

Submitter : Dr. James Spahn
Organization : EHOB, Incorporated
Category : Physician

Date: 10/10/2007

Issue Areas/Comments

GENERAL

GENERAL

As a physician and medical device manufacturer, I question the practice of allowing a company whose pressure ulcer prevention support surface has failed, to then provide a specialty bed to the facility at no cost. This practice may easily create a conflict of interest between the manufacturer and facility. A support surface which may not be appropriate for all patients would be purchased by the facility and then the facility rewarded with the receipt of an expensive bed, at no charge, due to the failure of the previous use of the inappropriate product. My concern centers around the ethics of this practice and I believe contradicts the intent of the new MS-DRG revision associated with pressure ulcer prevention and treatment. I would hope this practice will be specifically addressed in future ruling. Please address your response to the author, James Spahn, MD, FACS to 800.966.3462.

Submitter : Dr. Gary Wainer
Organization : MacNeal Hospital
Category : Hospital

Date: 10/11/2007

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1533-FC-45-Attach-1.DOC



#45
Dr. Gary Wainer
Vice President, MacNeal Hospital
3249 South Oak Park Avenue
Berwyn, Illinois 60402
Phone: 708-783-3007
Fax: 708-783-3489
E mail: gwainer@macneal.com

10/10/2007

Dear Sir/Madam,

I am writing to you today on behalf of MacNeal Hospital, Berwyn, Illinois in opposition to Inpatient Prospective Payment Final Rule. This year's Medicare hospital inpatient PPS final rule contained a proposal to eliminate capital IME payments that would result in an estimated annual aggregate cut to teaching hospitals of \$385 million. If finalized, the capital IME payment adjustment would be reduced by 50% in FY 2009 and 100% in FY 2010 and thereafter. We think this will have disastrous effects for the teaching institutions in our country which rely heavily on government moneys to continue to provide quality teaching.

MacNeal Hospital is a 427 bed community/teaching hospital in the suburbs of Chicago. We have one of the oldest Family Medicine Residency programs in the country, and the oldest in Illinois. We are affiliated with the University of Chicago and have a stand alone Transitional Year residency program, as well as training for University of Chicago residents in Obstetrics and Gynecology, Surgery, and Internal medicine, and University of Illinois residents in Emergency Medicine. We also serve the University of Illinois, Loyola University, Rush University and University of Chicago medical schools in Chicago by training their students. MacNeal is also an approved Family Medicine Residency for the American Osteopathic Association and 5 of the 12 of our first year Family Medicine residents are from osteopathic schools.

McNeal's population is a changing one and we serve primarily Hispanic and Eastern European ethnic populations. Along with the demographic changes, so too are the socioeconomic changes and we are seeing, like most other hospitals, a significant increase in those patients unable to pay for their sorely needed health care. In our last fiscal year, our actual charity cost approached 4% of gross charges, a significant amount. The presence of our teaching programs allows us to continue to provide that care to that population.

*MacNeal Hospital
3249 S. Oak Park Avenue
Berwyn, IL 60402*

In direct terms, the institution of this rule will have the following impact on MacNeal:

FY 2010 (100%) Impact of Capital IME Payment Elimination: \$0.3 million
FY 2009-2013 Impact of Capital IME Payment Elimination: \$1.34 million

Clearly y reduction of IME to this degree will have significant operating impact and our ability to both continue to care for our populations as well as continue to provide the kind of quality medical education we have become known for.

We would respectfully request to withdraw the present proposal and instead develop a rule that more accurately reflect the costs of teaching resident physicians.

Sincerely yours,

Gary C. Wainer, D.O.
Vice President,
MacNeal Hospital

*MacNeal Hospital
3249 S. Oak Park Avenue
Berwyn, IL 60402*

Submitter : Mr. Edward Karlovich

Date: 10/19/2007

Organization : UPMC

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1533-FC-46-Attach-1.DOC

#46 -

October 17, 2007

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

Via: UPS Delivery and
<http://www.cms.hhs.gov/eRulemaking>

ATTENTION: CMS-1533-FC

RE: CMS-1533-FC
Medicare Program; Changes to the Hospital Inpatient Prospective Payment
Systems and Fiscal Year 2008 Rates; Final Rule (Vol, 72, No.162), August
22, 2007

Dear Sir or Madam:

On behalf of the University of the Pittsburgh Medical Center (UPMC) we are submitting one original and two copies of our comments regarding the Changes to the IPPS Capital Related Costs detailed in Section V. of the Center for Medicare and Medicaid Services (CMS) final rule (Federal Register / Vol. 72, No. 162 / August 22, 2007 pages 47392 - 47401) "Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates; Final Rule". We also are submitting these comments electronically to <http://www.cms.hhs.gov/eRulemaking>.

Although UPMC believed it was appropriate that CMS decided not to adopt two separate Capital rates, (one for Urban and another for Rural) and decided not to freeze the urban capital update for fiscal year 2008, we are still concerned with the other stated changes to the "Capital IPPS Payment Adjustments" for FY 2008 and beyond.

The following is a brief summary of the UPMC position and concerns regarding the Changes to the IPPS for Capital Related Costs of the FY2008 final rule, with more detailed responses in subsequent pages

1. Policy Change in final rule to Eliminate Capital Teaching (capital IME) over a Three Year Phase-in Period (FR 47401)

UPMC opposes CMS's proposal to phase-out capital Indirect Medical Education (IME) payments for indirect teaching costs over three years, as excessive payments, due to positive capital margins of teaching providers. UPMC's innovative and cutting edge teaching hospitals need to make significant capital investments in order to

update facilities, purchase high tech equipment, and update information systems required to provide the environment necessary to administer and maintain medical education programs, provide free and subsidized care for an increasing number of uninsured patients, as well as, to better care for an aging population. Medicare margins are projected by MedPAC to fall to a negative 5.4% in 2007 and will plummet further if the proposed cuts for 2008 are implemented.

2. Elimination of Large Urban Capital Add-on of 3 Percent (FR Page 47398)

UPMC does not support the elimination of the large urban capital add-on of three percent adopted in the final rule dated August 22, 2007. The elimination of this add on adjustment will disrupt the ability of large urban teaching hospitals to meet their long-term financial obligations. Hospitals cannot sustain additional cuts in an already under-funded system. According to the Medicare Payment Advisory Commission overall Medicare margins will reach a ten-year low of a negative 5.4 percent in 2007. Therefore, we urge CMS to reconsider the elimination of the 3% capital add-on for large urban hospitals.

3. CMS Proposal to Keep All Capital Savings Without a Budget Neutrality Adjustment to the Standardized Capital Rates (FR Page 47401)

While UPMC does not support any reductions to the capital IPPS rates, based on capital profit margin analysis, we recognize that CMS may proceed despite the strong opposition comments from the hospital industry. UPMC believes that any capital savings realized from large urban, teaching, or disproportionate share providers should not be kept by CMS but should be rolled back into the federal capital standard base rate or into the operating base rate. This is necessary since these payment categories were taken from the capital payments in a budget neutral manner when capital IPPS was started in 1991. Since capital funding is already at the 90 percent level we believe the proposal by CMS to keep all additional savings would be doing a disservice to the hospital community and contradict the required 10 percent capital savings provision.

Below please find more detailed explanations and comments on our positions to capital IPPS payment adjustments as highlighted above. We appreciate your review and consideration of our comments prior to the completion of any future final guidelines.

