Submitter : Dr. Jose Elizondo **Date:** 06/09/2006

Organization : Advocate Illinois Masonic

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".

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

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

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

Sincerely,
Jose Elizondo, MD

Submitter : Ms. Janet Elezian **Date:** 06/09/2006

Organization : Scottsdale Healthcare

Category : Hospital

Issue Areas/Comments

MedPac Update Recommendation

MedPac Update Recommendation

After study and scrutiny of the AHA financial impact analysis, our facility supports the AHA stand that any changes to the weights and classification systems should be adopted simultaneously. We believe this would provide better predictabilty and a smoother transition given the changes that may affect our service lines. Given the magnitude of the changes we support the AHA stand of a one-year delay while the methodology of the proposed DRG-weighting based on hospital costs rather than charges is further evaluated. AHA's stand that the proposed HSRVcc method is flawed should be given time to be evaluated before hasty implementation.

Submitter : **Miss. Kaylene Chlopek** **Date: 06/09/2006**

Organization : **American Academy of Family Physicians**

Category : **Individual**

Issue Areas/Comments

GME Payments

GME Payments

As a student 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,

Kaylene J Chlopek

Submitter : **Dr. Todd May** **Date: 06/09/2006**

Organization : **UCSF Family Medicine Residency Program**

Category : **Physician**

Issue Areas/Comments

GME Payments

GME Payments

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Sincerely,

Todd A. May, MD

Submitter : **Date: 06/09/2006**

Organization :

Category : **Individual**

Issue Areas/Comments

GME Payments

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Sincerely,

Nicolas Hernandez

Submitter : Dr. L. Reed Walker, Jr **Date:** 06/09/2006

Organization : Dr. L. Reed Walker, Jr

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).

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Sincerely,

L. Reed Walker, Jr., MD

Submitter : Dr. Cat Livingston **Date:** 06/09/2006

Organization : OHSU

Category : Individual

Issue Areas/Comments

GME Payments

GME Payments

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Sincerely,

Cat Livingston, M.D.

Submitter : Dr. Joseph Zarlengo **Date:** 06/09/2006

Organization : Dr. Joseph Zarlengo

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

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Submitter : Dr. Gail Dressler **Date:** 06/09/2006

Organization : Gail A. Dressler, MD

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

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Sincerely,

Gail A. Dressler, MD

Submitter : **Mr. Paul Keinarth** **Date: 06/09/2006**

Organization : **Mr. Paul Keinarth**

Category : **Individual**

Issue Areas/Comments

GME Payments

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Submitter : Dr. Todd Brinker **Date:** 06/09/2006

Organization : Mayo Clinic

Category : Individual

Issue Areas/Comments

GME Payments

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Submitter : Dr. Debbi McCaul **Date:** 06/09/2006

Organization : Dr. Debbi McCaul

Category : Individual

Issue Areas/Comments

GME Payments

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Sincerely,
Debbi McCaul

Submitter : Dr. Steven Blair **Date:** 06/09/2006

Organization : Dr. Steven Blair

Category : Physician

Issue Areas/Comments

GME Payments

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

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

Sincerely,

Steven D. Blair, MD

Submitter : Dr. Matthew Finneran **Date:** 06/09/2006

Organization : Dr. Matthew Finneran

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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Matthew P. Finneran, MD

Submitter : **Date: 06/09/2006**

Organization :

Category : **Physician**

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Submitter : **Date: 06/09/2006**

Organization :

Category : **Individual**

Issue Areas/Comments

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Sincerely,

Beth Anne Fox, MD, MPH

Submitter : Dr. Erik Olsen **Date:** 06/09/2006

Organization : Dr. Erik Olsen

Category : Physician

Issue Areas/Comments

GME Payments

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Sincerely,

Erik Olsen

Submitter : **Mr. Matthew Wall** **Date: 06/09/2006**

Organization : **Texas Hospital Association**

Category : **Health Care Professional or Association**

Issue Areas/Comments

EMTALA

EMTALA

June 8, 2006
Attention: CMS-1488-P
RE: EMTALA (Proposed changes published in the April 25, 2006 Federal Register)

Ladies and Gentlemen:
On behalf of the Texas Hospital Association (THA), I appreciate the opportunity to provide the following comments concerning the proposed changes to the EMTALA rules.
Definition of labor
CMS proposes to modify the definition of labor at ' 482.24(b) to expand the scope of personnel who may certify that a woman is in false labor. The change would allow also a certified nurse-midwife or other qualified medical personnel operating under his or her scope of practice, as defined in hospital medical staff bylaws and in State law, to certify that a woman is in false labor.
Before addressing the expanded definition, THA believes that it is important to raise two issues. First, THA questions whether it is necessary to require a certification of false labor. Other clinical conditions such as a heart attack do not require a separate certification under EMTALA. Many clinical conditions that may be difficult to diagnose but that do not require a separate certification. Furthermore, not every woman having contractions is having false labor. For example, she could be undergoing pre-term labor which can be stopped with medication. This lack of certainty makes it unclear whether and when a certification of false labor is appropriate.
The Medicare conditions of participation require the patient s medical record to contain a hospital discharge summary. This discharge summary must contain the outcome of hospitalization, disposition of case, and provisions for follow-up care. Existing requirements already address the documentation of medical conditions and there is no clinical justification for requiring an additional, separate certification for false labor.
The second issue relates to the intent and application of the definition itself. It is confusing to place a directive in a definition. The false-labor certification requirement is contained in the labor definition.
Regarding the proposed expansion of the definition of labor, THA supports the change because it will increase flexibility in the allocation of health care personnel.
Specifically, THA recommends the following:
(1)Ask the EMTALA Technical Advisory Group to assess and advise CMS whether it is necessary to continue to require a separate certification for false labor, when other clinical conditions do not require a separate certification.
(2)If CMS determines that this separate certification requirement should remain, move it to another section of the rules that more clearly identifies it as a directive.
(3)If CMS determines that this separate certification requirement should remain, support allowing a certified nurse-midwife or other qualified medical personnel operating under his or her scope of practice, as defined in hospital medical staff bylaws and in State law, to certify that a woman is in false labor.

Application to Transfers to Hospitals Without Dedicated Emergency Departments
The proposed rules would require a hospital with specialized capability to accept appropriate transfers under EMTALA regardless of whether it has a dedicated emergency department. In the preamble, CMS states that the application of this requirement has been a longstanding policy of CMS. This interpretation is new to many, including THA.
Several types of hospitals generally may not have a comprehensive emergency department nor the capability to accept transfers. These include long-term acute care hospitals, rehabilitation hospitals, and psychiatric hospitals.
THA recommends that CMS work with the EMTALA TAG to clarify the application of the transfer requirements to facilities such as long-term acute care hospitals, rehabilitation hospitals, and psychiatric hospitals that may not have a dedicated emergency department.

Submitter : Dr. Marty Sweinhart **Date:** 06/09/2006

Organization : Dr. Marty Sweinhart

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,

Marty Sweinhart, MD

Submitter : **Date: 06/09/2006**

Organization :

Category : **Individual**

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Submitter : **Dr. Chris Lupold** **Date: 06/09/2006**

Organization : **Dr. Chris Lupold**

Category : **Individual**

Issue Areas/Comments

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Submitter : **Dr. David Solondz** **Date: 06/09/2006**

Organization : **OHSU**

Category : **Physician**

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David K. Solondz, MD

Submitter : Dr. George Bergus **Date:** 06/09/2006

Organization : University of Iowa

Category : Individual

Issue Areas/Comments

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Sincerely, George Bergus, MD, MA-Ed

Submitter : Dr. david myers **Date:** 06/09/2006

Organization : Dr. david myers

Category : Physician

Issue Areas/Comments

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Submitter : Dr. Tim Laird

Date: 06/09/2006

Organization : Dr. Tim Laird

Category : Individual

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

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

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

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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. David Carlson** **Date: 06/09/2006**

Organization : **Dr. David Carlson**

Category : **Individual**

Issue Areas/Comments

GME Payments

GME Payments

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Sincerely,

David Carlson, MD

Submitter : Dr. Fountain

Date: 06/09/2006

Organization : Dr. Fountain

Category : Individual

Issue Areas/Comments

GME Payments

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Submitter : Dr. James R Matthews **Date:** 06/09/2006

Organization : Dr. James R Matthews

Category : Individual

Issue Areas/Comments

GME Payments

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Submitter : Dr. Scott Rand **Date:** 06/09/2006

Organization : Dr. Scott Rand

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

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Submitter :

Date: 06/09/2006

Organization :

Category : Physician

Issue Areas/Comments

GME Payments

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Submitter : **Dr. Shelli Bodnar** **Date: 06/09/2006**

Organization : **Dr. Shelli Bodnar**

Category : **Physician**

Issue Areas/Comments

GME Payments

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Sincerely,
Shelli Bodnar, M.D.

Submitter : Dr. Hugh Taylor **Date:** 06/09/2006

Organization : Dr. Hugh Taylor

Category : Individual

Issue Areas/Comments

GME Payments

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Sincerely,
Hugh Taylor M.D.

Submitter : **Date: 06/09/2006**

Organization :

Category : **Physician**

Issue Areas/Comments

GME Payments

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Submitter : Dr. Christi Wiley **Date:** 06/09/2006

Organization : Northridge Family Practice Medical Group, Inc

Category : Physician

Issue Areas/Comments

GME Payments

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Sincerely,

Dr. Christi L Wiley, MD

Submitter : Dr. Gregg Sherman **Date:** 06/09/2006

Organization : Dr. Gregg Sherman

Category : Physician

Issue Areas/Comments

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Submitter : Dr. Rebecca Dwyer **Date:** 06/09/2006

Organization : Dr. Rebecca Dwyer

Category : Individual

Issue Areas/Comments

GME Payments

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Sincerely,

Rebecca Dwyer, M.D.

Submitter : Dr. Todd Shaffer **Date:** 06/09/2006

Organization : Dr. Todd Shaffer

Category : Individual

Issue Areas/Comments

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This will greatly affect our ability to adequately train primary care physicians in the future. Family physicians are already in short supply and we are on the verge of a huge shortage of physicians to care for the primary needs of our population.

Sincerely,
Todd Shaffer, MD

Submitter : Dr. Asha Kohli **Date:** 06/09/2006

Organization : Dr. Asha Kohli

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".

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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. Lisa Glenn **Date:** 06/09/2006

Organization : Dr. Lisa Glenn

Category : Individual

Issue Areas/Comments

GME Payments

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Submitter : Dr. Susan Fullemann **Date:** 06/09/2006

Organization : Burlingame Family Health Medical Group

Category : Physician

Issue Areas/Comments

GME Payments

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Sincerely,
Susan Fullemann,MD

Submitter : Dr. Chris Schlottmann **Date:** 06/09/2006

Organization : Dr. Chris Schlottmann

Category : Physician

Issue Areas/Comments

GME Payments

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Submitter : Dr. Javier D. Margo, Jr. **Date:** 06/09/2006

Organization : Dr. Javier D. Margo, Jr.

Category : Individual

Issue Areas/Comments

GME Payments

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Submitter : Dr. Helen Williams **Date:** 06/09/2006

Organization : Dr. Helen Williams

Category : Physician

Issue Areas/Comments

GME Payments

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Sincerely,

Helen T. Williams

Submitter : Dr. Tim Vega **Date:** 06/09/2006

Organization : Dr. Tim Vega

Category : Individual

Issue Areas/Comments

GME Payments

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Sincerely,

Tim Vega, M.D.

Submitter : Dr. Elizabeth Chmelik **Date:** 06/09/2006

Organization : Dr. Elizabeth Chmelik

Category : Physician

Issue Areas/Comments

GME Payments

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Submitter : **Date: 06/09/2006**

Organization :

Category : **Individual**

Issue Areas/Comments

GME Payments

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Submitter : Dr. Justin Wheeler **Date:** 06/09/2006

Organization : Oregon Health

Category : Physician

Issue Areas/Comments

GME Payments

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Sincerely,

Justin Wheeler, MD

Submitter : Marci Snodgrass **Date:** 06/09/2006

Organization : UCDMC

Category : Physician

Issue Areas/Comments

GME Payments

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Marci Snodgrass, MD

Submitter : **Date: 06/09/2006**

Organization :

Category : **Physician**

Issue Areas/Comments

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Submitter : lillian leong

Organization : lillian leong

Category : Individual

Date: 06/09/2006

Issue Areas/Comments

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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,

Lillian Leong

Submitter : Dr. fredric leary **Date:** 06/09/2006

Organization : Sts Mary and Elizabeth Medical 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".

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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,
Fredric Leary MD MBA FAAFP

Submitter : **Miss. Candace Basich** **Date: 06/09/2006**

Organization : **Miss. Candace Basich**

Category : **Individual**

Issue Areas/Comments

GME Payments

GME Payments

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

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Sincerely,

Candace Basich

Submitter : **Dr. Darren Farnesi** **Date: 06/09/2006**

Organization : **Encompass Clinical Research**

Category : **Physician**

Issue Areas/Comments

GME Payments

GME Payments

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Sincerely,

Darren Farnesi, MD

Submitter : Dr. Carolyn Rhode **Date:** 06/09/2006

Organization : Dr. Carolyn Rhode

Category : Individual

Issue Areas/Comments

GME Payments

GME Payments

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Submitter : Dr. Bella Carroll **Date:** 06/09/2006

Organization : AAFP

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.
Thank you for your consideration; God bless you.

Submitter : Dr. David Schneider **Date:** 06/09/2006

Organization : Univ TX HSC at San Antonio

Category : Individual

Issue Areas/Comments

GME Payments

GME Payments

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Sincerely,

David Schneider, MD

Submitter : Dr. Dulce Innocenzi **Date:** 06/09/2006

Organization : Dr. Dulce Innocenzi

Category : Individual

Issue Areas/Comments

GME Payments

GME Payments

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Sincerely,

Dr. Dulce Innocenzi

Submitter : Dr. James Vogus **Date:** 06/09/2006

Organization : Private Practice, James B. Vogus, MD

Category : Individual

Issue Areas/Comments

GME Payments

GME Payments

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Sincerely,

James B. Vogus, M.D., FAAFP

Submitter : **Date: 06/09/2006**

Organization :

Category : **Individual**

Issue Areas/Comments

GME Payments

GME Payments

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Sincerely,

Thomas R. Wenstrup MD

Submitter : Dr. Joseph Atkinson **Date:** 06/09/2006

Organization : Dr. Joseph Atkinson

Category : Individual

Issue Areas/Comments

GME Payments

GME Payments

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Joseph P Atkinson MD

Submitter : Dr. Marcel Goldberg **Date:** 06/09/2006

Organization : Dr. Marcel Goldberg

Category : Individual

Issue Areas/Comments

GME Payments

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Sincerely,

Marcel Goldberg, MD

Submitter : Dr. Micaela Wexler **Date:** 06/09/2006

Organization : Dr. Micaela Wexler

Category : Physician

Issue Areas/Comments

GENERAL

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

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,

Micaela Wexler, D.O.

Submitter : Dr. **Date:** 06/09/2006

Organization : Dr.

Category : Individual

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS or the Agency) proposed rule entitled "Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates." 71 Fed. Reg. 23996 (April 25, 2006). I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in "patient care activities." The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

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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. Peter Cho **Date:** 06/09/2006

Organization : Mendocino FamilyCare

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,

Peter Y. Cho, MD
Board-Certified Family Practice

Submitter : **Dr. Kimberly Cafarella** **Date: 06/09/2006**

Organization : **Dr. Kimberly Cafarella**

Category : **Physician**

Issue Areas/Comments

GME Payments

GME Payments

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

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

Background
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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,

Kim Cafarella, MD

Submitter : Dr. Karl Steinberg **Date:** 06/09/2006

Organization : UCSD, Camp Pendleton Naval Hospital

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

In my capacity as a family physician and non-salaried faculty member for two family medicine residency programs, 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. It is my strong belief that there is virtually 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.

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

Once again, 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. Why not just leave well enough alone? Graduate medical education, especially in primary care, has already taken a major hit from lawmakers and as we baby boomers hit our golden years, I fear there won't be enough competent docs to care for us!!

Very sincerely yours,

Karl Steinberg MD
760-414-7263

Submitter : Dr. Hani Sorour **Date:** 06/09/2006

Organization : UT Houston family practice residency program

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

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

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

Submitter : **Dr. Joseph Scherger** **Date: 06/09/2006**

Organization : **University of California, San Diego**

Category : **Physician**

Issue Areas/Comments

GME Payments

GME Payments

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

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

Sincerely,

Joseph E. Scherger, MD, MPH

Submitter : **Andrew Park** **Date: 06/09/2006**

Organization : **Andrew Park**

Category : **Individual**

Issue Areas/Comments

GME Payments

GME Payments

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Sincerely,

Andrew Park

Submitter : **Dr. andrew wallach** **Date: 06/09/2006**

Organization : **Dr. andrew wallach**

Category : **Individual**

Issue Areas/Comments

GME Payments

GME Payments

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Sincerely,

andrew wallach

Submitter : Dr. Clifford Jones **Date:** 06/09/2006

Organization : Dr. Clifford Jones

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,

Clifford Ray Jones, MD

Submitter : **Date: 06/09/2006**

Organization :

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,
Troy Kaji MD

Submitter : Dr. jyoti behl **Date:** 06/09/2006

Organization : UT houston 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).

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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. Mark Galfo **Date:** 06/09/2006

Organization : Dr. Mark Galfo

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

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

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

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

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

Submitter : Dr. Maya Aponte **Date:** 06/09/2006

Organization : California Academy of Family Physicians

Category : Individual

Issue Areas/Comments

GME Payments

GME Payments

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

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Sincerely,

Maya L Aponte, MD

Submitter : Dr. Brian Sugimoto **Date:** 06/09/2006

Organization : Merced Faculty Associates

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

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Sincerely,

Brian Sugimoto, M.D.

Submitter : Dr. Twylla Cox-Sugimoto **Date:** 06/09/2006

Organization : Merced Faculty Associates

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

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Sincerely,

Twylla R Cox-Sugimoto, M.D.

Submitter : **Date: 06/09/2006**

Organization :

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.

Submitter : Dr. Gila Wildfire **Date:** 06/09/2006

Organization : Contra Costa Regional Medical Center

Category : Physician

Issue Areas/Comments

GME Payments

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Submitter : Dr. Charles Booras MD **Date:** 06/09/2006

Organization : Dr. Charles Booras MD

Category : Physician

Issue Areas/Comments

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Submitter : Dr. Gary Hullquist **Date:** 06/09/2006

Organization : J.A.Thomas

Category : Health Care Industry

Issue Areas/Comments

DRGs: Severity of Illness

DRGs: Severity of Illness

It is the inherent complexity of the consolidated system, essentially APR-DRG in nature, that renders the process of DRG assignment only practical through utilization of software available solely from one source--the government contracted entity, 3M Health Information Systems.

Aware of the incredibly obscure and obtuse methodology employed by the APR-DRG system and the voluminous tables required to describe its operation, it appears doubtful that no single issue of the Federal Register would ever be capable of publishing it for hospital use. The APR-DRG system is essentially a black box. Even the CMS modification that "consolidates" a number of severity levels and reduces the total number of DRGs to maintain a three-digit designation admittedly does not dare tamper with the proprietary 18-step severity of illness subclassing process buried within 3M's system.

