

CMS-1533-FC-61

Submitter : Mr. Robert Reske

Date: 11/19/2007

Organization : University of Michigan Hospitals and Health Center

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

The UMHHC comments on the Capital IPPS IME Payment Adjustments that were published in the 8/22/07 federal register follow.

CMS-1533-FC-61-Attach-1.TXT



University of Michigan
Hospitals and
Health Centers

**Accounting and
Reimbursement Services**
2500 Green Rd. Suite 100
Ann Arbor, Michigan 48105-
1500
734-647-3321

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

Submitted Electronically

**RE: Capital IPPS Indirect Medical Education Payment Adjustments
August 22, 2007 Federal Register, Pages 47,394-47,401**

The University of Michigan Health System (UMHS) welcomes the opportunity to comment to the Centers for Medicare & Medicaid Services (CMS) regarding the Indirect Medical Education Payment adjustment.

As indicated in the FY 2008 IPPS final rule, CMS intends to phase out the Indirect Medical Education (IME) adjustment for capital payments over two years beginning in FY 2009. However, due to the significance of this change, the CMS is providing a comment period through November 20, 2007, and indicated that the agency will seek further comments upon release of the FY 2009 IPPS proposed rule.

UMHS strongly opposes the CMS proposal to reduce and ultimately eliminate the capital IME adjustment. As one of the largest academic-based providers in the country, UMHS would incur a very significant negative impact if this payment cut is implemented.

UMHS believes that CMS, and Medpac, are inappropriately relying on an analysis of recent payments and costs that shows teaching hospitals are receiving more than cost as a result of the IME adjustment. UMHS believes that it is inappropriate to draw conclusions from this analysis for two reasons:

1. The hospital capital cycle, and therefore the incurrence of capital costs, changes over time. At the time that Medicare capital PPS was implemented in the early 1990's the need for an IME adjustment was fully supported by the Agency's analysis. Since then, several environmental factors have resulted in a growth in capital payments that exceeds the growth in capital cost, including: industry consolidation, cash flow constraints, record-low interest rates, and business community pressure to curtail health care capital expansion. In the last five years,

UMHS has seen its total capital costs as a percentage of revenues drop sharply, in large part due to these factors.

However, 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 aging population. UMHS is anticipating that its capital costs as a percentage of revenues will increase 50% over the next five years, reversing the trend from the last five years.

What appears to be an excess capital payment today may prove to be a significant shortfall in payments five years from now, because of changes in the hospital capital cycle.

2. CMS has identified one component of hospital payments to focus on, without recognizing the impact that its policies have on teaching hospitals collectively. In the last decade, teaching hospitals have been disadvantaged by several CMS policy changes in GME, operating IME, area wage index, and OPPS. In fact, CMS just published its 2008 OPPS final rule and once again ignored the growing payment-to-cost gap between teaching and non-teaching hospitals. As a result of CMS policies, teaching hospitals have very poor Total Medicare Margins, which worsen every year, in spite of what seems to be better performance in this one component – inpatient capital.

UMHS urges CMS to reconsider its position on capital IME when it develops the 2009 IPPS rule, and to take into account the broader context and the significant negative effects that this payment cut could have on current and future medical education programs.

Again, UMHS appreciates this opportunity to comment on the proposal to modify the IME payment adjustments. Please contact me at 734 647 2579 should you have any follow up questions concerning these comments.

Tom Marks
Hospital Financial Services
University of Michigan Hospitals and Health Centers

Submitter : Dr. James Willerson
Organization : Univ. of Texas Health Science Center at Houston
Category : Academic

Date: 11/19/2007

Issue Areas/Comments

GENERAL

GENERAL

See attachment for The University of Texas Health Science Center at Houston's comments.

