148

June 4, 2007

Leslie Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: CMS-1533-P, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates; Proposed Rule (Vol. 72, No. 85),

May 5, 2007

Dear Ms. Norwalk:

On behalf of myself as an employee of Northern Hospital of Surry County in Mount Airy, North Carolina I would like to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule for the fiscal year (FY) 2008 hospital inpatient prospective payment system (PPS).

While I agree with many of the proposed rule's provisions I oppose the proposed "behavioral offset" cuts related to the move to severity-adjusted diagnosis-related groups (DRGs) and the cuts to capital payments. I have read and am in agreement with the proposal submitted by the American Hospital Association.

Please take this proposal into your consideration. I understand that the current system is strained and healthcare costs and government expenditures are public hot topics, however, cutting reimbursement to healthcare facilities is not going to "fix" the problem. I personally feel the worst thing that every happened to healthcare was "insurance" and what is has evolved into today. It is damaging proper care of patients and denying access to good healthcare to others all in the name of "money".

Please re-evaluate the proposed changes under CMS-1533-P. Consider the fact that if you cut reimbursement, the patient will be the one to suffer. I pray it won't be one of your family members that will feel the effects.

Sincerely,

Ginger Allred

Mr.s Ginger K. Allred
Manager of Support Services
Northern Hospital of Surry County

149

Wake Forest University Baptist

June 6, 2007

Gina B. Ramsey
Chief Financial Officer
North Carolina Baptist Hospital

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Ms. Leslie Norwalk
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: (CMS-1533-P)
200 Independence Avenue, S.W. Room 445-G
Washington, DC 20201

Dear Ms. Norwalk:

North Carolina Baptist Hospital (NCBH) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule entitled, "Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems (IPPS) and Fiscal Year 2008 Rates; Proposed Rule (Vo.72, No.85), May 3, 2007." NCBH is part of Wake Forest University Baptist Medical Center, an academic health system comprised of 1,157 acute care, psychiatric, rehabilitation and long-term care beds located in the northwestern section of North Carolina, the region's main tertiary referral center.

While NCBH supports many of the proposed rule's provisions, we oppose the proposed "behavioral offset" cuts related to the move to severity-adjusted-diagnosis related groups. These proposed cuts to the Medicare program will have a severe impact on the millions of Americans who rely on this program for their health care.

Background:

On May 3, 2007, CMS released CMS-1533-P, which adopts the Medicare Severity Diagnosis-Related Groups (MS-DRGs), which bases hospital reimbursements on the complexity of medical diagnosis and services. CMS' proposal would reconfigure the existing 538 DRGs into 745 refined MS-DRGs. The underlying system of classifying patients and "rules of thumb" for coding under the proposed MS-DRGs is generally the same as current practice. It is our belief that we, along with other hospitals across the country, will have little ability to change our classification and coding practices.

Impact:

According to CMS, the regulation as proposed would impose a 2.4 percent cut to all inpatient hospital services for Medicare patients in FY 08 and 09 based on the assumption that hospitals will change coding practices, resulting in higher payments. This proposed cut, referred to as a "behavioral offset," will result in a $24 billion cut in operating payments over the next five years. NCBH estimates their annual share would be in excess of $3.7 million.

There is no law mandating CMS to impose a behavioral offset in the IPPS regulation, yet it has chosen to do so. These proposed cuts in reimbursement are based on conjecture and there is no precedent in other payment systems for making a prospective adjustment of this magnitude without any evidence of actual changes in coding. NCBH believes in having a healthy Medicare program, but thinks the proposed regulation goes far beyond what is needed to attain financial stability. We firmly believe that CMS-1533-P would undermine the viability of the nation's health care system and reduce or eliminate access to health care services for millions of Medicare beneficiaries.

Recommendations:

NCBH urges CMS to eliminate the behavioral offset as set forth in the proposed rule.