CMS for FY 2006 introduced an initial effort to address severity within the existing DRG system by allocating 12 cardiac DRGs for recognition of system-specific CCs identified as Major Cardiovascular diagnoses. This is a natural and intuitive approach that can be applied similarly to the remaining MDCs. Rather than use a generalized collection of CCs across all MDCs, system-specific CCs should be identified for each MDC which can be demonstrated to correlate well with both cost and severity-mortality data for a given DRG within each MDC.

There needs to be a separation of severity on admission from severity after admission. The current system makes no such distinction within the recognized list of CCs and consequently provides for the potential of rewarding complications in addition to appreciating comorbidities. While the principal diagnosis, critical to the assignment of both MDC and DRG, must be present on admission, no such requirement is imposed on CCs. In the era of hospital performance and quality initiatives, it is alarming to find post-admission and post-operative complications contributing to increased reimbursement--a positive incentive for a negative outcome.

Separating severity levels from relative weights does address both quality and financial concerns by removing the distortion imposed by each factor on the other. Relative weights should be determined primarily by the principal diagnosis and surgical procedure. System specific comorbidities present on admission should contribute to a composite level of severity for each case based on a tiered set of increasingly high-risk diagnoses such as present in the APR-DRG system. The severity level may then secondarily modify the relative weight. This would produce two reportable values for each case: a relative weight for reimbursement and a severity weight for comparative clinical outcomes performance and quality measurements.

Conclusions

7 Whatever severity-modified system is adopted by CMS, the data elements (code-DRG associations) should be released to all providers consistent with past policy.

7 CMS should provide public dissemination of the Maryland APR-DRG trial results.

7 CMS should provide the health care industry with the list of the other companies they consulted in the analysis of the APR-DRG system beside 3M Health Information Systems.

7 We recommend that CMS not change the DRG system (consolidated, APR or otherwise) for FY2007 because of the insufficient time for preparing to make such extensive changes.

When it does modify the existing system or adopt a new one, CMS should consider the following recommendations:

7 each DRG should be provided with separate values for both cost-utilization and severity-outcome parameters

7 system-specific comorbidities present on admission should be identified for each MDC which correlate well with both cost and severity data.

CMS-1488-P-581-Attach-1.DOC

Attach # 581

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1270-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

June 8, 2006

Comment on FY2007 Proposed Rule for Hospital Inpatient Prospective Payment System

CMS-1270-P
DRGs: Severity of Illness

Adjusting the current DRG system for severity of illness involves a certain amount of conflict between meeting the needs of payers (who strive for appropriate reimbursement aligned with costs) and providers (who likewise desire proper payment while receiving fair characterization of their clinical outcomes through recognition of the true severity of their patient population). Hospital charge data, though traditionally used as a proxy for acuity, does not always parallel severity of illness.

For example, extremely ill patients readily fall within cost extremes. Severity within this patient group may be so high that they do not survive long enough to accrue a significant cost of care; while others linger on through protracted hospital stays and generate enormous financial burdens. Yet the pervasive DRG case-mix index has been widely used to both justify clinical outcomes and reimburse hospitals. This dilemma will always require compromise when indices of case assignment are derived from a single classification methodology.

Ideally, weighted case values tied to reimbursement should be purely derived from financially valid cost-utilization data; and weighted case values representing disease severity should be the product of clinically valid morbidity-mortality data. The APR-DRG system attempts to reconcile these two disparate goals by adjusting the resource-based case weight into three additional severity-based weights. The extent to which it meets the demands of both payers and providers is only now emerging in the state of Maryland and has not yet been reported for widespread analysis and review. The proposed consolidation of certain APR-DRGs only diminishes the severity stratification in favor of eliminating marginal reimbursement differences. Combining two or more severity levels is apparently justified on the bases of insignificant differences in cost without recognition of prevailing differences in severity for the affected DRG subpopulations. This appears to be a loss for the provider's severity adjusted design target and a win for the payer's goal of budget neutrality.

The APR Black Box
It is the inherent complexity of both systems, essentially APR-DRG in nature, that renders the process of DRG assignment only practical through utilization of software available solely from one source--the government contracted entity, 3M Health Information Systems.

Aware of the incredibly obscure and obtuse methodology employed by the APR-DRG system and the voluminous tables required to describe its operation, it appears doubtful that no single issue of the Federal Register would ever be capable of publishing it for hospital use. The APR-DRG system is essentially a black box. Even the CMS modification that "consolidates" a number of severity levels and reduces the total number of DRGs to maintain a three-digit designation admittedly does not dare tamper with the proprietary 18-step severity of illness subclassing process buried within 3M's system.

Expanding Severity

CMS for FY 2006 introduced an initial effort to address severity within the existing DRG system by allocating 12 cardiac DRGs for recognition of system-specific CCs identified as Major Cardiovascular diagnoses. This is a natural and intuitive approach that can be applied similarly to the

remaining MDCs. Rather than use a generalized collection of CCs across all MDCs, system-specific CCs should be identified for each MDC which can be demonstrated to correlate well with both cost and severity-mortality data for a given DRG within each MDC.

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Separating severity levels from relative weights does address both quality and financial concerns by removing the distortion imposed by each factor on the other. Relative weights should be determined primarily by the principal diagnosis and surgical procedure. System specific comorbidities present on admission should contribute to a composite level of severity for each case based on a tiered set of increasingly high-risk diagnoses such as present in the APR-DRG system. The severity level may then secondarily modify the relative weight. This would produce two reportable values for each case: a relative weight for reimbursement and a severity weight for comparative clinical outcomes performance and quality measurements.

Conclusions

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- We recommend that CMS not change the DRG system (consolidated, APR or otherwise) for FY2007 because of the insufficient time for preparing to make such extensive changes.

When it does modify the existing system or adopt a new one, CMS should consider the following recommendations:

- each DRG should be provided with separate values for both cost-utilization and severity-outcome parameters
- system-specific comorbidities present on admission should be identified for each MDC which correlate well with both cost and severity data.

Gary Hullquist, MD Chief Compliance Officer J.A.Thomas and Associates, Inc, Smyrna, Georgia

Joanne Webb, RN Chief Executive Officer, J.A. Thomas and Associates, Inc.

Don Leeper, Vice President of Technology/Physician Services, J.A. Thomas and Associates, Inc.

Submitter : Dr. Lisa Weiss **Date:** 06/09/2006

Organization : Forum Health, Western Reserve Health Care System

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

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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.
Thank you.
Sincerely,
Lisa Weiss, MD
Associate Director Forum Family Medicine Residency
Western Reserve Health Care
Youngstown, OH 44501

Submitter : Dr. Eduardo Gonzalez **Date:** 06/09/2006

Organization : University of South Florida College of Medicine

Category : Physician

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. Nicole Provost **Date:** 06/09/2006

Organization : Dr. Nicole Provost

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 non-hospital setting, such as a physician's office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not "related to patient care".

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

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

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

unreasonable and would add an extremely large and unnecessary administrative burden.

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

Submitter : Dr. Sandra Argenio **Date:** 06/09/2006

Organization : Florida Academy of Family Physicians

Category : Health Care Professional or Association

Issue Areas/Comments

GME Payments

GME Payments

As the President of the Florida Academy of Family Physicians, 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).

Florida ranks 44th in the nation in number of residency programs per population. We presently have only 9 family medicine residencies in Florida. We lost an excellent training program this year when the Shands Jacksonville Family Medicine residency was closed. All of our programs depend strongly on federal funds to support the training of our future Family Physicians. Since our Family Medicine residents spend a significant amount of time in outpatient settings, this CMS rule will have significant impact on our training programs and may potentially jeopardize programs. We in Florida cannot afford to loose any more Family Medicine training programs. Our future and the future health of Floridians depend upon them.

Therefore, on behalf of Florida's 9 family medicine residency programs and our 4,000 members, 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 separate out CMS's newly defined "patient care time" from didactic sessions in which general issues devolve to discussions of particular patients is an exercise in futility. As family physicians, we 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.

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

Thank you for your consideration.

Sandra L. Argenio, M.D.
President
Florida Academy of Family Physicians

Submitter : Dr. Anne Kittendorf **Date:** 06/09/2006

Organization : University of Michigan

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

As a faculty member of a department of family medicine, I
appreciate the opportunity to comment on the Centers for Medicare &
Medicaid Services' (CMS or the Agency) proposed rule entitled "Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates." 71 Fed. Reg. 23996 (April 25, 2006). I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time
spent in didactic activities and time spent in "patient care activities."
The effect of the proposed rule is to exclude medical resident time
spent in didactic activities in the calculation of Medicare direct
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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
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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, Anne L. Kittendorf

Submitter : Dr. Michael Okunj **Date:** 06/09/2006

Organization : University of Florida Movement Disorders Center

Category : Physician

Issue Areas/Comments

DRGs: Neurostimulators

DRGs: Neurostimulators

Dear CMS,

I am pleased you have allowed us to comment on the the neurostimulator DRG expiration.

By introduction let me say that Dr. Foote and I have been performing DBS for many years and we have been involved with hundreds of operations. DBS is an amazing surgery for patients with Parkinson disease and movement disorders.

In order for us to offer this very complex procedure we need to be sure that it is adequately paid and the upcoming change in DRG 001, 002 on the Kinetra system will not be adequate.

The DRG 543 is comparable to DRG 001, and we encourage you to move Kinetra cases to the 543 DRG.

Consolidated DRG's do not take into account the DBS systems, and this should be noted.

Really the issue is simple. If you do not adequately provide a DRG that pays sufficiently, we will not be able to offer DBS, neurosurgeons will not implant DBS, and one of the best therapies we have may be in danger of disappearing.

Large academic centers do many DBS operations, and we are changing people's lives for the better. Please consider allowing us the opportunity to provide this service to our patients.

Thanks for your time,

Michael S. Okun, M.D. and Kelly D. Foote, M.D.
Co-Directors University of Florida Movement Disorders Center

Submitter : Dr. Daniel Leiding **Date:** 06/09/2006

Organization : Bay Pines VA Healthcare System

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

Dear Ma'am or Sir,

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

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

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

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

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

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

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

Sincerely,
Daniel Leiding, MD

Submitter : Dr. Erica Moeller-Ruiz **Date:** 06/09/2006

Organization : Dr. Erica Moeller-Ruiz

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. Timothy Benton **Date:** 06/09/2006

Organization : Dr. Timothy Benton

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).

Submitter : Dr. Jenny Butler **Date:** 06/09/2006

Organization : Dr. Jenny Butler

Category : Individual

Issue Areas/Comments

GME Payments

GME Payments

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

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

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

Sincerely,

Jenny A. Butler, M.D.

Submitter : Dr. paul jackson **Date:** 06/09/2006

Organization : St. Francis Family Medicine

Category : Individual

Issue Areas/Comments

GME Payments

GME Payments

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

Sincerely,

Paul V Jackson MD

Submitter : Dr. Patricia Clancy **Date:** 06/09/2006

Organization : Dr. Patricia Clancy

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

As a family physician who teaches in a volunteer (I.E. barely paid) capacity in a residency training program, I would like 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 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 recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,

Patricia E Clancy MD

Submitter : Dr. Douglas Wadeson **Date:** 06/09/2006

Organization : Dr. Douglas Wadeson

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. Jerry Kirkland **Date:** 06/09/2006

Organization : Family Medicine Associates of Amarillo, P.A.

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. Angela Alfaro **Date:** 06/09/2006

Organization : Winter Haven 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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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. Jose R. Jimenez

Organization : University of Texas Health Center at Tyler

Date: 06/09/2006

Category : Individual

Issue Areas/Comments

GME Payments

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

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.

Jose R. Jimenez M.D.

Submitter : Dr. Michael Bailie

Organization : University of Illinois College of Medicine

Category : Physician

Date: 06/09/2006

Issue Areas/Comments

GME Payments

GME Payments

As a pediatrician, 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,

Michael D. Bailie

Submitter : Dr. Amby Bindra **Date:** 06/09/2006

Organization : Baylor

Category : Individual

Issue Areas/Comments

GME Payments

GME Payments

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

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Submitter : **Dr. Edwin Prevatte** **Date: 06/09/2006**

Organization : **Halifax Medical Center**

Category : **Physician**

Issue Areas/Comments

GME Payments

GME Payments

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

Submitter : Dr. Lisa R Nash **Date:** 06/09/2006

Organization : Family Medicine Residency

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. Donna Potts** **Date: 06/09/2006**

Organization : **St Vincents Family Medicine Center**

Category : **Physician**

Issue Areas/Comments

GME Payments

GME Payments

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Submitter :

Date: 06/09/2006

Organization :

Category : Physician

Issue Areas/Comments

GME Payments

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Submitter : Dr. Susan Howard

Organization : Halifax Medical Center, Daytona Beach, FL

Category : Individual

Date: 06/09/2006

Issue Areas/Comments

GME Payments

GME Payments

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Submitter : Dr. James Walker **Date:** 06/09/2006

Organization : Refugio County Memorial Hospital

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.

Submitter : **Dr. Phillip Rodgers** **Date: 06/09/2006**

Organization : **Department of Family Medicine, Univ. of Michigan**

Category : **Physician**

Issue Areas/Comments

GME Payments

GME Payments

Please see attached file.

Thank you for your time,

Phil Rodgers

CMS-1488-P-606-Attach-1.DOC

#606

June 9, 2006

To Whom It May Concern:

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

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I firmly believe that with the possible exception of extended time for "bench research," there is no residency experience that is not directly related to training our physicians in "patient care". And while the core learning model of graduate medical education (GME) continues to be delivery of care under the supervision of fully-trained faculty physicians, other learning activities—including lectures, seminars, individual skill development, and others—are critical to ensuring excellence in the "patient care" that our residency graduates will ultimately provide to their communities.

Furthermore, I fear that the proposed rule change would dampen educational innovation: if curricula must meet an artificially narrow standard to be viable, we are much less likely to see new learning techniques (such as clinical simulation experiences, telemedicine

platforms, and interactive technologies) blossom into vital tools for 21st century graduate medical education.

And finally, it is very difficult to imagine how my department could administratively ensure compliance with the proposed rule. Where are we to find the funding to pay for the significant staff time that would be needed to monitor each and every learning experience to document its compliance with "patient care" standard? Such requirements are unwieldy and unreasonable, and would and would distract scarce resources from core educational activities in our program.

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 essential value of diverse residency curricula to training the kinds of physicians that all of our communities deserve.

Sincerely,

Phillip E. Rodgers, MD
Assistant Professor
Department of Family Medicine
University of Michigan

Submitter : **Dr. Diane Hudson** **Date: 06/09/2006**

Organization : **Walton County Health Department**

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.

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Submitter :

Date: 06/09/2006

Organization :

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,

Dr. James E. Thompson, MD, FAAFP

Submitter : **Dr. Thomas Felger** **Date: 06/09/2006**

Organization : **St Joseph Family Medicine Residency, South Bend, I**

Category : **Physician**

Issue Areas/Comments

GME Payments

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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, Thomas A. Felger, M.D.

Submitter : Dr. Teresa King MD **Date:** 06/09/2006

Organization : Dr. Teresa King MD

Category : Individual

Issue Areas/Comments

GME Payments

GME Payments

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Submitter : Dr. William Clark **Date:** 06/09/2006

Organization : Mercy Family Medicine Residency

Category : Individual

Issue Areas/Comments

GME Payments

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Sincerely,

William D. Clark, MD

Submitter : Dr. Susan Schayes **Date:** 06/09/2006

Organization : Emory University School of Medicine

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

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Susan Schayes
Division Chief
Division of Family Medicine
Emory University School of Medicine

Submitter : Mr. Anthony Cooper **Date:** 06/09/2006

Organization : Arnot Ogden Medical Center

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

We support many of the goals announced by CMS for the redesign of IPPS. However we are unable to understand the changes that are being made. Some of them seem to indicate that payments are to be made based upon the severity of the illness of the patient as opposed to the resources required to care for that patient. If true, this would seem to be a substantial departure from the original intent of the system and, in our view, potentially a major error. Together with the AHA we urge a one-year delay in enactment of the proposals, that the change in weights and reclassifications be instituted simultaneously and that they be phased in over a three-year period.

Submitter : **Dr. Richard Wozniak** **Date: 06/09/2006**

Organization : **Dr. Richard Wozniak**

Category : **Physician**

Issue Areas/Comments

GME Payments

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Sincerely,
Richard S. Wozniak, MD

Submitter : **Dr. Clara Carls** **Date: 06/09/2006**

Organization : **Hinsdale Family Medicine Residency**

Category : **Individual**

Issue Areas/Comments

GME Payments

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Sincerely,

Clara L Carls, D.O.

Submitter : **Dr. John Speckmiear** **Date: 06/09/2006**

Organization : **Dr. John Speckmiear**

Category : **Individual**

Issue Areas/Comments

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Submitter : Dr. Andrew Eisenberg **Date:** 06/09/2006

Organization : Iron Mountain Medical Center

Category : Physician

Issue Areas/Comments

GME Payments

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Sincerely,

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Submitter : Ms. Marilyn Litka-Klein **Date:** 06/09/2006

Organization : Michigan Health & Hospital Association

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

Please see the attached comment letter regarding the FY 2007 proposed IPPS rule.

Thanks!

CMS-1488-P-618-Attach-1.DOC

#618

MICHIGAN HEALTH & HOSPITAL ASSOCIATION

Advocating for hospitals and the patients they serve.

June 9, 2006

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

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

Dear Dr. McClellan:

On behalf of its 145 member hospitals, the Michigan Health & Hospital Association (MHA) welcomes this opportunity to comment to the Centers for Medicare & Medicaid Services (CMS) regarding the proposed rule to update the Inpatient Prospective Payment System for FY 2007. While the rule, which was published in the April 25, 2006, *Federal Register*, provides a 3.4 percent market basket increase for hospitals that submit data for the ***expanded*** CMS quality measures, we are very concerned about the proposed DRG weight changes that will result in significant underpayments of procedures that utilize expensive implants and the redistribution of Medicare inpatient payments among hospitals throughout the country.

The adequacy of Medicare payments to cover the cost of services provided is crucial for ensuring the future viability of Michigan's nonprofit hospitals. Based on the latest data available, approximately **57 percent** of Michigan hospitals experienced a negative margin on all Medicare services. This represents a 25 percent increase in the number of hospitals that lose money providing services to Medicare beneficiaries when compared to two years earlier. This is very concerning particularly since Michigan's population is aging and the number of Medicare beneficiaries is projected to increase significantly over the next decade. By 2020, the number of Michigan residents who are 65 and older is expected to comprise 16.6 percent of the state's population.