CMS-1533-FC-62-Attach-1.DOC

November 20, 2007

Kerry Weems
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1533-FC
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

File Code: CMS-1533-FC

Dear Mr. Weems:

On behalf of The University of Texas Health Science Center at Houston, I am commenting in response to the provision in section V of the final FY 2008 inpatient prospective payment system (IPPS) rule issued by the Centers for Medicare and Medicaid Services (CMS) on August 22, 2007 that phases out over three years the special indirect medical education (IME) adjustment provided to teaching hospitals under the capital IPPS. The UT Health Science Center at Houston is the largest health related institution in Texas and is a component institution in the second largest academic health system in the country and the largest in the State of Texas. We are affiliated with two teaching hospitals, Memorial Hermann – Texas Medical Center and LBJ General Hospital which is part of the Harris County Hospital. These hospitals and our clinics together annually train more than 750 physicians in over 50 residency programs. We object strongly to the CMS decision to phase out a payment adjustment critically important to our teaching hospitals and others around the country in helping to pay for the capital-related costs of inpatient services.

Texas Medicare beneficiaries turn to our teaching hospitals for both routine inpatient care services and highly specialized care that no one else can provide. Indeed, quite frequently, our teaching hospitals are the sole resource in their communities for the care required by the severely ill and those with rare or complex conditions. They look to us for transplant services, cardiac surgery, innovative oncology treatment, and other sophisticated inpatient services. This requires us to have in place the advanced infrastructure and state-of-the-art technology necessary to meet such complex specialty care needs. Capital IME payments have been invaluable in enabling our affiliated

November 19, 2007

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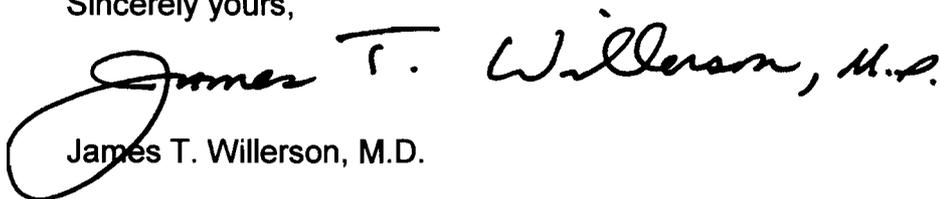
teaching hospitals to invest in specialty care infrastructure. A phase-out of the capital IME adjustment would undermine our ability to provide our Medicare patients with innovative, high quality, and cost-effective inpatient hospital care.

The reduction in capital IME payments would imperil patient safety and hospital efficiency at a time that CMS is encouraging safety and efficiency. As a safety concern, reduced funding for capital equipment will force existing capital equipment to be used longer, often beyond its expected service life. This renders the equipment more prone to malfunction or failure while being used on a patient and so is unsafe. As an efficiency concern, older equipment reduces the efficiency of a hospital stay due to its propensity to malfunction or fail. Similarly, the older equipment is often much slower than newer equipment so that the number of patients who can receive care with the older equipment per unit time is reduced compared to the new equipment. This inefficiency will prolong hospital stays and increase hospital expenses, another aspect of the imposed inefficiency.

Given the role our affiliated teaching hospitals play in the community as tertiary care institutions, it is essential that they remain well-equipped with state-of-the art equipment. Furthermore, it is essential that our trainees, the physicians of tomorrow, have direct experience in the use of this equipment so that they can take these skills wherever they practice after they complete their training. Therefore, reduction of the special indirect medical education adjustment to teaching hospitals that supports the purchase of capital equipment would have a negative effect both on the provision of patient care and the training of the future physicians of our country.

Thank you for the opportunity to express our views of the CMS proposal concerning the capital IME adjustment. We appreciate your consideration of our comments. We urge CMS not to proceed with phasing out the capital IME adjustment and instead continue to incorporate the adjustment into the calculation of capital IPPS payments for teaching hospitals.

Sincerely yours,

A handwritten signature in black ink that reads "James T. Willerson, M.D." The signature is written in a cursive style with a large, looping initial "J".

James T. Willerson, M.D.

cc: Kenneth I. Shine, M.D., Executive Vice Chancellor for Health Affairs, UT System
Giuseppe Colasurdo, M.D., Dean, Medical School, UTHSC-Houston
Dan Wolterman, CEO & President of Memorial Herman Health Care Center
David Lopez, CEO of the Harris County Hospital District
Juanita Romans, CEO of Memorial Hermann Hospital - Texas Medical Center
Kevin Dillon, C.O.O., C.F.O. at UTHSC-Houston

Submitter : Mr. David Buckley
Organization : St. John Health
Category : Hospital

Date: 11/19/2007

Issue Areas/Comments

GENERAL

GENERAL

"Sec Attachment"

CMS-1533-FC-63-Attach-1.DOC



November 19, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1533-FC
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850.