It remains committed to working with CMS, other health care organizations, such as the American Hospital Association (AHA), Association of American Medical Colleges (AAMC) and the National Association of Public Hospitals (NAPH) to ensure that Medicare beneficiaries have continued access to high quality, efficient and effective health care. We look forward to a continuing dialog as it relates to this proposed rule.

If you have any questions concerning these comments, please contact Joanne C. Ruhland, Vice President, Government Relations at jruhland@wfubmc.edu or 336-716-4772.

Sincerely,

Gina B. Ramsey
Vice President, Financial Services/CFO
North Carolina Baptist Hospital

cc: Senator Elizabeth Dole
Senator Richard Burr
Representative Virginia Foxx
Representative Mel Watt

NATIONAL
ASSOCIATION
OF EPILEPSY
CENTERS
NAEC

June 12, 2007

Leslie Norwalk
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Room 445-G
Washington, DC 20201

Re: CMS-1533-P, Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rate

Dear Ms. Norwalk,

The National Association of Epilepsy Centers (NAEC) is an organization of over 100 specialized centers in the U.S. that diagnose and treat patients with complex and intractable epilepsy. We appreciate the opportunity to comment on the proposed changes to the hospital inpatient PPS for FY 2008. NAEC applauds the changes in the DRG structure to better recognize differences in patient severity. Consistent with that objective, NAEC has two recommendations to refine the DRGs reported for seizures—DRG 100, Seizures with Major Complications or Comorbidities and DRG 101, Seizures without Major Complications or Comorbidities.

Most Medicare patients are admitted in the Seizure DRGs for acute treatment provided in a general medical/surgical setting. Patients with uncontrolled seizures or intractable epilepsy are admitted to an epilepsy center for a comprehensive evaluation to determine the epilepsy seizure type, cause and location. The inpatient admission typically includes 4 – 6 days of 24 hour monitoring with video and EEG along with cognitive testing and brain imaging procedures. A patient's experience in an epilepsy center is comparable to the highly technical care received in a hospital intensive care unit. More information on intractable epilepsy and the work of the specialized epilepsy centers can be found on the attached fact sheet.

With the assistance of an outside consultant (Christopher Hogan, Direct Research, Inc.) we conducted an analysis of the cost of cases in DRGs 100 and 101[1]. Specifically, we

[1] Claims were selected from the FY 2006 MedPAR proposed rule file. The file consisted of all claims in MS DRGs 100and 101 that passed the edits that CMS uses when recalibrating the charge portion of the DRG weights. Standardized charges were calculated using the new 2008 CMS methodology that separately standardized operating and capital costs. Standardization was based on the payment factors listed in the 2008 proposed rule impact file. Standardized cost was calculated as standardized charges in the 13 CMS charge categories on MedPAR, multiplied by the 13 national average cost-to-charge ratios published in the proposed rule, then summed to yield total standardized cost.

looked at the cost data for a target group - cases with a diagnosis of epilepsy (345.0 – 345.9) or convulsions (780.39) and where an EEG Video Monitoring (vEEG) procedure (ICD 89.10) or a Wada test (ICD 89.19) was performed. These cases are the patients that are seen in specialized epilepsy centers. We suspected that these patients would be substantially more costly to treat than other cases in these DRGs.

We analyzed the standardized costs and length of stay for all cases in each DRG and compared this to the standardized costs and length of stay for the target group cases (i.e., a diagnosis of 345 or 780.39 and either ICD 89.10 or 89.19 performed), and the standardized costs for cases in each DRG without the target cases. The data is as follows:

	mean std cost/all	mean std cost/non-target	mean std cost/target
DRG 100	$7,933 (6.3 days)	$7,912 (6.3 days)	$9,117 (7.1 days)
DRG 101	$4,142 (3.7 days)	$4,096 (3.7 days)	$5,118 (4.5 days)

For DRG 100, the mean cost of cases with the target diagnosis and procedures was about 15 percent more costly than other cases in that DRG and the length of stay was about 13 percent longer. For DRG 101, the cost of cases in the target group was about 25 percent higher and the length of stay was about 22 percent longer.

