportunity to submit these comments. If you have any questions about our remarks, please feel free to contact me or Paul Salles, vice president of Health Reimbursement Policy, at (225) 928-0026 or psalles@lhaonline.org.

Sincerely,

John Matessino

John A. Matessino
President & CEO

Submitter : Ms. D Ewert **Date:** 06/08/2006

Organization : Ms. D Ewert

Category : Individual

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).

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,
D. Ewert

Submitter : Mr. Gregory Martin **Date:** 06/08/2006

Organization : Mr. Gregory Martin

Category : Individual

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Sincerely,

Greg Martin

Submitter : Dr. Scott Henderson **Date:** 06/08/2006

Organization : Mercy Family Medicine Residency

Category : Physician

Issue Areas/Comments

GME Payments

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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,
Scott T. Henderson, M.D.

Submitter : Dr. Mark Penn **Date:** 06/08/2006

Organization : Summa Health System

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

Please refer to attachment.

CMS-1488-P-377-Attach-1.DOC

#377

June 8, 2006

Centers for Medicare and Medicaid Services

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

As a family medicine residency program associate director, 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.

I 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.

I would most certainly NOT wish to be a patient cared for by a resident whose training was devoid of didactic activities such as classroom lectures, seminars, journal clubs, or nonhospital educational experiences. It is, indeed, these activities that provide the infrastructure and framework upon which appropriate medical judgment is founded!

To reiterate, I strongly 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 correctly recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,

Mark A. Penn, MD
Associate Director of Family Medicine Education
Summa Health System
Akron, Ohio
Phone: (330) 375-3504

Submitter : Dr. Paul Lazar **Date:** 06/08/2006

Organization : McLaren Family Practice Residency

Category : Physician

Issue Areas/Comments

GME Payments

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Everything that we do with residents is based on seeking the answers to questions that arise as a result of patient care, finding the answers and applying them to patient care as immediately as possible. This is the case whether we are in the patient's room, the hall, the library, the conference room, or the lecture hall. 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.

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Paul A. Lazar, MD

Director, McLaren Family Practice Residency

Submitter : Dr. Donald Briscoe **Date:** 06/08/2006

Organization : Dr. Donald Briscoe

Category : Physician

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Submitter : Dr. brett johnsonm **Date:** 06/08/2006

Organization : methodist health system

Category : Physician

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Submitter : Dr. Alice House **Date:** 06/08/2006

Organization : Mercer School of Med and GA Acad Fam Physicians

Category : Individual

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Submitter : Dr. neeta Gautam **Date:** 06/08/2006

Organization : The Methidost Hospital Family Medicine Residency P

Category : Individual

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Submitter : Dr. Troy Fiesinger **Date:** 06/08/2006

Organization : Conroe Family Medicine Residency

Category : Physician

Issue Areas/Comments

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Submitter : Mr. Joseph LeValley **Date:** 06/08/2006

Organization : Mercy Medical Center - Des Moines

Category : Hospital

Issue Areas/Comments

Impact Analysis

Impact Analysis

It is estimated that the cumulative effect of the proposed changes, related to the DRG reweighting and the wage index for Des Moines, is a negative $6 million per year for Mercy Medical Center - Des Moines. Obviously, this is a serious concern and an unfair shifting of resources away from a tertiary medical facility that already struggles to meet the needs of Medicare patients due to unfairly low reimbursement rates. Please delay and modify the proposed changes, or couple them with other equity fixes that stop rewarding high cost, inefficient hospitals in other states, and begin rewarding low cost, high quality facilities in states like Iowa. Thank you for your time and consideration.

Joe LeValley
Senior Vice President
Mercy Medical Center - Des Moines

Submitter : Dr. David Ross **Date:** 06/08/2006

Organization : Methodist Health System

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.

Submitter : Dr. Charles Jones **Date:** 06/08/2006

Organization : Conroe Family Medicine Residency Program

Category : Academic

Issue Areas/Comments

GME Payments

GME Payments

This proposed rule change would destroy community based family medicine residency programs. Just a reminder over 80% of family medicine residency programs are currently in community hospitals. Family medicine residency programs provide access to care for the most vulnerable population and we also provide the "first line" of care for all ages and disease processes. I request that this proposed rule change be abandoned. Thanks, Charles A. Jones,MD, FM Residency Program Director.

Submitter : Dr. Scott Rand **Date:** 06/08/2006

Organization : Lone Star Sports Medicine Clinic

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

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Submitter : Dr. John Wright **Date:** 06/08/2006

Organization : Dr. John Wright

Category : Individual

Issue Areas/Comments

GME Payments

GME Payments

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Submitter : **Dr. William Bina** **Date: 06/08/2006**

Organization : **Dr. William Bina**

Category : **Individual**

Issue Areas/Comments

GME Payments

GME Payments

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care experiences of residents during their residency programs.

Sincerely,

William F. Bina, III, MD

Submitter : **Dr. Thomas Shima** **Date: 06/08/2006**

Organization : **methodist Charlton Family Practice Residency**

Category : **Physician**

Issue Areas/Comments

GME Payments

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Submitter : **Dr. Charles Driscoll** **Date: 06/08/2006**

Organization : **Lynchburg Family Medicine**

Category : **Physician**

Issue Areas/Comments

GME Payments

GME Payments

As a family physician and residency 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).

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Sincerely, Charles E. Driscoll, MD

Submitter : Dr. Joanne Wu **Date:** 06/08/2006

Organization : Dr. Joanne Wu

Category : Individual

Issue Areas/Comments

GME Payments

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Sincerely,

Joanne Wu

Submitter : Ms. Anita Orenstein **Date:** 06/08/2006

Organization : Intermountain Health Care

Category : Health Care Provider/Association

Issue Areas/Comments

Hospital Quality Data

Hospital Quality Data

The attached comments are in regard to the following areas:
1. The expansion of quality measures
2. Public Reporting and Data Warehouse Restrictions
3. CDAC Validation Appeal Process
4. Warehouse Edits
5. Validation of Quality Measures

CMS-1488-P-393-Attach-1.DOC

Attach #313

COMMENTS FOR PROPOSED FFY 2007 MEDICARE DRG RULE

1. Expansion of Quality Measures

CMS wants to expand the measure sets from the existing 10 measures and begin to adopt the baseline set of measures as defined in the IOM report. These are currently described as the Hospital Quality Alliance measure, HCAHPS® and "three structural measures" defined in the value-based section as (1) computerized provider order entry; (2) intensive care intensivists; and (3) evidence-based hospital referrals. Additionally, the Secretary has broad discretion to replace measures on the basis that they are not appropriate.

CMS and the Secretary should adopt a procedure or policy for the timely development of standard definitions for all measures. Measures should be defined early enough to allow sufficient time for process development in facilities, resources allocation, performance measurement vendor programming and training for data collection. Hospitals exert considerable effort attempting to interpret what is forthcoming, whereas having standard measure definitions would decrease the burden placed upon organizations. Sufficient time to prepare for the implementation of new measures should include one year for programming and training and one additional year for any requirement considered resource intensive (such as hiring intensivists, purchasing systems for computerized physician order entry, etc).

CMS and the Secretary need to carefully consider the resource and financial burden of the data collection as the Secretary uses his broad discretion to replace and increase data collection. Algorithms and data requirements are becoming increasingly complex with some data elements > 4 pages adding significant complexity in the process of data abstraction.

a) Public Reporting and Data Warehouse Restrictions

The intent of public reporting is to "empower consumers with quality of care information to make informed decisions about their health care while also encouraging hospitals and clinicians to improve the quality of care." That being said, CMS does not allow for correction of the data entered in error into the warehouse after the submission date. Currently one quarter's error is reflected for one year of reporting.

CMS and the Secretary should adopt a process for correction of inaccurate data identified in the warehouse. This process should be allowed after CMS publishes the requirements for CDAC validation and APU processing. It is of greater value for the public to have correct information than to be limited by a rigid restriction. Hospitals would be willing to provide a nominal fee for such ability.

b) CDAC Validation Appeal Process

The current appeal process for CDAC validation gives the QIO final authority for all decisions. For times when the NHQM is not sufficiently clear (such as in identifying populations), QIOs have not allowed those issues to be appealed or have rejected the appeal. For these times, there needs to be an appeal process higher than the QIO.

CMS and the Secretary should define an appeals process that is higher than the QIO when the hospital can demonstrate that the QIO is incorrect in their review.

C) Warehouse Edits

CMS Clinical Data Warehouse edits do not currently follow the algorithm process as defined in the NHQM Manual. For example, heart failure patients with a discharge status of 02, 04, 50, 51 are rejected from all 4 measures in the heart failure set whereas the algorithm places that patient record in the "B" bucket for excluded population. Additionally, CMS limits the amount of diagnosis and procedure codes, which will limit inclusion into the warehouse and affect risk adjustment.

CMS data warehouse does currently have edits, which violates instructions for data algorithm processing according to the NHQM Manual. To ensure integrity and consistency with other organizations reporting the same data, the front-end edits should be immediately aligned to match the algorithms.

CMS should increase the capacity of its current clinical data warehouse to accept all diagnosis and procedure codes to recognize severity of illness levels.

CMS needs to define with explicit clarity the initial population definitions for all measure sets (e.g., define by UB-92 or UB-04 what is defined as an acute inpatient).

d) Validation of Quality Measures

For the FY 2007 payment update, hospitals must pass our validation requirement of a minimum of 80 percent reliability, based upon our chart-audit validation process, for the first three quarters of data from CY 2005.

CMS should change this language to clarify that the 80% is a composite score of all three quarters and not an 80% for each individual quarter. (There are a couple of sentences that start at the bottom of page 339 of the regulations that address this issue. They say: "In reviewing the hospital data, we plan to combine the samples for first quarter, second quarter, and third quarter (15 cases) into a single stratified sample to determine whether the 80-percent reliability level is met. This gives us the greatest accuracy when estimating the reliability level."