When all payors are aggregated, Michigan hospitals experienced a negative 1.8 percent patient margin, with **85 hospitals**, or **59 percent,** losing money on patient care services. The proposed changes will further threaten the future viability of hospitals and access to healthcare services for Medicare beneficiaries and other residents of the state of Michigan. **We strongly urge the CMS to delay for one year the revision to the DRG weighting system from charges to cost and revise the DRG weight methodology to:**

SPENCER JOHNSON, PRESIDENT
CORPORATE HEADQUARTERS ◆ 6215 West St. Joseph Highway ◆ Lansing, Michigan 48917 ◆ (517) 323-3443 ◆ Fax (517) 323-0946
CAPITOL ADVOCACY CENTER ◆ 110 West Michigan Avenue, Suite 1200 ◆ Lansing, Michigan 48933 ◆ (517) 323-3443 ◆ Fax (517) 703-8620
www.mha.org

- **Eliminate the artificial reductions to DRGs with high cost implants or drugs**

- **Recognize hospital-specific cost-to-charge ratios, vs. national averages, in the cost calculation.**

The MHA believes it is important for the CMS to recognize that the proposed payment changes alone will not remove the inappropriate incentives created by physician self-referral to limited-service hospitals. Below are our key concerns regarding the proposed policy changes:

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

(Federal Register Pages 24004-24049*)*

The CMS is proposing the most significant changes to the calculation of the DRG relative weights since the beginning of the PPS. These changes would result in a dramatic redistribution among both the DRGs and hospitals. For FY 2007, the CMS proposes two major changes: use of hospital-specific relative values (HSRVs) and a modified version of cost-based weights instead of weights based on charges. In addition, the CMS proposes to refine the DRGs to account for patient acuity, with implementation in FY 2008 ***or earlier***.

The revised DRG weights will result in a significant redistribution of Medicare inpatient payments among hospitals. Although on a statewide basis, the FY 2007 CMI changes will have a minimal impact, a recent analysis indicates that the impact for individual hospitals will vary from a decrease of approximately 11 percent for some to an increase of approximately 10 percent for others, depending upon the specific mix of services provided at each hospital. For FY 2007, in general, weights for the medical DRGs are increasing while those for surgical DRGs are decreasing significantly.

The MHA is opposed to the CMS' proposed changes primarily due to a fundamental flaw in the methodology used by the CMS in determining the new relative weights. The CMS inappropriately made the following assumptions:

- A consistent mark-up between hospital ancillary departments, which isn't the case. For example, high-cost surgical implants, such as cardiac stents and artificial hips and knees, typically have a significantly lower mark-up than lower cost items, such as general surgical supplies. This results in distorting the relative weights when charges are converted to cost using the same ratio for all departments, and results in inappropriately reducing the relative weights for the high cost surgical implants.

- A consistent cost-to-charge ratio for all hospitals throughout the country, which also isn't the case. Hospital cost to charge ratios vary widely based on each individual hospital's cost and charge structure. Applying an average cost to charge ratio results in a significant distortion in the calculated hospital cost and the DRGs treated at those hospitals. As a result, hospitals that have a cost to charge ratio higher than the average used by the CMS would have too little cost included in the CMS analysis,

while hospitals with ratios lower than the average used by the CMS would have too much cost included in the CMS analysis.

In addition, the CMS is proposing to implement Consolidated Severity-Adjusted DRGs in FY 2008 *or sooner*. The CMS estimates that the implementation of refined DRGs will, in some instances, offset the impact of the new weighting methodology proposed for FY 2007.

The MHA opposes the proposed recalculation of DRG weights as it is based on flawed methodology and urges the CMS to delay implementation of the revised DRG weighting system. If the CMS is utilizing the same "cost" methodology for establishing the FY 2008 weights under the consolidated severity-adjusted DRGs, those weights are equally flawed. In addition, minor inconsistencies have also been identified in the CMS methodology, such as inclusion of organ acquisition costs in the data used to develop DRG weights. These costs should be excluded.

Long-Term Care Hospital (LTCH) DRGs

The MHA is very concerned about the proposed reweighting of the long-term care hospital (LTCH) DRGs for FY 2007. The projected payment cut of 1.4 percent, due to the re-weighting, in combination with the 7.1 payment cut that will result from the recent LTCH PPS final rule will cause substantial volatility for LTCH providers, and ultimately restrict access for patients needing these services. It would be extremely difficult for any provider group to withstand an 8.5 percent payment reduction. By pursuing these changes, the CMS is misinterpreting MedPAC's estimate of the 2006 Medicare margins for LTCHs and creating an extremely unstable regulatory environment for LTCHs. MedPAC projected a 7.8 percent Medicare margin for LTCHs in 2006 and recommended no market basket update for FY 2007. However, this MedPAC projection does not include two major policy changes that also decrease Medicare margins for LTCHs: the projection excludes the impact of the "25% Rule" limiting payments to co-located LTCHs and the new reductions associated with the LTCH short-stay outlier policy. Therefore, we strongly believe that the CMS has gone too far with this proposal which will reduce Medicare payments even further.

Given these considerations, the MHA urges the CMS to forgo the proposed 1.4 percent cut and instead implement the reweighting in a budget-neutral manner. We believe the CMS should focus on developing further patient and facility criteria for LTCHs to ensure that patients who are clinically suitable continue to have access to the LTCH setting. As a result, we strongly support the CMS' pursuit of a scientific foundation for these expanded criteria and are eager to review the recommendations currently under development by CMS' contractor the Research Triangle Institute.

Update of Standardized Operating Amount

(*Federal Register* pages 24419 – 24420)

Effective Oct. 1, 2006, the CMS is proposing a 3.4 percent annual update for hospitals that submit data on 10 quality indicators involving heart attack, heart failure and pneumonia. Under a provision of the Medicare Modernization Act of 2003 (MMA), hospitals that failed to submit data were to receive a 0.4 percentage point reduction to their payment updates from FY 2005 through 2007. Approximately 98 percent of eligible hospitals submitted the required data and receiving full updates for FYs 2005 and 2006. The Deficit Reduction Act of 2005 (DRA) modified this requirement by increasing the number of quality indicators that hospitals must report to receive the full inflationary update in FY 2007 and beyond. The DRA also increased the negative impact for hospitals that do not report quality data from 0.4 percentage points to 2.0 percent.

To be eligible for a full marketbasket update in FY 2007, the CMS proposes using data submitted by hospitals for the first three calendar quarters of 2005 for the initial 10 quality measures. In addition, the CMS would require hospitals to pledge to submit the full set of 21 quality measures for services retroactively to October 1, 2005. To be considered a reporting hospital, hospitals must continually submit quarterly information on the quality measures and pass the validation process established for FY 2006.

Although the CMS is proposing a full 3.4 percent market basket update for hospitals that submit quality data, the MHA believes this update is inadequate. **Recent data for 1998 to 2006 indicates that on a cumulative basis, hospital costs increased 37.9 percent during which time Medicare payments increased only 19.7 percent, resulting in an estimated payment shortfall of $4.4 billion for Michigan hospitals.** This is particularly alarming given the fact that approximately 57 percent of Michigan hospitals lose money providing services to Medicare patients. Based on the most current data available, the average Medicare margin for Michigan hospitals is just slightly above break-even, at 0.3 percent. On an aggregate basis, it is anticipated that hospitals will experience further deterioration in their Medicare margins during FY 2007, even without the negative impact that some hospitals will experience due to changes included in the FY 2007 inpatient proposed rule. **The continual under-funding by the CMS will further threaten the financial viability of Michigan's nonprofit hospitals and their ability to provide services to Medicare beneficiaries and others.**

As currently proposed, the rule would require hospitals to reopen files from which data have already been abstracted, renegotiate agreements with the vendors that assist them in collecting and processing the required information, and resubmit information to the clinical data warehouse. Such retroactive alterations in the data files are difficult and costly, and open the door for the introduction of many new kinds of errors in the data. To require this reopening of the files makes no sense. **We believe strongly that the CMS should make the data collection on a prospective basis. This could be accomplished by requiring hospitals pledge to submit the relevant data for all 21 measures for patients beginning on or after October 1, 2006, so that it is prospective.**

The MHA believes that it is unconscionable for the CMS to require that hospitals submit data on the 21 expanded quality measures on a retrospective basis for discharges that occurred during the first calendar quarter of 2006. Based on the proposed rule, hospitals will be required to submit this data to the Quality Improvement Organization (QIO) Clinical Warehouse by August 15, 2006. If the IPPS rule is finalized August 1, 2006, hospitals will only have 14 days to abstract the additional data from medical records and submit or risk losing 2.0 percent of their FY 2007 update.

We strongly urge the CMS to select measures only from those used by the HQA for public reporting. In addition, whenever the Secretary intends to expand the set of measures linked to payment, **the CMS should consider publishing the proposal at least one full year prior to the start of the fiscal year.** This would enable hospitals and their vendors to put the necessary data collection processes in place to be able to provide the requested data.

In addition, the MHA urges the CMS to review, on a case-by-case basis, any incidence where a hospital's payment would be put in jeopardy as a result of the validation process. It should allow the hospital to submit information showing that it made a good-faith effort to supply the data warehouse with accurate information so that the public could be informed about the quality of its care. If the hospital has made a good-faith effort, it should receive full payment regardless of whether the data are deemed accurate enough for public display. In addition, the CMS should instruct its QIO data warehouse to accept any significant corrections so that the public can have a full and accurate picture of hospital quality.

Cost Outliers

(*Federal Register* pages 24149 – 24151)

The CMS is proposing to increase the fixed-loss cost outlier threshold from the current $23,600 to $25,530, which represents an 8.2 percent increase. Although a 5.1 percent pool was set aside each year for outlier payments, the CMS estimates that it spent only 4.1 percent for outliers in FY 2005 and that it will spend only 4.7 percent in FY 2006. **As a result, the MHA, the American Hospital Association (AHA) and other state associations believe the increase in the outlier threshold is unwarranted. Due to the fact that the CMS did not spend the entire pool of funds set aside for outlier payments during previous years, the MHA urges the CMS to maintain the outlier threshold at the current level of $23,600, or at a maximum increase it to $24,000, since the AHA's analysis indicates that the estimated fixed-loss amount that would result in payment of the full 5.1 percent outlier pool is $24,000.**

We believe the CMS underspent the funds set aside for outliers by an estimated $3 billion over FYs 2004, 2005 and 2006. **This is a real cut in payments to hospitals that cannot be recouped. If the CMS maintains the threshold at the proposed $25,530, rather than decreasing it to $24,000, we believe that the CMS will again significantly underspend by over $300 million.** We urge the CMS to adopt our recommended methodology to reduce the outlier threshold.

Wage Index Budget Neutrality

The CMS eliminates the critical access hospital (CAH) data from the wage index file it uses to compute the national average hourly wage (NAHW) since they are not paid under the IPPS. For FY 2007, 1,191 CAHs, which represent approximately 24 percent of all inpatient PPS hospitals (as of FY 2000) or 55 percent of all rural hospitals in FY 2000, were eliminated from the file. Because CAHs have lower average hourly wages (AHWs) than the average PPS hospital, the elimination of this data results in overstating the NAHW. While the NAHW has been increasing, the systematic withdrawal of low-wage hospitals has artificially inflated the NAHW to some extent. This artificial increase is included in the negative budget neutrality adjustment that consequently reduces payment, resulting in the national inpatient PPS operating payments being understated by an estimated $1.52 billion over five years (2003-2007). **As a result, the MHA believes that the CMS should apply a positive budget neutrality adjustment in FY 2007 to compensate for the underpayments.** The understatement increases each year as more hospitals become CAHs and more data are eliminated from the wage index data. However, we believe that this could be a one-time adjustment as it is anticipated that few hospitals will convert to CAH status in the future since the necessary provider designation is no longer an option.

Additional Payments for New Technology

(*Federal Register* pages 24068 – 24074)

Due to a lack of cost data for new technologies, the CMS provides additional add-on payments for approved items. To be approved for payment as a new technology, an item must be considered new, be inadequately paid otherwise and represent a substantial clinical improvement over previously available technologies. The cost threshold for new technologies to qualify for add-on payments is the lower of the following:

- 75 percent of the standardized amount (increased to reflect the difference between costs and charges)
- 75 percent of one standard deviation for the DRG involved

In FY 2007, the CMS proposes to retain two of the three existing approved technologies for add-on payments and is considering three additional technologies.

New FY 2007 Applications — The CMS is seeking input on three new technologies under consideration for add-on payments in FY 2007:

- C-Port® Distal Anastomosis System
- X STOP® Interspinous Process Decompression System
- NovoSeven® for Intracerebral Hemorrhage

While C-Port® Distal Anastomosis System was recently approved by the FDA, the CMS is concerned that it may not meet the definition of new, as it is similar to technologies already on the market. However, the CMS suggests that the technology would meet the cost threshold. **The**

MHA recommends that the CMS approve the C-Port® Distal Anastomosis System for the new technology add-on payment.

The CMS believes that the X STOP® Interspinous Process Decompression System meets the newness and cost threshold requirements. However, the CMS does not believe the application sufficiently supports the assertion that it represents a substantial clinical improvement over previous technologies. **The MHA urges the CMS to reconsider its initial decision and to provide new technology payments for X STOP® Interspinous Process Decompression System.**

NovoSeven® for Intracerebral Hemorrhage is not yet FDA-approved for this indication. As a result, the CMS did not discuss its compliance with the requirements for approval. **The MHA urges the CMS to provide new technology payments for NovoSeven® for Intracerebral Hemorrhage** once FDA approval is received.

Graduate Medical Education

***(Federal Register* pages 24107 – 24115)**

The proposed rule makes a number of changes to direct graduate medical education (GME) and indirect medical education (IME), which will impact teaching hospitals.

IME Adjustment — As required by section 502 of the MMA, the CMS reduces the IME payment adjustment multiplier from 1.35 to 1.32. This will reduce the IME adjustment from a 5.55 percent to 5.38 percent.

Exclusion of Didactic Training — The proposed rule states that resident training occurring at non-hospital sites must be related to patient care if a hospital includes time for GME and IME payment purposes. Resident time spent in didactic activities that often occur in associated medical schools, such as educational conferences, journal clubs and seminars, would be specifically excluded. The CMS noted that its statement in a previous letter on this topic "implying that didactic time spent in non-hospital settings could be counted for direct GME and IME ... was inaccurate." The CMS also noted that time spent in these activities could be counted for GME purposes **if** they occur in a hospital; however, the counting prohibition applies for IME payments regardless of where the educational activity occurs.

As a result of "clarifications" issued by the CMS in recent years, in order for a provider to include in its resident FTE count for IME and GME purposes rotations to the nonprovider setting, the provider is required to compensate the nonprovider setting for the cost incurred by the nonprovider setting in teaching and supervision activities. Moreover, the CMS has stated that the provider is required to compensate the nonprovider setting for cost related to the didactic time, not for the time spent in the provision of patient care, since the nonprovider setting already is compensated for the provision of patient care. The proposed rule, therefore, establishes a paradox: The didactic time for which the CMS requires the provider to compensate the nonprovider is the time that the provider cannot include in its FTE count. Accordingly, if a provider does not compensate the nonprovider setting for costs related to didactic time, the

provider should have the right to claim the nondidactic time in its FTE count. We strongly urge the CMS to rescind the purported "clarification" in the proposed rule that excludes medical resident time spent in didactic activities in the calculation of Medicare GME and IME payments. The stated rationale for the exclusion of this time is that it not "related to patient care." This position is contrary to the CMS' position as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include "scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty." We strongly agree with the CMS' 1999 position since the activities cited are an integral component of the patient care activities engaged in by residents during their residency programs. In addition, it would be very difficult to separate time spent at these activities. **As a result, the MHA urges the CMS to withdraw this change in the proposed rule relating to the counting of didactic time for purposes of GME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.**

The proposed rule also includes several minor technical changes relating to documentation requirements, GME aggregation agreements and determination of per resident amounts when teaching hospitals merge.

Although the reduction in the IME payment adjustment for FY 2007 is based upon a statutory change included in the BIPA, the MHA opposes this reduction in IME payments and recommends that the CMS maintain IME payments at the current level. This payment reduction will further threaten the financial viability of Michigan's teaching hospitals. Failure to adequately fund teaching programs will result in closures of these programs, as hospitals cannot continue to operate graduate medical education programs, which are vital to ensuring an adequate supply of future physicians, at a financial loss.

Critical Access Hospitals (CAHs)

On Nov. 14, 2005, the CMS issued interpretive guidelines regarding the relocation of CAHs as a follow up to the FY 2006 IPPS 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."

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, because of seismic safety concerns, or other similar concerns. **Such improvements will undoubtedly result in higher quality care, better patient outcomes and more efficient service, yet the CMS' guidelines discourage these improvements.**

The 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, their hospital districts and their lenders cannot risk investing in a hospital that will be unsure of its status until a year after moving. **The CMS should create a preliminary approval process to give assurances to those involved in the project that the CAH relocation will be approved if it meets the assertions made in the attestation submitted to the CMS.**

We urge the CMS to ensure that a safe harbor be established 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 the CMS and the state survey agencies as well. **We urge the CMS to create a safe harbor for CAHs moving a short distance and to make significant changes to these guidelines.**

Overall Financial Impact of FY 2007 Proposals on Hospitals

According to the CMS impact assessment, the overall changes would provide, on average, a 3.4 percent payment increase to hospitals. Urban hospitals would receive a 3.0 percent average increase, while rural hospitals would receive a 6.7 percent average increase. The CMS estimates that the total impact of these changes for FY 2007 operating payments will result in a $3.3 billion increase over FY 2006.

Although overall, the changes proposed are projected to result in a 3.4 percent payment increase, on average, the MHA is extremely concerned about the major impact of the changes on individual hospitals. While some Michigan hospitals are projected to experience increases of 10 percent, others will experience decreases in their total Medicare inpatient payments, especially those providing services with high cost implants. The unknown impact of the occupational mix adjustment, based on data submitted June 1, adds another level of uncertainty to the hospitals' ability to estimate their Medicare inpatient payments effective October 1, 2006.

OTHER FUTURE CONCEPTS

Health Care Information Transparency Initiative

(Federal Register pages 24120- 24121)

In 2006, the Department of Health and Human Services (HHS) proposes to undertake a new effort to expand the availability of information on health care quality and pricing. The HHS intends to identify several regions in the United States with high health care costs and use its leadership role in health care policy to help lead change in those areas.

The AHA, the Federation of American Hospitals and the Association of American Medical Colleges partnered with the CMS and others to form the Hospital Quality Alliance (HQA). The work of the HQA has led to the voluntary reporting of 21 quality measures on the Hospital

Compare Web site and more measures of hospital quality and patient satisfaction are planned for the future.

While progress has been made in quality transparency, similar information on hospital pricing is less accessible. The proposed rule discusses the CMS perspective on the difficulties in providing information for health care consumers and offers several options to consider. Proposals offered by the CMS include:

- publishing a list of hospital charges, either for every region of the country or for selected regions of the country
- publishing the rates that Medicare actually pays to a particular hospital for every DRG, or for selected DRGs, that could be adjusted to take into account the hospital's labor market area, teaching hospital status and disproportionate share hospital status
- establishing a Medicare condition of participation for hospitals to post prices and/or post their policies for discounts or other assistance for uninsured patients
- posting total Medicare payments for an episode of care — Under this proposal, the CMS could include the costs for an inpatient hospital stay, physician payments (including the surgeon and the anesthesiologist), and payments for post-acute-care services such as those provided in an inpatient rehabilitation facility, SNF or LTCH for a certain service (such as hip replacement).

While the MHA is supportive of moving toward transparency, we believe partial data, or data without adequate explanation, impedes progress. Reporting of hospital payments without standardization for area wage index, DSH, GME and IME payments would provide the consumer with false information on the relative cost of care at different hospitals. The CMS, and Congress, have sound policy for these additional payments. Without standardization, a teaching hospital located in an urban area that treats a significant number of uninsured patients will be viewed as a high cost provider when compared to a community hospital without teaching that treats mainly well-insured patients.