Section V., “Capital IPPS Payment Adjustments” (FR page 47392)

CMS Overview of Capital Payment Reductions and Proposals – CMS has identified several major capital payment reductions for “Large Urban”, “Teaching” and

“Disproportionate Share” hospitals in FY 2008 and / or beyond. These proposed capital adjustments and our concerns are discussed in further detail below.

1. CMS Plans to Eliminate Capital Teaching IME Payments over Three Years (FR Page 47401)

CMS Policy Change FY 2008 and Beyond: After receiving provider comments on the appropriateness of the teaching capital adjustment CMS indicated they will now exercise their discretion under the capital IPPS rules to eliminate the capital teaching (IME) adjustment. CMS indicates that they will accomplish this with a three year phase-out. In FY 2008 CMS will pay 100% of the capital IME; in FY 2009 CMS will pay 50% of the capital IME; and in FY 2010 CMS will totally eliminate payment for capital IME. CMS has also indicated that they will not increase the standard Federal capital rate to account for the savings from this phase-out of capital IME payments. CMS indicates that the record of relatively high and persistent positive capital margins for teaching hospitals under the capital IPPS indicates that this payment is no longer necessary.

Response: UPMC does not support these changes in payment policy, as indicated here and in our previously submitted IPPS comment letter of June 11, 2007. Once again, we urge CMS to drop their plan of eliminating capital IME for the following reasons:

First, the adoption of updated CMS capitalization policies may be a probable cause for higher capital profit margins for the larger urban providers. After the 10 year capital transition period ended and hospitals began getting paid based on 100% of the federal IPPS capital rates, many hospitals may have converted to newer CMS capitalization policies. Older CMS guidelines required capitalization of an asset if it was \$500 or more with an estimated useful life of at least two years. The newer guideline required an historical cost of at least \$5,000 and an estimated useful life of 2 or more years (CMS-Pub. 15-1, § 108.1 Acquisitions). Providers are permitted to establish capitalization policies with lower minimum criteria, but cannot exceed the \$5,000 limit. The adoption of these updated CMS guidelines would help providers, especially large providers with large volumes of equipment purchases, to reduce the administrative burden of identifying, tagging, depreciating, and tracking newer capital purchases since they would now be considered minor equipment and part of operating costs. It is conceivable that a shift in equipment purchases within these levels could amount to a significant decrease in capital costs which would result in higher capital margins. However, operating margins would decrease at the same time capital margins increased. Thus the consideration of only capital margins by CMS does a disservice to the providers under the scenario given. We believe that CMS should have done their analysis on total margins and “total cost” regression equations and payment simulation models just as CMS did when capital PPS began back in 1991. We believe that if total margins were considered by CMS they would not see large sustained profit margins but would see a sharp and steady decline in margins since 2002 – from a positive 2.4 percent to an estimated negative 5.4 percent in 2007.

These declining margins are substantiated by comments from MedPAC which indicate:

“...that urban and rural hospitals overall Medicare margins, reflecting both operating and capital inpatient payments along with payments for outpatient and hospital based post-acute services are roughly equal.” (MedPAC comment on page 47398 of the 8-22-2007 FR.)

“MedPAC also estimated an overall hospital Medicare margin in 2007 of negative 5.4 percent.” (per MedPAC March 2007 Report, page Xii.)

Second, while the Social Security Act does not specifically require IME payments or DSH payments in its required capital PPS it did give the Secretary substantial latitude in implementing the capital prospective payment system.

The SSA Requirements for Capital PPS (sections 1886(g)(1)) that the Secretary had to meet were:

Implement a PPS capital payment system for cost reporting periods on or after 10-1-1991

- Aggregate PPS capital payments from 1992 through 1995 shall be equal to a 10 percent reduction in the payment of capital-related cost that would have been made each year under the reasonable cost method.
- Provides for capital prospective payments on a per discharge basis appropriately weighted for the classification of the discharge. It also gives the Secretary discretion to provide for adjustments to capital prospective payments for relative cost variations in construction by building type or area, for appropriate exceptions (including those to reflect capital obligations), and for adjustments to reflect hospital occupancy rate.

The Secretary chose to model final Capital PPS adjustments after “Operating PPS” adjustments with some modifications based on regression analysis and payment simulations. (Several of the Modifications have been listed below):

- Establish a standard Federal rate for inpatient capital-related costs on a discharge basis
- Adjust payment for DRG weights
- Adjust payment for geographical location
- Provide for a disproportionate share payment adjustment for urban hospitals with 100 or more beds
- Adjust standard capital payment for adjustments in a budget neutral manner and to conform to 10 percent reduction requirements noted above
- Base all capital payment adjustments on total costs regression equations and payment simulations (The final capital rule as published in the FR 8-30-1991 shows the adoption of the following adjustments based on total cost analysis):

- a. We will increase a hospital's payments under the Federal rate by approximately 6.8 percent for every 10 percent increase in the hospital's wage index value.
- b. We will make a 3 percent add-on payment to large urban hospitals.
- c. We will increase a hospital's payments by approximately 2.0 percentage points for every .10 increase in its disproportionate share patient ratio.
- d. We will increase a hospital's payment by approximately 2.8 percentage points for every .10 increase in its ratio of residents to average daily inpatient census.
- e. We will make a cost of living adjustment in the payment to hospitals located in Alaska and Hawaii based on the current adjustment provided under the operating system.

Third, since these capital IME and DSH payment adjustments were founded based on "total cost" regression equations, payment simulations and modeled with some minor modifications after mandated operating PPS adjustments, we believe these historic capital add-ons should not be eliminated. CMS provided nothing in the current proposal to dispute the "total cost" regression computation and analysis from 1991. In addition, these capital add-ons have been in effect since 10-1-1991 and were based on actual provider cost data which clearly indicated that these larger teaching and DSH hospitals had costs greater than non-teaching providers...

See CMS response from (56 Federal Register 43358, August 30, 1991 – Section IV.)

"Notwithstanding this improvement in the capital cost data base, we have decided to establish the payment adjustments in this final rule using regression analysis of total costs per case (that is, combined operating and capital costs but not including direct medical education and other excluded costs) rather than using regression results applicable only to capital costs per case. We are persuaded by the argument advanced by some commenter's, including ProPAC, that in the long run the same adjustments should be applied to capital and operating payments and that the level of the adjustments should be determined by examining combined operating and capital costs. ProPAC recommended that the unified adjustments be calculated within two years. However, we believe that it would be most appropriate to implement these adjustments with respect to the capital prospective payment systems from the outset. While the payment adjustments for the operating prospective payment system are determined by the Act (and therefore cannot be modified by the rulemaking process), we have the latitude to develop adjustments based on combined costs for the capital prospective payment system."

Fourth, Capital Costs Related to Indirect Medical Education (IME) are Excluded from Operating IME Rates - The CMS response in the final Capital PPS rules confirms that the capital IME costs are not included in the operating IME and that the capital cost and IME rates were established based on "total cost regression analysis", and does not duplicate any other Medicare payment. CMS Capital Comment 8-30-1991:

8-30-1991 Response:” We disagree with the commenter’s with respect to the indirect costs of medical education. The indirect teaching adjustment under the operating prospective payment system is designed to represent the additional operating costs associated with teaching activity. It does not include any factor for higher capital costs since, prior to cost reporting periods beginning October 1, 1991, the capital costs have been payable on a reasonable cost basis. While the indirect teaching adjustment for capital costs that we are establishing in this final rule is based on the total cost regression analysis, adjusting capital payments by this factor will pay only the capital prospective payment system share of the indirect costs of medical education. Capital-related costs directly attributable to graduate medical education are classified as direct graduate medical education costs and included in the per resident amounts. These costs are not included in the capital-related costs used to establish the Federal rate or the payment adjustments. Further, the direct graduate medical education costs are removed from the costs used in the total cost regression equation. That is, the total cost regression equation includes only inpatient operating and capital costs and does not include the costs of graduate medical education.”