Submitter : Mr. Dan Coleman **Date:** 06/08/2006

Organization : John C. Lincoln Health Network

Category : Hospital

Issue Areas/Comments

DRG Weights

DRG Weights

Because of the complexity of this change, the difficulty in understanding its impact, and having to deal with the impact in a very short time frame, I request that implementation of the new weights be delayed one year. Because of the profound but, as yet, unknown impact on hospitals, this biggest change since DRGs were implemented should, after a one-year delay, be phased in over three years

I cannot overemphasize the importance of this delay and phase-in. This will have a dramatic impact on hospitals, and we need to have time to deal with this so that our services to our community are not interrupted.

Submitter : Dr. Michelle Cervin **Date:** 06/08/2006

Organization : St. Joseph Regional Medical center Family Medicine

Category : Physician

Issue Areas/Comments

GME Payments

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Sincerely, M. Cervin D.O.

Submitter : Mr. Stephen Garland **Date:** 06/08/2006

Organization : Shands Jacksonville Medical Center

Category : Hospital

Issue Areas/Comments

FTE Resident Count and Documentation

FTE Resident Count and Documentation

June 8, 2006

Mr. Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMAS-1488-P
P. O. Box 8010
Baltimore, MD 21244-8050

RE: Resident Time in Patient Activities and Proposed Changes to the Hospital Inpatient Prospective Payment System and Fiscal Year 2007 Rates

Dear Dr. McClellan:

Shands Jacksonville 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 would like to comment on the didactic activities clarification and the proposed certification requirement of residents data.

Residents Didactic Activities Clarification

We strongly urge the Agency to rescind the purported clarification in the proposed rule that excludes medical and dental 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.

Residents Data Certification

This comment is in regard to the proposed rule that the documentation information referred to in, 42 CFR 413.75(d), must be certified by an official of the hospital and, if different, an official responsible for administering the residency program . It is unclear to us as to what CMS is requiring us to certify and in what format. The IRIS report requires all of this information; would certification of the report and its contents meet this requirement?

Thank you for the opportunity to comment on the proposed FFY 2007 rules. If you should have any questions please do not hesitate to contact me @ steve.garland@jax.ufl.edu or (904) 244-1964.

Sincerely,

Stephen L. Garland
Director of Reimbursement
Shands Jacksonville

Submitter : Ms. Allison Matters **Date:** 06/08/2006

Organization : Indiana Academy of Family Physicians

Category : Individual

Issue Areas/Comments

GME 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,

Allison Matters

Submitter : Mr. Brad Sher **Date:** 06/08/2006

Organization : BryanLGH Medical Center

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

CMS-1488-P-398-Attach-1.TXT

Attachment #398

June 7, 2006

Centers for Medicare & 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

My hospital is a 535-bed acute care hospital located in Lincoln, Nebraska. As a major health care provider in our area, we implant medical devices and perform other cardiac procedures on a significant number of Medicare beneficiaries in the inpatient setting. Because inpatient services are a key component of what we provide, I am writing to express my concerns regarding the inpatient payment proposed rule and its recommendations to change the way Medicare pays for inpatient services.

First, it adopts a methodology called hospital-specific relative values that is specifically known to have an adverse impact on payments to hospitals that deliver cardiology services. Second, it adopts a new and untested approach to what are known as "cost-based" DRG weights that inappropriately reduces payments for cardiology procedures featuring device implants such as drug-eluting stents, ICDs, and pacemakers. In fact, these are the hardest hit of *all* procedures in the DRG system. And finally, even within the new CMS methodology, there are technical errors and assumptions that worsen the overall payment cuts to cardiology. Any move to a cost-based system from the current charge-based system should be predicated on requirements for improved cost reporting by hospitals. Hospital cost reports were never intended to be used to develop accurate procedure-specific payment weights.

The impact of the CMS proposal will reduce reimbursement to cardiac services across all hospitals by about 10%. Application of hospital specific values to the current DRG system would result in an overall average decrease of approximately 6% to surgical DRGs, while increasing medical DRGs by 6%. In addition, technology intensive DRGs will also be significantly reduced under the CMS proposals. As a result of these changes, the proposed DRGs for stents will be reduced 24 to 34%, ICD implants will be reduced 22 to 24% and pacemakers will be reduced 12 to 14% severely impacting these services.

With regard to the severity adjustment proposed for next year (FY08), severity does not include the technology costs paid by hospitals for more complex cases. As a result, my technology costs could be underpaid.

The payment methodology changes that CMS has proposed would have a severe financial impact on my hospital – without accurate data to justify the change. This is particularly true for device

intensive cardiology DRGs where the proposed payment level is often significantly less than my hospital's actual cost to deliver the service.

The reduction in payment for cardiology services would also have a severe impact on the infrastructure I have built up over the years to treat the number one killer in America today - heart disease. In addition to requiring the potential dismantling of this infrastructure I would now face the uncertainty of knowing that next year, or any other year, CMS could decide to under-fund whatever service area I build up next to meet patient needs. Obviously, as I'm forced to scale back or not develop service capacity due to payment swings and financial uncertainties, patient access could be negatively affected.

I respectfully request that CMS delay the proposed inpatient payment revision, with a return to the current methodology, until the methodology and underlying cost data are improved to ensure the accuracy of payments. Similarly, severity adjusted DRGs should not be implemented until the technology costs incurred by my hospital can be appropriately reflected in the DRG payments.

Thank you for your consideration.

Sincerely,

Brad Sher
Vice President Managed Care/Public Policy

:cre

cc: US Senator Ben Nelson
US Senator Chuck Hagel
US Representative Jeff Fortenberry
Laura Redoutey, Nebraska Hospital Association

Submitter : **Date: 06/08/2006**

Organization : **Lone Star Family Health Center**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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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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. Kevin Speer **Date:** 06/08/2006

Organization : Indiana Academy of Family Physicians

Category : Individual

Issue Areas/Comments

GME Payments

GME Payments

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Sincerely,

Kevin Speer

Submitter : Dr. Diane Homan **Date:** 06/08/2006

Organization : Rush-Copley Medical Center

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.

Submitter : Dr. Jeremy Ruskin **Date:** 06/08/2006

Organization : Massachusetts General Hospital

Category : Physician

Issue Areas/Comments

DRGs: MCVs and Defibrillators

DRGs: MCVs and Defibrillators

Re: Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates
As a practicing heart rhythm specialist, also known as an electrophysiologist, at an 800 bed hospital located in Boston, Massachusetts, I am quite concerned Medicare beneficiaries will have limited access to life-saving and life-enhancing cardiac care due to the recently proposed inpatient rule. Technologies such as implantable cardioverter defibrillators are used to prevent sudden cardiac arrest, the nation s number one cause of mortality. Cardiac ablations are used to treat debilitating and life threatening cardiac arrhythmias such as ones that lead to stroke.
The full implementation of the CMS proposed Inpatient Prospective Payment System would have a devastating impact on my hospital s ability to serve patients in my community. These proposed reductions will impact hospital staffing for these critical procedures which will ultimately be translated into reduced patient access and care. CMS and Congress have emphasized the development of quality measures and activities. For example, the recent CMS mandate for hospitals to enroll in the ICD Registry represents personnel the hospital has to dedicate for this important initiative. Without accurate and appropriate reimbursement for these critical services, hospitals will not be able to dedicate resources to important quality improvement initiatives such as this.
I support an accurate hospital payment system and the goal of improving payment accuracy in the DRG system. However, the implementation of these sweeping changes will replace one system with another that has inherent flaws and miscalculations. I am concerned that CMS has used old data that is not reflective of current practice and that the data used from cost reports is not accurate. Additionally, it is troubling to me that significant errors and technical decisions have been made by CMS that exacerbate the problem. It is my understanding that over 200 hospitals were thrown out of the data set including large numbers of academic health centers. This will distort any analysis that CMS conducts. Additionally, CMS failed to adjust for hospital volume of care. The result of this flawed approach is that a small hospital of 50 beds has as much weight in the calculation as a large tertiary care center/academic health center.
Furthermore, CMS has failed to address issues related to charge compression. The rule fails to fix the charge compression problem that has penalized technology-intensive procedures for years. In fact, it makes the situation worse. Instead of increasing specificity to identify actual device costs, the rule lumps costs together into just 10 national cost centers to derive cost-to-charge ratios. Most devices and supplies are in a single cost center. Under this rule, distinctions between procedures - and even hospital departments - are lost.
The goal of the proposal is to improve the accuracy of the current payment system by designing a more refined system than the existing DRGs for grouping patients. CMS proposes to implement a new system based on the severity of the patient s illness in 2008 or earlier. The new CMS-DRG system does not make distinctions based on complexity, so a move in this direction is a good one. However, technologies that represent increased complexity, but not greater severity of illness, also need to be recognized. The payment methodology changes and the DRG severity changes should be implemented together, but there is no way to fairly identify and respond to their joint impact this year.
Thank you very much for your consideration of these comments. On behalf of my patients and the community in which I serve, I thank you and recommend that these changes be deferred so that all stakeholders can better understand the impacts and that CMS devotes the time necessary to get this right.
Sincerely,
Jeremy N. Ruskin, MD
Director, Cardiac Arrhythmia Service

Submitter : Mrs. Deeda Ferree **Date:** 06/08/2006

Organization : Indiana Academy of Family Physicians

Category : Individual

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.

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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,

Deeda Ferree

Submitter : Ms. Missy Lewis **Date:** 06/08/2006

Organization : Indiana Academy of Family Physicians

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,

Missy Lewis

Submitter : Mr. Dan Coleman **Date:** 06/08/2006

Organization : John C. Lincoln Health Network

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

I am very concerned about the proposed severity classification changes to be implemented in FY 2008. It is impossible in such a short time to be able to know if the proposed classification approach is an improvement over what we have now. We need time for hospitals and our hospital associations to work with CMS to study the proposed system. I propose that this work occur over the next year.