Submitted Via e-Rulemaking

Re: Capital IPPS Payment Adjustments (File Code: CMS-1533-FC)

To Whom It May Concern:

St. John Health (SJH), a not-for-profit, faith based, health system located in Southeast Michigan currently training over 400 residents in our accredited allopathic and osteopathic teaching programs welcomes this opportunity to provide the following comments on the proposed rule to abolish the capital indirect medical education ("IME") adjustment.

SJH Hospitals committed to training Southeast Michigan's future physicians through our accredited allopathic and osteopathic teaching programs include:

- 1) St. John Hospital & Medical Center- Detroit, Michigan
- 2) Providence Hospital & Medical Centers- Southfield, Michigan
- 3) St. John Macomb-Oakland Hospital (Both campuses)
Oakland Center, Madison Heights, Michigan
Macomb Center, Warren, Michigan
- 4) St. John River District Hospital- East China, Michigan

In response to the request by the Centers for Medicare and Medicaid Services ("CMS") for comments on its proposal, St. John Health submits the following comments.

1. Introduction

It is well established and undisputed that teaching hospitals face greater operating costs than the average hospital, even after direct education costs are taken into account. Congress and the Secretary of Health and Human Services ("Secretary") have attributed these increased costs to such factors as residents ordering more diagnostic tests, an increased volume of medical

records needed for resident training, increased patient acuity at teaching hospitals and greater use of emerging technology used to train residents. These same realities that increase operating costs must logically increase capital costs. For example, there are capital costs necessarily associated with the laboratory and medical records (e.g., space and equipment). In addition to the costs discussed by Congress and the Secretary, the high capital cost of maintaining essential standby units, such as burn or trauma units, falls disproportionately upon teaching hospitals.

Despite these facts, CMS is proposing to eliminate the capital IME adjustment because it has only considered half the picture, that is, the positive capital margins calculated by CMS for teaching hospitals in the aggregate. *See* 72 Fed. Reg. 47130, 47401 (Aug. 22, 2007). In 1991, however, when CMS, then HCFA, implemented the capital PPS and the capital IME adjustment, CMS knew that looking at only half the picture made the capital IME adjustment appear unnecessary. CMS soundly rejected that incomplete methodology, though, and decided instead to use a *total* regression analysis that took both operating and capital costs into consideration. Using this more comprehensive analysis, CMS found a significant correlation between increases in teaching intensity and increases in capital costs and instituted a capital IME adjustment to account for Medicare's share of this difference. As it did in 1991, CMS should look at the entire payment system in evaluating the rate of the capital IME adjustment. In doing so, we are confident that CMS will again come to the conclusion that teaching hospitals bear a disproportionate share of capital costs and should be fairly compensated for those costs.

If CMS eliminates the capital IME adjustment as it proposes, it will be taking a course of action inconsistent with both the regulatory history of the adjustment and the statutory demand that the Secretary pay for the capital-related costs of inpatient acute hospital services. *See* Social Security Act § 1886(g).

2. Increased Capital Costs of Teaching Hospitals

The Secretary and Congress instituted IME payments based on consistent evidence that even after the quantifiable costs of having a residency program are taken into account, teaching hospitals face greater operating costs than other hospitals. As discussed below, Congress and the Secretary identified several potential reasons for these increased costs. We submit that it defies logic to hold that these increased operating costs have no impact on the capital costs of teaching hospitals.

In the preamble where the Secretary first instituted an IME adjustment, the Secretary cited more voluminous medical records as an example of increased indirect costs borne by teaching hospitals: "a hospital with an approved medical education program may be required, for training purposes, to maintain more detailed and complete medical records." 64 Fed. Reg. 21582, 21584 (Apr. 1, 1980). In 1983, Congress followed the Secretary's lead and enacted an IME payment adjustment while highlighting three factors that contribute to the higher costs of operating a teaching hospital:

- 1) “severity of illness of patients”;
- 2) “specialized services and treatment programs provided by teaching institutions”; and
- 3) “additional costs associated with the teaching of residents,” including the costs of “additional tests and procedures ordered by residents as well as the extra demand put on other staff as they participate in the education process.”