Fifth, Patients Expect the Latest Cutting Edge Technology - These proposed capital cuts (and others) would make it more difficult to purchase the advanced technology, equipment and clinical information systems that consumers have come to expect from large urban and teaching providers, and could have the effect of slowing clinical innovation. CMS has not completed an analysis of the impact of these proposed changes on the high-caliber medical education of our future physicians and the community-wide services on which hospitals often lose money providing, such as burn and neonatal units. CMS should not make such changes without assessing the broader ramifications to the health care teaching environment.

We again urge CMS to reverse their planned elimination of capital IME since it fails to recognize how CMS capitalization guidelines could affect a shift in costs from capital margins to operating margins. We believe that our example noted above clearly shows the inter relationship between the capital and operating margins of providers and that one should not be considered without the other. We also contend that to ignore this inter relationship and to proceed with this planned capital reduction is doing a disservice to the hospital community since hospital total margins are projected by MedPAC as negative -5.4 % for 2007, which is a ten year low. It is critical that hospitals have positive margins in low spending years to supplement payments in high spending years. We also disagree with the CMS proposal that all capital savings should be kept by CMS and not returned to the standardized capital or operating base rates developed in 1991.

2. Elimination of Large Urban Capital Add-on of 3 Percent (FR Page 47398)

FY 2008 Rule: CMS implemented the elimination of the three percent capital add-on for large urban hospitals, due to larger positive profit margins that exceed those of rural providers. CMS has also indicated they will not increase the standard capital rate

for the estimated funds saved by the elimination of this three percent “large urban capital add-on” adjustment. CMS indicates the Medicare program should realize this savings and not make the adjustment in a budget neutral manner, even though the base capital rate at PPS capital inception was reduced by the estimated expenditures attributed to this “large urban” capital add-on adjustment.

Response: We do not support the elimination of the large urban capital add-on of three percent, as implemented by CMS for FY2008 and urge the reversal of this elimination. This elimination of large urban capital add-on by CMS should be reconsidered for several reasons:

First, it is a major departure from the capital policies adopted by Medicare at the inception of capital PPS in FY 1992. At that time Medicare recognized through regression analysis, that large urban hospitals would be underpaid and rural hospitals would be overpaid relative to their actual capital costs per case without a payment differential between urban and rural. See CMS response from (56 Federal Register 43358, August 30, 1991 – Section IV.)

“CMS Response 8-30-91: We are setting the large urban add-on at 3.0 percent in this final rule. The total cost regression equations using the pooled data from cost reporting periods beginning in FY 1988 and FY 1989 indicate that large urban and other urban hospitals have higher total costs, with regression coefficients of 0.1808 and 0.1277 respectively. These results imply that the Federal payment rate should be approximately 18.1 percent higher for large urban hospitals, and 12.8 percent higher for other urban hospitals, compared to the payment to rural hospitals.” ...

“Making this comparison, we found that we would underpay rural hospitals relative to other hospitals if we were to adopt the differentials indicated by the regression equations. Moreover, we believe payment differentials of the magnitude suggested by the total cost regression equation would be contrary to the direction taken by Congress in section 4002 of Public Law 101-508 to phase out by fiscal year 1995 the separate standardized amounts for rural and other urban hospitals under the prospective payment system for operating costs.”...

“When we simulated a payment system with no payment differential for hospitals in a large urban location, we determined that these hospitals would be underpaid relative to other urban and rural hospitals. When we simulated a payment system with a 1.6 percent payment differential, equivalent to the differential in the proposed rule, we found that large urban hospitals would still be relatively underpaid. When we simulated a payment system with a payment differential of 5.3 percent, equivalent to the difference between the large urban and other urban regression coefficients, we determined that we would underpay hospitals in other urban areas relative to other hospitals. We then simulated a payment differential of 3.0 percent for hospitals located in a large urban area, and concluded that this adjustment provided the most appropriate balance between payments to hospitals in the three different geographic locations in that the percentage change from total cost per case for large urban and other urban hospitals is more comparable than in the other simulations.”

Second, while CMS has currently expressed its concern over the lower profit margins of the rural providers in relation to the higher profit margins of large urban and

teaching providers, they provided no performance factors, occupancy rates, length-of-stay, or cost per case trends to prove that the higher profit margin providers did not out perform the less profitable rural providers. In fact, the March 2007 MedPAC report indicates on page 64 that high margin hospitals (18% of hospitals) had a standardized 2005 cost per case of \$4,527 while low margin providers (18% of hospitals) had a standardized cost of \$6,203. The MedPAC report also indicated the low Medicare margin hospitals had smaller declines in length of stay, had higher growth costs and higher overall inpatient cost increases than those providers with consistently high margins. As a result providers with more consistent profit margins did work harder and were under more financial pressure to keep costs down to realize and maintain a profit. The stated intent of the Prospective Payment System (PPS) was to provide financial incentives to providers to provide a quality service to Medicare beneficiaries at a known fixed IPPS rate. Efficient providers would be rewarded with the cost savings and inefficient providers would lose money. Since CMS decided to adopt this capital proposal and eliminate the large urban three percent add-on, efficient providers may become discouraged to find cost savings when this was clearly not the intent of PPS and capital PPS.

We do not support the capital payment cuts implemented and proposed for large urban hospitals. The elimination of the large urban capital add-on adjustment, the proposed capital teaching IME elimination and possible future elimination of disproportionate share capital add-on payments can disrupt the ability of large urban teaching hospitals to meet their existing long-term financial obligations. These hospitals have committed to various long-term capital improvements, clinical information systems, or other high-tech advances under the expectation that Medicare's PPS capital-related cost formulas and rates would remain a stable source of income. Reducing these capital payments creates significant financial difficulties for our Nation's largest and most innovative hospitals. We urge CMS not to make further capital rate reductions and to reinstate the large urban capital add-on adjustment, especially when hospital margins are expected to reach a ten-year low in 2007 of negative 5.4 percent. (Per March 2007 MedPAC report).

3. CMS Proposal to Keep All Capital Savings Without a Budget Neutrality Adjustment to the Standardized Capital Rates (FR Page 47401)

CMS Policy Change FY 2008 and Beyond: CMS has repeatedly indicated that all savings generated from policy revisions to the capital IPPS will be kept by CMS and not rolled into the standard Federal capital base rate.