I then propose that whatever is agreed to in this next one-year period be phased in over a three-year time frame - at the same time that I would like to see the DRG weighting changes be phased in.

These are huge changes for hospitals. It is impossible at this time to be able to accurately quantify the impact of these changes. We need more time to understand and modify them, and then we need to implement them over a three-year period so that the implementation won't have a destructive impact on hospitals and our ability to serve our community.

Submitter : Dr. Tom Miller **Date:** 06/08/2006

Organization : SIU Quincy Fam Med Blessing

Category : Academic

Issue Areas/Comments

GME Payments

GME Payments

As a family medicine residency program director, 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, 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,
Tom Miller,MD
Residency Director
SIU Quincy Family Medicine
Quincy, Illinois

Submitter : Dr. Michael Girgis **Date:** 06/08/2006

Organization : Charlton Methodist Hospital of Dallas

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.

Submitter : Dr. Monique Davis-Smith **Date:** 06/08/2006

Organization : Mercer University School of Medicine

Category : Physician

Issue Areas/Comments

GME Payments

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Sincerely,

Dr. Monique Davis-Smith

Submitter : Dr. Brian Bachelder **Date:** 06/08/2006

Organization : AAFP, OAFP

Category : Individual

Issue Areas/Comments

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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,
Brian Bachelder, MD

Submitter : **Date: 06/08/2006**

Organization :

Category : **Physician**

Issue Areas/Comments

GME Payments

GME Payments

As a family medicine residency program director, 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, 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,

James R. Richard,M.D.
Program Director
Barberton Family Practice Residency
Barberton, Ohio 44203

Submitter : Ms. Carol Spector **Date:** 06/08/2006

Organization : Midwestern University

Category : Individual

Issue Areas/Comments

GME Payments

GME 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,
Carol Spector

Submitter : **Dr. Thomas Horton** **Date: 06/08/2006**

Organization : **Rainsville Family Practice**

Category : **Physician**

Issue Areas/Comments

GME Payments

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.

Sincerely,
Thomas L. Horton, MD

Submitter : **Ms. Cherie Durkin** **Date: 06/08/2006**

Organization : **Lee's Summit Hospital**

Category : **Health Care Professional or Association**

Issue Areas/Comments

DSH Adjustment

DSH Adjustment

Hospital Quality Data - It is clearly unfair to choose a start date of January 2006 - if this is enacted it should be effective January 2007 after the legislative session. It may be good for CMS to go back and look at some of the ways certain indicators are measured. While evidence bases medicine is the correct way to practice how that is actually measured may clearly not be very scientific. An example of this is HF - medication instructions. A measure of what is the intent of the physician at the time of the patients discharge is important. To add to that what the physician may or may not dictate later is in no way acceptable. That measure is simply a measure of how well tht physician dictates, not his or her expertise in careing for that particular patient. While the CMS and other organizations mean well in trying to keep the patient safe there needs to be more thought to the scientific method when setting up the indicators.

In all fairness to all citizens the start date for this adjustment should be after it passes - if it passes. I really ask that you give move thought to this and hopefully you have collected all the information required to make such a decision that can impact our healthcare system even further. Thanks you for your time. Cherie Durkin

Submitter : **Dr. Ricca Dimalibot** **Date: 06/08/2006**

Organization : **CHRISTUS Health**

Category : **Individual**

Issue Areas/Comments

GME Payments

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.

Submitter : Dr. Kathryn Stewart **Date:** 06/08/2006

Organization : Mt. Sinai Hospital Chicago

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,

Kathryn Stewart, MD, MPH

Submitter : **Dr. Timothy McCurry** **Date: 06/08/2006**

Organization : **Resurrection Family Medicine**

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).

You are in the process of gutting the training that immediately impacts the health of the Medicare patients. Didactic lectures, supplemented with the less structured but critical clinical learning should be supported, no matter where it is. Non-clinical training has traditionally been an important part of our training and in its abscence leads to slower, less uniform learning. If CMS does not support the structured learning environment for its beneficiaries, I believe that it is liable for the resultant decrease that will follow.

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.

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 R. McCurry

Submitter : **Dr. joe stallings** **Date: 06/08/2006**

Organization : **ahecne**

Category : **Physician**

Issue Areas/Comments

GME Payments

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.

Sincerely, Joe Stallings M.D.

Submitter : **Dr. Paul Cullen** **Date: 06/08/2006**

Organization : **Washington Hospital Family Medicine**

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,

Paul T. Cullen, MD

Submitter : Dr. Hazel Bluestein **Date:** 06/08/2006

Organization : Montgomery 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).

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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,
Hazel M. Bluestein,MD

Submitter : **Ms. Anita Orenstein** **Date: 06/08/2006**

Organization : **Intermountain Healthcare**

Category : **Health Care Provider/Association**

Issue Areas/Comments

DRGs: Severity of Illness

DRGs: Severity of Illness

The attached document summarizes comments for the proposed FY 2007 Medicare DRG rule for the following:

1. Clinical issues.

2. Financial impact of changes.

3. Administrative burden of changes.

CMS-1488-P-420-Attach-1.DOC

Attach #420

COMMENTS FOR PROPOSED FFY 2007 MEDICARE DRG RULE

This document summarizes comments for the proposed FY 2007 Medicare DRG rule for the following:

1. Clinical issues.

2. Financial impact of changes.

3. Administrative burden of changes.

CLINICAL ISSUES

1. Transparency In Grouping Methodology

The current CMS DRG grouping methodology is available to the public and is, therefore, transparent to the user. In contrast, the proposed grouping methodology for the consolidated severity-adjusted DRGs uses proprietary software. As a result, the methodology is not transparent to the user, and the software vendor (i.e., 3M Health Information Systems) will have a monopoly for the programming of the grouper.

CMS should make more information about the proposed grouping methodology available to both the public as well as to other software vendors with appropriate time to accomodate.

2. Number Of Accepted Diagnoses And Procedures

CMS wants to implement the consolidated severity-adjusted DRGs to be able to better recognize severity of illness levels in individual claims. However, Medicare's claims processing system will presently only accept nine diagnoses and six procedure codes. Consequently, the limit on the number of codes artificially restricts the calculation of the true severity of illness and may impact the reimbursement to the hospital. Furthermore, since hospitals store more codes than CMS in their systems, some of their consolidated severity-adjusted DRGs will not be the same as those determined by Medicare. This will complicate the monitoring of processed claims.

CMS should increase the capacity of its system to accept more diagnoses and procedure codes prior to the adoption of DRGs that recognize severity of illness

levels, even if making such a system change causes the implementation of the proposed system to be delayed. Otherwise, CMS will not be receiving and reimbursing on a true reflection of the hospital's casemix and SOI.

4. New Technology

Under the consolidated APR-DRG there is not a distinction for new technology. Because new technology is often costly, it will greatly impact the hospitals ability to be reimbursed appropriately for services that require often very expensive technologies (such as implants).

CMS needs to reevaluate this decision and consider either integrating new technologies into the consolidated severity adjusted DRG or creating an add-on payment in these cases.

FINANCIAL IMPACT OF CHANGES

1. Adoption Of Hospital-Specific Relative Cost Values In FY 2007

The projected detrimental financial impact of the change from charge-based to cost-based weights is too large for facilities that perform a significant volume of cardiac, orthopedic, and other surgeries to absorb in a single year. *As a result, CMS should provide for a transition for the use of the cost-based weights. A four-year transition is preferable and consistent with other historical transitions of similar type.*

Providers also need more information to be able to determine that CMS appropriately matched revenue codes with cost centers for the calculation of the cost-based weights. For example, tertiary facilities that perform cardiac surgery may use a cost center that is in the section for "other" ancillary cost centers for a cardiovascular lab. This is a different cost center than line 53 that has the normal EKG services.

2. Implementation Of Consolidated Severity-Adjusted DRGs

a) Affordability Of 3M Software

If 3M Health Information Systems has a monopoly on the programming of the consolidated severity-adjusted grouper, it may be able to charge exorbitant prices for the software. *If the new DRGs are adopted, CMS should insure that the 3M software prices for software, training and implementation*

would be reasonable. Ideally, other vendors in the DRG grouping business should be able to develop a competing product prior to implementation.

b) Unknown Financial Impacts

CMS should not even consider the early adoption of the consolidated severity-adjusted DRGs in FY 2007 for several reasons. First, it has not yet studied how the payments for Medicare indirect education and disproportionate share hospital reimbursement will be affected by the new DRGs. Consequently, the providers have no assurance that the system will be implemented in a budget neutral manner.

Second, CMS has not yet made a financial impact file for the consolidated severity-adjusted DRGs available to the public. As a result, hospitals that currently do not run an APR-DRG grouper do not have the ability to project the impact of the change to the new system without purchasing the expensive MedPAR file data.

CMS should not implement the consolidated severity-adjusted DRGs until after the above financial impact information has been studied by Medicare and made available to the public.

ADMINISTRATIVE BURDEN OF CHANGES

1. Needed Programming For New Grouper

CMS assumes that providers will not have large programming issues because the new grouper runs off of the current claims data that is being submitted and because it uses the same three-digit numbering scheme. However, the reality is that hospitals will have a large administrative burden both to negotiate the purchase of the new grouper and to program all of the required interfaces to make the grouper work properly. The grouping of DRGs for Medicare and Tricare is sensitive logic; this now adds another layer of complexity that will require highly skilled technical resources. Programming and testing takes time, especially because providers already have competing priorities for the programming required for the National Provider Identifier, the new 1500 billing form, the new CMN forms, and the new UB-04 billing form. These current regulatory projects have already depleted our resources to the point that user requested enhancements have been put on hold. This new grouping will severely impact available resources.

CMS should not implement the consolidated severity-adjusted DRGs until two years after the final rule adopting the new DRG system is published. The adoption timeframe should be tied to the final rule and not the proposed rule because

hospitals will not want to purchase a grouper until they are 100% certain that the system will be implemented.