H.R. Rep. No. 98-25, 140-41 (1983); *see also* S. Rep. No. 98-23, 52-53 (1983).

Clearly, each of these factors that lead to increased operating costs at teaching hospitals cannot help but have an effect on capital costs. Treating patients with a greater “severity of illness” and offering “specialized services” requires specialized equipment and facilities that teaching hospitals must purchase, maintain, and frequently update. An increased volume of lab tests requires increased laboratory space as well as more laboratory equipment. The facilities and equipment are also likely to depreciate faster due to additional use by residents. Likewise, an increased volume of medical records necessitates a bigger medical record room and more sophisticated archival equipment.

These increased capital costs logically follow from the increased operating costs posited by the Secretary and Congress. Yet, if CMS eliminates the capital IME adjustment as it proposes, none of Medicare’s share of these increased costs will be reimbursed.

Moreover, the factors discussed above are under-inclusive. For example, MedPAC, in its March 2007 report to Congress (“MedPAC March Report”), identified teaching facilities as primary providers of “standby services,” that is, services that a hospital must continuously maintain so that they are available in the event of a crisis, but that operate considerably below capacity on a day-to-day basis. Because they operate on “standby,” the costs of these units are not fully reflected in the cost of patient care. Examples of standby units are trauma and burn centers. A comparison between the prevalence of these types of units in major teaching hospitals and hospitals nationally is striking. Only 2.5 percent of hospitals nationally have burn units, compared to 28.7 percent of major teaching hospitals that have such units; only 6.1 percent of hospitals nationally had transplant units, compared to 59.4 percent of major teaching hospitals; and only 13.6 percent of hospitals nationally had trauma units, compared to 63.6 percent of major teaching hospitals. *See* MedPAC March Report at 76. The drastically increased prevalence of these state-of-the-art standby units among teaching hospitals translates into significant construction and maintenance capital costs.

More generally, simply training residents to be prepared to practice medicine in the 21st century necessitates that teaching hospitals incur significant capital costs to maintain up-to-date medical technology, state-of-the-art facilities, and sophisticated information technology. All of these elements are extremely costly. In its March 2007 report to Congress, MedPAC expressed concern about the ability of teaching hospitals to “prepare residents for practice in the 21st

century,” yet allowing Medicare to avoid its fair share of these capital costs significantly undermines this essential mission.

3. Regulatory History of the Capital IME Adjustment Supports Its Continuation

The fact that the capital IME adjustment, standing alone and independent of total costs, appears superfluous should come as no surprise to CMS—it knew this to be the case more than fifteen years ago *when it implemented the capital IME adjustment*. A capital IME adjustment was not part of the proposed capital PPS rulemaking. It was, however, implemented by CMS, in the final rule so that “[s]ince the inception of the capital IPPS . . . the system has provided adjustments for teaching hospitals . . .” 72 Fed. Reg. 47396. CMS, explaining why it initially “did not propose an adjustment for the indirect costs of medical education” stated, “the results of our fully specified *capital* cost regressions indicated that the teaching variable was negative and statistically significant.” 56 Fed. Reg. 43358, 43379 (Aug. 30, 1991) (emphasis added). CMS felt that “[t]he negative coefficient indicated that the other payment variables more than fully account for the higher capital costs of teaching hospitals and that a payment adjustment for teaching activity was not warranted.” 56 Fed. Reg. 43379 – 380.

Although this argument sounds like CMS’s current rationale for eliminating the capital IME adjustment, it was made and dismissed by CMS more than fifteen years ago. CMS adopted the capital IME adjustment in the final 1991 rulemaking because, once CMS refined its methodology and performed a new regression analysis that took into consideration both the operating and capital costs, it discovered a correlation between increased teaching intensity and increased capital costs. CMS therefore “establish[ed] an adjustment for indirect medical education costs based on the results of the *total* cost regression analysis.” 56 Fed. Reg. 43380 (emphasis added).