The data demonstrate that the "target" cases are substantially more costly than other cases within each of these DRGs. Consistent with CMS' objective of more accurately recognizing differences in patient severity, these cases should be classified separately. We therefore recommend to CMS that it subdivide DRGs 100 and 101 breaking out cases with a diagnosis of epilepsy where one of these costly diagnostic procedures was performed from all other cases in that DRG. These DRGs could be designated "Epilepsy Evaluation with MCCs" and "Epilepsy Evaluation without MCCs."

The target group cases constitute a small proportion of the total cases performed in these DRGs - less than 2 percent for cases in DRG 100 and about 5 percent for cases in DRG 101. We would also note that these diagnostic procedures are performed by a small minority of hospitals in the United States. Thus, the recommended refinement of the DRGs would have a minimal impact on other hospitals but would substantially improve the accuracy of payment to hospitals specializing in epilepsy care.

Please contact Ellen Riker, NAEC's Washington Representative (202-833-0007 or Ellen@marcassoc.com) with any questions.

Thank you again for the opportunity to comment.

Sincerely,

Robert J. Gumnit, MD

Robert J. Gumnit, MD

President

NATIONAL ASSOCIATION OF EPILEPSY CENTERS

NAEC

Specialized Epilepsy Centers

What is intractable epilepsy?
An estimated 2.7 million Americans suffer from some form of epilepsy. Even under the care of general neurologists or epileptologists, approximately 25 percent of patients with epilepsy do not attain adequate seizure control. Their epilepsy is characterized as *intractable*.

What is the purpose of a specialized epilepsy center?
Approximately 100 U.S. hospitals provide Level 3 or 4 epilepsy services. These hospitals staff a multi-disciplinary team of neurologists, neurosurgeons, psychiatrists, psychologists, social workers, nurses, and technicians to treat patients with complex and intractable epilepsy.

The primary goal of the team is to achieve complete control or at least a reduction in the frequency of seizures and/or medical side effects experienced by patients with intractable epilepsy so they might live with the best possible quality of life under the circumstances.

What is required to achieve the goal?
A comprehensive epilepsy evaluation provides epilepsy specialists with the necessary information to formulate a treatment plan, whether medical, surgical, or using an implanted stimulator. Treating intractable epilepsy patients on the basis of anything other than a comprehensive epilepsy evaluation is simply guesswork.

In order to determine a patient's intractable seizure type, cause, and location, a hospital-based evaluation usually is necessary. Video-EEG monitoring is the essential diagnostic tool used in Level 3 and 4 epilepsy centers. An even more intensive evaluation is a necessary prelude to selecting the 10% of intractable patients who would benefit from resective brain surgery or implanted brain stimulators.

What is a comprehensive epilepsy evaluation?
A comprehensive epilepsy evaluation can include video-EEG monitoring, cognitive testing, other specialized brain imaging and procedures to determine the diagnosis and to prepare the most effective medical or surgical treatment plan. During hospitalization, anticonvulsant medication withdrawal is often necessary in order for the patient to experience seizures. In some cases, this may precipitate overt seizures (balancing the need to provoke seizures but not induce status epilepticus requires expertise and intensive care). Seizures are recorded with video and EEG and analyzed by an epileptologist. Large amounts of data are collected and evaluated by specialists who collectively determine the patient's course of treatment.

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Evaluation for resective epilepsy surgery and implanted brain stimulators may include the implantation of intracranial electrodes, depth electrodes, strip electrodes or a grid electrode array to locate the seizure focus in the brain and its relationship to vital brain functions. Once the electrodes are in place on the surface of the brain, the epileptologist records activity to determine more precisely the location of the seizure focus and whether resective surgery is an option.

If it is determined that resective surgery is a viable option, the neurosurgeon will remove the affected brain tissue or lesion. Nationally, fewer than 1,000 patients each year require this double surgery, but this number is growing.