2. Coordination Of Benefit Issues

In the special Open Door Forum conference call on May 5, 2006, CMS indicated that its responsibility is solely to address the payment system for Medicare beneficiaries, and it does not care what happens to other payers who may have adopted the current CMS-DRG system. However, since Medicare is often the secondary payer on claims, the payment methodology used by other insurance carriers is very relevant to the total Medicare budget.

Many payers that currently use the CMS-DRGs will not be able to adopt the consolidated severity-adjusted DRGs at all or will implement the new system several years after Medicare. Consequently, this will require hospitals to determine how to store both the old CMS-DRG as well as the new consolidated severity-adjusted DRG for a single claim. This is also problematic because the 837 only allows for the reporting of a single DRG.

Another issue is that insurance companies that remain on the current CMS-DRG system will eventually have an outdated payment methodology that does not recognize new ICD-9-CM codes or technologies. Again, this could be a problem for CMS since Medicare is the secondary payer for many claims.

Expected reimbursement and contract monitoring systems may need to be updated. How will this affect the Medicare Advantage plans that you deal with?

CMS needs to study the potential impact of the adoption of the consolidated severity-adjusted DRGs in light of the above information. Furthermore, hospitals should be given sufficient time (i.e., at least two years after a published final rule) to determine how to appropriately handle the coordination of benefit issues.

3. Medicare Advantage Plan Issues

Many Medicare Advantage Plans have negotiated contracts that pay the equivalent of Medicare fee for service rates. As a result, those plans will need to adopt the consolidated severity-adjusted DRGs, too.

CMS should not implement the consolidated severity-adjusted DRGs until it has had time to communicate with the Medicare Advantage Plans and provided them with a reasonable timeframe (i.e., two years) to adopt the new DRG system.

4. Needed Education For Coders and Analysts

Because of the major change to the grouper with consolidated severity-adjusted DRGs, providers need time to appropriately educate their Health Information System (i.e., Medical Records) personnel about the new system. Furthermore, this will take time due to the conflicting priority of also having to provide education regarding the future implementation of the ICD-10 system.

In addition, analysts will need to become very familiar with the methodology and differences in the new IPPS as compared to the CMS DRG in order to continue to effectively manage and understand casemix and what it means in terms of patient care, quality of care, and finance. Because the differences in the two grouping methodologies are so great, there will be extensive training that will be needed.

CMS should give hospitals a reasonable amount of time (i.e., at least two years after a published final rule) to allow for the education of Health Information System personnel as well as analysts. In addition, CMS should study the impact of the upcoming change to the ICD-10 system on the proposed consolidated severity-adjusted DRGs. This impact should be reported to the public.

5. Casemix Analysis

If CMS adopts a severity adjusted DRG classification based on proprietary software, hospitals will need to purchase two separate but very similar patient grouping programs (APR-DRG and Severity-adjusted DRG). CMS represents both Medicare and Medicaid populations, and many state Medicaid programs reimburse hospitals using the DRG system and Medicare grouper. Are Medicaid payers prepared to purchase and process claims using the new severity-adjusted DRG grouper?

We realize that Medicare's fundamental concern is a system that accurately measures resource utilization required to treat cases in order to reimburse providers. Hospitals have been utilizing the APR-DRG grouper for analysis and in order to have continuity of data, we will be required to continue purchasing the APR-DRG grouper along with the severity adjusted grouper. This will put additional financial and programming burdens on hospitals.

Current DRG values serve as the mapping source for internal Service Line Grouping used extensively in Case Mix analysis. We will need to define service line mappings for all the new severity-based DRGs.

We will need to regroup all accounts in the Case Mix database using the severity-based DRG grouper. A potential roadblock to doing this regroup successfully is the potential inability for the new grouper to recognize now invalid ICD9 codes, which were used when valid, to code accounts dating back to 1997.

Whatever CMS adopts, I think we'd want the new system fully reflected in the Case

Mix Summary File (DGPACSM) fields with history mass-updated. Parallel systems that may need to continue running (APRDRGs, 'traditional' Medicare DRGs, etc.) would be better stored in new, linkable, subsidiary files.

If CMS adopts a severity based DRG classification based on proprietary software designed by 3M, we encourage them to include diagnostic categorization for all cases including neonates and the pediatric patient population. Because of the overwhelming impact of a change to the consolidated severity adjusted DRGs to casemix management, CMS should consider putting off implementation until two years after the final rule has been published.

Submitter : **Dr. Jesus Lizarzaburu** **Date: 06/08/2006**

Organization : **TPMG**

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,

Jesus L. Lizarzaburu, MD, FAAFP

Submitter : Dr. Jerry Bruggeman **Date:** 06/08/2006

Organization : Dr. Jerry Bruggeman

Category : Individual

Issue Areas/Comments

GME Payments

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Sincerely,

Jerry Bruggeman, MD
Family Physician - Columbia, Missouri

Submitter : Dr. Tim Lessmeier **Date:** 06/08/2006

Organization : Heart Clinics Northwest

Category : Physician

Issue Areas/Comments

DRGs: MCVs and Defibrillators

DRGs: MCVs and Defibrillators

Dear Sirs: I am an electrophysiologist in private practive and would like to comment on your proposed reduction in hospital inpatient payment reductions to cardiac services by 10% with some procedure DRGs decreasing by over 24% (ICDs and Stents) and pacemaker DRGs decreasing by 12-14%. While I don't pretend to understand the medicare system, I believe you will cause significant disruption in cardiac care to medicare patients with these severe abrupt changes which appear to be based on unproven hospital specific relative values and some type of estimated "cost-based" DRGs. I already practice in a state (Washington) that has poor medicare reimbursement (which has never been adjusted relative to other regions). I have little faith that your reimbursement formulas will fairly compensate the hospital based on available data. I believe as a physician it is my job to ensure that my patients get the most appropriate device without cost being the predominant factor. What will my choices be when you impliment this faulty program and who will be responsible for the outcomes? I would like to see a system that fairly reimburses based on long term outcomes and quality care and does so without consuming most of our health care dollars for administration.

Submitter : Dr. Jeff Weinfeld **Date:** 06/08/2006

Organization : Georgetown University Family Medicine Residency

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

As a family physician and residency faculty member, 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,
Jeff Weinfeld, MD
Residency Faculty Member
Family Physician

Submitter : Dr. tina swarm **Date:** 06/08/2006

Organization : forum health

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

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Tina Swarm DO

Submitter : **Dr. Leon Feldman** **Date: 06/08/2006**

Organization : **Desert Cardiology Center**

Category : **Physician**

Issue Areas/Comments

DRGs: MCVs and Defibrillators

DRGs: MCVs and Defibrillators

As a practicing heart rhythm specialist, also known as an electrophysiologist, at a 300 bed hospital located in Rancho Mirage, CA. I am quite concerned Medicare beneficiaries will have limited access to life-saving and life-enhancing cardiac care due to the recently proposed inpatient rule. Technologies such as implantable cardioverter defibrillators are used to prevent sudden cardiac arrest, the nation s number one cause of mortality. Cardiac ablations are used to treat debilitating and life threatening cardiac arrhythmias such as ones that lead to stroke.

The full implementation of the CMS proposed Inpatient Prospective Payment System would have a devastating impact on my hospital s ability to serve patients in my community. These proposed reductions will impact hospital staffing for these critical procedures which will ultimately be translated into reduced patient access and care. CMS and Congress have emphasized the development of quality measures and activities. For example, the recent CMS mandate for hospitals to enroll in the ICD Registry represents personnel the hospital has to dedicate for this important initiative. Without accurate and appropriate reimbursement for these critical services, hospitals will not be able to dedicate resources to important quality improvement initiatives such as this.

I support an accurate hospital payment system and the goal of improving payment accuracy in the DRG system. However, the implementation of these sweeping changes will replace one system with another that has inherent flaws and miscalculations. I am concerned that CMS has used old data that is not reflective of current practice and that the data used from cost reports is not accurate. Additionally, it is troubling to me that significant errors and technical decisions have been made by CMS that exacerbate the problem. It is my understanding that over 200 hospitals were thrown out of the data set including large numbers of academic health centers. This will distort any analysis that CMS conducts. Additionally, CMS failed to adjust for hospital volume of care. The result of this flawed approach is that a small hospital of 50 beds has as much weight in the calculation as a large tertiary care center/academic health center.

Furthermore, CMS has failed to address issues related to charge compression. The rule fails to fix the charge compression problem that has penalized technology-intensive procedures for years. In fact, it makes the situation worse. Instead of increasing specificity to identify actual device costs, the rule lumps costs together into just 10 national cost centers to derive cost-to-charge ratios. Most devices and supplies are in a single cost center. Under this rule, distinctions between procedures - and even hospital departments - are lost.

The goal of the proposal is to improve the accuracy of the current payment system by designing a more refined system than the existing DRGs for grouping patients. CMS proposes to implement a new system based on the severity of the patient s illness in 2008 or earlier. The new CMS-DRG system does not make distinctions based on complexity, so a move in this direction is a good one. However, technologies that represent increased complexity, but not greater severity of illness, also need to be recognized. The payment methodology changes and the DRG severity changes should be implemented together, but there is no way to fairly identify and respond to their joint impact this year.

Thank you very much for your consideration of these comments. On behalf of my patients and the community in which I serve, I thank you and recommend that these changes be deferred so that all stakeholders can better understand the impacts and that CMS devotes the time necessary to get this right.

Sincerely,

Leon A. Feldman, MD

Submitter : Dr. Tyson Ikeda **Date:** 06/08/2006

Organization : UCSD School of Medicine

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

As a family medicine residency program director, 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. 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.

CMS-1488-P-427-Attach-1.DOC

Submitter : Dr. David McInnes **Date:** 06/08/2006

Organization : St. Vincent's Family Medicine Residency

Category : Physician

Issue Areas/Comments

GME Payments

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Sincerely,

David McInnes, MD
Program Director
St. Vincent's Family Medicine Residency Program
Jacksonville, Florida

Submitter : Dr. John Purvis **Date:** 06/08/2006

Organization : Tallahassee Memorial

Category : Physician

Issue Areas/Comments

GME Payments

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Sincerely,
John R. Purvis, M.D.