As the CMS has already determined, hospital charges for the same procedure vary widely throughout the country and within states. Publishing this information would not aid consumers as their Medicare coinsurance is based on Medicare payments, not charges. Therefore, the MHA does not support this proposal.

Providing *meaningful* information to consumers about the price of their hospital care is the most significant challenge hospitals, and the CMS, face in increasing transparency of hospital pricing information. Objectives for improving pricing transparency should include:

- Presenting information in a way that is easy for consumers to understand and use;
- Making information easy for consumers to access;

- Using common definitions and language to describe pricing information for consumers;
- Explaining to consumers how and why the price of their care can vary; and
- Encouraging consumers to include price information as just one of several considerations in making health care decisions.

The MHA recommends that the CMS convene a workgroup comprised of representatives from hospitals, the AHA and state associations, and Medicare beneficiaries to identify the core issue to be resolved by the transparency initiative. Once that is identified, the hospital industry can provide valuable input to resolve the problem.

Another option the CMS offered is establishing a Medicare condition of participation to post prices on assistance programs for uninsured. While many hospitals are moving toward transparency in this area, including this as a condition of participation seems punitive and will not resolve the CMS core issue of what hospitals are doing to assist the uninsured. It is important for the CMS to understand that the income level of the uninsured varies by community and charity care policies will also vary. **Therefore, the MHA objects to the CMS expanding the conditions of participation to include posting of prices on assistance programs to the uninsured.**

Although we have learned much about the type of information consumers want about the quality of their health care, we know significantly less about what they want in regard to pricing information. Depending upon whether and how they are insured, consumers need different types of price information as illustrated below:

- **Traditional Insurance.** Because traditional insurance typically covers nearly all of the cost of hospital care, individuals with this type of coverage are likely to want information about what their personal out-of-pocket cost would be if they receive care at one hospital versus another.
- **Health Maintenance Organization (HMO) Insurance**. Individuals who have HMO coverage will have more specific price information needs since they typically face no additional cost for care beyond their premium and applicable deductibles and co-payments. Persons covered by an HMO must agree to use physicians and hospitals that are participating in that HMO plan. As a result, these individuals likely have little, if any need for specific price information.
- **High-Deductible or Health Savings Account (HSA) Insurance.** Individuals with HSAs have more interest regarding price information compare to a typically-insured person since these plans are designed to make consumers more price-sensitive and encourage consumers to be prudent "shoppers" for the care they need. Since a typical plan of this type has a deductible of $2,500, consumers with HSA coverage are likely to be more interested in price information for physician and ambulatory care than for inpatient hospital care.

- **Uninsured Individuals of Limited Means.** Uninsured individuals have limited means to pay for the health care services they receive and need to know how much of their hospital or physician bill they may be responsible for paying. In the case of hospital care, the information these patients need must be provided directly by the hospital, after the hospital can ascertain whether the individual is eligible for state insurance programs of which they were unaware, charity care provided by the hospital, or other financial assistance.

Value-based Purchasing

***(Federal Register* pages 24095 – 24100)**

The DRA required the CMS to develop a plan to implement hospital value-based purchasing (pay-for-performance) beginning in FY 2009. The plan must consider the following issues:

- measure development — the ongoing development, selection and modification process for measures of quality and efficiency in hospital inpatient settings
- data infrastructure and refinement — reporting, collecting and validating of quality data
- incentives — the structure of payment adjustments, including the determination of thresholds for improvements in quality that would substantiate a payment adjustment, the size of such payments and the sources of funding for the payments
- public reporting — disclosure of information on hospital performance

Significant resources already have been invested in the HQA effort and the *Hospital Compare* Web site by all of the participants. Nearly 4,200 hospitals – representing more than 99 percent of all eligible Medicare PPS hospitals and over 600 CAHs – have committed to this process, leading the way by sharing data with their communities and the public. **This is a solid foundation on which we must continue to build, and it should be the foundation for any pay-for-performance program included in legislation. To base the pay-for-performance initiative on the work of a group other than the HQA would be duplicative, wasting significant knowledge and expertise.** We believe that, for now, pay-for-performance initiatives should focus solely on quality improvement.

Incentive approaches to payment should use a system of rewards to increase payments or reduce regulatory burden for successful providers. Because the Medicare inpatient PPS already pays less than the cost of care for more than one-third of hospitals, incentives involving penalties should not be used. Additionally, rewards should be sizeable enough to cover the costs of implementing process changes and allow for reinvestment in quality improvement efforts.

To be effective, **incentive approaches must align hospital and physician incentives,** encouraging all to work toward the same goal of improving quality and providing effective, appropriate care. This is imperative. Incentive approaches rewarding improvement can be

successful only if physician and hospital performance can be successfully aligned, in terms of both performance and finances.

The MHA encourages the CMS to develop a workgroup comprised of industry representatives, including physicians, to develop pay-for-performance measures that will work for all parties. To date, the MHA has identified the following issues:

- **Consistent measurement tools for all hospitals**
- **Demonstrated improvement to patient safety/quality — collecting and reporting data without improvements to patient safety**

Health Information Technology

(*Federal Register* pages 24100 – 24101)

The proposed rule summarizes the CMS-identified benefits of health information technology (IT) and requests comments on the CMS's statutory authority to encourage the adoption and use of health IT, the inclusion of health IT in a value-based purchasing program, and the inclusion of health IT requirements in Medicare's conditions of participation.

The CMS is seeking comments on the following:

- Statutory authority to encourage the adoption and use of HIT;
- The appropriate role of HIT in any value-based purchasing program, beyond the intrinsic incentives of the IPPS, to provide efficient care, encourage the avoidance of unnecessary costs, and increase quality of care; and
- The promotion of the use of effective HIT through hospital conditions of participation, perhaps by adding a requirement that hospitals use HIT that is compliant with and certified in its use of the HIT standards adopted by the Secretary of Health and Human Services.

The MHA encourages the expansion and increased use of IT in healthcare and believes IT improvement would increase the efficiency while improving outcomes within the healthcare system. However, we believe this is an unfunded mandate and that the CMS should provide additional funding specifically for IT improvements in hospitals, similar to funds provided for hospital financing of buildings and equipment. The MHA firmly believes that the CMS should not include health IT in the Medicare conditions of participation (COP) for hospitals.

Hospital-Acquired Infections

(*Federal Register* Page 24100)

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

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

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

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

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

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

The MHA believes the CMS proposal that complications are solely the result of hospital actions is fundamentally flawed. To reduce hospital payments for a condition present upon admission, but not documented, is too punitive. In addition, there is good evidence to suggest that even when reliable science and appropriate care processes are applied in the treatment of patients, not all infections can be prevented. Rather, the MHA recommends that the CMS expand demonstration projects such as the MHA Keystone Center to truly improve patient safety and quality for Medicare and all patients.

Again, the MHA appreciates this opportunity to provide comments to the CMS regarding this proposed inpatient rule and urge you to please take them into consideration. We believe our suggested modifications will result in positive changes for hospitals and the Medicare beneficiaries they serve. If you have questions on this comment letter, please contact me at (517) 703-8603 or mklein@mha.org.

Sincerely,

Marilyn Litka-Klein

Marilyn Litka-Klein
Senior Director, Health Policy

Submitter : Mr. Mike Everson **Date:** 06/09/2006

Organization : Froedtert Hospital

Category : Hospital

Issue Areas/Comments

DRG Weights

DRG Weights

See attached file. Comment Letter Support of AHA & AAMC

FTE Resident Count and Documentation

FTE Resident Count and Documentation

See attached file Comment Letter

CMS-1488-P-619-Attach-1.DOC

CMS-1488-P-619-Attach-2.DOC

#619

VIA ELECTRONIC SUBMISSION

June 8, 2006

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

Dear Administrator McClellan:

Froedtert Hospital welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS or the Agency) proposed rule entitled *"Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates."* 71 Fed. Reg. 23996 (April 25, 2006). We have read both AHA and AAMC's comment letters related to the proposed rule. We would like to go on record of supporting the recommendations they have outlined in their respective letters. With should a dramatic charge in the method of computed the DRG weights, a though analysis and implementation plan should be developed.

Sincerely,

Mike Everson

Mike Everson
Manager of Reimbursement Affairs
Froedtert & Community Health
(414) 805-5947
(414) 805-5941 fax
http://www.froedtert.com

#619

VIA ELECTRONIC SUBMISSION

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:

Froedtert Hospital welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS or the Agency) proposed rule entitled *"Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates."* 71 Fed. Reg. 23996 (April 25, 2006). We strongly urge the Agency to rescind the purported "clarification" in the proposed rule that excludes medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

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.

This would appear as an attempt to further racket down the number of residents the government is willing to pay their fair share of the costs of training residents. As a hospital attempts to manage residents numbers to the caps established in 1996 (or the most recent, reallocated caps), this issue was not addressed.

This was presented as a clarification, which could potentially be retroactively applied. Teaching programs have never been asked tracked resident time in such detail and we are unsure how this would be applied when documentation may not exist. A strict application of this clarification could have far reaching impacts to the financial viability the teaching programs across the country.

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,

Mike Everson

Mike Everson
Manager of Reimbursement Affairs
Froedtert & Community Health
(414) 805-5947
(414) 805-5941 fax
http://www.froedtert.com

Submitter : Dr. Andrew Schechtman **Date:** 06/09/2006

Organization : San Jose - O'Connor Family Medicine Residency

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

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

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

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

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

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

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

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

Sincerely,

Andrew Schechtman, M.D.
Faculty, San Jose-O'Connor Family Medicine Residency Program
Adjunct Clinical Instructor, Stanford University School of Medicine

Submitter : **Dr. Timothy Davlantes** **Date: 06/09/2006**

Organization : **Dr. Timothy Davlantes**

Category : **Physician**

Issue Areas/Comments

GME Payments

GME Payments

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

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

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

Submitter : Rona Stacy **Date:** 06/09/2006

Organization : Eastern Oklahoma Medical Center

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

Not all facilities can afford the services of the 3-M Grouper due to the cost.

CMS nees to 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 disclosurer and the transparency of its casemix grouping and severity adjustment rules. THe propriearyl logis of this system may be disclosed to the government, but it's not likely the same level of transparency will be provided to the 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 pulbic discussion and scrutiny. IT is crucial that the classification systems 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 immediate and sustained decrease in coder productivity. The consequence is a longer revenue cycle. For the past 23 years coders have worked ina 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 the alternatives for the APR DRG System are readily available, there is nothing to indicate that CMS considered any of them for its impact IPPS. FUrther CMS did not conduct a single independent study to determie the impact the implementation of this methodology will have on coding and billing productivity or hospital cash flow especially in the rural areas.

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 informaiton systems modifcations, 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 liekly to be mandated within the next for years.

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

Submitter : Dr. Charles Wright **Date:** 06/09/2006

Organization : Dr. Charles Wright

Category : Individual

Issue Areas/Comments

GME Payments

GME Payments

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

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Submitter : Dr. ROBERT LEE **Date:** 06/09/2006

Organization : Dr. ROBERT LEE

Category : Physician

Issue Areas/Comments

GME Payments

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Sincerely,

Robert Lee

Submitter : Dr. William Crow, Jr. **Date:** 06/09/2006

Organization : Lynchburg Family Medicine Residency (Centra Health

Category : Individual

Issue Areas/Comments

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Sincerely,

William C. Crow, Jr., MD

Submitter : Dr. Kim Stoneking **Date:** 06/09/2006

Organization : Dr. Kim Stoneking

Category : Physician

Issue Areas/Comments

GME Payments

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Submitter : Dr. Saverio Barbera **Date:** 06/09/2006

Organization : Heart Rhythm Consultants of New York

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 200 bed hospital located in Smithtown, NY, 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,

Saverio Barbera MD

Submitter :

Date: 06/09/2006

Organization :

Category : Individual

Issue Areas/Comments

GME Payments

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Submitter : **Dr. Paul Daluga** **Date: 06/09/2006**

Organization : **Dr. Paul Daluga**

Category : **Individual**

Issue Areas/Comments

GME Payments

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Submitter : Ms. Ellen Kugler **Date:** 06/09/2006

Organization : National Association of Urban Hospitals

Category : Hospital

Issue Areas/Comments

Operating Payment Rates

Operating Payment Rates

See attached document

CMS-1488-P-630-Attach-1.DOC

#630

NATIONAL ASSOCIATION OF URBAN HOSPITALS

Private Safety-Net Hospitals Caring for Needy Communities

June 9, 2006

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

Subject: CMS-1488-P
Issue Identifier: Operating Payment Rates

To Whom it May Concern:

I am writing on behalf of the National Association of Urban Hospitals to express our opposition to the increase in the outlier threshold that the Centers for Medicare & Medicaid Services (CMS) has proposed for the Medicare inpatient PPS system for fiscal year 2007. We believe this increase will result in Medicare failing to pay out its statutorily required proportion of PPS funds as outlier payments for fiscal year 2007 and will cause serious harm to hospitals that incur significant costs from legitimate outlier cases.

Medicare Outliers: The Situation Today

Medicare recognizes that some hospital admissions fall so far outside the norms captured by its prospective payment system (PPS) that they must be paid in an entirely different manner. Consequently, it employs a system of what it calls outliers. Under this system, hospital cases involving selected medical services that exceed a specific Medicare cost threshold are reimbursed by Medicare on a cost basis, through additional payments above and beyond the Medicare PPS payment. These cases are known as outliers. While outlier reimbursement is said to be on a cost basis, outlier payments do not actually reimburse providers for the full cost of the care they provide in cases designated as outliers.

In the current fiscal year, the threshold for a qualified case to become a Medicare outlier is $23,600.

Medicare Outliers: The Proposed Change in Regulations

In the proposed fiscal year 2007 Medicare inpatient PPS regulation, CMS calls for raising the outlier threshold for the coming year from the current $23,600 to $25,530.

21351 Gentry Drive • Suite 210 • Sterling, VA 20166 • (703) 444-0989 • Fax: (703) 444-3029
www.nauh.org

Medicare Outliers: NAUH's Objections to the Proposed Policy Changes

NAUH believes that the proposed outlier threshold is too high and will result in Medicare failing to meet its statutory requirement of paying out between five and six percent of its PPS payments as outliers. In 2004, with the outlier threshold at $31,000, outlier payments amounted to only 3.5 percent of PPS payments – well short of the statutory requirement. This year, with the threshold at $23,600, outlier payments are on a pace to constitute only about 4.71 percent of PPS payments – again, well short of the statutory requirement. It stands to reason, we believe, that if Medicare cannot fulfill its statutory minimum of five percent with a threshold of $23,600 this year, it is likely to fall even further from its statutory minimum, not draw closer to it, if that threshold is raised to $25,530 – even allowing for a generous increase in the overall cost of health care services. NAUH believes the outlier threshold should be decreased below the current $23,600, not increased.

Medicare's failure to pay an appropriate level of outliers has serious implications for hospitals. Even when it does pay out to an appropriate level, outlier payments themselves do not adequately compensate hospitals for the extraordinary costs they incur providing care to patients with extraordinary medical problems; they only help cushion the blow of such costs. Compounding this problem is that in today's environment, hospital margins are shrinking like never before, with more and more hospitals suffering negative margins. In some situations, just a few outlier cases can mean the difference between a hospital breaking even or losing money. This is especially true for large, private, non-profit urban safety-net hospitals such as those represented by NAUH because they care for higher proportions of low-income elderly and uninsured patients than other hospitals. Medicare's failure to live up to its statutory requirements has implications for hospitals nation-wide, and NAUH believes that Medicare should live up to its legal obligation to pay out at least the legally required minimum amount of payments as outliers. The threshold proposed for 2007 will not enable Medicare to achieve this goal.

Medicare Outliers: NAUH's Proposed Solution

NAUH believes that CMS's current approach to calculating Medicare's outlier threshold does not work. While NAUH would welcome an opportunity to work with CMS officials to develop a better methodology, we believe the agency's first priority at this time should be to develop a more appropriate threshold for fiscal year 2007 – a threshold that will enable Medicare to meet its statutory obligation. The proposed threshold of $25,530 will not achieve this end and will keep Medicare out of compliance with the statutory requirement yet again.

For this reason, NAUH suggests an interim approach: CMS should use a ratio, based on the current threshold and its likely percentage of overall PPS payouts, to revise the threshold and ensure that outliers constitute at least 5.1 percent of overall PPS payments. This would enable CMS to use projections instead of a formula that clearly is not working and would lead to a decrease, instead of an increase, in the FY 2007 threshold.

An alternative would be to calculate what the outlier threshold would need to be for the current (FY 2006) year to enable outlier payments to account for at least 5.1 percent of Medicare PPS payments and then to use that figure as the FY 2007 threshold.

Yet another alternative would be to calculate an FY 2007 threshold that would result in Medicare expending 5.5 percent of inpatient payments on outliers. Because in recent years outlier payments have fallen short of the statutory requirement of five to six percent, calculating based on a target threshold of 5.5 percent instead of 5.1 percent might improve Medicare's chances of having outlier payments reach the required level.

* * *

We appreciate your attention to the concerns we have expressed about the proposed increase in the Medicare outlier threshold for fiscal year 2007 and welcome any questions you have about our organization, this issue, or our rationale for the positions we have stated in this letter.

Sincerely,

Ellen J. Kugler, Esq.
Executive Director

Submitter : Dr. Richard Branoff **Date:** 06/09/2006

Organization : Halifax Medical Center Family Medicine Residency P

Category : Physician

Issue Areas/Comments

GME Payments

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Submitter : Dr. Kevin Cozzi **Date:** 06/09/2006

Organization : Dr. Kevin Cozzi

Category : Individual

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, 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.

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,
Kevin J. Cozzi

Submitter : Dr. Wesley Nord **Date:** 06/09/2006

Organization : Center for Family Medicine

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-633-Attach-1.DOC

RESPONSE TO FEDERAL REGISTER NOTICE
DUE JUNE 12TH

June 9, 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 Center For Family Medicine in Sioux Falls, SD, 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.

Even practicing physicians hold conferences to discuss both individual patient problems and the generic approach to patient care, and these discussions are an ordinary part of patient care. Separation of these components in the graduate medical education setting is arbitrary, artificial and entirely counter productive.

In addition, I cannot conceive of how any program director 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,

Wesley J. Nord, MD
Associate Director
Sioux Falls, Family Practice Residency
Sioux Falls, SD

Submitter : craig czarsty **Date:** 06/09/2006

Organization : craig czarsty

Category : Individual

Issue Areas/Comments

GME Payments

GME Payments

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

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

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

Residency Program Activities and Patient Care
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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,
Craig W. Czarsty, M.D.

Submitter : Dr. Kent Lee **Date:** 06/09/2006

Organization : Christus St. Joseph Family Medicine Residency

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

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

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

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

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

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

Please remember that residency programs disproportionately serve the Medicaid/Medicare population, and are frequently one of the only resources for care for these populations. As fewer private physicians choose to participate in Medicare and Medicaid, there is a danger that large geographic areas will be left with no provider, if funding changes force closure of primary care residencies.

Funding decisions should enhance this role, not make it less possible, as teaching facilities are often the most effective source of this care.

Kent Alan Lee, MA. MD.