Intractable epilepsy makes for a very resource intensive patient. The patients seen at specialized epilepsy centers are often the most complex, requiring sophisticated testing and a high level of expertise in this specialty. A patient's experience in a specialized epilepsy center is comparable to the type of highly technical care received in a hospital intensive care unit.

MAYO CLINIC

151

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507-284-2511

June 12, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1533-P
P.O. Box 8011
Baltimore, MD 21244-1850

Re: File Code CMS-1488-P

Comments to Proposed Rule 72 FR 24680, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates

We appreciate the opportunity to provide comments on the proposed changes to the Inpatient Prospective Payment System (IPPS) that were published in the May 3, 2007 Federal Register.

"DRG Reform and Proposed MS-DRGs"

We understand your rationale for developing a severity adjusted DRG system, however, we respectfully disagree with the proposed timing of the implementation. This represents a significant change from the current DRG system, and materially redistributes reimbursement across hospitals. A proposed change of this magnitude deserves a complete review of the logic behind the proposed changes. RAND delivered a preliminary report analyzing five systems that CMS may consider adopting in future years. However, RAND did not review the proposed MS-DRG system. There is no mention of a completed independent third party review of the proposed severity adjusted system. We recommend that the proposed implementation be delayed to permit a complete analysis.

We strongly disagree with the proposed adjustment to the standardized rate by 2.4 percent each year for FY 2008 and FY 2009. The 2.4 percent behavioral offset is based on assumptions made with little to no data or experience, and can not be justified in advance of making the DRG changes. The analysis used to determine the adjustment relies on assumptions that may not extrapolate to the nation. The assumptions used in determining the percentages do not have statistical support. For example, CMS states, "...we believe the weight given to teaching hospitals should be higher than the 10 percent for the two early transition hospitals but lower than the 50 percent of discharges that they account for in Maryland. The Actuary gave a weight of 25 percent for teaching hospitals and 75 percent for the rest of Maryland to the excess growth in case-mix over the national average" (72 FR 24710). The analysis does not provide a rational reason for weighting the teaching hospitals at 25 percent other than it is between 50 percent and 10 percent. CMS fails to prove if the mix of hospitals and services provide a representative sample of the nation. The analysis also does not analyze if practice changes, or other changes other than coding behavioral changes, impact the case mix index changes for two hospitals that determine 25 percent of the adjustment.

The proposed 2.4 percent adjustment does not correlate to the coder's ability to improve coding. Coders report that all complications and comorbidities are currently reported on the claim, regardless of reimbursement impact. Quality benchmark reporting purposes currently provide incentive to

hospitals to accurately report all complications and comorbidities. Coders do not expect to change the level of coding because of a grouper change.

We believe a one year postponement of implementation of a severity adjusted DRG system will allow all stakeholders time to adequately review the RAND report, and the corresponding CMS proposal. The postponement will also create more stability to the DRG payment system by requiring only one change to a severity-adjusted system rather than multiple changes, as proposed now. Further, a postponement will allow time to better understand the implications on coding and refine the calculation to determine if a behavioral offset is necessary. We also recommend posting a separate proposed rule further in advance to allow for more time for stakeholder review, rather than including this significant change in the Inpatient Proposed Rule published annually in May.

Another option for CMS to consider is to transition the new system over a period of time (eg. three or four years). This would spread the significant redistribution over a period of time.

"DRGs: Relative Weight Calculations"

We agree with both , Research Triangle Institute's (RTI's) and CMS's recommendation to revise the cost reporting instructions to improve consistency between how charges are reported on cost reports and in the Medicare claims.

Currently, in accordance with cost report instructions, hospitals have three different options for reporting costs and charges within the cost report. Each method achieves aligning of costs with charges within the various cost report line numbers. However, with the shift from using charges to costs to recalibrate the DRG weights, CMS's methodology fails to account uniformly for these various types of reporting by providers. Since the cost report now has a direct impact to the calculation of the DRG weights, we support a unified approach to reporting costs and charges within the cost report. We recommend that CMS revise its cost report instructions to providers in order to more appropriately determine cost weights with the current CMS methodology.