Submitter : Dr. Michael Sampson **Date:** 06/08/2006

Organization : Virginia College of Osteopathic Medicine

Category : Individual

Issue Areas/Comments

GME Payments

GME Payments

June 8, 2006

To Whom It May Concern:

As a family physician and Department Chair of Family Medicine, I appreciate the opportunity to comment on the
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>Sincerely,

Michael J. Sampson, DO
Department Chair, Family Medicine
Associate Professor, Sports Medicine/OMM
Medical Director, VIATECH Institute for Health and Wellness
Virginia College of Osteopathic Medicine
Team Physician-Virginia Tech

Submitter : Marc McKenna **Date:** 06/08/2006

Organization : Chestnut Hill Family Practicxe Residency

Category : Individual

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.

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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, Marc McKenna, MD

Submitter : **Date: 06/08/2006**

Organization :

Category : **Physician**

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Sincerely,

David Fox M.D.

Submitter : Dr. Thomas Yaeger **Date:** 06/08/2006

Organization : Guthrie Health Family Medicine Residency

Category : Physician

Issue Areas/Comments

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Sincerely,

Submitter : Mr. T. Scott Holder **Date:** 06/08/2006

Organization : T. Scott Holder, M. D.

Category : Physician

Issue Areas/Comments

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Sincerely,

Submitter : **Dr. Jeffrey Smith** **Date: 06/08/2006**

Organization : **Dr. Jeffrey Smith**

Category : **Physician**

Issue Areas/Comments

GME Payments

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Submitter : Mr. Craig Sheagren **Date:** 06/08/2006

Organization : McDonough District Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

Attachment

CMS-1488-P-436-Attach-1.DOC

Attach #436

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

Dear Sir/Madam:

We are a Sole Community Hospital operating 97 Acute Care beds and 16 Skilled Care beds. As a rural hospital, our bottom line is very sensitive to both changes in volumes of services provided and the payment systems we are subjected.

We respectfully request that CMS delay implementation of the new weighting system and the new classification system for a minimum of one year while our industry can assess the new proposal more adequately. We have adjusted reasonably well to a system that has been in place since 1983, but need additional time to be sure that the new system has been developed fairly, accurately and is the best system available to base payments.

Sincerely,

Craig W. Sheagren
Senior Vice-President

Submitter : Dr. Kent Anthony **Date:** 06/08/2006

Organization : San Jacinto Methodist Hospital

Category : Physician

Issue Areas/Comments

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Submitter : **Dr. Reid Blackwelder** **Date: 06/08/2006**

Organization : **Kingsport Family Medicine Residency**

Category : **Physician**

Issue Areas/Comments

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Sincerely,
Reid Blackwelder, MD

Submitter : Dr. Robert Reneker Jr. **Date:** 06/08/2006

Organization : Dr. Robert Reneker Jr.

Category : Physician

Issue Areas/Comments

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Sincerely,

Robert E Reneker Jr., MD

Submitter : **Ms. Janet Gallaspy** **Date: 06/08/2006**

Organization : **The Provider Roundtable**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment.

CMS-1488-P-440-Attach-1.DOC

Attach #1/10

Ardent Health Services, TN
Asante Health System, OR
Avera Health, SD
Carolinas Healthcare System, NC
Community Hospital Anderson, IN
Forrest General Hospital, MS
Health First, Inc., FL
Mercy Medical Center, IA
OhioHealth Corporation, OH
Our Lady of Lourdes Regional Medical Center, LA
Saint Joseph's Hospital, WI
Saint Mary's Hospital, MN
Sisters of Mercy Health System, MO
University Health System, TX
University of Colorado Hospital, CO
White River Medical Center, AR
Vanguard Health Systems, TN

June 9, 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:

The following comments are submitted by the Provider Roundtable (PRT), a provider forum with members from around the country that originated in 2003 for the purpose of providing comments to CMS. PRT members are each involved in implementing and managing the changes imposed by CMS on a daily basis and in a variety of settings. We hope to provide a window to the hospital world and share what we perceive as the impact of CMS proposals on the operational and financial well-being of hospital providers. A list of current PRT members is provided in **Appendix A**.

These comments are made in response to the *Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates; Proposed Rule,* published in the Federal Register on April 25, 2006. In discussions among PRT members, a common concern for all is easily identified. Whether we agree or disagree with individual proposals we all agree that the changes proposed by CMS in the 2007 update to IPPS are so sweeping and radical that hospitals NEED MORE TIME to evaluate the effects and prepare for implementation. Hospitals also have other change initiatives to deal with such as the move to the UB-04 claim form, the change to National Provider Identifiers, and the impending change to ICD-10 to name just a few. While change is an ever present challenge to hospital operations, it is much easier to manage when the change is controlled and well planned with sufficient advance notice.

DRGS: RECLASSIFICATIONS

Cardiac services will see a reduction in reimbursement of approximately 10% across the board with the DRG weights proposed for 2007. When any single hospital service has a large reduction such as this, beneficiaries as well as the providers feel the impact. Equity in payment for all hospitals is a desirable goal but this must be balanced with the need to maintain access to necessary and life saving services.

Healthcare experts note that providers performing high volumes of service have better opportunities for quality outcomes and for effective and efficient services. These changes hurt providers that have invested in high volume quality cardiovascular service lines.

HSRVcc WEIGHTS

The PRT is concerned that the methodology used to set the cost-based weights is not sound. More time and study is needed to develop a means to better calculate the cost-based weights. Any significant change such as proposed with cost-based weights versus charge-based weights should be phased in – at a minimum 25% a year. There is long-standing precedent for CMS to phase-in significant changes to the IPPS system. Changes in wage indices have been phased-in. CMS will create financial difficulties for hospitals by drastically changing payments for significant product lines such as orthopedic surgery and cardiovascular services in one year.

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, 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 the 10 CMS designated cost centers. CMS would then calculate the average cost to charge ratios for each of the cost centers. In making the national calculations, the ratios are not weighted by each hospitals Medicare charges. Some hospitals have higher CCRs than others depending upon their mark ups. The proposal to use the estimated cost base weights, would shift dollars from the surgical DRGs to medical DRGs and thus certain high volume, high technology surgical procedures such as stent and ICD implants along with pacemakers would significantly decrease.

Medical Supplies was 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 was also one of the 10 cost centers utilized in the Cost Center Charge Group for analysis. Per Table A in the April 25th proposed rule, 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.

New treatment methods and/or high resource cases should be considered further. The severity of a patient's condition is not a sole indicator of the number 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.

We do not feel that CMS has supplied the provider community with adequate data to perform the proper analysis 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" system, we believe additional time and resources will be required to make necessary recommendations on best approaches for moving forward. 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.

DRGS: SEVERITY OF ILLNESS

The PRT generally agrees that refining the current DRG system to account for severity of illness is appropriate. However, we stress that any change such as this should be made carefully and with adequate time for hospitals to prepare.

APR-DRGs is a proprietary system developed by 3M and is based on a larger number of diagnoses and procedure codes than CMS used in its analysis. It is likely that the CMS analysis that resulted in the Consolidated APR-DRGs is skewed because the complete data set is truncated and CMS did not use comparable data to what 3M uses for the complete APR-DRGs. CMS should delay Consolidated APR-DRGs until it can analyze complete diagnosis and procedure code data with the implementation of UB04 and the expanded diagnoses and procedure code fields.

Without purchasing the APR-DRG grouper, providers are not fully able to evaluate the impact of these proposed changes. Currently no vendor supports the Consolidated APR-DRGs and there is no available crosswalk from current DRGs to Consolidated APR-DRGs. Providers need a method to evaluate at least a year's worth of data 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.

Many of the other major payers use the Medicare DRG methodology as a template for payment. They may use the Medicare grouper with a differing base rate, 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. CMS needs to partner with providers to evaluate and estimate the total impact before implementing a change to a severity-adjusted system.

Certified coders are in short supply across the nation. The proposed changes will slow the coding of each case and increase competition among hospitals for the already short supply of trained coders. This will serve to increase the cost of hiring coders as well as increase the number of new and untrained coders hired to fill the gaps. Use of coders with little or no training can reduce the accuracy of coding and increase providers' exposure to compliance risks. Slower coding also

means that claims are not billed as quickly. This negatively impacts a hospital's cash flow.

Regarding the discussion under section II-3-c related to 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. Today 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. In most hospitals 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." Many hospitals also ask that coders assign codes to many non-invasive procedures which currently do not affect the DRG. While there may be some providers who improve coding practices, we believe the increase will not be as significant as CMS anticipates. Reimbursement should not be reduced to account for an expected increase in coding accuracy that may not be realized.

Prior to implementation of any severity-adjusted DRG system CMS should conduct nationwide coding and documentation education including education for physicians. Hospital payment under the current DRG system and the proposed Consolidated APR-DRGs is tied to physician documentation. The incentives in this system are backwards – a physician is paid for each day of their services or for their surgery whether or not they properly document signs, symptoms, diagnoses and co-morbidities in the hospital medical record; whereas, the hospital that incurs significant drug, diagnostic testing, nursing and other expenses has its payment limited or denied in some cases, due to the lack of documentation by the physician. Asking hospitals to educate the physicians is burdensome and ineffective. In addition, current hospital budgets do not account for the need to provide intensive training to coders, billers, and others to implement all the changes being proposed.