Response: While we do not support any reductions to the capital IPPS rates, based on capital profit margin analysis, we recognize that CMS has already implemented reductions and may continue to proceed with reductions despite the strong opposition comments from the hospital industry. As such we believe that any capital savings realized from large urban or teaching providers should not be kept by CMS but must be rolled back into the federal capital standard base rate or at last resort into the operating base rate. At the inception of PPS Capital in 1991 all capital payment add-

on provisions were taken from total capital payments in a budget neutral manner, so any capital savings generated (if adopted) should be returned to the capital base rate. In addition, we also contend that the CMS proposal to keep additional capital cost savings beyond the 90 percent level already taken when PPS capital base rates were established in FY 1992 appears to be a conflict to section 4001(b) of Public Law 101-508, section 1886(g)(1)(A) of the Act. Medicare was required to make capital payment reductions not to exceed 10 percent of the capital payments on a reasonable cost basis, and these savings were to be based on the best available data at the time. Since PPS Capital rates were established at levels equal to 90 percent of the aggregate Medicare capital cost under the reasonable cost basis, all proposals to keep additional capital savings (i.e. 3 percent of large-urban capital add-on; capital IME, etc.) would mean that CMS would exceed the required 10 percent capital cost savings. This proposal would appear to contradict that provision. We again urge Medicare to drop all capital payment reductions, but at the point they are adopted, we believe CMS must restore them to the base capital rate (or possibly the operating base rate.)

Closing Response on Proposed Capital Payment Reductions – UPMC opposes CMS’s proposal that capital payments for teaching and large urban hospitals are excessive and need to be reduced or eliminated. UPMC is an innovative and cutting edge health system that needs to make significant capital investments in order to update facilities, purchase high-tech equipment, and update information systems required to provide the environment necessary to administer and maintain medical education programs, as well as, to better care for an increasingly aging population. These reductions will affect all patients nationwide. The need for hospital care for seniors and the disabled covered by Medicare is increasing at a time when Medicare payments remain well below the cost of providing the care. Large urban teaching hospitals that also receive disproportionate share payments have an added burden of providing free and subsidized care for an increasing number of uninsured patients. In addition, large urban teaching hospitals are expected to be at the forefront of preparing for disasters such as pandemic and terrorist threats, and providing leadership in patient safety and infection control programs. Medicare needs to shore up these programs that provide for Medicare patients, not jeopardize them further. Medicare margins are projected by MedPAC to fall to a negative 5.4% in 2007 and will plummet further if the proposed cuts for 2008 are implemented. This trend is unsustainable over the long term. CMS’s proposed cuts in funding will disrupt the ability of large urban teaching hospitals to meet existing long-term financing obligations. UPMC has committed to these high-cost improvements expecting that Medicare funding provide a continuing stable source of income. UPMC again urges CMS to refrain from any reductions to capital payments for teaching, disproportionate share and large urban hospitals.

Conclusion

Due to the significance of the planned “capital Inpatient Prospective Payment Systems (IPPS) adjustments” we appreciate this additional opportunity to submit these comments for your consideration.

If you have any questions regarding our comments please telephone Paul Stimmel at (412) 623-6719.

Sincerely,

Edward Karlovich
Chief Financial Officer
Academic and Community Hospitals

CC: Concordia, Elizabeth
Farmer, David M.
Kennedy, Robert A.
Lewandowski, Christine
Stimmel, Paul
System CFO's
Zerega, Dennis

Submitter : Ms. Jody McGinnis
Organization : Adventist Health System
Category : Hospital

Date: 10/24/2007

Issue Areas/Comments

GENERAL

GENERAL

I understand that charting to a standard or charting by exception is no longer acceptable un the new PPS system for inpatients? Is there a period of time allotted timeframe for changing the platform for those who have an electronic version of documentation to a standard built and in practice already. This is a huge cultural practice shift. This will place undue burden on those with a live electronic version of documentation to a standard. This will require us to rebuild our documentation in the Cerner system. Any guidance you can give me will be greatly appreciated!

Submitter : Mr. Jerome Ndayishimiye

Date: 10/25/2007

Organization : Kaleida Health

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

This comment is about OPPS regarding hospital E/M visit

CMS-1533-FC-48-Attach-1.DOC

CMS-1533-FC-48-Attach-2.DOC

REQUEST FOR HCPCS CODING ADVICE

I have a question about reporting of triage services only **when the patient leaves before being seen by a physician** or another independent practitioner.

Our hospital does a full triage of patients which includes chief complaint, history of the chief complaint, medical history, condensed and/or focused body assessment, medication reconciliation, high risk social screening, pain assessment, standing orders/ protocols (e.g. blood draw, EKG, X-ray, etc), and give pain medications when necessary.

Since Medicare asked hospitals to report E/M visits based on hospital resources, would it be appropriate to report lower E/M visit (per hospital policy) and/or any other services provided by a nurse per standing order/protocols (e.g. EKG, lab, x-ray) if the patient decided to leave before a physician saw him/her?

Sincerely,

Jerome Ndayishimiye MS, RHIA, CIC
Outpatient Coding Coordinator

Kaleida Health
Buffalo General Hospital
100 High St
Buffalo, NY 14203

(Phone) 716-859-1948
(Fax) 716-1964

Submitter : Dr. Ron Anderson
Organization : Parkland Health & Hospital System
Category : Hospital
Issue Areas/Comments

Date: 10/29/2007

GENERAL

GENERAL

See attachment.

CMS-1533-FC-49-Attach-1.DOC



Parkland Health & Hospital System

October 11, 2007

Mr. Kerry N. Weems
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, D.C. 20201

*Parkland
Memorial
Hospital*

Re: 1533-FC Changes to the Hospital Inpatient Prospective Payment systems and Fiscal Year 2008 Rates

*Community
Oriented
Primary Care*

Dear Mr. Weems:

Parkland Health & Hospital System (Parkland) writes to convey serious concerns regarding the Centers for Medicare and Medicaid Services' (CMS) proposed elimination of capital Indirect Medical Education (IME) payments contained in the FY2008 Hospital Inpatient Prospect Payment Systems rates. ***Parkland strongly requests that CMS rescind this provision from the final rule.***

*Parkland
Community
Health
Plan, Inc.*

Parkland fills a unique place in the Dallas / Fort Worth Metroplex and has since our inception in 1894. We are mandated to furnish medical aid and hospital care to indigent and needy persons residing in Dallas County. However, our services go far beyond the Dallas County lines as we are a regional referral center. We provide \$409 million in uncompensated care annually. This is due to the fact that we were the first Level I trauma center in the state and are only one of two in Dallas County. Additionally, we operate a Level III Neonatal Intensive Care Unit and the second largest civilian burn center in the United States. On an annual basis, we will admit 42,682 patients and deliver 16,489 babies. Through our outpatient clinics and our system of community health centers, we will have 876,555 visits annually. In short, we are the provider of last resort. Dallas County has few other options should Parkland go away.

*Parkland
Foundation*

Elimination of the capital IME payments would result in an estimated annual aggregate cut to teaching hospitals of \$385 million. If finalized, the capital IME payment adjustment would be reduced by 50 percent in Fiscal Year 2009 and 100 percent in Fiscal Year 2010 and thereafter.

Based on our analysis of the proposed rule, Parkland would lose \$.88 million beginning in Fiscal Year 2010 when the 100 percent elimination takes effect. Over five years, Parkland will lose approximately \$3.99 million.

One of Parkland's primary missions is the education and training of health care professions. Fulfillment of this mission takes both operating resources, such as extra lab & radiological testing to assure accurate diagnosis, and capital resources such as more exam rooms because residents take longer to perform examinations and procedures. With a confluence of factors such as the dwindling number of physicians and the baby boomers ready to hit the Medicare system, we should be strengthening our medical education training programs, not removing funding from the facilities that host them.

Parkland appreciates the opportunity to submit these additional comments and to reiterate our strong opposition to the provisions of this Final Rule. If you have any questions, please contact Keri Disney with our government reimbursement department or Dr. Jennifer Cutrer and Steven Bristow with our legislative affairs department.