In the 1991 final rulemaking, CMS vigorously defended its decision to include a capital IME adjustment against claims “that capital costs related to teaching are already considered in the payments for operating costs for both direct and indirect costs of medical education.” 56 Fed. Reg. 43380. CMS explained that “[t]he 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.” 56 Fed. Reg. 43380. Given this, a capital IME adjustment was necessary to reimburse hospitals for Medicare’s share of the increased capital costs entailed in having a residency program. *Id.* CMS also defended its proposal to include a capital IME adjustment against claims that using the total regression analysis resulted in compensating teaching hospitals twice for operating costs: “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.” *Id.*

CMS’s decision to *include* a capital IME adjustment in 1991 was based on significant research and analysis that considered the entire picture. CMS performed “extensive regression analysis of the relationship between capital costs and the payment variables used in the prospective payment system for operating costs in order to determine which adjustments would be appropriate for capital payments.” 56 Fed. Reg. 43369. To hone further the results derived

from the regression analyses, CMS performed multiple “payment simulations.” 56 Fed. Reg. 43369. CMS thus had solid evidence for the capital payment adjustments it implemented in 1991, including the capital IME adjustment. These adjustments should not be eliminated, therefore, without careful consideration and analysis. Most importantly, CMS should look at the entire picture, that is, at both operating and capital margins together, and not revert to its previously rejected one-sided analysis. To resurrect this old methodology and refuse to look at the total payment picture is inconsistent with the history of the capital IME adjustment.

4. Overall Regression Analysis Should Be Used

Using a total regression analysis is not only in keeping with the regulatory history of the capital IME adjustment from its inception, it also reflects economic reality. Whether categorized as operating costs or capital costs, the effect of these costs on a provider’s bottom line is the same. The positive capital margins CMS is relying on to support its decision to eliminate the capital IME adjustment only tell half the story and are phantoms to most hospitals. If a hospital is losing money overall for each Medicare beneficiary it treats, it is no consolation that in one isolated area it has a positive margin. Operating and capital payments are simply different sides of the same payment coin.

Other commenter’s have already highlighted MedPAC’s estimate that the “overall Medicare margin has trended downward since 1997” and will be negative 5.4 percent in 2007. These commenters have also urged CMS to take into account both operating and capital margins in its analysis. CMS’s response, that the merger of the capital and operating payment systems had not materialized as it had expected in 1991, misses the point. *See* 72 Fed. Reg. 47399. Whether or not the two payment systems have merged does not affect the fiscal reality that the total impact on a hospital’s bottom line is what counts.

If one looks at the operating margins of teaching hospitals, one finds that while some larger teaching hospitals had modest margins of 4.2 percent in 2005, all “other teaching” hospitals had negative margins of 3.9 percent—this is lower than the national average of negative 3.3 percent. MedPAC March Report at 60. These operating margins are modest at best, and as MedPAC has pointed out, a positive margin for teaching hospitals “is inevitable given that the denominator of the margin ratio is the cost of treating Medicare patients and the numerator includes extra payments unrelated to the cost of treating Medicare patients.” MedPAC March Report at 74. Since Congress made a conscious decision to fund the IME adjustment at twice the estimated impact of teaching on Medicare costs, one cannot then penalize teaching hospitals for having modestly positive margins.¹

In addition to the modest *operating* margins of teaching hospitals, MedPAC’s report shows that the positive *capital* margins for teaching hospitals have decreased by almost 25% in just the three years between 2002 and 2005. The capital margins for large urban teaching hospitals have decreased by almost 22% for that same period. In addition, MedPAC predicts a

¹ Unlike the operating IME adjustment, which is set above the empirical level, the “capital IME adjustment is based on the measured effect of teaching intensity on hospitals’ costs” which is why “the add-ons are much smaller than those made for operating payments, where the rate is set substantially above the empirical level.” *See* MedPAC 2006 Report.

16 percent increase in capital spending by hospitals in 2006 suggesting that 2005 might in fact represent a cyclical low in capital spending. *See* MedPAC March Report at 58. For CMS to eliminate multiple capital payment adjustments, including the capital IME adjustment, without knowing the impetus or trajectory of these trends that are already narrowing the capital margins at teaching hospitals is irresponsible.