"IME Adjustment"

We believe vacation time and sick leave are part of a residents benefit package and the hospital must incur the costs for these residents while on sick leave and vacation. A hospital is expected to have these types of benefits for their residents. An appropriate allocation of the time should follow the resident's rotation prior to the sick leave or vacation time. The inclusion of this time should be recorded as the same rotation schedule in which the resident was assigned prior to the first day of the absent. We present the following recommendations for counting and tracking these absences:

- If a resident is on a hospital rotation the day prior to sick leave or vacation time, than the time would be recorded as hospital time.
- If a resident has split time between hospital and clinic, than the sick leave or vacation time would be recorded as such.
- If a resident is off campus prior to vacation, than the sick leave or vacation time would be recorded as non-allowable time.

These recommendations would more appropriately account for the sick leave or vacation time and in some cases, would result in lower FTE count as well as a higher FTE count and be less burdensome to the providers for calculation purposes.

The Federal Register proposed vacation and sick time be removed from the numerator and denominator of the FTE count for both IME and direct GME. Removing the FTE counts from the numerator and denominator will create even more tedious documentation for the provider and additional tracking efforts. The removal of the time from the numerator and denominator will also create a need to update provider's software applications currently used for tracking purposes since most software and reporting systems are based on 365 days per year. This change will create a significant increase in resource allocation for teaching hospitals with minimal reimbursement impact. We request CMS consider the following questions:

- What type of documentation would be required for the vacation and sick time elimination?
- If the numerator and denominator are to be adjusted from the calculation, how will this affect the IRISV3 database since it is based on 365 days? Would this be updated by CMS?
- Consider the costs and additional resources for providers to upgrade tracking systems for a proposal that has minimal impact on reimbursement.

We understand the attempt to properly classify vacation and sick time. We also understand the importance of appropriately accounting for the time in the FTE calculation. However, the additional burden of incorporating the change into FTE calculations outweighs the benefit of any immaterial changes in the FTE counts. (For hospitals, that are at or over the FTE cap, the change does not have an impact on reimbursement.) We respectfully request that CMS consider the administrative burden of this proposal and elect to continue the current practice of accounting for resident FTE time related to vacation and sick time.

"Capital IPPS"

CMS states in the proposed rule:

> "Hospital margins, the difference between the costs of actually providing services and the payments received under a particular system, thus provide some evidence concerning whether payment rates have been established and updated at an appropriate level over time for efficient providers to provide necessary services." (72 FR 24819)

The 2007 MedPAC report indicates that overall margins are -5.4% on services provided by hospitals to the Medicare program, and trending downward over the past five years. Applying CMS logic to current hospital margins, we conclude there is significant evidence proving that established payment rates, and updates, are below an appropriate level to provide necessary services.

We strongly disagree with any proposals to reduce or eliminate capital updates or payments, in any form, without analyzing all hospital payment rate mechanisms and the appropriateness of their current level. Reducing only the capital payments, without analyzing other areas of hospital reimbursement that have significant negative margins, will only further reduce the overall margin on services provided to Medicare beneficiaries. We recommend CMS delete the proposal to remove the large urban add-on, and recommend CMS not implement the zero percent proposed update

factor for urban hospitals. Similar to rural hospitals, we recommend applying the 0.8 percent update to urban hospitals.

"Rural Floor"

The Federal Register states, "...keeping with the statute, which requires that the rural floor will not result in aggregate payments that are greater or less than those that would have been made in the absence of a rural floor." (72 FR 24792)

We interpret this comment to mean that overall Medicare payments must remain the same as if the rural floor did not exist. From 1999 through 2006 CMS has applied the rural floor budget neutrality adjustment to the standardized wage index amount. However, CMS has not reversed the prior year rural floor adjustment. This has led to a compounding effect of the rural floor budget neutrality adjustment for those years, and consequently reduced the aggregate payments to hospitals.