Respectfully,

Ron Anderson, MD
President & CEO

Submitter : Ms. Sally Enevoldson
Organization : University of Kansas Hospital
Category : Hospital

Date: 11/01/2007

Issue Areas/Comments

Capital IPPS Payment Adjustments

Capital IPPS Payment Adjustments

The University of Kansas Hospital (UKH) appreciates the opportunity to comment on CMS's proposed rule regarding the capital IPPS teaching adjustment. We are a 512-bed teaching hospital with approximately 437 residents.

We understand that CMS is proposing to phase out the capital IPPS teaching adjustment by reducing it by 50% in FY 2009 and eliminating it in FY 2010. Based on the table of Hospital Inpatient Medicare Capital Margins, it would be easy to come to the conclusion that teaching hospitals are being overpaid for capital. Unfortunately, the table does not reflect the tremendous costs that we are beginning to incur to replace infrastructure that is 30 years old and does not prepare the way for expansion due to an increase in the number of patients.

UKH has spent approximately \$22 million over the past four years to replace an aging utility plant with insufficient capacity for both University and Hospital growth. UKH has spent \$55 million over the past three years to purchase and renovate a building and supply it with state-of-the-art equipment to house its ever-expanding cancer center in preparation of application for National Cancer Institute designation. UKH plans to spend in excess of \$56 million over the next ten years to replace its aging air handling units, steam and chilled water piping, duct work, electrical system and exterior siding.

We are grateful that CMS would like to provide teaching hospitals an opportunity to plan and make adjustments to the change, since many other teaching hospitals are also facing an increased demand in capital needs due to aging buildings and infrastructure. Unfortunately for UKH, that might mean that we must re-evaluate the unprofitable lines of business that we provide as a community service.

For example, the UKH Poison Control Center has served the state of Kansas for 25 years. The center is staffed by pharmacists and nurses specifically trained to handle emergencies involving chemicals, drugs, bites, stings and environmental hazards. Led by the state's only toxicologist, the center handled more than 25,100 calls from the public, emergency rooms, EMS services and schools in 2007. The service is available 24 hours a day, 365 days a year. The poison center's medical director, managing director and education coordinator provide educational programs throughout the state of Kansas each year.

UKH also operates a 28-station Outpatient Dialysis Center. Most of these dialysis patients qualify for Medicare reimbursement, which does not adequately cover the expenses associated with this highly specialized service.

UKH requests that CMS rescind this proposal. Thank you for your consideration.

Submitter : Dr. Robert Wetz
Organization : Staten Island University Hospital
Category : Hospital

Date: 11/05/2007

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1533-FC-51-Attach-1.PDF

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

The attachment cited in this document is not included because of one of the following:

- The submitter made an error when attaching the document. (We note that the commenter must click the yellow "Attach File" button to forward the attachment.)
- The attachment was received but the document attached was improperly formatted or in provided in a format that we are unable to accept. (We are not are not able to receive attachments that have been prepared in excel or zip files).
- The document provided was a password-protected file and CMS was given read-only access.

Please direct any questions or comments regarding this attachment to (800) 743-3951.

Submitter : Mr. Fred Manchur
Organization : Kettering Medical Center
Category : Hospital

Date: 11/06/2007

Issue Areas/Comments

Capital IPPS Payment Adjustments

Capital IPPS Payment Adjustments

October 30, 2007

Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore MD 21244-1850

I m writing to comment on the great harm that this year s Medicare hospital inpatient PPS final rule will cause to teaching hospitals and to the nation s ability to train physicians to meet the growing demand of our aging population.

The final rule contains a proposal to eliminate capital IME payments that would result in an estimated annual aggregate cut to teaching hospitals of \$385 million. Those cuts pose great harm to all teaching hospitals. I have no doubt that these funding cuts will damage our ability to care for patients and to provide quality training for physicians.

If it is finalized, the capital IME payment adjustment would be reduced by 50% in FY 2009 and 100% in FY 2010 and thereafter. Kettering Medical Center, for example, would lose about \$2,000,000 from FY 09-13 if the rule is not changed.

The impact of this rule will be to drive up the cost of health care by making it more difficult to train enough physicians to serve our nation. That would seem counterproductive to the agency s overall efforts to lower health care costs and increase access to care for all of our citizens.

Sincerely,

Fred Manchur
President
Kettering Medical Center

Submitter : Maurice Washington

Date: 11/09/2007

Organization : Nevada State Senate

Category : State Government

Issue Areas/Comments

Capital IPPS Payment Adjustments

Capital IPPS Payment Adjustments

Nevada Senator Maurice E. Washington opposes proposed Capital IPPS Payment Adjustments.

GENERAL

GENERAL

See attachment

CMS-1533-FC-53-Attach-1.RTF

November 9, 2007

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1533-FC
Post Office Box 8011
Baltimore, Maryland 21244-1850

Re: Capital IPPS Payment Adjustments, CMS-1533-FC

Dear Sir or Madam:

As Chairman of the Nevada State Senate Committee on Human Resources and Education and the Vice-Chairman of Nevada's Legislative Committee on Health Care, I am writing to protest the cuts in capital payments to hospitals that appear in the CMS-1533-FC, the final rule with comment period to revise Medicare's Inpatient Prospective Payment System (IPPS), as published in the August 22, 2007, *Federal Register* by the Centers for Medicare and Medicaid Services (CMS), United States Department of Health and Human Services. This letter is being submitted during the extended public comment period for Section V., "Changes to the IPPS for Capital-Related Costs," which runs until November 20, 2007.

Specifically, I protest the CMS' elimination of the 3 percent add-on to capital payments for large urban hospitals and the phase-out of the indirect medical education (IME) adjustment to capital payments in Fiscal Year (FY) 2009 and FY 2010.

Capital cuts of this magnitude, made without congressional direction, are unprecedented. They will disrupt hospitals' ability to meet existing long-term financing obligations for capital improvements. These improvements are essential if hospitals are to increase capacity where needed, address ongoing maintenance requirements, update facilities, and keep pace with important technological improvements.

Putting the situation into perspective, Nevada's 15 largest hospitals invested \$348 million in 2005 in expansion and improvement projects, and rural hospitals invested another \$42 million. Nevada is a state deeply in need of hospital expansion because of our rapid population growth.

We rank nearly last in the Nation in number of hospital beds per capita and have one of the lowest ratios of physicians per capita. Cuts in capital payments by Medicare will threaten the expansion of hospital facilities we need and do not bode well for efforts to recruit the physicians and other medical personnel in such short supply in Nevada. Phasing out the IME adjustment will further penalize hospitals serving an essential role in training new physicians.

Like any business, a hospital must have a margin in low spending years in order to access financing for large, long-term projects. Yet CMS' calculations appear to be based on margins through FY 2004 and, thus, do not take into account the subsequent downward trend. In addition, CMS apparently has concluded that even a modest capital margin, such as 5.1 percent, is excessive.

According to the Nevada Hospital Association, approximately half of hospitals in Nevada lose money each year, even without factoring in new capital cuts. Hospitals in Nevada realized only a 2.8 percent profit margin in 2005, compared to profit margins of 19 percent for the gaming industry, 26 percent for pharmaceutical corporations, and 10 percent for accident and health insurance companies. Even grocery companies and the ailing airline industry showed a 5 percent profit margin.