Submitter : **Tracy Hendershot** **Date: 06/09/2006**

Organization : **Tracy Hendershot**

Category : **Individual**

Issue Areas/Comments

GME Payments

GME Payments

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

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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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 future 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 d uring their residency programs.

Submitter : **Ms. Ann Spicer** **Date: 06/09/2006**

Organization : **Ohio Academy of Family Physicians**

Category : **Individual**

Issue Areas/Comments

GME Payments

GME Payments

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

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

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

Sincerely,

Ann M. Spicer, Executive Vice President, Ohio Academy of Family Physicians

Submitter : Dr. Conrad Flick **Date:** 06/09/2006

Organization : Dr. Conrad Flick

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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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,

Conrad L. Flick, MD

Submitter : Dr. James Cooke

Organization : University of Michigan

Category : Physician

Date: 06/09/2006

Issue Areas/Comments

GME Payments

GME Payments

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

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I firmly believe that with the possible exception of extended time for "bench research," there is no residency experience that is not directly related to training our physicians in "patient care". And while the core learning model of graduate medical education (GME) continues to be delivery of care under the supervision of fully-trained faculty physicians, other learning activities including lectures, seminars, individual skill development, and others are critical to ensuring excellence in the "patient care" that our residency graduates will ultimately provide to their communities.

Furthermore, I fear that the proposed rule change would dampen educational innovation: if curricula must meet an artificially narrow standard to be viable, we are much less likely to see new learning techniques (such as clinical simulation experiences, telemedicine platforms, and interactive technologies) blossom into vital tools for 21st century graduate medical education.

And finally, it is very difficult to imagine how my department could administratively ensure compliance with the proposed rule. Where are we to find the funding to pay for the significant staff time that would be needed to monitor each and every learning experience to document its compliance with "patient care" standard? Such requirements are unwieldy and unreasonable, and would distract scarce resources from core educational activities in our program.

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 essential value of diverse residency curricula to training the kinds of physicians that all of our communities deserve.

Submitter : Mrs. Megan Smith **Date:** 06/09/2006

Organization : Ohio Academy of Family Physicians

Category : Individual

Issue Areas/Comments

GME Payments

GME Payments

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

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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,

Megan D. Smith, Director of Communications, Ohio Academy of Family Physicians

Submitter : Mr. Joseph Dougherty **Date:** 06/09/2006

Organization : WVU School of Medicine

Category : Other Health Care Professional

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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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 : Dr. Kim Volz **Date:** 06/09/2006

Organization : Deaconess Family Medicine Residency

Category : Individual

Issue Areas/Comments

GME Payments

GME Payments

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

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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,

K.A. Volz, M.D.

Submitter : **Mrs. Kate Mahler** **Date: 06/09/2006**

Organization : **Ohio Academy of Family Physicians**

Category : **Individual**

Issue Areas/Comments

GME Payments

GME Payments

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

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

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,

Kate Mahler, Director of Meeting Services, Ohio Academy of Family Physicians

Submitter : **Philip Zazove** **Date: 06/09/2006**

Organization : **University of Michigan**

Category : **Physician**

Issue Areas/Comments

GME Payments

GME Payments

As a faculty member in the Department of Family Medicine 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. 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 directly related to training our physicians in "patient care". And while the core learning model of graduate medical education (GME) continues to be delivery of care under the supervision of fully-trained faculty physicians, other learning activities including lectures, seminars, individual skill development, and others are critical to ensuring excellence in the "patient care" that our residency graduates will ultimately provide to their communities.

Furthermore, I fear that the proposed rule change would dampen educational innovation: if curricula must meet an artificially narrow standard to be viable, we are much less likely to see new learning techniques (such as clinical simulation experiences, telemedicine platforms, and interactive technologies) blossom into vital tools for 21st century graduate medical education.

And finally, it is very difficult to imagine how my department could administratively ensure compliance with the proposed rule. Where are we to find the funding to pay for the significant staff time that would be needed to monitor each and every learning experience to document its compliance with "patient care" standard? Such requirements are unwieldy and unreasonable, and would and would distract scarce resources from core educational activities in our program.

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 essential value of diverse residency curricula to training the kinds of physicians that all of our communities deserve.

Submitter : Ms. Emily Pavoni **Date:** 06/09/2006

Organization : Ohio Academy of Family Physicians

Category : Individual

Issue Areas/Comments

GME Payments

GME Payments

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

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

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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 Pavoni, Communications Coordinator, Ohio Academy of Family Physicians

Submitter : Dr. Phillip Disraeli **Date:** 06/09/2006

Organization : Dr. Phillip Disraeli

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. **Date:** 06/09/2006

Organization : Dr.

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. Anne Brewer** **Date: 06/09/2006**

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

Sincerely,
Anne A. Brewer, MD
Associate Director
Stamford Hospital Family Practice Residency

Submitter : **Ms. Erin Jech** **Date: 06/09/2006**

Organization : **Ohio Academy of Family Physicians**

Category : **Individual**

Issue Areas/Comments

GME Payments

GME Payments

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

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Sincerely,

Erin Jech, Meeting Services Coordinator, Ohio Academy of Family Physicians

Submitter : **Dr. lisa clemons** **Date: 06/09/2006**

Organization : **austin medical education program**

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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for removal from TAFP e-mail list, contact kmccarthy@tafp.org

Submitter : Ms. Ellen Kreider **Date:** 06/09/2006

Organization : Ohio Academy of Family Physicians

Category : Individual

Issue Areas/Comments

GME Payments

GME Payments

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

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Sincerely,

Ellen Kreider, Financial Coordinator, Ohio Academy of Family Physicians

Submitter : **Dr. James Herman** **Date: 06/09/2006**

Organization : **Penn State College of Medicie**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

#6152

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 : Ms. Val Lay **Date:** 06/09/2006

Organization : Ohio Academy of Family Physicians Foundation

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,

Val Lay, Executive Director, Ohio Academy of Family Physicians Foundation

Submitter : Mr. Gene Wright **Date:** 06/09/2006

Organization : Upson Regional Medical Center

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

Please see attachment.

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

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

Submitter : Mrs. Marie McCoy McCoy **Date:** 06/09/2006

Organization : Northwest Hospital and Medical Center

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-655-Attach-1.DOC

#655

NORTHWEST HOSPITAL
& MEDICAL CENTER
1550 N 115th St.
Seattle, Washington 98133

6/8/06

Centers for Medicare and Medicaid Services
Department of Health and Human Services

RE: **CMS-1488-P**
Proposed rule, public comment

The following comments are supplied as requested in the proposed rule. Overall this proposal seems to improve the DRG system. The following outlines the 2 areas of concern and I request your review and consideration of the recommendations provided.

DRGs: Severity of Illness (Consolidated Severity – Adjusted DRGs)

1. The proposed timeline. The proposal recommends implementation in October 2007 or earlier.
    a. There is a great deal of work needed by health care organizations to obtain software, make system changes, test and implement. Hospitals are reliant upon various vendors for these efforts and vendors need time to write code and provide products.
    b. Implementation earlier than October 2007 will place extreme pressure on healthcare and vendors with the real possibility of no software support to help the hospitals manage this new process.
2. In addition to the technical component, use of this new coding methodology requires staff training. Hospitals need to be able to evaluate the coding impact of this change. It is possible the greater detail needed in this methodology will decrease coder productivity and place hospitals in a position of needing to increase staff. With coders in short supply, nation-wide, this will be a problem.

Recommendation: Consider implementation date of October 2007 or later.

APR-DRG methodology and software is proprietary. 3M Health Information Systems owns the proposed methodology.

It seems inappropriate for the federal government to eliminate the competitive market place for this software.

1. Health care organizations and insurance companies throughout the nation use various vendors to provide DRG and coding software.
2. Selection of proprietary software by CMS will most likely cause additional health care expenses, loss of current vendor relationships and severely limit or completely eliminate the ability of hospitals to use the market place to help control costs.

3. Has consideration been given to other severity methodologies that are already in the public domain?
    a. Refined DRGs (RDRGs)
    b. Severity-adjusted DRGs (SDRGs)

Recommendation: Do not limit the DRG methodology to proprietary software.

Thank you for considering our feedback on this important and critical rule.

Sincerely;

Marie McCoy, RHIT
Application Analyst
Health Information Management
For: Northwest Hospital and Medical Center

Submitter : **Dr. Alfred Berg** **Date: 06/09/2006**

Organization : **University of Washington**

Category : **Physician**

Issue Areas/Comments

GME Payments

GME Payments

See Attachment

CMS-1488-P-656-Attach-1.DOC

#656

June 9, 2006

ToCMS:

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,

Alfred Berg, MD, MPH
Professor and Chair
Department of Family Medicine
University of Washington
Seattle

Submitter : **Date: 06/09/2006**

Organization :

Category : **Individual**

Issue Areas/Comments

GME Payments

GME Payments

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

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

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

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

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,

Family Medicine Resident

Submitter : Mr. David Wiesman **Date:** 06/09/2006

Organization : Indiana Hospital

Category : Health Care Professional or Association

Issue Areas/Comments

SCH/MDH Changes in Qualification Status

SCH/MDH Changes in Qualification Status

Attached, please find our comments in Microsoft Word format.

CMS-1488-P-658-Attach-1.DOC

#658

June 12, 2006

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

Re: Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates; 71 *Fed. Reg.* 23,996 *et weq.* (Apr. 25, 2006); CMS-1488-P

Dear Sir or Madam:

The Indiana Hospital&Health Association respectfully requests that the Centers for Medicare & Medicaid Services ("CMS") address several ambiguities in its proposal, and modify the proposed reporting requirements for Sole Community Hospitals ("SCH").

SCHs are currently afforded certain benefits because of their defined geographic isolation and their critical importance to the healthcare infrastructure of their communities and their financial vulnerability.

The following comments are in regard to **Mandatory Reporting Requirements for Any Changes in Qualification Status** provisions of the proposed rule.

Current rules provide that an approved classification as a sole community hospital remains in effect without need for reapproval unless there is a change in the circumstances under which the classification was approved. The proposed rule would require a SCH to report to its appropriate CMS Regional Office when the circumstances under which the hospital was approved for SCH status have changed. Although clarifying to whom to report changes, the proposed rule is still ambiguous in that it is not clear whether a change in circumstance that would not disqualify a SCH from retaining that status would still need to be reported. In the case of a hospital that has qualified by virtue of not more that 25 percent of residents or Medicare beneficiaries who become hospital inpatients in the hospital's service area are admitted to other like hospitals located within a 35-mile radius of the hospital, its percentage number would change on a daily basis. To address this issue, we would recommend that an existing SCH would remain qualified for a specified length of time, for example three years, at which time the SCH would be required to determine whether they

still met the criteria for classification as a SCH and self-report any change in their qualification status to the CMS Regional Office.

A defined qualification period would also allow the SCH to effectively plan its activities and budget in a more concrete manner. The proposed rule indicates that after a review by CMS, a hospital's SCH status can be revoked within 30 days. A SCH that has planned and budgeted under the assumption of SCH status could be financially devastated with this limited time period under which to adjust to a new payment status. The defined qualification period would at least add some certainty for a period of time. At a minimum, if a specified period of qualification is not possible, then we would suggest that SCH status would remain in effect for the later of six months or the beginning of the next cost reporting period. This would better enable an affected hospital the opportunity the make some of the adjustments to its planning and budgeting.

We would also suggest that CMS consider looking at more than just a point in time to determine continued qualification status. Again, in the 25 percent example noted earlier, a hospital that is very close to the qualification standard could fall above the standard in one year, while generally meeting the standard in other years. We think it would be reasonable to consider that a hospital meeting the criteria over a three year rolling average period would be deemed to have met the qualification standard. Another possibility would be to deem a hospital that has met the qualifying criteria in two out of the last three years as having met the qualifying criteria.

Again, a hospital meeting the 25 percent criteria is measured against other "like" hospitals located within a 35 mile radius of the hospital. A SCH might not necessarily know if and when a "new" hospital becomes a "like" hospital. For example, a Critical Access Hospital located within the 35-mile radius might lose its CAH status and therefore become a "like" hospital. A SCH might not necessarily know of the change until the CAH is audited by the fiscal intermediary a number of years later.

Finally, we are concerned with the situation where the "circumstances affecting a hospital's SCH classification changes and the hospital does not disclose the information to the CMS Regional Office." A SCH might not know if a CAH loses its CAH status and therefore becomes a "like" hospital. Under this situation the proposal would have CMS "cancel the hospital's SCH designation effective on the earliest discernable date on which the fiscal intermediary can determine that the hospital no longer met the criteria for classification." This proposal would seem to include those situations where there was no knowledge by the hospital that a circumstance had changed, for example, the above noted situation where a CAH loses its CAH-status. While we agree that in those cases where a hospital knowingly withholds information in order to retain its SCH status, a severe penalty should be forthcoming, we do not agree that a circumstance that is unknown to a hospital should possibly result in multiple years of reimbursement recovery. This is another reason why a defined qualification period with periodic submission of qualification information would be desirable.

Thank you for providing this opportunity to comment on this portion of the proposed rule. Please feel free to call me at 317/423-7741 if you have any questions about these comments.

Very truly yours,

David Wiesman

David H. Wiesman
Vice President

Submitter : Dr. **Date:** 06/09/2006

Organization : Dr.

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

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

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

Background

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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 : David Serle **Date:** 06/09/2006

Organization : David Serle

Category : Other Health Care Professional

Issue Areas/Comments

GME Payments

GME Payments

As an Administrator of Residency Programs, 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.

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,

David M. Serle

Submitter : **Dr. Brian Bacak**

Organization : **Rose Family Medicine**

Category : **Physician**

Date: 06/09/2006

Issue Areas/Comments

GME Payments

GME Payments

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

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

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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.

Additionally, with new CMS emphasis on quality and patient safety, the direct link between time spent on education and its contribution to safe direct patient care is even stronger. This time can not be separated out and putting Graduate Medical Education funding at risk in an attempt to separate this out is dangerous and an exercise in futility.

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 Bacak, MD

Submitter : Dr. Shawn Sutton **Date:** 06/09/2006

Organization : Concord Family Medicine, Concord Hospital

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

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

I strongly urge CMS to rescind the language in the proposed rule that
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payments (regardless of setting), and for DGME payments when the
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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,

Shawn Irene Sutton, MD

Submitter : Dr. Frank Lang **Date:** 06/09/2006

Organization : Dr. Frank Lang

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,

Frank J. Lang, Jr. M.D.

Submitter : Dr. Stephen Richards **Date:** 06/09/2006

Organization : Dr. Stephen Richards

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

The proposed changes to what physicians canbe reimbursed for in providing training to family practice residents would be devasting to the future of family practice residency programs. This comes at a time when the need for physicians who do chronic disease management is increasing. CMS itself is pushing toward pay for preformance programs that will reward physicians who do better jobs of providing care to diabetics, congestive heart failure and copd. It is family physicians who are best trained and capable of providing this valuable and cost effective care.

Please reconsider rule changes that will "rob peter to pay paul".

Submitter : Mr. James Caldas **Date:** 06/09/2006

Organization : Washington Hospital Center

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-665-Attach-1.DOC

#665

Washington
Hospital Center

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

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

Dear Administrator McClellan:

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

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

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

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

Sincerely,

James F. Caldas
President

Submitter : **Ms. Barbara Hart** **Date: 06/09/2006**

Organization : **Sentara Healthcare**

Category : **Other Health Care Professional**

Issue Areas/Comments

DRG Reclassifications

DRG Reclassifications

My concern is about the time frame for implementation of the proposed changes to the DRG system. Having just heard about it at the end of May, I do not feel that implementation (even partially) by October 1, 2006 is a realistic date from an educational standpoint. 1) We have >50 coders to be trained in the new methodology plus half that many concurrent documentation specialists. They cannot all be trained at once because of interruptions to the work flow. 2) Encoder vendors will have to update their software in a short amount of time. 3) We have to test the software to be sure it works appropriately. 4) I am concerned about the financial impact on the hospitals of switching systems without proper education beforehand. My preference would be to delay implementation of the APRDRG system until October 2007. I do think that the change will be more reflective of the actual situations of each patient. Barbara Hart, RHIA, CCS, TC Coding Educator, Sentara Healthcare

Submitter : **Dr. Katherine Miller** **Date: 06/09/2006**

Organization : **Dr. Katherine Miller**

Category : **Physician**

Issue Areas/Comments

GME Payments

GME Payments

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

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

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

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

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

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

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

Sincerely,

katherine miller md

Submitter : Dr. David Anthony **Date:** 06/09/2006

Organization : Memorial Hospital of Rhode Island

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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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,

David Anthony, MD

Submitter : Mr. Peter Davis **Date:** 06/09/2006

Organization : St Joseph Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

I would like to support the decision made by CMS and don't see the need for a delay!
Thank you

Submitter : Dr. Roy Chew **Date:** 06/09/2006

Organization : Grandview Medical Center

Category : Hospital

Issue Areas/Comments

Impact Analysis

Impact Analysis

I have attached a letter outlining our deep concerns about these proposed changes.
Sincerely,
Roy Chew, PhD
President
Grandview Medical Center

CMS-1488-P-670-Attach-1.DOC

#670

June 8, 2006

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

Re: Medicare Program; Proposed Changes to the Hospital Inpatient PPS and Fiscal Year 2007 Rates; Proposed Rule

Dear Dr. McClellan:

On behalf of Grandview Medical Center and the Kettering Medical Center Network, I appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) proposed rule on the FY'07 Medicare Inpatient Prospective Payment System (IPPS) published in the April 25, 2006 *Federal Register*. Given the complexities of CMS' proposal to revise the diagnosis-related group (DRG) system and the magnitude of impact this could have on our hospital network we are writing to urge a one-year delay in implementing these policy proposals.

CMS proposes to move from the historical charge-based DRG system to a cost-based system and to implement hospital-specific relative weights by October 1, 2006. CMS also proposes modifying the DRG classification system to account for differences in patient severity and allow for a payment amount that more closely tracks the cost of providing care. In its proposal, CMS states that it would replace the current 526 DRGs with either the proposed 861 consolidated severity-adjusted DRGs by FY'08 or a similar system that accounts for the level of patient severity, developed in response to public comments that it receives.

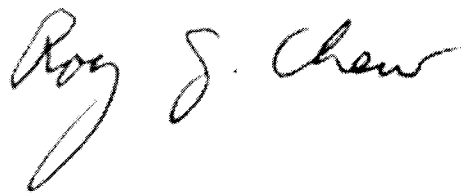
Grandview Medical Center and the Kettering Medical Center Network supports meaningful improvement to Medicare payments for inpatient services and applauds the tremendous effort CMS has put forth to devise a DRG system that more accurately reflects the costs of providing inpatient services. We recognize that your agency has taken these steps to make payments fairer to hospitals and to assure beneficiary access

to services in the most appropriate setting. In the proposed rule, CMS seeks input on the proposed methodologies and solicits alternatives to the consolidated severity-adjusted DRG model. While we welcome the opportunity to work with CMS and other stakeholders in ensuring that any system implemented accomplishes the stated goals, we are extremely concerned with the tight timeline provided for developing comments and the implementation dates outlined in the proposal. Restructuring the DRG system as proposed in the rule would represent the most significant policy change to the IPPS since its inception. A change of this magnitude warrants a thoughtful and thorough review by hospitals, a task not easily accomplished during a 60-day comment period, given the complexity of the proposals.