Hospital providers have long complained that physicians and specialty hospitals "cherry pick" the profitable conditions and payers leaving the full-service hospitals to provide care for the remaining patient population. CMS must support full-service hospitals in this endeavor or there will be no one to provide the less profitable services or to provide care for underinsured patients. Many of the proposed changes in the 2007 IPPS update are made as an attempt to improve the accuracy of IPPS payment and 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;
- 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 QUALITY DATA

The proposed rule would require hospitals to continue to submit data on the original 10 quality data elements and 11 additional expanded data elements. The proposed rule would require hospitals to begin reporting the 11 additional expanded quality data elements retroactively with discharges beginning on or after January 1, 2006. This retroactive reporting requirement will place a significant burden on hospitals, with regard to data collection.

CMS's goal for reporting of quality data should be to move toward concurrent data collection. One of the most significant drawbacks to the quality data is the retrospective nature of the abstracting and data reporting. Hospitals need concurrent data to truly impact the quality of care for patients. In other words, if they know that smoking cessation was not done on a heart failure case within 24 hours of admission, notice can be made so that the counseling can be given before discharge.

Concurrent data collection will require real-time data systems. CMS should sponsor demonstration projects with hospitals that build upon order entry and real-time electronic medical records to capture this information. In this fashion, CMS could lead the way for improved information technology dissemination in hospitals, particularly technology leading to evidence-based medicine and quality of care.

GME PAYMENT

Didactic activities in which residents participate are an integral part of the patient care experience and such resident time should be counted for both IME and DGME payment purposes regardless of the setting. In addition, the proposal 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.

OUTLIER PAYMENT THRESHOLD

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 .09 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 held constant at the FFY 06 level of $ 23,600.

OCCUPATIONAL MIX ADJUSTMENT

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. We request CMS take appropriate steps to ensure hospitals are financially prepared to absorb the impact of this change. 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 some form of 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.

TRANSPARENCY OF HEALTH CARE INFORMATION

CMS should understand that many 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 Charges: As the recent report "A Study of Hospital Charge Setting Practices" by the Lewin Group prepared for MEDPAC pointed out, the methodologies used by hospitals to set and maintain charges are numerous and varied. In light of the different methodologies, posting charges for public view will very likely be confusing to the consumer and they will have a very difficult time comparing "apples to apples." 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

We suggest that with the significant, sweeping changes CMS is proposing for the IPPS in 2007 and 2008, the proposal to require coding of diagnoses as present or not present on admission should be delayed for implementation at a later date. However, if it must be implemented due to statutory requirements then we suggest that CMS fully define when a diagnosis is to be coded as 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? How would a single diagnosis that has 4^{th} or 5^{th} digits that change depending on whether the condition is chronic, acute, or acute on chronic be coded if the patient arrives at the hospital with the chronic condition and then develops an acute exacerbation while in the hospital? These questions may seem simple-minded 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 and if reimbursement is associated with that decision, then it becomes a question for compliance if they decide incorrectly.

CLOSING

The Provider Roundtable 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. Comments are submitted for the Provider Roundtable electronically by Janet Gallaspy, BS, RN, CPUR, CPC-H and questions may be directed to jgallaspy@forrestgeneral.com. A full list of the Provider Roundtable members is included in **Appendix A.** Thank you for your attention.

Sincerely,

Members of the Provider Roundtable

CURRENT LIST OF PROVIDER ROUNDTABLE MEMBERS

Jennifer L. Artigue, RHIT, CCS
Dir. Revenue Mgt, CDM & Medical Records
Our Lady of Lourdes Regional Medical Center
Lafayette, LA

Kathi L Austin, CPC, CPC-H, CCP
Corporate Director Revenue Integrity
Sisters of Mercy Health System
St. Louis, MO

Barbara Bunge, RHIA, CCS, CCS-P
Coding Quality Specialist, HIM
Mercy Medical Center
Cedar Rapids, IA

Kathy Dorale, RHIA, CCS, CCS-P
Director of Health Information Management
Avera Health
Sioux Falls, SD

Janet V. Gallaspy, BS, RN, CPUR, CPC-H
Medical Auditor, Corporate Compliance
Forrest General Hospital
Hattiesburg, MS

Jerry Hill, MA
ChargeMaster Coordinator
University Health System
San Antonio, TX

Marion G. Kruse, BSN, RN, MBA
Director of Clinical Consulting
OhioHealth Corporation
Columbus, OH

Carol Leffeler, RN, BA
CDM Coordinator
White River Medical Center
Batesville, AR.

Monica Lenahan, CCS
Coding Manager
University of Colorado Hospital
Denver, CO

Bonnie Malterer, RHIT, BA
APC Coordinator, Outpatient Coding Supervisor
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Duluth, MN

Yvette Marcan, RN, MA, RHIA, CCS
Clinical Reimbursement Analyst
Health First, Inc.
Melbourne, FL

Ann M. Meehan, RHIA
Corporate AVP, HIM Services
Ardent Health Services
Nashville, TN

Terri Rinker, MT(ASCP), DLM, MHA
Reimbursement Manager
Community Hospital Anderson
Anderson, IN

Valerie A. Rinkle, MPA
Revenue Cycle Director
Asante Health System
Medford, OR

Julie Rodda, RHIT
Revenue Cycle/Reimbursement Coordinator
St. Joseph's Hospital
Marshfield, WI

John Settlemyer, MBA/MHA
Director, Financial Services/CDM
Carolinas Healthcare System
Charlotte, NC

Denise Williams, RN, CPC-H
Corporate CDM Manager
Vanguard Health Systems
Nashville, TN

Submitter : **Date: 06/08/2006**

Organization :

Category : **Individual**

Issue Areas/Comments

GME Payments

GME 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.

Submitter : Mrs. Nancy Blevins **Date:** 06/08/2006

Organization : Nancy Y. Blevins, M. D.

Category : Physician

Issue Areas/Comments

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Sincerely,

Submitter : **Dr. Laura Bowen** **Date: 06/08/2006**

Organization : **ETSU Family Physicians of Kingsport**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Sincerely,

Laura M. Bowen

GME Payments

GME Payments

To whom it may concern

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Sincerely,

Laura M. Bowen, MD
bowen@mail.etsu.edu

Submitter : Dr. james king **Date:** 06/08/2006

Organization : ept of family med, utmb, galveston,tx

Category : Physician

Issue Areas/Comments

GME Payments

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Submitter : Dr. J. J. Carr **Date:** 06/08/2006

Organization : Dr. J. J. Carr

Category : Individual

Issue Areas/Comments

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Submitter : **Dr. Robert Solomon** **Date: 06/08/2006**

Organization : **Montgomery Family Practice**

Category : **Physician**

Issue Areas/Comments

GME Payments

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Sincerely,
Robert A. Solomon MD

Submitter : **Emily Burns** **Date: 06/08/2006**

Organization : **Emily Burns**

Category : **Other Health Care Professional**

Issue Areas/Comments

GME 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,

Emily Burns

Submitter : **Dr. Ayaz Madraswalla** **Date: 06/08/2006**

Organization : **Mansfield 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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Sincerely,

Ayaz T. Madraswalla, MD
President
CT Academy of Family Physicians.

Submitter : **Date: 06/08/2006**

Organization :

Category : **Physician**

Issue Areas/Comments

GME Payments

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Submitter : **Dr. Martin Wieschhaus** **Date: 06/08/2006**

Organization : **SJRMC Medical Center- South Bend**

Category : **Individual**

Issue Areas/Comments

GME Payments

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Sincerely,

Martin F Wieschhaus,MD

Submitter : Mr. Kevin Lofton **Date:** 06/08/2006

Organization : Catholic Health Initiatives

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

Please see attached comment letter from Kevin Lofton, President and Chief Executive Officer of Catholic Health Initiatives

CMS-1488-P-451-Attach-1.DOC

Attach # 151

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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:

Catholic Health Initiatives 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. Catholic Health Initiatives is a faith-based health system that includes 70 hospitals, 43 long-term care, assisted-living and residential units, and five community health service organizations in 19 states.

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.

Catholic Health Initiatives supports 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 hospitals, we would like to comment specifically on the following issues:

HRSV Weights

Catholic Health Initiatives supports a move to cost-based weights but has 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.

Catholic Health Initiatives recommends 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

CMS has proposed a new classification system to reflect severity of illness among patients beginning in FY 2008 or earlier. CMS has proposed adoption of CMS-developed Consolidated Severity-Adjusted DRGs (CS-DRGs) rather than the widely applied All Patients Refined DRG system endorsed by MedPAC. Additional information and further analysis is needed to determine whether the CMS-proposed system, or another classification system, would result in an improved hospital payment system.

Until hospitals have a final GROUPER that can accurately assign the new CS-DRGs, it is difficult to calculate the impact. While we have surrogate methods of calculating the impact, GROUPERs used to calculate payments have changed in the past and minor changes can cause major changes in reimbursement.

We anticipate that for some hospitals the reimbursement changes resulting from new severity adjustments would adjust payments in the opposite direction from reimbursement changes resulting from new cost-based DRG weights. For other hospitals, both changes could be positive or both negative.

We are concerned about the impact of making two major payment changes in two successive years. We are also concerned about the ability of hospitals to adapt to these major changes in PPS in the short time frame proposed.

If the need for and best approach for changing the patient classification system is clearly demonstrated, CMS should simultaneously implement the DRG weight changes and new classification system to provide greater stability and predictability in hospital payments. These changes should not be implemented before FY 2008. A three-year phase-in period with "stop loss" protections should be provided to ensure that redistribution of hospital payments is not unduly disruptive to negatively impacted hospitals.

Catholic Health Initiatives recommends further analysis by CMS to determine if the proposed CS-DRGs, or an alternative patient severity classification approach, would result in more accurate payments. If the effectiveness of, and need for, a new patient classification system is demonstrated, CMS should implement the new DRG system at the same time as the DRG weight changes. A three-year phase-in with "stop loss" protections should be allowed to provide greater stability and predictability in hospital payments. A new patient classification system should not be implemented before FY 2008.