An analysis conducted by the American Hospital Association prior to the publication of CMS-1533-FC indicated that proposed reductions in capital payments would cost Nevada hospitals \$2.4 million in FY 2008 and \$18 million from FY 2008 through FY 2012. Fortunately, the final rule did not include a proposal to freeze capital payments to urban hospitals and eliminate a .9 percent update these hospitals are due to receive. While this reprieve is appreciated, total projected losses to Nevada's hospitals due to the capital cuts would still be significant. To the extent possible, hospitals would need to pass these costs along to the paying customers, which in most cases are the insurance companies. Insurers would then raise premiums, resulting in more uninsured Nevadans who cannot afford health insurance.

I certainly understand the need to control government spending. However, CMS has chosen to accomplish these cuts through the rulemaking process, without consideration of congressional guidance or intent. In addition, CMS may have understated the severity of the proposed capital cuts, since they appear to be based on an out-of-date analysis of profit margins.

Page 3
November 9, 2007

I urge the CMS to reconsider imposing these onerous and counterproductive cuts in capital payments to hospitals.

Sincerely,

A handwritten signature in black ink, appearing to read "Maurice E. Washington".

Maurice E. Washington
Nevada State Senator

MEW/sg:W79025

Submitter : Ms. Heather Hulscher
Organization : Iowa Hospital Association
Category : Health Care Provider/Association

Date: 11/14/2007

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1533-FC-54-Attach-1.PDF



November 14, 2007

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

Ref: CMS—1533—FC Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and FY 2008 Rates; Final Rule with Comment Period (72 *Federal Register* 47130), August, 22, 2007.

Dear Mr. Weems,

On behalf of Iowa’s 17 hospitals providing medical education, the Iowa Hospital Association (IHA) is pleased to take this opportunity to provide comment on the Centers for Medicare & Medicaid Services (CMS) final rule with comment period for the FY 2008 inpatient Prospective Payment System (PPS) published in the August 22, 2007 *Federal Register*.

Capital IPPS Payment Adjustments

In this final rule with comment period, CMS finalized the elimination of capital Indirect Medical Education (IME) payments with a three year transition period.

IHA opposes any attempt by CMS to reduce graduate medical education payments to Iowa hospitals. Iowa’s teaching hospitals will lose an estimated \$10.3 million over the next five years as a result of this payment cut.

The Iowa health care system is on the brink of a physician supply crisis. This is a pervasive issue that affects the state as a whole, including Medicare recipients. Relocation to other states is significant and is the principal reason for attrition from the supply of Iowa physicians, accounting for more than 60 percent of the annual loss, according to a University of Iowa’s Carver College workforce report released in 2007. The physician shortage is a direct correlation to inadequate reimbursement from the Medicare program for both hospitals and physicians.

Compounding Iowa’s low Medicare reimbursement rates is Iowa’s large percentage of Medicare population; Iowa has the fourth highest percentage of residents 65 years and older, and ties second in the

nation for residents 85 years and older. Given Iowa's aging population, the demand for physician services will only increase.

Iowa's hospitals receive among the lowest reimbursement from the Medicare program in the country with total Medicare margins of **negative 3.4 percent**, and an expected loss of \$100 million in 2006. While the agency has chosen to specifically isolate capital IME margins, IHA contends CMS must consider the totality of the financial health of teaching hospitals and the impact to Medicare recipients prior to making harmful payment policy changes. The financial constraints under which these hospitals are operating make it difficult to continue providing the medical education for residents because there is no other financial source to offset the additional costs of training residents. And as detailed below, a recent interpretation by the Iowa Medicare fiscal intermediary (FI) will very soon result in harmful reductions to Iowa's residency programs.

In addition, CMS has provided no analysis on the impact of this payment reduction on the high-caliber medical education of future physicians, and the corresponding impact on Medicare beneficiaries. What this payment cut will achieve is the creation of more barriers for Iowa's Medicare recipients accessing necessary health care services.

The FI interpretation referenced earlier involves intern and resident time related to non-provider settings for shared programs. Shared programs are where two or more hospital providers jointly fund an intern and resident program. Typically, these shared programs are operated through a foundation. In order for a hospital to count a full-time equivalent (FTE) resident in a graduate medical education (GME) program at a non-hospital site, it must assume financial responsibility for the full complement of residents training at the non-hospital site in a specific GME program. A hospital cannot count any FTE resident time in a GME program working at a non-hospital site if it incurs all, or substantially all, of the costs for only a portion of the FTE residents in that program at the non-hospital site.

Because two or more hospitals may be involved with a foundation, interns and residents keep time studies to document the time spent on patient care activities in each location for the particular hospital to determine its financial responsibility. The foundation in turn bills the hospital on a regular basis (monthly), for *all* the costs of providing education to the interns and residents, both in the hospital and in the non-provider setting.

The FI's position is that since this is a shared program, neither hospital incurs all or substantially all of the costs to run the program, and therefore, the FI is unable to allow time spent in non-hospital settings to count toward the resident FTE. At issue is the FI's contention that the hospital is funding the foundation, rather than the residents.

Further troubling is that the Iowa FI is retroactively applying this interpretation to past cost reporting periods. Iowa hospitals had no reason to believe this type of relationship would be in question a few years ago because there was no written guidance or rules to state otherwise.

Because of this retroactive application by the FI, Iowa hospitals will begin to be negatively affected this fiscal year due to the three-year rolling average calculation for FTEs. Iowa hospitals' ability to fund medical residency programs will be in question in the near future absent corrections to this interpretation.

This structure of a foundation for medical education programs greatly reduces inefficiencies by eliminating duplication of administrative work that would necessarily be required by both hospitals, and

thus raise the cost of providing these programs. Iowa hospitals should be rewarded for their efficiencies, not penalized.

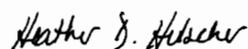
In addition to reversing the capital IME cuts stated in the final rule, IHA urges CMS to instruct its contractors to allow medical education program arrangements as stated above and to retroactively correct any audits that have occurred, without requiring the provider to go through the appeal process.

The Medicare program has continually reduced medical education payments over the past several years, making it difficult, if not impossible, for Iowa's hospitals to continue to provide this service and to recruit and retain the necessary work force to provide the medical services Iowa's Medicare population depends on.

On a more technical note, the policy as written in the August 22 *Federal Register* provides a one-year transition period as opposed to the three-year transition period stated in the rule. The rule as written begins with a 50 percent reduction in capital IME payments in FY 2009, followed by a 100 percent reduction in FY 2010.

Thank you for your review and consideration of these comments. If you have questions, please contact me at the Iowa Hospital Association at 515/288-1955.

Sincerely,



Heather D. Hulscher
Director, Finance Policy
Iowa Hospital Association

cc: IHA Board of Officers and Trustees
Iowa Congressional Delegation
Iowa Hospitals
CMS Kansas City Regional Office

Submitter : Dr. Kenneth Shine
Organization : The University of Texas System
Category : Other Health Care Provider

Date: 11/15/2007

Issue Areas/Comments

GENERAL

GENERAL

See attached.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES
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. Marilyn Litka-Klein
Organization : Michigan Health & Hospital Association
Category : Health Care Provider/Association

Date: 11/15/2007

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1533-FC-56-Attach-1.DOC



MICHIGAN HEALTH & HOSPITAL ASSOCIATION

Advocating for hospitals and the patients they serve.