As such, we strongly urge CMS to delay implementing both the proposed DRG reclassification and the changes to the relative weights until FY'08. The additional time will allow Grandview Medical Center and the Kettering Medical Center Network and other hospitals to more thoroughly evaluate the proposals and offer constructive feedback to your agency.

Again, thank you for the opportunity to share our comments on the DRG provisions of the proposed IPPS rule.

Sincerely,



Roy G. Chew, PhD
President
Grandview Medical Center

Submitter : Dr. J. Summer Liston **Date:** 06/09/2006

Organization : Oregon Health and Sciences University

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

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

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

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

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

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

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

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

Sincerely,

J. Summer Liston, MD
Family Medicine Resident
Oregon Health and Sciences University
Portland, OR

Submitter : Dr. Scott Levin **Date:** 06/09/2006

Organization : West Suburban Medical Center

Category : Individual

Issue Areas/Comments

GME Payments

GME Payments

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

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.

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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,

Scott A. Levin, MD
Program Director
West Suburban Medical Center
Family Medicine Residency Program

Clinical Associate Professor of Family Medicine
Family Medicine Clerkship Director
Loyola Stritch School of Medicine

Submitter : Dr. Daniel Wells **Date:** 06/09/2006

Organization : Sutter Health -Sac Sierra Region

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

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

Sincerely,

Dr. Daniel Wells

Submitter : Dr. Jeff Friedman **Date:** 06/09/2006

Organization : Family Care Physicians, LLP

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

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

Submitter : Dr. Robert Nicewander **Date:** 06/09/2006

Organization : RIAFP

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. The financial support of quality Family Medicine training is essential to building a quality, primary-care based system, available to all.

Sincerely,
R.Kurt Nicewander, M.D. FAAFP,CABFP

Submitter : Richard Young **Date:** 06/09/2006

Organization : Richard Young

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 : **Douglas Pile** **Date: 06/09/2006**

Organization : **Douglas Pile**

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,

Douglas D. Pile, M.D.

Submitter : **Mr. Halsey Bagg** **Date: 06/09/2006**

Organization : **Mohawk Valley Heart Institute**

Category : **Hospital**

Issue Areas/Comments

DRG Weights

DRG Weights

Re: Medicare Program: Proposed Changes to the Hospital Inpatient Prospective Payment System and Fiscal Year 2007/Rates. 4/25/06 Federal Register pages 23995-24550

After studying the impact on my community I am very concerned about the unintended negative impact. To better understand how significant the impact is I need to explain how cardiology services are organized in Utica, NY. In the mid 1990 s all three Utica hospitals collaborated to form the Mohawk Valley Heart Institute (MVHI), which is a New York State article 28 hospital corporation with its own operating certificate. MVHI holds the certificate of need to perform interventional cardiology and cardiac surgery. The agreement to make this happen at that time was to consolidate all obstetrical services at St. Luke s Hospital and all interventional cardiac services at St. Elizabeth Medical Center. In 2001, Faxton Hospital and St. Luke's Hospital merged. Today, MVHI is wholly owned by the two competing hospital systems in Utica, Faxton-St. Luke's Healthcare (FSLHC) and St. Elizabeth Medical Center (SEMC). Any profits generated by the cardiology services are shared by these two not for profit community hospitals. New York State has recognized MVHI as a model program for cardiology services.

The impact to MVHI if the changes are implemented is catastrophic. At St Elizabeth Medical Center there will be about $3,500,000 less revenue (6% decline). About 43.5% of discharges at SEMC are cardiac. At Faxton-St. Luke's healthcare, because of the corresponding increase in medical DRGs, there will be an estimated increase in $3,000,000 revenue. So, the impact will be to cause one of the collaborators to have a wind fall while the other suffers greatly. Our community has created a cardiac specialty hospital for the purpose of providing high quality care and not duplicating resources. How can the community justify keeping MVHI when the financial impact rewards one institution and penalizes the other?

Since one of the purposes of changing the DRG reimbursement system is to restrict the growth of for profit specialty hospitals, especially cardiac, MVHI has also become a target of this effort. Rather than change reimbursement for cardiac DRGs as the method of impacting these for profit cardiac specialty hospitals, why not propose a specific tax on these for profit specialty hospitals, or even better not allow them to exist. Wouldn't that be a more direct way of resolving this issue?

The reimbursement of hospitals should be tied to the health care needs of our country. Heart disease is still the major reason for death from disease in America. How can we justify decreasing resources for this disease when the needs are so great?

I believe that a not for profit entity such as the Mohawk Valley Heart Institute should somehow be held harmless from this proposed change.

Sincerely,

Halsey Bagg

Director Cardiology Services
St. Elizabeth Medical Center

Co-Coordinator
Mohawk Valley Heart Institute

Submitter : Dr. Thomas Hunt **Date:** 06/09/2006

Organization : University Nevada school of Medicine

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.

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

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

Submitter : Dr. Thomas Schwenk **Date:** 06/09/2006

Organization : University of Michigan

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

As a faculty member in the Department of Family Medicine 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. 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 directly related to training our physicians in "patient care". And while the core learning model of graduate medical education (GME) continues to be delivery of care under the supervision of fully-trained faculty physicians, other learning activities including lectures, seminars, individual skill development, and others are critical to ensuring excellence in the "patient care" that our residency graduates will ultimately provide to their communities.

Furthermore, I fear that the proposed rule change would dampen educational innovation: if curricula must meet an artificially narrow standard to be viable, we are much less likely to see new learning techniques (such as clinical simulation experiences, telemedicine platforms, and interactive technologies) blossom into vital tools for 21st century graduate medical education.

And finally, it is very difficult to imagine how my department could administratively ensure compliance with the proposed rule. Where are we to find the funding to pay for the significant staff time that would be needed to monitor each and every learning experience to document its compliance with "patient care" standard? Such requirements are unwieldy and unreasonable, and would and would distract scarce resources from core educational activities in our program.

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 essential value of diverse residency curricula to training the kinds of physicians that all of our communities deserve.

Submitter : **Dannen Mannschreck** **Date: 06/09/2006**

Organization : **Dannen Mannschreck**

Category : **Individual**

Issue Areas/Comments

GME Payments

GME Payments

Thank you for the opportunity to comment on 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 am a Family Physician who has been involved in rural family practice and in the teaching medical students and Family Medicine residents for many years.

I strongly urge CMS to rescind the language in the proposed rule that excludes resident didactic activities from the definition of "patient care activities" for the calculation of Medicare direct graduate medical education (DGME and indirect medical education (IME) payments.

In the setting of residency education such activities as journal clubs, classroom lectures and seminars are used as the basis for patient care of patients who currently are being treated in the hospital or who may present to the hospital for care. Sometimes these activities are conducted in physicians offices or in the medical school classroom, but they still apply directly to the patient care provided by the residents and faculty in the hospital setting.

As recently as 1999, the Agency has supported these didactic activities as part of patient care activities. I believe that this view makes the most sense for the education of residents and for the on-going care of patients.

Apart from the benefits fo these activities to patient care and education of residents, the administrative effort to identify and separate didactic activities from discussions of patients being treated at that time would be very burdensome for the hospitals and the residency programs.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didacatic time for purposes of DGME and IME payments and recognize that these activities are essential to the patient care experiences of resident during their residency training.

Submitter : Mr. Michael Healy **Date:** 06/09/2006

Organization : Avera Sacred Heart Hospital

Category : Hospital

Issue Areas/Comments

SCH/MDH Changes in Qualification Status

SCH/MDH Changes in Qualification Status

June 7, 2006

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

RE: Medicare Program; Proposed changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates; 71 Fed. Reg. 23,996 et seq. (Apr. 25, 2006); CMS-1488-P

Dear CMS Representative:

On behalf of Avera Sacred Heart Hospital, we appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) proposed rule on the FY 07 Medicare Inpatient Prospective Payment System (IPPS) published in the April 25, 2006 Federal Register. Our concern is specific to the Sole Community Hospital (SCH) proposed changes.

Avera Sacred Heart Hospital is a Sole Community Hospital and a Rural Referral Center that provides comprehensive acute health care services to rural areas of Southeastern South Dakota and Northeastern Nebraska. It includes a service area of 80,000 residents in ASHH s seven county service area. Avera Sacred Heart Hospital provides access to health care for these residents because more intense services are not available in the hospitals in ASHH s geographic referral area. For example, each of the hospitals within a 35 mile radius of ASHH are either Critical Access Hospitals or a specialty hospital. Most of the hospitals do not have many services critical for the area, for example, obstetrics services, emergency services with physician coverage, intensive care services, and dialysis services. The Sole Community Hospital designation has enabled ASHH to provide services such as these on a 24-hour basis for residents many who travel more than sixty miles one way for emergency health care. A definition of like hospitals is not an adequate means of identifying the care provided within these hospitals compared to ASHH.

Avera Sacred Heart Hospital requests that the Centers for Medicare and Medicaid Services consider any proposed changes be only for future Sole Community Hospital applicants. ASHH s ability to provide the necessary critical access to health care for thousands in rural communities has been dependent upon maintaining the Sole Community Hospital status.

Avera Sacred Heart Hospital requests that the Centers for Medicare and Medicaid Services consider retaining the Sole Community Hospital designation for existing facilities if the Medicare case mix index exceeds those hospitals within the original designated radius (for Avera Sacred Heart Hospital it was 25 miles) required to be designated as a Sole Community Hospital, and that volume threshold is met for any like hospitals within the original designated radius.

Your consideration to our comments is appreciated. Should you have any questions, please do not hesitate to contact us at 605-668-8321.

Sincerely,

Michael T. Healy
Vice President/Finance

Submitter : Mr. Thomas Malasto **Date:** 06/09/2006

Organization : The Indiana Heart Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-683-Attach-1.PDF

#683

June 8, 2006

Mark B. McClellan, MD, PhD
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS – 1488 – P
P.O. Box 8010
Baltimore, MD 21244-1850

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

Dear Dr. McClellan:

The Indiana Heart Hospital, LLC, appreciates the opportunity to submit comments related to the proposed 2007 Centers for Medicare and Medicaid Services (CMS) Hospital Inpatient Prospective Payment System (IPPS), released on April 12, 2006 and published in the Federal Register on April 25, 2006. Our comments are submitted on behalf of all cardiovascular programs, specialty hospitals and administrative professionals across the United States.

The Indiana Heart Hospital, LLC, (TIHH) is a for-profit, specialty-dedicated cardiovascular hospital, built on the premise of innovation, creativity and digital services. TIHH is comprised of 15% physician ownership and 85% ownership by a not-for-profit health system, Community Health Network (CHNW). We believe this minority ownership by the physicians aligns the incentives with CHNW and allows TIHH to create a truly exceptional experience for the patient, their family, the physicians and the employees. This is supported by our strong clinical outcomes and patient, physician and employee satisfaction results. Further, TIHH is responsible for the management of cardiovascular services for the other Indianapolis acute care facilities within the CHNW. Ranked among the top 40 integrated health care networks in the nation, CHNW has more than 70 sites of care throughout central Indiana. This includes Community Hospitals East, North and South in Indianapolis and Community Hospital Anderson; The Indiana Heart Hospital; MedCheck urgent care centers; Indiana Surgery Centers; 70 primary care physician practices; Community Home Health Services; nursing homes; and other health care facilities.

We appreciate the considerable effort you and your staff members have put into the development and improvement of the inpatients prospective payment system (IPPS) and specifically recognize the need to continually evolve the payment system to reflect the

current landscape within the field of medical services. We further recognize the significant complexities associated with gathering reasonably accurate cost data – data that should serve as the foundation of payment systems such as the proposed IPPS.

Origins of the Proposal

CMS is proposing to make the most significant changes to the hospital inpatient payments system since the late 1980s. The proposed changes appear to have their roots in the Medicare Payment Advisory Commission's (MedPAC) 2005 Report to Congress on Medicare payments for a certain subset of "specialty" hospitals. The MedPAC report raised concerns that the specialty hospitals were selecting the most profitable cases in their area and leaving the other acute care hospitals with less profitable services. Rather than addressing this issue of specialty hospitals in independent fashion, MedPAC recommended changing the payments for ALL acute care hospitals to reduce the incentives in the overall inpatient payment system that fueled the growth of specialty hospital facilities.

CMS should certainly weigh the issues and concerns raised in the MedPAC report when considering policy changes. However, the proposed changes to the inpatient payment system are the equivalent of throwing the baby out with the bath water. A closer review of TIHH and CHNW will confirm that our program is in fact not selecting only the most profitable services in our area and leaving the other acute care hospitals with less profitable services.

Issues with the proposed IPPS

<u>The cost reimbursement methodology for devices such as stents, heart valves, AICD's and Pacemakers is flawed.</u>

> The basis for reimbursement is the use of the 2003 cost report data that hospitals submitted and Medicare is using this information and reducing reimbursement by 25-33%, believing that the hospitals have a mark-up of their costs by this amount from the vendor invoice. New procedures initiated since the 2003 cost report are not given any different consideration on reimbursement.

<u>There is wide variation in Medicare reimbursement across the United States without accounting for severity adjustment among the DRG's</u> from the complex procedures being performed and hospitals offering a variety of different levels of intervention from non-invasive to tertiary invasive.

The decreased reimbursement for devices gives those hospitals that do not perform these procedures a higher reimbursement as a result, which divides the hospital community from uniting against this discriminatory reduction among higher complex procedures such as stents and ICD implantation.

There has been no opportunity for input on the methodology from the providers who perform these services.

The proposed reductions were arrived at from a purely accounting standpoint. This annual recalculation is specifically aimed at the largest disease process in the nation in an attempt to gain some control over runaway technology and the research behind it, which affords Americans a higher quality of life and longer survival. Annual reductions are made from one designated clinical area so that another growing clinical area can reap some increases in reimbursement without an overall increase in budget allocations.

Summary

Again, we appreciate the opportunity to provide our commentary on the 2007 CMS IPPS proposal. The Indiana Heart Hospital remains fully supportive of prospective payment for hospital inpatient services, and commends CMS for its ongoing efforts to ensure adequate reimbursement for all clinical services. Moreover, we recognize the extremely complex issues involved in establishing appropriate reimbursement for procedures performed in the inpatient setting. As such, The Indiana Heart Hospital remains committed to working with CMS and other affected parties to ensure that hospitals remain able to provide access to high quality cardiovascular care involving cutting-edge technologies in all settings of care. Finally, The Indiana Heart Hospital supports CMS's efforts to ensure that Medicare beneficiaries have continued access to high quality, efficient, and effective cardiovascular services.

Sincerely,

Thomas A. Malasto
Chief Executive Officer
The Indiana Heart Hospital

TM/cw

Submitter : Mr. Vincent Keenan **Date:** 06/09/2006

Organization : Illinois Academy of Family Physicians

Category : Health Care Provider/Association

Issue Areas/Comments

GME Payments

GME Payments

As staff to the Illinois professional medical specialty society for family physicians, 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,

Vincent D. Keenan, CAE
Executive vice presient
Illinois Academy of Family Physicians

Submitter : **Ms. Tina Williams** **Date: 06/09/2006**

Organization : **St. Joseph Healthcare**

Category : **Other Health Care Professional**

Issue Areas/Comments

Hospital Quality Data

Hospital Quality Data

As new measures are added and mandated for public reporting, payment should not be based on simply the indicator%, but rather to also include the % change of improvement or the quarters of sustained improvement. Data collected during process improvement is test data until processes are stable. Just as indicators are tested and validated, process improvement provides data that is test data. Transparency of data reporting connected to payment, needs to allow a test period for data to not 'count' toward payment. Hospital should be given up to 3-4 quarters of test data to allow time for process design. In this manner, transparency is achieved, the commitment to improvement is not overshadowed by payment, and the public can be taught to utilize data to look for hospitals that show commitment to quality management and process improvement, i.e. to look for a hospital that 'moves the dot' in the right direction.

Submitter : **Dr. William Gillanders** **Date: 06/09/2006**

Organization : **Providence Health and Services**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

June 9, 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. 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,

Bill Gillanders, Providence Health System, Family Medicine Program Director, Clinical Professor, OHSU

Submitter : glen couchman **Date:** 06/09/2006

Organization : glen couchman

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Dear Sirs:

I am the Chairman of Family Medicine at Texas A&M University. I am the academic affiliate for Family Medicine programs in Bryan, Tmeple, Corpus Christi, and Fort Worth Texas. Our combined programs have over 140 Family Medicine residents in them each year. 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 would like to 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.

It is my belief that with the possible exception of extended time for "bench research," the entire residency experience is 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 independently functioning 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,

Glen R Couchman MD
Chairman Dept of Family Medicine
Texas A&M University
Scott & White

Submitter : Dr. Robin Ledyard **Date:** 06/09/2006

Organization : Gary/Methodist Family Medicine Residency

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

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

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

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

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

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

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

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

Sincerely,

Robin Ledyard

Submitter : Dr. Lucy Candib **Date:** 06/09/2006

Organization : Family Health Center of Worcester

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. This would have a devastating effect on the family practice residency program that is central to staffing and education in our community health center in an underserved inner city.

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,

Lucy M. Candib, M.D.
Family Health Center of Worcester

Submitter : Dr. John Chahbazi **Date:** 06/09/2006

Organization : McLaren FP Residency

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

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

John Chahbazi, MD

Submitter : **Mr. Terry Lambert** **Date: 06/09/2006**

Organization : **Newman Regional Health**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

Thank You for the opportunity to comment on CMS-1488-P and P2, Medicare Program; Proposed changes to the Hospital Inpatient Prospective Payments Systems and Fiscal Year 2007 rates; Proposed rule.

I appreciate CMS looking at changing the payment system. I personally think this is mainly in response to the hot (difficult) issue of Specialty Hospitals. They are, due to physician self-referral, cherry picking surgical cases and as a result are making outrageous profits from Medicare patients! I do think, however, that the real issue of physician self referral needs to be addressed. Your current plan is your way of NOT addressing the real issue. Having said that, I think your idear of looking at changing the DRG System is a good idea. In the models that I have seen, there does not seem to be enough increase given to the non-surgical DRGs. Decrease the profits of a limited service surgical facility by 5-6% will only cause them to have a margin of 30% instead of 35% and you may have actually hurt the full service community hospital in the process. I think the CMS needs to take another year, at least, to study the impact of the proposed changes. I truly do support moving to a DRG-weighting methodology based on hospital costs rather than charges, but CMS'proposed HSRVcc method is flawed. Also, I feel that this change may require a phase in or transition period. I encourage you to work with the American Hospital Association as you move forward with any proposed changes. Finally, I encourage you to have the courage to do the right thing and address physician self referral, which is the real problem. Medicare is a good system for our seniors. It is administered in an efficient fashion but it is being exploited by a few greedy individuals due to a loop hole!

Thank you,

Terry R. Lambert, CEO
Newman Memorial County Hospital
d/b/a Newman Regional Health
1201 W. 12th Avenue
Emporia, KS 66801

Submitter : Dr. William Robertson **Date:** 06/09/2006

Organization : Family Medicine Assoc.

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

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

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

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

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

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

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

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

Sincerely,
William Robertson,MD

Submitter : Steven Kukla **Date:** 06/09/2006

Organization : Mercy Medical Center - Des Moines

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See attached comment letter.