Physician-Owned, Limited Service Hospitals

The DRG changes proposed by CMS seek to address the proliferation of physician-owned, limited service hospitals in response to recommendations from the Medicare Payment Advisory Commission. However, we do not believe that payment changes alone will remove the inappropriate incentives created by physician self-referral to limited-service hospitals. Physicians will still have the ability and incentive to steer financially attractive patients to facilities they own, avoid serving low-income patients, practice similar forms of selection for outpatient services and drive up utilization for

services. We strongly urge CMS to rigorously examine the investment structures of physician-owned, limited-service hospitals.

Catholic Health Initiatives urges CMS to continue the suspension of issuing new provider numbers to physician-owned, limited-service hospitals until the CMS strategic plan has been developed and Congress has had an opportunity to consider CMS' final report on physician-owned, limited service hospitals.

Hospital Quality Data

Catholic Health Initiatives supports expansion of the number of measures to be reported for the Annual Hospital Payment Update. This expansion follows the recommendation of the Institute of Medicine. However, we do have a concern with the timing of the final regulation and the requirement to begin the expanded reporting with January 1, 2006 discharges.

Hospitals are currently abstracting information for quality reporting for the January – March 2006 period with a closing date of mid-July. For those hospitals that have been collecting the "starter set" of 10 quality measures and have not begun abstracting the additional 11 measures, this retroactive requirement may pose an undue monetary and administration burden.

By the time the final rule is published, these hospitals may not have time to go back retrospectively and still meet the data submission deadlines for that period, especially if they need to have their vendor contracts amended to allow for the addition of an entire core measure set. These hospitals may also have difficulty retroactively collecting the second quarter information.

Catholic Health Initiatives recommends that CMS start the reporting period for the expanded quality measures with services provided on or after July 1, 2006.

Critical Access Hospitals

On November 14, 2005, CMS issued interpretive guidelines on the relocation of CAHs as a follow-up to the FY 2006 inpatient PPS final rule that established the "75% test" – serving 75 percent of the same population, providing 75 percent of the same services and employing 75 percent of the same staff – for necessary provider CAHs. The guidelines not only extended the 75% test to *all* CAHs, but also altered the definitions of "mountainous terrain" and "secondary road."

We believe that these guidelines go well beyond the regulations included in the FY 2006 rule that provoked numerous critical responses from individual CAHs and congressional representatives. The "mountainous terrain" and "secondary road" definitions are overly prescriptive and the 75% test does not provide reasonable flexibility based on natural variation in demographics, patient needs distribution patterns, normal employee and board attrition, and necessary changes in services to meet community needs. Rural hospitals that move a few miles are clearly the same providers serving the same communities.

Many CAHs are planning to rebuild in the near future to improve site safety and quality of care by adding fire and smoke barriers, upgrading infrastructure to support utilities and air handling, modernizing telecommunications to support health information technology, or making other essential upgrades. Facilities expect to relocate when they rebuild for a multitude of reasons: to be closer to a highway, to connect to municipal water and sewer, to serve a moving population, or other similar concerns. Such improvements will undoubtedly result in higher quality care, better patient outcomes and more efficient service, yet CMS' guidelines discourage these improvements.

CMS' guidelines will not only impose an unnecessary burden on CAHs, but will preclude many of them from securing financing for needed capital improvements. The hospitals themselves and their lenders cannot risk investing in a hospital that will be unsure of its status until a year after moving.

Almost 60 congressional representatives signed a letter to CMS showing their support for their CAHs and urging changes to these guidelines. We agree with their recommendations and urge establishment of a safe harbor for hospitals relocating within five miles of their existing locations. These providers are not only clearly serving the same communities, but trying to improve the quality of and access to needed health care services. A safe harbor will reduce the administrative burden on not only the hospitals, but CMS and the state survey agencies as well.

Catholic Health Initiatives recommends use of a preliminary approval process by CMS to give assurances that the CAH relocation will be approved if it meets the assertions made in the attestation submitted to CMS. We urge CMS to create a safe harbor for CAHs moving a short distance. We also encourage CMS to make significant changes to the relocation guidelines based on the feedback received from CAHs around the nation.

Value-Based Purchasing

The Deficit Reduction Act of 2005 requires the Secretary to identify by October 1, 2007 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 application of evidence-based guidelines.

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. CMS seeks input on which conditions and which evidence-based guidelines should be selected.

The proposed rule discusses hospital acquired infections as a complication that could trigger higher payments and an area for consideration. Our concern with the selection of hospital acquired infections as a condition for denying additional payment is that the codes currently used in billing data do not accurately distinguish hospital-acquired infections from community-acquired infections.

Even surgical site infections, which should intuitively be accurately identified through administrative data, have proven to be grossly in error when compared to data collected and reviewed by infection control practitioners using Centers for Disease Control and National Infection Surveillance System definitions.

Instead of hospital acquired infections, CMS may want to consider hospital falls with injury and pressure ulcers not present on admission as two conditions that are potentially preventable through use of evidence-based practices.

In any case, we believe that administrative data should not be the sole decider. Just as there is additional data gleaned from records for the core quality measures, we believe that the adverse outcome concept can only be adequately gauged by reviewing the actual record to ensure that the event is accurately captured, and that the appropriate preventive measures were, or were not, followed. Only then would it be reasonable to base reimbursement on the occurrence.

Catholic Health Initiatives recommends that CMS select two "preventable" conditions for additional payment denial that can be most accurately identified as not present upon admission through billing data. Once identified, patient records should be reviewed to determine whether appropriate preventive measures were followed before denying additional payment for the condition.

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

Sincerely,

Kevin E. Lofton
President and Chief Executive Officer

Submitter : Dr. Afshan Malik **Date:** 06/08/2006

Organization : Wichita Falls Family Medicine Residency Program

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.

Submitter : Dr. Michael O'Dell **Date:** 06/08/2006

Organization : North Mississippi Medical Center

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

See attachment

CMS-1488-P-453-Attach-1.DOC

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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. O'Dell, M.D., M.S.H.A.
Director, Family Medicine Residency Center
North Mississippi Medical Center

Submitter : **Dr. Donald Philgreen** **Date: 06/08/2006**

Organization : **Gopper Trinity FAmily Care--Residency Program**

Category : **Physician**

Issue Areas/Comments

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Sincerely,
Donald E. Philgreen, MD

Submitter : Dr. Gabriel Neal **Date:** 06/08/2006

Organization : AAFP

Category : Physician

Issue Areas/Comments

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.

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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 : Dr. Michael McGarry **Date:** 06/08/2006

Organization : Dr. Michael McGarry

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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Sincerely,

Michael E. McGarry, M.D.

Submitter : Dr. sandra argenio **Date:** 06/08/2006

Organization : Dr. sandra argenio

Category : Physician

Issue Areas/Comments

GME Payments

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Submitter : Dr. Tamara McGregor **Date:** 06/08/2006

Organization : UT Southwestern Family Medicine

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.

Submitter : Dr. E. Kevin Heist **Date:** 06/08/2006

Organization : Massachusetts General Hospital

Category : Physician

Issue Areas/Comments

DRGs: MCVs and Defibrillators

DRGs: MCVs and Defibrillators

Re: Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates

As a practicing heart rhythm specialist, also known as an electrophysiologist, at a hospital located in Boston, Massachusetts, I am quite concerned Medicare beneficiaries will have limited access to life-saving and life-enhancing cardiac care due to the recently proposed inpatient rule. Technologies such as implantable cardioverter defibrillators are used to prevent sudden cardiac arrest, the nation s number one cause of mortality. Cardiac ablations are used to treat debilitating and life threatening cardiac arrhythmias such as ones that lead to stroke.

The full implementation of the CMS proposed Inpatient Prospective Payment System would have a devastating impact on my hospital s ability to serve patients in my community. These proposed reductions will impact hospital staffing for these critical procedures which will ultimately be translated into reduced patient access and care. CMS and Congress have emphasized the development of quality measures and activities. For example, the recent CMS mandate for hospitals to enroll in the ICD Registry represents personnel the hospital has to dedicate for this important initiative. Without accurate and appropriate reimbursement for these critical services, hospitals will not be able to dedicate resources to important quality improvement initiatives such as this.

I support an accurate hospital payment system and the goal of improving payment accuracy in the DRG system. However, the implementation of these sweeping changes will replace one system with another that has inherent flaws and miscalculations. I am concerned that CMS has used old data that is not reflective of current practice and that the data used from cost reports is not accurate. Additionally, it is troubling to me that significant errors and technical decisions have been made by CMS that exacerbate the problem. It is my understanding that over 200 hospitals were thrown out of the data set including large numbers of academic health centers. This will distort any analysis that CMS conducts. Additionally, CMS failed to adjust for hospital volume of care. The result of this flawed approach is that a small hospital of 50 beds has as much weight in the calculation as a large tertiary care center/academic health center.

Furthermore, CMS has failed to address issues related to charge compression. The rule fails to fix the charge compression problem that has penalized technology-intensive procedures for years. In fact, it makes the situation worse. Instead of increasing specificity to identify actual device costs, the rule lumps costs together into just 10 national cost centers to derive cost-to-charge ratios. Most devices and supplies are in a single cost center. Under this rule, distinctions between procedures - and even hospital departments - are lost.

The goal of the proposal is to improve the accuracy of the current payment system by designing a more refined system than the existing DRGs for grouping patients. CMS proposes to implement a new system based on the severity of the patient s illness in 2008 or earlier. The new CMS-DRG system does not make distinctions based on complexity, so a move in this direction is a good one. However, technologies that represent increased complexity, but not greater severity of illness, also need to be recognized. The payment methodology changes and the DRG severity changes should be implemented together, but there is no way to fairly identify and respond to their joint impact this year.

Thank you very much for your consideration of these comments. On behalf of my patients and the community in which I serve, I thank you and recommend that these changes be deferred so that all stakeholders can better understand the impacts and that CMS devotes the time necessary to get this right.

Sincerely,

E. Kevin Heist MD PhD

Submitter : **Dr. Sean Mullendore** **Date: 06/08/2006**

Organization : **USAF**

Category : **Physician**

Issue Areas/Comments

GME Payments

GME Payments

As a faculty member in 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.