November 15, 2007

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

RE: Capital IPPS Indirect Medical Education (IME) Payment Adjustments, Aug. 22, 2007 *Federal Register*, Pages 47394 -47401

Dear Sir:

On behalf of Michigan’s 145 nonprofit hospitals, the Michigan Health & Hospital Association (MHA) appreciates the opportunity to provide comments to the Centers for Medicare & Medicaid Services (CMS) regarding the phase-out of the indirect medical education (IME) adjustment for capital payments. Based on recommendations from MedPAC, as indicated in the FY 2008 IPPS final rule, the CMS intends to phase out the IME adjustment for capital payments. However, due to the significance of this change, the CMS is providing a comment period through Nov. 20, 2007, and indicated that the agency will seek further comments upon release of the FY 2009 IPPS proposed rule.

In FY 2008, the CMS will maintain the current IME adjustment under the capital IPPS but will reduce the teaching adjustment by 50 percent in FY 2009 and eliminate it entirely in FY 2010. The MHA objects to this policy change which is projected to reduce payments to Michigan’s teaching hospitals by approximately \$14 million in FY 2009 and \$28 million in FY 2010 and subsequent years. This payment reduction will threaten the financial viability of Michigan’s teaching hospitals while also threatening Michigan’s supply of future physicians to treat Medicare enrollees and other Michigan patients.

Background

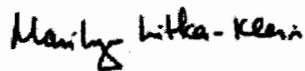
Under the Medicare inpatient prospective payment system (IPPS), Medicare is required to pay for the capital-related costs of inpatient hospital services. These costs include depreciation, interest, taxes, insurance and similar expenses for facilities, renovations, expensive clinical information systems and high-tech equipment (e.g., MRIs and CAT scanners). This is done through a separate capital PPS payment. Under the capital inpatient PPS, capital payments are currently adjusted by the same DRG weight for each case, as is done under the operating PPS.

PPS reimbursement for capital-related costs was implemented in FY 1992. Over a ten-year period, capital payments were transitioned from a reasonable cost-based methodology to a prospective methodology. Under the capital IPPS, the CMS has provided a teaching adjustment to eligible providers for indirect medical education (IME). Beginning in FY 2002, all hospitals were paid based on 100 percent of the capital federal rate, which is updated based on changes in a capital input price index (CIPI) and several other policy adjustment factors.

As indicated in its comments regarding the FY 2008 IPPS proposed rule, **the MHA strongly opposes the CMS' phase out of the IME under the capital PPS payment methodology.** The CMS has not analyzed the impact of this change on the high-caliber medical education of our future physicians and the community-wide services on which hospitals often lose money providing, such as burn and neonatal units. We believe it is irresponsible of the CMS to make such changes without a clear understanding of the broader ramifications, especially when many hospitals already face physician shortages, particularly in rural areas. **The MHA believes that it is vital that the CMS continue to provide this funding to support the technology needs of teaching hospitals to ensure that residents have access to training using the latest high-tech equipment and technology.**

Again, the MHA appreciates this opportunity to provide input to the CMS and urge you to withdraw the elimination of IME capital payments. If you have questions or require additional information, please contact me at (517) 703-8608 or mklein@mha.org.

Sincerely,



Marilyn Litka-Klein
Senior Director, Health Policy

Submitter : Mr. Kyle Sims
Organization : St. Anthony Hospital
Category : Nurse

Date: 11/15/2007

Issue Areas/Comments

GENERAL

GENERAL

We believe that the removal of "Uncontrolled DM" from the CC list is an error. Uncontrolled DM does effect a pt's stay and resources used. Whether it be from the scheduled FSBS checks and subsequent insulin dosing to the every hour FSBS checks and subsequent insulin drip adjustments. Uncontrolled DM also plays a part in the healing process of patients. Pt's with uncontrolled DM heal slower and have a greater risk of infection....therefore more intense monitoring and treating of the sugars are needed. If an infection of some sort rears itself then resources are utilized that may not have had to be if the DM was controlled. We strongly suggest and urge you to reconsider your decision to remove uncontrolled diabetes mellitus from the comorbid condition list and re-instate it as a comorbid condition. Thank you for your time with this.

Submitter : Mr. Don Snell
Organization : MCG Health, Inc.
Category : Hospital

Date: 11/16/2007

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1533-FC-58-Attach-1.PDF



Don Snell
President and Chief Executive Officer

November 12, 2007

Kerry N. Weems
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
Room 445-G
200 Independence Ave, SW
Washington, DC 20201

Re: Capital IME Payments

Dear Mr. Weems:

I am writing on behalf of MCG Health, Inc. (MCGHI). MCGHI is a 632 bed, two (2) hospital, public teaching hospital / safety net hospital (Level I Trauma Center, Level III NICU), that serves the patients and families of Georgia, South Carolina, and much of the Southeast. I am writing to urge the Centers for Medicare & Medicaid Services (CMS) to rescind the proposed rule that seeks to eliminate the adjustments to capital payments that currently are provided to teaching hospitals. Finalizing this rule would further erode the financial condition of teaching hospitals and hamper their ability to make the capital improvements necessary to train the next generation of doctors.

CMS has stated that Medicare Payment Advisory Commission (MedPAC) data demonstrates that teaching hospitals are receiving "excessive payment levels" and a cut to capital payments is warranted. MedPAC's data, however, does not take into account a full capital cycle of 15 to 20 years and the capital margins reported by MedPAC are not indicative of the overall financial positions of teaching hospitals. Cuts in both state and federal funding continue to make it difficult for teaching hospitals to operate in the black. A big picture perspective makes it clear that overall hospital margins for teaching hospitals continue to drop. Therefore, focusing solely on capital margins in recommending a cut in capital IME payments is not an accurate barometer of the financial environment in which teaching hospitals are operating.

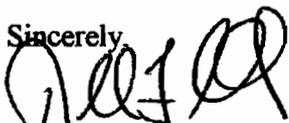
Teaching hospitals such as MCGHI rely on Medicare capital payments as a source of revenue for needed capital improvements. If the capital IME cut takes place, MCGHI will lose approximately \$500,000 in FY 2009 and is projected to lose \$4,000,000 from FY 2010 through FY 2013. MCGHI treats a high volume of low-income and indigent patients. When this fact is combined with the high costs associated with running a

teaching hospital, cutting capital IME payments will hamper MCGHI's (and all teaching hospitals') ability to make essential capital improvements so that it can remain competitive and provide high-quality services to Medicare patients. Staying ahead of the technology curve is critical for any hospital, but it is even more critical for hospitals such as MCGHI that are responsible for training the nation's doctors.

In addition to delaying or preventing timely capital improvements, as others have pointed out, positive capital margins are necessary if teaching hospitals are to continue investing in health information technology. The federal government has been at the forefront of pushing the expanded use of such technology. In fact, health information technology is key to implementing the quality improvement efforts and accountability measures that CMS itself has been promoting. The proposed capital IME cuts, however, will limit the ability of teaching hospitals to invest in this important technology.

Finally, teaching hospitals provide an environment in which clinical research can flourish and where highly specialized tertiary patient care such as trauma and cardiac care, and transplant services take place. Because of their education and research missions, teaching hospitals offer the most advanced, state-of-the-art services and equipment; and with residents and supervising physicians available around-the-clock, teaching hospitals care for the nation's sickest patients. Most recently, teaching hospitals, especially Level I trauma centers such as MCGHI, are looked to as front-line responders in the event of a biological, chemical, or nuclear attack and are implementing plans to fulfill that role. Given their important roles and the current and future financial uncertainty for America's teaching hospitals, a steady stream of capital payments are critical to ensuring that our hospital and all teaching hospitals are able to maintain the readiness infrastructure that is needed to train doctors and face such crises. **We urge the Agency to rescind the proposed rule.**

Sincerely,



Don Snell

President and CEO
MCG Health, Inc.