In its June 12, 2007 comment letter, the Association of American Medical Colleges (AAMC) has cited one consultant's finding that eliminating the capital IME adjustment would reduce the aggregate capital margin for major teaching hospitals to just 1.7 percent. As the AAMC points out, since the total margins, from all payments sources, of major teaching hospitals is around zero, such a significant reduction in Medicare capital payments may cause overall negative margins at particular teaching hospitals affecting their viability. While Medicare should not pay teaching hospitals to make up for general shortfalls, it should pay for its fair share of the extra capital costs borne by teaching hospitals.

5. Insufficient Analysis Supporting the Capital Adjustment Reductions

CMS should also consider the other cuts it is making to the capital PPS when assessing the impact that the elimination of the capital IME adjustment will have on teaching hospitals. According to a June 2006 MedPAC report titled *Hospital Acute Inpatient Services Payment System* ("MedPac 2006 Report"), nearly 95% of teaching facilities are located in urban areas. It is likely, therefore, that CMS's elimination of the 3.0 percent capital add-on payment to hospitals located in large urban areas will significantly and disproportionately affect teaching hospitals and further decrease their already decreasing capital margins. *See* 72 Fed. Reg. 47397. Despite this fact, CMS offers no analysis in its proposed rule of how eliminating both the large-urban add-on and the capital IME adjustment will affect the nation's teaching hospitals.

As a final point, it is worth noting that MedPAC never advocated eliminating the capital IME payment and has not analyzed the consequence of this action. In its March 2007 report to Congress where MedPAC carefully laid out its policy recommendations and gave substantial supporting analysis, MedPAC never raised the possibility of eliminating the capital IME payments. MedPAC's recommendation was that the *operating* IME adjustment be reduced by one percentage point (from 5.5 to 4.5) to make up for the one percentage payment increase MedPAC excepted teaching hospitals to receive under the new DRG weighting system. When specifically asked about the capital IME adjustment, MedPAC did state its belief that the "Secretary should seriously reexamine the appropriateness of the current capital IME adjustment," but in the same paragraph stated only that "[s]ome *reduction* in the capital IME adjustment would be consistent with the Commission's finding that the IME adjustment is set too high." MedPAC June 11, 2007 (emphasis added). "Some reduction" in the adjustment is not equivalent to an elimination of the adjustment.

Once again, we believe that further analysis should be performed before such significant payment reductions, having an unknown impact on the essential mission of teaching hospitals, are made. While it is possible that such an analysis will support a reduction in the capital IME adjustment due to the increased capital costs borne by teaching hospitals, we do not believe it could logically support the elimination of the adjustment.

St. John Health
Comments on Proposed Rules
Capital IPPS Payment Adjustments (File Code: CMS-1533-FC)
November 19, 2007

6. Conclusion

Based on the forgoing, St. John Health requests that CMS abandon its proposal to eliminate the capital IME adjustment and ensure that Medicare pays its share of the increased capital costs borne by teaching hospitals. In this way, CMS will help guarantee that teaching hospitals have the capital necessary to continue their mission of training the physicians needed to serve the nation's population over the coming decades.

Thank you for your review and consideration of these comments. Please contact me at david.buckley@stjohn.org with any questions regarding these comments you may have.

Sincerely,

David R. Buckley

David R Buckley

Corporate Director of Reimbursement

St. John Health

Submitter : Mr. Mike Thompson

Date: 11/19/2007

Organization : Memorial Health University Medical Center, Inc.

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

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

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

Submitter : Ms. Ellen Kugler
Organization : National Association of Urban Hospitals
Category : Health Care Provider/Association

Date: 11/19/2007

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1533-FC-65-Attach-1.DOC

Submitter : Ms. Day Hsu
Organization : Stanford Hospital and Clinics
Category : Hospital

Date: 11/19/2007

Issue Areas/Comments

Capital IPPS Payment Adjustments

Capital IPPS Payment Adjustments

November 19, 2007

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

Attention: CMS-1533--FC

Dear Mr. Weems:

Stanford Hospital and Clinics welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS or the Agency) final rule with comment period entitled "Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems [IPPS] and Fiscal Year 2008 Rates." 72 Fed. Reg. 47130 (August 22, 2007). As specified in the rule, our comments are limited to section V, "Capital IPPS Payment Adjustments."