CMS-1488-P-693-Attach-1.DOC

693

Mercy
MEDICAL CENTER
DES MOINES
A member of Mercy Health Network

1111 6th Ave.
Des Moines, IA 50314-2611
515-247-3222

ADMINISTRATION

June 9, 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:

Mercy Medical Center – Des Moines 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. Mercy Medical Center is one of the Midwest's major referral centers with areas of excellence in heart, cancer, birthing/pediatrics, emergency/trauma, neurology and medical imaging.

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.

We support improving DRG payments to more accurately reflect resources used in caring for Medicare patients, but it is not clear that the proposed DRG weight changes or new patient classification system will result in a more accurate hospital payment system. Impact estimates at the DRG and hospital level are extremely sensitive to methodological variations. Implementation in FY 2007 would be premature.

We urge CMS to delay these changes, undertake more in-depth analyses of their impact, and evaluate alternative methodologies for improving the DRG system.

While the proposed rule has many provisions impacting our hospital, we would like to comment specifically on the following issues:

HRSV Weights

We support a move to cost-based weights but have several concerns about the adequacy and validity of the proposed methodology. More work is needed to determine the best way to create cost-based weights. If changes are made to DRG weights, those changes should be phased in over three years with "stop loss" protections to allow significantly impacted hospitals time to prepare for payment changes.

In particular, **CMS should further analyze and evaluate the impact of:**

- **Use of 2004 Data** – CMS uses claims data taken from the FY 2004 MedPAR file in its methodology. Clinical practice has changed in many areas, especially cardiology, over the past two years. The data used may not reflect current clinical practice. CMS may need to make specific changes to specific DRGs to reflect the change in clinical practice. For example, interventional cardiology DRGs do not reflect the cost of current clinical practice.

- **Variation in Markups** – The CMS methodology assumes a uniform hospital markup, but markups vary from product to product.

- **Distortion of Costs** – The proposed methodology would distort the accuracy of cost estimates by combining multiple cost centers on hospital cost reports into ten CMS-designated cost center. CMS would then determine ten national average cost-to-charge ratios for each of the designated costs centers but the ratios would not be weighted by each hospital's Medicare charges. This would allow very small hospitals to have just as much of an impact on the national cost-to-charge ratios as larger hospitals.

- **Access to Centers of Excellence** – The proposed changes are particularly significant for large volume hospitals and may have a negative impact on Centers of Excellence, which could impede beneficiary access to high quality services.

We recommend delaying until at least FY 2008 the proposed cost-based DRG weights. CMS should undertake a more thorough analysis, including parallel pilot testing, of the proposed changes to identify any unintended consequences. If DRG weight changes are implemented, they should be phased in over three years with "stop loss" protections.

DRGs: Severity of Illness

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 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.

We recommend 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.

We urge 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

We support 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.

We recommend 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.

We recommend 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.

We recommend 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,

Steven F. Kukla
Senior Vice President
Chief Financial Officer

Submitter : Dr. Mikki Jo Leathers **Date:** 06/09/2006

Organization : Dr. Mikki Jo Leathers

Category : Individual

Issue Areas/Comments

GME Payments

GME Payments

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

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

Background

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

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Residency Program Activities and Patient Care

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

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

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

Submitter : Dr. Edward Onusko **Date:** 06/09/2006

Organization : Clinton Memorial Hospital Fam Med Residency

Category : Physician

Issue Areas/Comments

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Sincerely,
Edward Onusko M.D.

Submitter : roy jacobson **Date:** 06/09/2006

Organization : Univ of Cincinnati

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,
Roy Jacobson, MD, PhD.

Submitter : **Dr. Karl Wenner** **Date: 06/09/2006**

Organization : **Klamath Orthopedic Clinic**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

June 6, 2006

Centers for Medicare and Medicaid Services
Department of Health and Human Services
ATTN: CMS-1488-P
RE: X Stop IPD
P.O. Box 8011
Baltimore, MD 21244-1850

Dear Sir/Madam:

The X Stop IPD for spinal stenosis is a valuable option for patients with spinal stenosis, as it is associated with low morbidity and rapid recovery. It is particularly beneficial for older patients who are frail and have comorbid conditions. It is fantastic to be able to offer these patients a new procedure that is low risk and effective.

I see perhaps 40 patients with lumbar spinal stenosis each moth, and the vast majority are elderly and receiving Medicare. Typically, I offer them conservative treatments including 1-3 steroid injections, some physical therapy, and over-the-counter pain medications. Only perhaps 20 to 30 percent of my spinal stenosis patients would be referred to laminectomy with or without fusion. I judge that perhaps 25 percent of the cases I see would be appropriate for X Stop IPD.

The surgery relieves pain associated with standing and walking and leg extension. Post-operative x-rays show that there is little impact on adjacent levels little impact on flexion, lateral bending, and axial rotation. My patients report relief of leg symptoms either completely or intermittently. They also report relief in lower back pain. I have an 80 year-old female patient who was worried she would have to move to a nursing home because she could no longer walk or get out of the house to shop. Now she is living at home, shopping, and has complete relief of symptoms. In my view, this procedure works better than overall decompression surgery, and patients get better more quickly.

The X Stop IPD is particularly useful for patients who have coronary and pulmonary illnesses. I use general anesthesia, allowing patients to take advantage of the procedure without undue stress and recovery. I believe X Stop IPD should be paid for in the Medicare hospital system, as it truly benefits older patients.

Sincerely,

Karl Wenner, M.D.

Submitter : Dr. Robin Pritham **Date:** 06/09/2006

Organization : Eastern Maiine Medical Center Family Medicine Resi

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,

Robin PRitham, MD

Submitter : Mrs. Sandra Broder **Date:** 06/09/2006

Organization : Henry Medical Center

Category : Hospital

Issue Areas/Comments

Hospital Quality Data

Hospital Quality Data

In accordance with the requirements in the DRA of 2005 , CMS has proposed expansion of the 10 quality measure starter set to a total of 21 quality measures and linked the reporting of these
measures to the hospital annual payment update (APU) for fiscal year (FY) 2007. The focus areas of the 11 additional measures are acute myocardial infarction, heart failure, pneumonia, and
surgical infection prevention (SIP).The rule also proposes that the data collection for the expanded set of quality measures begin with discharges occurring in the first calendar quarter of 2006 January March discharges. This data must be submitted to the QIO Clinical Warehouse no later than August 15, 2006 for hospitals paid under the CMS prospective payment system (PPS) to receive their full market basket update. Failure to submit the data on these additional measures in the time frame proposed
will result in those hospitals receiving the full market basket update minus 2 percentage points.
A. Hospital Quality Data
" Timing: The final ruling for this proposal will not be announced until August 1, 2006. At this time, hospitals will have only 15 days to comply and submit data for the first 3 months of calendar year (CY) 2006. Although data is not required to be in the data
warehouse until August 15, 2006, hospitals must have their data submitted to their performance measurement vendors sometime between June 15 and June 30 depending on the performance measurement vendor, well before the final announcement.
Performance measurement vendors have had to move back their cutoff dates to allow hospitals sufficient time to abstract medical records. In essence, a large number of hospitals have only been given about six weeks to meet the new abstraction requirements in this proposed rule.
" Vendor Issues: In preparing to meet the deadlines proposed in this rule, hospitals have to enter into agreements with their performance measurement vendors in order institute a process that allows them to abstract medical records for the additional measures;Hospitals that may have been collecting the data have not authorized their performance measurement vendors to transmit that data to the QIO Clinical Warehouse. In addition, some vendors will need to implement and test new programming quickly to for hospitals
to comply.
" Hospital Costs: Hospitals will incur the additional expenses associated with the work required by their respective performance measurement vendors. In addition, overtime costs are required for staff needed to perform this work under an expedited time frame.
Hospitals have not been given sufficient time to ensure appropriate training of their medical records staff to ensure a high degree of accuracy in the data abstraction,particularly with respect to the SIP measures. The SIP measures are particularly problematic since few hospitals are presently collecting and reporting these measures to the QIO Clinical Warehouse. Hospitals are concerned about validation scores on these new measures and how it will impact their market basket update.
Recommendations - We strongly urges that CMS require the submission of the additional measures, specifically the SIP measures, to begin with 3rd quarter 2006 discharges and that the annual payment update be tied to successful transmission of the measures. Also
recommended is that the SIP measures not be included in the formal validation process for the annual payment update until after one full year of reporting of the additional measures.We do support a review of the records by the Clinical Data Abstraction Center (CDAC)for these measures, especially the SIP measures, to permit hospitals to obtain feedback about the data abstraction for learning purposes during the course of the year.
Please develop a process that affords hospitals sufficient time prospectively to begin collection and reporting of any additional measures that will be considered in an annual payment update for hospital in the future. Thank you.

Submitter : Dr. B Becker **Date:** 06/09/2006

Organization : MCH

Category : Hospital

Issue Areas/Comments

GME Payments

GME Payments

As an affiliated hospital 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).

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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. Timothy Rowland **Date:** 06/09/2006

Organization : Riverside Family Practice

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

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

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

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

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

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

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

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

Sincerely,
Timothy E. Rowland, M.D.

Submitter : Dr. Kenneth Dardick **Date:** 06/09/2006

Organization : Dr. Kenneth Dardick

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,

Kenneth Dardick, MD
Mansfield Family Practice LLC
Storrs, Connecticut

Submitter : **Dr. michael burdulis** **Date: 06/09/2006**

Organization : **UMASS Family Medicine 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).

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

Residency Program Activities and Patient Care

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

In addition, I cannot conceive of how 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,

Michael Burdulis, MD

Submitter : **Dr. Bruce Becker** **Date: 06/09/2006**

Organization : **Medical Ctr Hosp**

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.

Submitter : **Dr. John Bossian** **Date: 06/09/2006**

Organization : **Dr. John Bossian**

Category : **Physician**

Issue Areas/Comments

GME Payments

GME Payments

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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].
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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 Bossian DO FAAFP

Submitter : Dr. Laura Eaton **Date:** 06/09/2006

Organization : UCSF

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,

Laura J Eaton, MD, MPH

Submitter : Mr. Devon Huff **Date:** 06/09/2006

Organization : Mr. Devon Huff

Category : Individual

Issue Areas/Comments

GME Payments

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As a medical student, 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,

Devon Huff

Submitter : Dr. Stacy Taylor **Date:** 06/09/2006

Organization : ProHealth Physicians LLC

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

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Background
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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,

Stacy Taylor, MD

Submitter : **Katie Patterson** **Date: 06/09/2006**

Organization : **Katie Patterson**

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.

Submitter : Amy Jacobson **Date:** 06/09/2006

Organization : University of South Dakota School of Medicine

Category : Academic

Issue Areas/Comments

GENERAL

GENERAL

See attachement

CMS-1488-P-710-Attach-1.DOC

June 9, 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 University of South Dakota 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).

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Even practicing physicians hold conferences to discuss both individual patient problems and the generic approach to patient care, and these discussions are an ordinary part of patient care. Separation of these components in the graduate medical education setting are arbitrary, artificial and entirely counter productive.

In addition, I cannot conceive of how any program director 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,

Amy Jacobson
Director, Graduate Medical Education

Submitter : Grant Fowler **Date:** 06/09/2006

Organization : Grant Fowler

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.

Submitter : Dr. William Chavey **Date:** 06/09/2006

Organization : University of Michigan

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

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

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I firmly believe that with the possible exception of extended time for "bench research," there is no residency experience that is not directly related to training our physicians in "patient care". And while the core learning model of graduate medical education (GME) continues to be delivery of care under the supervision of fully-trained faculty physicians, other learning activities including lectures, seminars, individual skill development, and others are critical to ensuring excellence in the "patient care" that our residency graduates will ultimately provide to their communities.

Furthermore, I fear that the proposed rule change would dampen educational innovation: if curricula must meet an artificially narrow standard to be viable, we are much less likely to see new learning techniques (such as clinical simulation experiences, telemedicine platforms, and interactive technologies) blossom into vital tools for 21st century graduate medical education.

And finally, it is very difficult to imagine how my department could administratively ensure compliance with the proposed rule. Where are we to find the funding to pay for the significant staff time that would be needed to monitor each and every learning experience to document its compliance with "patient care" standard? Such requirements are unwieldy and unreasonable, and would and would distract scarce resources from core educational activities in our program.

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 essential value of diverse residency curricula to training the kinds of physicians that all of our communities deserve.

Submitter : **Dr. Christopher Doehring** **Date: 06/09/2006**

Organization : **St. Francis Hospital, Indianapolis**

Category : **Physician**

Issue Areas/Comments

GME Payments

GME Payments

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

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

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

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

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

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

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

Sincerely,

Christopher B. Doehring, MD

Submitter : Dr. **Date:** 06/09/2006

Organization : Dr.

Category : Individual

Issue Areas/Comments

GME Payments

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

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

Submitter : Dr. David Keller **Date:** 06/09/2006

Organization : University of Massachusetts Medical School

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

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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,

David Keller MD

Submitter : Ms. Deb Fischer-Clemens **Date:** 06/09/2006

Organization : Avera Health

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-716-Attach-1.DOC

#716

June 9, 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 Avera, the health ministry of the Benedictine and Presentation Sisters, 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. Avera serves the people in South Dakota, Minnesota, Iowa, Nebraska and North Dakota with hospitals, nursing homes, clinics and other health services at more than 100 locations.

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

Our hospitals support meaningful improvements to Medicare's inpatient PPS. We believe that Avera 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, Avera supports the following:

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

Avera appreciates the opportunity to submit these comments. If you have any questions about our remarks, please feel free to contact me at (605) 322-4668 or deb.fischerclemens@avera.org.

Sincerely,

Deb Fischer-Clemens
Director, Avera Center for Public Policy

Submitter : Vi Naylor **Date:** 06/09/2006

Organization : Georgia Hospital Association

Category : Health Care Provider/Association

Issue Areas/Comments

Hospital Quality Data

Hospital Quality Data

Please see attached letter of comment regarding proposed rule 1488-P

CMS-1488-P-717-Attach-1.PDF

#717

June 12, 2006

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

RE: A. Reporting of Hospital Quality Data for Annual Hospital Payment Update (§ 412.64 (d)(2))
B. Value-Based Purchasing

Dear Dr. McClellan:

On behalf of the more than 150 member hospitals, the Georgia Hospital Association (GHA) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) requirements regarding Hospital Quality Data found in the Deficit Reduction Act (DRA) of 2005.

In accordance with the requirements in the DRA of 2005 , CMS has proposed expansion of the 10 quality measure starter set to a total of 21 quality measures and linked the reporting of these measures to the hospital annual payment update (APU) for fiscal year (FY) 2007. The focus areas of the 11 additional measures are acute myocardial infarction, heart failure, pneumonia, and surgical infection prevention (SIP).

The rule also proposes that the data collection for the expanded set of quality measures begin with discharges occurring in the first calendar quarter of 2006 – January – March discharges. This data must be submitted to the QIO Clinical Warehouse no later than August 15, 2006 for hospitals paid under the CMS prospective payment system (PPS) to receive their full market basket update. Failure to submit the data on these additional measures in the time frame proposed will result in those hospitals receiving the full market basket update minus 2 percentage points.

A. **Hospital Quality Data**

- Timing: The final ruling for this proposal will not be announced until August 1, 2006. At this time, hospitals will have only 15 days to comply and submit data for the first 3 months of calendar year (CY) 2006. Although data is not required to be in the data warehouse until August 15, 2006, hospitals must have their data submitted to their performance measurement vendors sometime between June 15 and June 30 depending on the performance measurement vendor, well before the final announcement. Performance measurement vendors have had to move back their cutoff dates to allow hospitals sufficient time to abstract medical records. In essence, a large number of hospitals have only been given about six weeks to meet the new abstraction requirements in this proposed rule.

- Vendor Issues: In preparing to meet the deadlines proposed in this rule, hospitals have to enter into agreements with their performance measurement vendors in order institute a process that allows them to abstract medical records for the additional measures; Hospitals that may have been collecting the data have not authorized their performance measurement vendors to transmit that data to the QIO Clinical Warehouse. In addition, some vendors will need to implement and test new programming quickly to for hospitals to comply.
- Hospital Costs: Hospitals will incur the additional expenses associated with the work required by their respective performance measurement vendors. In addition, overtime costs are required for staff needed to perform this work under an expedited time frame. Hospitals have not been given sufficient time to ensure appropriate training of their medical records staff to ensure a high degree of accuracy in the data abstraction, particularly with respect to the SIP measures. The SIP measures are particularly problematic since few hospitals are presently collecting and reporting these measures to the QIO Clinical Warehouse. Hospitals are concerned about validation scores on these new measures and how it will impact their market basket update.

Recommendations - GHA strongly urges that CMS require the submission of the additional measures, specifically the SIP measures, to begin with 3rd quarter 2006 discharges and that the annual payment update be tied to successful transmission of the measures. Also recommended is that the SIP measures **not** be included in the formal validation process for the annual payment update until after one full year of reporting of the additional measures. GHA does support a review of the records by the Clinical Data Abstraction Center (CDAC) for these measures, especially the SIP measures, to permit hospitals to obtain feedback about the data abstraction for learning purposes during the course of the year.

GHA further recommends that CMS develop a process that affords organizations sufficient time prospectively to begin collection and reporting of any additional measures that will be considered in an annual payment update or part of a value-based purchasing program for hospitals in the future.

Future Measures

The DRA requires the expansion to other quality measures. The types of measures that may be added include: the HCAHPS® patient perception of care survey findings; structure measures as detailed in the recent Institute of Medicine report *Performance Measurement: Accelerating Improvement;* and other measures that reflect consensus among affected parties as required.

Recommendations - CMS has clearly indicated that HCAHPS® results will be considered as part of a future measure expansion. Therefore, hospital payment update may be tied to having HCAHPS® results in the QIO Clinical Warehouse before next fiscal year. Hospitals are required to participate in a dry run before their data is shared publicly but some hospitals have not yet participated. GHA recommends that CMS identify when hospitals will need to have HCAHPS® data reported to the QIO Clinical Warehouse to meet possible time lines for the next fiscal year's APU and to offer another dry run period that will assist hospitals to meet those time frames. Further, GHA recommends that CMS work with the Hospital Quality Alliance (HQA) partners to identify other measures that reflect the quality of hospital care.

B. **Implementing Hospital Value-Based Purchasing in FY 2009**

To improve the quality and efficiency of care delivered to Medicare beneficiaries in America's hospitals, CMS encourages participation in the HQA as a strategy to encourage hospital accountability by making comparative information about hospital performance publicly available.

CMS also notes in the proposed rule that "all providers to which a specific Medicare payment system applies receive the same amount for a service, regardless of its quality or efficiency. As a result, Medicare's payment systems can direct more resources to hospitals that deliver care that is not of the highest quality or include unnecessary services (duplicative tests and services or services to treat avoidable complications)." Consequently, CMS has indicated that it is examining the concept of "value-based purchasing," which may use a range of incentives to achieve identified quality and efficiency goals as a means of promoting better quality of care and more effective resource use in the Medicare payment systems. And, the DRA of 2005 has directed CMS to develop a plan to implement value-based purchasing beginning with FY 2009.