Don Snell
President and Chief Executive Officer

November 12, 2007

Kerry N. Weems
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
Room 445-G
200 Independence Ave, SW
Washington, DC 20201

Re: Capital IME Payments

Dear Mr. Weems:

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CMS has stated that Medicare Payment Advisory Commission (MedPAC) data demonstrates that teaching hospitals are receiving "excessive payment levels" and a cut to capital payments is warranted. MedPAC's data, however, does not take into account a full capital cycle of 15 to 20 years and the capital margins reported by MedPAC are not indicative of the overall financial positions of teaching hospitals. Cuts in both state and federal funding continue to make it difficult for teaching hospitals to operate in the black. A big picture perspective makes it clear that overall hospital margins for teaching hospitals continue to drop. Therefore, focusing solely on capital margins in recommending a cut in capital IME payments is not an accurate barometer of the financial environment in which teaching hospitals are operating.

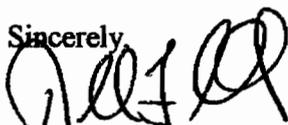
Teaching hospitals such as MCGHI rely on Medicare capital payments as a source of revenue for needed capital improvements. If the capital IME cut takes place, MCGHI will lose approximately \$500,000 in FY 2009 and is projected to lose \$4,000,000 from FY 2010 through FY 2013. MCGHI treats a high volume of low-income and indigent patients. When this fact is combined with the high costs associated with running a

teaching hospital, cutting capital IME payments will hamper MCGHI's (and all teaching hospitals') ability to make essential capital improvements so that it can remain competitive and provide high-quality services to Medicare patients. Staying ahead of the technology curve is critical for any hospital, but it is even more critical for hospitals such as MCGHI that are responsible for training the nation's doctors.

In addition to delaying or preventing timely capital improvements, as others have pointed out, positive capital margins are necessary if teaching hospitals are to continue investing in health information technology. The federal government has been at the forefront of pushing the expanded use of such technology. In fact, health information technology is key to implementing the quality improvement efforts and accountability measures that CMS itself has been promoting. The proposed capital IME cuts, however, will limit the ability of teaching hospitals to invest in this important technology.

Finally, teaching hospitals provide an environment in which clinical research can flourish and where highly specialized tertiary patient care such as trauma and cardiac care, and transplant services take place. Because of their education and research missions, teaching hospitals offer the most advanced, state-of-the-art services and equipment; and with residents and supervising physicians available around-the-clock, teaching hospitals care for the nation's sickest patients. Most recently, teaching hospitals, especially Level I trauma centers such as MCGHI, are looked to as front-line responders in the event of a biological, chemical, or nuclear attack and are implementing plans to fulfill that role. Given their important roles and the current and future financial uncertainty for America's teaching hospitals, a steady stream of capital payments are critical to ensuring that our hospital and all teaching hospitals are able to maintain the readiness infrastructure that is needed to train doctors and face such crises. **We urge the Agency to rescind the proposed rule.**

Sincerely



Don Snell

President and CEO
MCG Health, Inc.

Submitter : Mrs. Mary Whitbread
Organization : Henry Ford Health System
Category : Hospital

Date: 11/16/2007

Issue Areas/Comments

GENERAL

GENERAL

see attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES
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. Marilyn Litka-Klein
Organization : Michigan Health & Hospital Association
Category : Health Care Professional or Association

Date: 11/19/2007

Issue Areas/Comments

GENERAL

GENERAL

Please see the MHA's attached comment letter which has been revised from the one submitted on 11/15/07.

Thank you.

CMS-1533-FC-60-Attach-1.DOC



MICHIGAN HEALTH & HOSPITAL ASSOCIATION

Advocating for hospitals and the patients they serve.

November 19, 2007

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

RE: Capital IPPS Indirect Medical Education (IME) Payment Adjustments, Aug. 22, 2007 *Federal Register*, Pages 47394 -47401

Dear Sir:

On behalf of Michigan's 145 nonprofit hospitals, the Michigan Health & Hospital Association (MHA) appreciates the opportunity to provide comments to the Centers for Medicare & Medicaid Services (CMS) regarding the phase-out of the indirect medical education (IME) adjustment for capital payments. Based on recommendations from MedPAC, as indicated in the FY 2008 IPPS final rule, the CMS intends to phase out the IME adjustment for capital payments. However, due to the significance of this change, the CMS is providing a comment period through Nov. 20, 2007, and indicated that the agency will seek further comments upon release of the FY 2009 IPPS proposed rule. **The MHA strongly opposes the CMS proposal to reduce and ultimately eliminate the capital IME adjustment, as this will have a significant negative impact on Michigan's hospitals if this cut is implemented.**

In FY 2008, the CMS will maintain the current IME adjustment under the capital IPPS but will reduce the teaching adjustment by 50 percent in FY 2009 and eliminate it entirely in FY 2010. The MHA objects to this policy change which is projected to reduce payments to Michigan's teaching hospitals by approximately \$14 million in FY 2009 and \$28 million in FY 2010 and subsequent years. This payment reduction will threaten the financial viability of Michigan's teaching hospitals while also threatening Michigan's supply of future physicians to treat Medicare enrollees and other Michigan patients.

Background

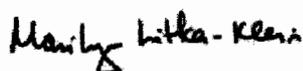
Under the Medicare inpatient prospective payment system (IPPS), Medicare is required to pay for the capital-related costs of inpatient hospital services. These costs include depreciation, interest, taxes, insurance and similar expenses for facilities, renovations, expensive clinical information systems and high-tech equipment (e.g., MRIs and CAT scanners). This is done

through a separate capital PPS payment. Under the capital inpatient PPS, capital payments are currently adjusted by the same DRG weight for each case, as is done under the operating PPS. PPS reimbursement for capital-related costs was implemented in FY 1992. Over a ten-year period, capital payments were transitioned from a reasonable cost-based methodology to a prospective methodology. Under the capital IPPS, the CMS has provided a teaching adjustment to eligible providers for indirect medical education (IME). Beginning in FY 2002, all hospitals were paid based on 100 percent of the capital federal rate, which is updated based on changes in a capital input price index (CIPI) and several other policy adjustment factors.

As indicated in its comments regarding the FY 2008 IPPS proposed rule, **the MHA strongly opposes the CMS' phase out of the IME under the capital PPS payment methodology.** The CMS has not analyzed the impact of this change on the high-caliber medical education of our future physicians and the community-wide services on which hospitals often lose money providing, such as burn and neonatal units. We believe it is irresponsible of the CMS to make such changes without a clear understanding of the broader ramifications, especially when many hospitals already face physician shortages, particularly in rural areas. **The MHA believes that it is vital that the CMS continue this funding to support the technology needs of teaching hospitals to ensure that residents have access to training using the latest high-tech equipment and technologies.** The IME capital payments are critical as most teaching hospitals are completing and/or planning major capital expenditures to renovate or replace aging facilities, keep up with changes in medical technology, develop clinical information systems and electronic medical records and meet the demands of an increasing aging population.

Again, the MHA appreciates this opportunity to provide input to the CMS and urge you to withdraw the elimination of IME capital payments. If you have questions or require additional information, please contact me at (517) 703-8608 or mklein@mha.org.

Sincerely,



Marilyn Litka-Klein
Senior Director, Health Policy