According to the final rule with comment period, CMS seeks to eliminate the capital indirect medical education (IME) adjustment beginning in federal fiscal year (FFY) 2009. According to the rule, the IME adjustment would be reduced by 50 percent in FFY 2009 and eliminated altogether in FFY 2010 and beyond. If implemented, this decision would result in an annual aggregate payment cut to Stanford Hospital and Clinics of approximately \$2-\$3 million. A payment cut of this magnitude is not warranted. We urge CMS to reconsider this decision and retain the current IME adjustment level in the capital PPS system until a more thorough examination is conducted.

We believe that any decision that results in the complete elimination of a payment adjustment should not be entered into lightly. This is particularly true in the context of IME payments. An analysis by Vaida Consulting shows that eliminating the capital IME adjustment would result in an aggregate capital margin that is only 1.7 percent for major teaching hospitals-and this analysis is based on capital payments and costs in 2004, a year that many observers believe is part of a lower-spending phase of the capital cycle (which results in higher margins). If this analysis were conducted during a higher-spending period of time, eliminating capital IME payments would likely result in a negative aggregate margin. This contention is particularly true for Stanford Hospital and Clinics, given that high capital spending is projected for the next 10 years to seismic retrofit the existing facility and the expansion of the hospital. Consequently, we believe it is imprudent of CMS to determine that the adjustment should be reduced or even eliminated at a time when capital spending could be at, or near, its lowest point. Rather, like MedPAC, we urge the Agency to do a more complete reexamination of this adjustment before making any IME reduction determinations. Given that the capital cycle is roughly twenty years, such an examination should include analysis on the impact of IME cuts under various "capital spending" scenarios (ie, higher-spending periods versus lower spending periods).

It is crucial that Stanford Hospital and Clinics maintains positive margins and a desirable outcome of the capital PPS. This reflects that Stanford Hospital and Clinics is acting responsibly in terms of preserving payments for future capital needs.

Moreover, a decision to cut Medicare capital IME payments should not be viewed solely from a Medicare perspective. Stanford Hospital and Clinics is a leading teaching hospital. Payment cuts from any source affect the Stanford Hospital and Clinics fiscal condition which will influence all aspects of our operations. Operations that include providing education for all types of health care professionals; providing an environment in which clinical research can flourish; and offering highly specialized tertiary patient care such as burn care, trauma and cardiac care, and transplant services.

We urge CMS to delay a final decision regarding whether to cut IME payments, and by how much, until more analyses are conducted.

Your consideration of the comments is greatly appreciated.

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see attachment

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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. Kay Marsyla
Organization : Trinity Health West MI Finance Shared Svcs
Category : Hospital

Date: 11/20/2007

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1533-FC-69-Attach-1.DOC



November 20, 2007

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

West Michigan Finance Shared
 Services
 1820 44th Street SE
 Kentwood, MI 49508

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

Dear Sir:

Trinity Health West Michigan Finance Shared Services (WMFSS), comprised of Battle Creek Health System (23-0075), Mercy General Health Partners (23-0004) and Saint Mary's Health Care (23-0059), welcomes this opportunity to comment to the Centers for Medicare & Medicaid Services (CMS) regarding the phase-out of the indirect medical education (IME) adjustment for capital payments.

WMFSS commented on this issue June 7, 2007 as part of the IPPS proposed rule and again comments on the IME phase out based on the final rule published on August 22, 2007.

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. WMFSS objects to this policy change which is projected to reduce payments to our teaching hospitals by approximately \$377,000 in FY 2009 and \$754,000 in FY 2010 and subsequent years. This payment reduction will threaten the financial viability of our teaching hospitals while also threatening our supply of future physicians to treat Medicare enrollees and other patients.

Hospitals have already committed funds toward various capital projects (The Hauenstein Center for Neurological Services at Saint Mary's Health Care and Center for Cancer Care at Mercy General Health Partners) with the expectation that Medicare funding would be available to cover a portion of the cost. At this time, the CMS and Congress are also pushing hospitals to move to electronic medical records as well as other computer based systems (drug ordering, digital x-rays, etc) to reduce medical errors, enhance patient safety and quality of medical treatment. The WMFSS hospitals are embracing all of these movements but they are very expensive. WMFSS feels that the phasing out a portion of the capital payments when teaching hospitals are expected to be at the cutting edge of technology is irresponsible.