Comments

- In the CMS proposed rule, the MedPAC report, and the President's FY 2007 Budget, new monies will not be invested in the Medicare program to be used as a quality incentive payment pool. Rather, a small proportion of Medicare hospital payments (1-2 percent of payments) will be set aside to fund a quality incentive payment pool in order to maintain budget-neutrality. CMS has indicated that as its ability to measure quality improves, the amount of money set aside to reward quality performance should increase significantly. Further, MedPAC has recommended that any quality incentive program reward hospitals for improvement and attaining/exceeding certain benchmarks.
- GHA supports the concept of rewarding hospitals both for improvements and attaining/exceeding certain benchmarks, and understands the effort that needs to be invested by hospitals to make and sustain quality improvements in processes of care. However, setting aside 1-2 percent of Medicare payments might not be sufficient to make meaningful awards to hospitals for making improvements and attaining the benchmarks.

Recommendations

- There should be ongoing discussions with partners in the HQA (including the National Quality Forum) with regard to which measures should be added or deleted from any pay-for-performance measurement system.
- GHA supports the development of a composite score for a particular disease category or measure set and believes that composite scoring may help in improving consumer understanding of the processes/dimensions of care as well as assist hospitals in communicating with its clinical teams. Of the two methods described in the proposed rule, GHA prefers the use of the "opportunity model" used in the Premier Hospital Quality Incentive Demonstration project. GHA believes the "opportunity model" provides the flexibility needed to accommodate more individual process and/or outcome measures and the ability to determine whether and how to assign more weight to various measures. GHA would be interested in responding to other composite scoring methodologies under consideration by CMS.
- It is essential that CMS work with HQA partners in developing quality incentive proposals that could be shared in the near future with hospitals for comment given the

short-time frame that has been mandated by Congress to begin a Medicare value-based hospital purchasing program.

- An iterative review process should be utilized to build consensus with regards to the value-based hospital purchasing program that CMS selects to implement. GHA recommends that CMS consider implementing a process similar to that used jointly by CMS and the Agency for Healthcare Research and Quality (AHRQ) in shaping the HCAHPS® perception of care survey/ survey methodology. This is a process that involved multiple opportunities for public comment.

B.5. Considerations Related to Certain Conditions, Including Hospital Acquired Infections

Under the Medicare diagnosis-related group (DRG)-based inpatient PPS, payments to hospitals can increase when a post-admission complication, such as infection, occurs. Because of the current design of the DRG system, hospitals with low complication rates could be viewed as being financially penalized because they receive less reimbursement for providing quality care. Under the proposal, hospitals would not receive additional payment for treatment of conditions that potentially could have been prevented if the hospital had implemented evidence-based guidelines.

Recommendations

- Central-line associated bloodstream infections, surgical site infections, and/or ventilator-associated pneumonia would be good candidates for consideration by CMS because there are existing evidence-based guidelines and it would build off CMS' current Surgical Care Improvement Project (SCIP).
- GHA strongly urges CMS to do extensive work to subject the reimbursement schema only to those potentially preventable complications, such as hospital-acquired infections (HAI). Complications do not necessarily represent medical errors, since they are not always preventable even with optimal care. Secondary diagnosis codes indicative of infection serve as poor proxies in identifying true HAIs. Even IF the use of secondary diagnosis codes was an accurate way to detect HAIs, not all HAIs are preventable in every patient. Some patients may be more susceptible to infection due to their disease or condition and not as a result of poor care.
- Another candidate for consideration may be the development of deep vein thromboses or pressure ulcers as they may be more clear-cut and more easily identifiable using secondary diagnosis codes and still build off of the SCIP program.
- GHA recommends that CMS consider a smaller-scale demonstration project to test any methodology with hospitals before a national implementation.

For questions regarding the comments submitted by the Georgia Hospital Association, please feel free to contact Vi Naylor, Executive Vice President, GHA at (770)249-4500 or vnaylor@gha.org.

Sincerely,

Vi Naylor
Executive Vice President

Submitter : Ms. Holly Shane **Date:** 06/09/2006

Organization : Sioux Falls Family Medicine Residency

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-718-Attach-1.DOC

#718

RESPONSE TO FEDERAL REGISTER NOTICE
DUE JUNE 12TH

June 9, 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 Sioux Falls 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.

Even practicing physicians hold conferences to discuss both individual patient problems and the generic approach to patient care, and these discussions are an ordinary part of patient care. Separation of these components in the graduate medical education setting are arbitrary, artificial and entirely counter productive. [DELETE THIS NOTE OR INSERT ANY ADDITIONAL DISCUSSION THAT FOCUSES ON THE EDUCATIONAL ACTIVITIES MENTIONED ABOVE AND HOW YOUR PROGRAM AND FACULTY VIEW THESE ACTIVITIES AS INTEGRALLY RELATED TO THE DELIVERY OF PATIENT CARE. PLEASE MAKE PARTICULAR NOTE IN YOUR COMMENTS REGARDING THE WAYS THAT THE ACTIVITIES INVOLVE DISCUSSIONS OF SPECIFIC PATIENTS OR CURRENT PATIENTS.]

In addition, I cannot conceive of how any program director 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,

Holly Shane

Submitter : Dr. ALYSIA FURGATCH **Date:** 06/09/2006

Organization : AMEP

Category : Physician

Issue Areas/Comments

GME Payments

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Submitter :

Date: 06/09/2006

Organization :

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,

William Tsai, D.O.

Submitter : Dr. marc feingold **Date:** 06/09/2006

Organization : self

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,

marc feingold, md
family medicine

Submitter : Dr. Gary Mitchell **Date:** 06/09/2006

Organization : Newman Memorial Hospital

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

CMS-1488-P-722-Attach-1.DOC

#722

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

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

While Newman supports many of the proposed rule's provisions, we have serious concerns about the proposed changes to the DRG weights and classifications. The hospital field supports meaningful improvements to Medicare's inpatient PPS. We believe the member hospitals of AHA 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 redistributes from $1.4 to $1.7 billion within the inpatient system. Newman Memorial Hospital is expected to see a reduction in payments for FFY2007 of over $83,000. Although our reduction doesn't seem large, it is difficult to absorb and to understand being paid less for care than we presently are while cost continue to escalate and margins are poor. Our additional concern that this does not include extra cost in purchasing new software, training and transition cost. The AHA 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 changes.

Specifically, Newman Memorial Hospital supports the AHA positions of:

- **One-year Delay,**

- **Valid Cost-based Weights,**
- **A New Classification System Only if the Need Can Be Demonstrated,**
- **Simultaneous Adoption of Any Changes to Weights and Classifications,**
- **Three-year Transition, and**

- **Collaborative Approach to Moving Forward.**

AHA has submitted detailed comments that further explain hospital concerns and recommendations on the proposed DRG weight and classification system changes, as well as hospital provider positions on many other issues in the proposed rule.

The Newman Memorial Hospital appreciates the opportunity to submit these comments. If you have any questions about our remarks, please feel free to contact me.

Sincerely,

Gary W Mitchell, D.Ph., CHE
Chief Executive Officer

Submitter : Dr. Robert Barnabei **Date:** 06/09/2006

Organization : UPMC McKeesport

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

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

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

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

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

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

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

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

Sincerely,

Robert A. Barnabei, MD

Submitter : Dr. Leslie Pitts **Date:** 06/09/2006

Organization : New Hampshire Academy of Family Physicians

Category : Individual

Issue Areas/Comments

GME Payments

GME Payments

As President of the New Hampshire Academy of Family Physicians, and as a practicing family physician, I would like to 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).

I strongly urge CMS to rescind the language in the proposed rule that differentiates resident training time spent in didactic activities from 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. As I understand it, the stated rationale for the exclusion of this time is that the time is not related to patient care.

I firmly believe that, with the possible exception of bench research, there is little residency experience that is not, in some way, related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision and guidance of experienced physicians. This model is central to everything that a resident physician learns in the course of an approved residency training program.

To separate out CMS's newly defined patient care time from didactic sessions, in which discussions frequently concern the care of particular patients, seems unnecessarily burdensome, cynical, and unfair. 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 Pitts, MD
President, New Hampshire Academy of Family Physicians

Submitter : Dr. JOann D'Aprile-Lubrano **Date:** 06/09/2006

Organization : ETSU

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,

Joann D'Aprile-Lubrano, D.O.

Submitter : Mrs. Annette Humphrey **Date:** 06/09/2006

Organization : Mrs. Annette Humphrey

Category : Individual

Issue Areas/Comments

GME Payments

GME Payments

As an individual who depends on family physician care, 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.

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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. Alan Cementina **Date:** 06/09/2006

Organization : Dr. Alan Cementina

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

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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,

Alan Cementina, MD

Submitter : Dr. Nancy Lares **Date:** 06/09/2006

Organization : Dr. Nancy Lares

Category : Individual

Issue Areas/Comments

GME Payments

GME Payments

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Background

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

Residency Program Activities and Patient Care

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

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

Submitter : Warren Ferguson **Date:** 06/09/2006

Organization : Warren Ferguson

Category : Individual

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,

Warren J. Ferguson, MD

Submitter : Dr. Kevin Phelps **Date:** 06/09/2006

Organization : Medical University of Ohio

Category : Physician

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,

Kevin A. Phelps, D.O.
Program Director
Medical University of Ohio
Family Medicine Residency Program

Submitter : Dr. Ronald Brimberry **Date:** 06/09/2006

Organization : UAMS AHEC-NW Family Practice Residency Program

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

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(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.

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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,

Ronald Brimberry, M.D.
Associate Professor
UAMS Dept of Family and Preventive Medicine
AHEC-NW Family Practice Residency Program

Submitter : Dr. Roger Moore **Date:** 06/09/2006

Organization : Roger Moore Medical Clinic

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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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. Thomas Agresta **Date:** 06/09/2006

Organization : University of Connecticut School of 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".

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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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Furhtermore as an academic physician who directly supervises residents caring for patients in the hospital, outpatient office and in home settings I can honestly state that residents immediatly use information from the educational settings to provide improved care for patients. I believe that a change of the nature proposed would have devestating effects on the ability to teach quality improvement measures and is in direct contrast to many of the other goals of CMS.

Sincerely,

Thomas P. Agresta M.D.

Submitter : Dr. lucinda hautaniemi **Date:** 06/09/2006

Organization : individual

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

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Sincerely,

Lucinda Hautaniemi, MD

Submitter : Gary Partin **Date:** 06/09/2006

Organization : none

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

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Submitter : Dr. David Ortiz **Date:** 06/09/2006

Organization : University of Texas

Category : Physician

Issue Areas/Comments

GME Payments

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Submitter :

Date: 06/09/2006

Organization : Island Hospital

Category : Hospital

Issue Areas/Comments

Hospital Quality Data

Hospital Quality Data

The statement on page 337, "We do not anticipate significant additional burden on hospitals regarding the....anticipated 21 clinical quality measures because all JCAHO-accredited hospitals are currently required to adhere to these sampling requirements in AMI, HF, PNE and SIP for accreditation and core measure reporting purposes" is not a factual statement. At the present time, JCAHO requires participation in 3 sets of measures, not 4. The additional requirements WILL add a significant burden due to the time involved in retrieving accurate and specific data items from charts meeting the criteria.

These measures are all important in providing quality to our patients, and it is important to be aware that each time a requirement is added, there IS a significant increased burden to those organizations involved in reporting those measures to external agencies.

The other key point about adding the Surgical Infection Prevention requirement is that to make it retroactive back to 1/1/06 does not seem to be a reasonable action. Whatever the date for approval of the official requirement is should be the EARLIEST that the requirement should go into effect!

The hospital validation requirements in their current state have one major flaw. Because only 5 charts each quarter are reviewed, there is one instance where if ONE question is answered incorrectly, it essentially causes that ENTIRE chart to be counted as incorrect, resulting in an automatic 80%. This is in the PNEUMONIA category. If the hospital abstractor says the patient did not have a working diagnosis of pneumonia on admission, the abstraction is to be stopped. However, if the CDAC abstractor says there WAS a working diagnosis of pneumonia on admission, then all the questions should have been answered. Since no other questions would have been answered, it is an automatic failure. Something needs to be done to rectify this if hospital payments are going to be based on 80% validation. One solution would be to include only cases identified as having a working diagnosis of pneumonia in the charts submitted to CDAC for validation.

Submitter : Dr. Margaret Sun **Date:** 06/09/2006

Organization : Dr. Margaret Sun

Category : Individual

Issue Areas/Comments

GME Payments

GME Payments

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

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

Sincerely,

Submitter : Dr. Mark Rood **Date:** 06/09/2006

Organization : South Russell Family Practice, Inc.

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,
Mark N. Rood, MD, FAAFP

If you have any questions, please feel free to contact the AAFP DC office or Kevin Burke, director, Government Relations with AAFP by sending an e-mail to KBurke@aafp.org .

Submitter : Mrs. Gray **Date:** 06/09/2006

Organization : St. Vincent's Family Medicine Residency

Category : Individual

Issue Areas/Comments

GME Payments

GME Payments

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

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Submitter : Mr. Richard Jones **Date:** 06/09/2006

Organization : Abington Memorial Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-741-Attach-1.DOC

#741

June 9, 2006

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
ATTN: CMS-1488-P and P2
Room 445-G Hubert H. Humphrey Building
200 Independence Avenue, SW
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 Rate

Dear Dr. McClellan:

No doubt you are receiving an unprecedented volume of mail regarding the above captioned proposed changes to PPS payments to hospitals.

I speak for this institution that such proposed changes (Medicare is our best and largest payor) will have a drastic negative impact on this safety net hospital and will therefore have a significant negative impact on the quality of care and direct provision of services. The yearly impact is conservatively estimated at $700,000 annualized.

We ask you to:

- Adopt a one-year delay in implementing these proposed changes to the DRG weights. More work needs to be done to assess an appropriate approvals for changing the patient classifications system.

- CMS must consider a simultaneous implementation of the DRG weight changes and new classification system over a three-year period.

Our ability to provide quality, safe and effective care is being compromised in these proposed changes.

We are constantly at the edge of being less effective by these proposed changes. There needs to be more thought and analysis done to determine impact.

Please delay the implementation to give time to more careful thought.

Sincerely,

Richard L. Jones, Jr.
President & Chief Executive Officer
Abington Memorial Hospital
1200 York Road
Abington, PA 19001

Submitter : Dr. Dennis J. Battock **Date:** 06/09/2006

Organization : Colorado Heart Institute, LLC

Category : Physician

Issue Areas/Comments

DRGs: MCVs and Defibrillators

DRGs: MCVs and Defibrillators

See attachment

CMS-1488-P-742-Attach-1.DOC

#742

Friday, June 9, 2006

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: MEDICARE PROGRAM; PROPOSED CHANGES TO THE HOSPITAL INPATIENT PROSPECTIVE PAYMENT SYSTEMS AND FISCAL YEAR 2007 RATES

I appreciate the opportunity to comment on the proposed rule change for the payment rates for the 2007 fiscal year. I am the Medical Director for the Colorado Heart Institute (CHI), which is a cardiac catheterization laboratory that has been in existence since 1987. CHI has worked in conjunction the The Medical Center of Aurora and is committed to control costs for the expensive cardiac technology that currently exists as well as provide the highest quality of care for patients. In fact, The Medical Center of Aurora in conjunction with CHI was recently awarded one of only four Cardiac Centers of Excellence for all of the HCA hospitals and we have also pioneered a Cardiac Alert program that has received national recognition for one of the shortest door to balloon times for patients with acute myocardial infarctions.

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In association with this major health care provider, CHI manages implant medical devices and performs other cardiac procedures on a significant number of Medicare beneficiaries in the inpatient setting. Because inpatient services are a key component of the services provided in our cath labs, 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.

At this time, the bulk of hospital costs these services are paid out to the vendors of implantable devices. Drug-eluting stents are supplied only by two vendors. I understand that two additional vendors will enter the drug-eluting stent market within 18 to 24 months. I urge CMS to not reduce drug-eluting stent prices until after the competitive market impacts and reduces the implantable supply costs to the hospital. Otherwise, the hospital is squeezed in the middle.

Similarly, the bulk of the cost of an implantable cardiac defibrillator (ICD) implant hospitalization is for the cost of the device itself. The ICD technology is still relatively new and the manufacturers continue to leap-frog in technologies. The competition has been in technological innovation, rather than price reductions. Perhaps a small decrease in reimbursement would signal to the manufacturers that they should begin to compete on price, rather than technological innovations. Again, to reduce reimbursement puts the hospital in the middle and creates a financial squeeze.

First, this change 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, hospital technology costs could be underpaid.

The payment methodology changes that CMS has proposed would have a severe financial impact on the 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 the hospital's actual cost to deliver the service.

The reduction in payment for cardiology services would also have a severe impact on the infrastructure that I and others 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, all hospitals as well as physicians would now face the uncertainty of knowing that next year, or any other year, CMS could decide to under-fund whatever service area is necessary to meet patient needs. Obviously, if all of the hospitals and physicians who partner with the hospitals are 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 the hospital can be appropriately reflected in the DRG payments.

Thank you for your consideration.

Sincerely,

Dennis J. Battock, M.D., FACC
Medical Director, Colorado Heart Institute
1455 South Potomac St, Suite 101
Aurora, CO 80012
303 369-7565

Deleted: ¶

cc: Wayne Allard, US Senator
cc: Ken Salazar, US Senator

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Wayne Allard, Colorado US Senator
521 Dirksen Senate Office Building
Washington, DC 20510
Fax DC: 202-224-6471

Ken Salazar, Colorado US Senator
Pikes Peak Region
3 South Tejon, Suite 300B
Colorado Springs, CO 80903
Fax DC: 202-228-5036

Submitter : **Erica Douglass** **Date: 06/09/2006**

Organization : **SUNY Buffalo School of Medicine**

Category : **Other Practitioner**

Issue Areas/Comments

GME Payments

GME Payments

As a health care professional, 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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Erica Douglass

Submitter : Dr. Michael Parchman **Date:** 06/09/2006

Organization : Dr. Michael Parchman

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).

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

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

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

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

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

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

Sincerely,

Michael L. Parchman, MD

Submitter : Dr. Frederic Baker **Date:** 06/09/2006

Organization : UMMHC

Category : Individual

Issue Areas/Comments

GME Payments

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Sincerely,

Frederic Baker, MD

Submitter : Dr. Jonathan Bertman **Date:** 06/09/2006

Organization : South County Family Medicine, Inc.

Category : Physician

Issue Areas/Comments

GENERAL

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Hey, you guys nuts over there? Do you really want to continue to decrease money for training and education? Our medical community is already signifcantly worse than other developed nations - and removing money to train and educate our future primary care physicians is the surest way to ensure nobody capable or caring is around when you have a heart attack.

Submitter : Dr. Corrine Ganske **Date:** 06/09/2006

Organization : Iowa Health-Des Moines

Category : Physician

Issue Areas/Comments

GME Payments

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Sincerely,
Corrine M. Ganske, MD
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Submitter : Dr. Todd Kettering **Date:** 06/09/2006

Organization : Akron General Center for Family Medicine

Category : Individual

Issue Areas/Comments

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Sincerely,
Todd O. Kettering, D.O.

Submitter : Dr. Edmund Kim **Date:** 06/09/2006

Organization : Dr. Edmund Kim

Category : Individual

Issue Areas/Comments

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Edmund Kim

Submitter : Dr. E. C. Seeley **Date:** 06/09/2006

Organization : AAFP/KAFP

Category : Individual

Issue Areas/Comments

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