We respectfully request the final rule include an increase to the budget neutrality adjustment to correct the previous non-reversals of budget neutrality adjustments, related to the rural floor, for periods 1999 through 2006. This request will allow the rural floor payment adjustments related to align with the referenced statute.

"Occupational Mix Adjustment"

Section 1886(d)(3)(E) of the Social Security Act provides for the collection for the Occupational Mix Adjustment data every three years. CMS acknowledges that some hospitals did not complete the survey data form, and other hospitals submitted data that could not be used because it was determined to be "aberrant". We propose that a penalty be established to a hospital that does not submit occupational mix survey data. Similar to the penalty for not reporting Hospital Quality Data, we suggest a penalty of a two percent reduction in the hospital's wage index value in FFY 2010 for non submission, or submission of aberrant data related to the occupational mix survey.

"DRGs: Hospital-Acquired Conditions"

CMS has identified Catheter-Associated Urinary Tract Infections (CAUTI), and Staphylococcus Aureus Bloodstream Infection/Septicemia as two hospital-acquired conditions that will no longer be eligible for a higher DRG payment beginning in FY 2009. We disagree with the choice of CAUTI, and Staphylococcus Aureus Bloodstream Infection/Septicemia as a reportable hospital acquired condition.

The proposal on CAUTI seems to be consistent with guidance on the appropriate selection/utilization/elimination of urinary catheters in hospitalized patients. Assuming hospitals are consistent in their coding using the CDC and NHSN definitions, this would be a reasonable proposal. However, a previous study/audit done in Pennsylvania at Lehigh Valley showed that only 55 percent of those coded as CAUTI really met the diagnostic/epidemiologic criteria. Thus, there may be over-coding of these infections which would then result in an incorrect reduction in reimbursement.

In addition, most CAUTI cases seen in large tertiary care hospitals are bacteruria without disease. Many are community-acquired bacteruria only documented after Urinary Catheter usage. The cost of

screening for pre-existing bacteruria would far exceed any savings in catheter associated UTI reduction.

Another problem can occur in evaluating patients with febrile illness or unexplained leukocytosis or mentation changes, particularly in the elderly (Medicare patients). Urine cultures are often obtained as it is the most convenient sample when the patient has an indwelling urine catheter. These may reflect catheter associated bacteriuria from catheter biofilms and not truly pathogenic infection but are often treated with antibiotics and labeled CAUTI.

We also disagree with the choice of Staphylococcus Aureus Bloodstream Infection/Septicemia as a reportable hospital acquired condition. Staphylococcus aureus sepsis and bacteremia reduction is an arbitrary focus that diverts effort and resources for a financial reason, not on an institutional patient needs basis. This may be convenient as an indicator for CMS, but is not a rational "carve out" for overall patient safety nor an appropriate resource allocation for all institutions. Staph sepsis does not indicate quality nor inferior care. The rate may vary because of many factors unrelated to care provided. It may relate to patient population, geographic location, case mix, nursing home component, or other factors. Variables are introduced that are independent of actual institutional performance.

Infectious complications are not always preventable and we believe that the pay for performance goal will not be completely achieved by this proposal. An alternative approach would be to monitor the average rate for such infectious complications, available from the CDC NNIS data, and deny payment for excess cases of the complication to institutions that exceed the average rate. The cost of some infectious conditions can be very high and denial of payment for unavoidable complications has the result of shifting the health cost burden to other stakeholders.

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Thank you for the opportunity to comment on this proposed rule and for consideration of our comments. If you have any questions, please contact Chris Tholen at 507-284-0940 or me at 507-284-4627.

Very truly yours,

Ronald Grousky

Ronald Grousky
Director, Medicare Strategy Unit

bcc: Chris Tholen, Mayo Foundation
Bruce Kelly, Mayo Foundation