Sincerely,

(Dr.) Sean T. Mullendore, Maj, USAF, MC
Family/Sports Medicine
Offutt AFB/UNMC Family Medicine Residency
Offutt AFB, NE

Submitter : Dr. Kimberly Krohn **Date:** 06/08/2006

Organization : Dr. Kimberly Krohn

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

As a family medicine residency program director, I appreciate the opportunity to comment on the Centers for Medicare & 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 (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. 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,
Kimberly T. Krohn, MD, MPH, FAAFP

Submitter : Dr. J Brad Lichtenhan **Date:** 06/08/2006

Organization : Dr. J Brad Lichtenhan

Category : Physician

Issue Areas/Comments

GME Payments

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Submitter : Dr. Anne Sly **Date:** 06/08/2006

Organization : Research Family Medicine Residency

Category : Physician

Issue Areas/Comments

GME Payments

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Sincerely,
Anne K. Sly, MD

Submitter : **Dr. Marguerite Picou** **Date: 06/08/2006**

Organization : **Family Medical Clinic**

Category : **Individual**

Issue Areas/Comments

GME Payments

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Sincerely, Marguerite B. Picou

Submitter : Dr. Trinette Moss **Date:** 06/08/2006

Organization : Dr. Trinette Moss

Category : Individual

Issue Areas/Comments

GME Payments

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thank you,

Trinette Moss, M.D.

Submitter : Dr. Arno Loeffler **Date:** 06/08/2006

Organization : Dr. Arno Loeffler

Category : Individual

Issue Areas/Comments

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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. Karen Radley **Date:** 06/08/2006

Organization : Price 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
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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 : Dr. Wei-Ann Lin **Date:** 06/08/2006

Organization : Dr. Wei-Ann Lin

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.

Submitter : **Dr. Janalynn Beste** **Date: 06/08/2006**

Organization : **Dr. Janalynn Beste**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GME Payments

GME Payments

As a family medicine residency program director, 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 CareI firmly

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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,
Janalynn Beste, MD

Submitter : **Date: 06/08/2006**

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.

Submitter : **Dr. Julia Jenkins** **Date: 06/08/2006**

Organization : **Bayfront 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.

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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. Michael Magill **Date:** 06/08/2006

Organization : University of Utah

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

Sirs:

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.

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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,

Michael K. Magill, MD

Submitter : Dr. Mark S Mlcak **Date:** 06/08/2006

Organization : Dr. Mark S Mlcak

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.

Submitter : **Dr. Patricia Lindholm** **Date: 06/08/2006**

Organization : **Fergus Falls Medical Group**

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,

Patricia J. Lindholm, MD

Submitter : Dr. David Nelsen **Date:** 06/08/2006

Organization : University of Arkansas for Medical Sciences

Category : Individual

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).

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Sincerely,

David A. Nelsen, Jr., MD, MS

Submitter : Dr. Jamie Osborn **Date:** 06/08/2006

Organization : Loma Linda Family Medicine Residency

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

As a family medicine residency program director, 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
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Sincerely,
Jamie S. Osborn MD
Program Director
Loma Linda University Family Medicine Residency

Submitter : Dr. gordon rafool **Date:** 06/08/2006

Organization : aafp

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.

Submitter : Dr. Carlos Suarez **Date:** 06/08/2006

Organization : ETSU Physicians of Kingsport

Category : Individual

Issue Areas/Comments

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.

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,

Carlos Suarez MD

Submitter : Dr. Rich Londo **Date:** 06/08/2006

Organization : Univ of Ill College of Medicine at Rockford

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

As a family medicine residency program faculty member, 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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In addition, I cannot conceive of how our program 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,
Rich Londo, M.D.
Assistant Professor of Clinical Family Medicine
University of Illinois College of Medicine at Rockford
Family Medicine Residency

Submitter :

Date: 06/08/2006

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.

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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 : Mr. Lynn Holland **Date:** 06/08/2006

Organization : North Mississippi Health Services, Inc.

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

I am writing in order to comment on the Inpatient Hospital PPS Proposed Rule for 2007 (CMS-1488-P). North Mississippi Health Services is a six-hospital system serving North Mississippi and Northwest Alabama. We provide a wide range of services including significant volumes of cardiovascular services and general surgery. System wide we have 883 licensed beds and 38,000 admissions per year. We are a true rural Integrated Delivery System with one large regional hospital with integrated clinical information systems between hospitals, primary care clinics and school based clinics. The levels of uninsured population in our service area are above the national average and therefore we provide significant levels of charity care.

The proposed inpatient rule is obviously very complex, comprehensive and represents maybe the most significant change in the hospital payment mechanism since the implementation of DRG s.

The principles behind the significant changes which supposedly help the general care and rural hospitals and reduces payments to specialty hospitals are ones we as a company support and believe in. We provide a wide array of services, some that are very profitable, some that are not profitable. Our mission is to continuously improve the health of the people of our region and we believe that mission requires us be a full service healthcare system regardless of the profitability of those services.

The information we have received on the impact of this rule however seems to contradict the idea that the general care hospital will benefit from these changes. Preliminary analysis provided to us by the American Hospital Association estimates that the impact to our system resulting from the HSRVcc (DRG Weights based on cost rather than charges) change would be a loss of reimbursement in excess of $1.8 million. The estimated impact from the change to severity adjusted DRG s is a loss of almost $7.8 million in reimbursement. The total impact of these changes is estimated to be a loss of $9.4 million. Our consolidated income for the fiscal year ended September 30, 2005, was about $18 million. Needless to say the impact of these changes appears to severely impact us.

Obviously, these estimates are preliminary and could be in error, but that s the basic problem we have with the proposed changes. There has not been sufficient time for us to understand the impact and ramifications of the proposed rule and, if these are implemented for 2007, there will not be time to understand them within that time frame as well. The financial impact appears to be more significant than the CMS estimates assume and there are a multitude of operational issues that would require changes in processes, systems, education and training that make implementation of this proposed rule on October 1 impractical and irresponsible.

More importantly, we believe the impact of these changes, as we can determine them today, will jeopardize our ability to provide increasing levels charity care and will jeopardize our ability to continue as a going concern.

Therefore, we oppose these changes in the DRG payment mechanism in their entirety, and request the rule as proposed, not be implemented.

I appreciate your time and consideration.

Lynn Holland
Vice President - Finance
North Mississippi Health Services, Inc.

Submitter : **Dr. Brian Wasson** **Date: 06/08/2006**

Organization : **Family Medical Care 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).

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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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 Wasson, M.D.

Submitter : **Dr. Mark S. Mayfield** **Date: 06/08/2006**

Organization : **Grapevine Health Care Associates**

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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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. Margaret Wiedmann** **Date: 06/08/2006**

Organization : **UIC/ Illinois Masonic Family Medicine 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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Background
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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,

Margaret Wiedmann, MD

Submitter : Dr. Roger Hofford **Date:** 06/08/2006

Organization : Carilion Health System

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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Sincerely,

Roger A. Hofford, M.D.

Submitter : Dr. James E. Dunn **Date:** 06/08/2006

Organization : AAFP

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

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Submitter : Dr. Gulrukh Rizvi **Date:** 06/08/2006

Organization : Dr. Gulrukh Rizvi

Category : Individual

Issue Areas/Comments

GME Payments

GME Payments

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Submitter : Dr. Christopher Stanton **Date:** 06/08/2006

Organization : EPHC

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

I urge the 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."

Submitter : Dr. William Mitchell **Date:** 06/08/2006

Organization : Dr. William Mitchell

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.

Submitter : **Dr. Allan Abbott** **Date: 06/08/2006**

Organization : **private practice physician**

Category : **Individual**

Issue Areas/Comments

GME Payments

GME Payments

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Sincerely,

Allan V. Abbott, MD
Professor of Family Medicine

Submitter : **Sheri Dickstein** **Date: 06/08/2006**

Organization : **Sheri Dickstein**

Category : **Individual**

Issue Areas/Comments

GME Payments

GME Payments

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Sincerely,
Sheri Dickstein, MD

Submitter : **Dr. Kim Georgiou** **Date: 06/08/2006**

Organization : **Dr. Kim Georgiou**

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.

Submitter : **Dr. Gary Morey** **Date: 06/08/2006**

Organization : **individual provider**

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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Gary E. Morey, MD, MBA

Submitter : **Dr. Antoine Mourra** **Date: 06/08/2006**

Organization : **Irvine Family Practice Medical Group**

Category : **Physician**

Issue Areas/Comments

GME Payments

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Sincerely,

A. Mourra, MD

Submitter : **Michael Huff** **Date: 06/08/2006**

Organization : **Michael Huff**

Category : **Individual**

Issue Areas/Comments

GME Payments

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Sincerely,

Michael Huff, M.D.

Submitter : Dr. Rob Kassan **Date:** 06/09/2006

Organization : Dr. Rob Kassan

Category : Individual

Issue Areas/Comments

GME Payments

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Rob Kassan

Submitter : Dr. Asha Subramanian **Date:** 06/09/2006

Organization : Georgetown University Dept of Family Medicine

Category : Health Care Professional or Association

Issue Areas/Comments

GME Payments

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Sincerely,

Asha Subramanian, MD, MPH

Submitter : **Dr. Bradley Fedderly** **Date: 06/09/2006**

Organization : **American Academy of Family Physicians**

Category : **Individual**

Issue Areas/Comments

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Sincerely,

Bradley J. Fedderly, MD
Family Physician
Volunteer Faculty Medical College of Wisconsin

Submitter : **Dr. Erica Weirich** **Date: 06/09/2006**

Organization : **Palo Alto Medical Foundation**

Category : **Physician**

Issue Areas/Comments

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Erica Weirich MD

Submitter : **Dr. Karen Mitchell** **Date: 06/09/2006**

Organization : **Dr. Karen Mitchell**

Category : **Individual**

Issue Areas/Comments

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