As indicated in its comments regarding the FY 2008 final rule, WMFSS strongly opposes the CMS' phase out of the IME capital IPPS payment. 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 cancer care and neonatal units. We believe it is irrational of the CMS to make such changes without a clear understanding of the broader ramifications, especially when many hospitals already face physician shortages. WMFSS 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, WMFSS appreciates this opportunity to provide comments to the CMS regarding this capital payment phase out and urge you to please take them into consideration. If you have questions on this comment letter, please contact me at (616) 643-3569 or marsylkp@trinity-health.org.

Sincerely,

Kay Marsyla, FHFMA
Senior Reimbursement Specialist
Trinity Health West Michigan Finance
Shared Services

Submitter : Mr. Eric Kemper
Organization : The Ohio State University Health System
Category : Hospital

Date: 11/20/2007

Issue Areas/Comments

Capital IPPS Payment Adjustments

Capital IPPS Payment Adjustments

November 20, 2007

Kerry Weems

Acting Administrator

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

Attention: CMS-1533--FC

Dear Mr. Weems:

The Ohio State University Health System welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS or the Agency) final rule with comment period entitled "Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems [IPPS] and Fiscal Year 2008 Rates." 72 Fed. Reg. 47130 (August 22, 2007).

As specified in the rule, our comments are limited to section V, "Capital IPPS Payment Adjustments."

According to the final rule with comment period, CMS seeks to eliminate the capital indirect medical education (IME) adjustment beginning in federal fiscal year (FFY) 2009. According to the rule, the IME adjustment would be reduced by 50 percent in FFY 2009 and eliminated altogether in FFY 2010 and beyond. If implemented, this decision would result in an annual aggregate payment cut to the Ohio State University Health System of approximately \$1,600,000. A payment cut of this magnitude is not warranted. We urge CMS to reconsider this decision and retain the current IME adjustment level in the capital PPS system until a more thorough examination is conducted.

In the final rule, CMS states that the Agency agrees with the Medicare Payment Advisory Commission (MedPAC) that the "appropriateness of the teaching adjustment should be seriously reexamined." Yet, the very next sentence reads "the record of high and persistent positive margins for teaching hospitals indicates that the current teaching adjustment is unnecessary . . ." (72 Fed. Reg. at 47401).

We believe that any decision that results in the complete elimination of a payment adjustment should not be entered into lightly. An analysis by Vaida Consulting shows that eliminating the capital IME adjustment would result in an aggregate capital margin that is only 1.7 percent for major teaching hospitals and this analysis is based on capital payments and costs in 2004, a year that many observers believe is part of a lower-spending phase of the capital cycle (which results in higher margins). If this analysis were conducted during a higher-spending period of time, eliminating capital IME payments would likely result in a negative aggregate margin. Consequently, we believe it is unwise to determine that the adjustment should be reduced or even eliminated at a time when capital spending could be at, or near, its nadir. Rather, like MedPAC, we urge the Agency to do a more complete reexamination of this adjustment before making any IME reduction determinations. Given that the capital cycle is roughly twenty years, such an examination should include modeling the impact of IME cuts under various "capital spending" scenarios (ie, higher-spending periods versus lower spending periods).

As we stated in our comments on the FFY 2008 proposed rule, we strongly dispute CMS's views that teaching hospitals' capital PPS payment levels are "too high" (72 Fed. Reg. at 47401). Positive margins are necessary and a desirable outcome of the capital PPS and, in our view, reflect that teaching hospitals are acting responsibly in terms of preserving payments for future capital needs.

Moreover, a decision to cut Medicare capital IME payments should not be viewed solely from a Medicare lens. With over 60% of our volumes related to fixed payors it does preclude us from having the ability to offset a cut of this magnitude from other sources.

We urge CMS to delay a final decision regarding whether to cut IME payments, and by how much, until more analyses are conducted. If CMS rejects this comment, we believe the more prudent course of action would be to implement a smaller reduction in FFY 2009 and or a more significant transition period.

Submitter : Mr. Abe Feld

Date: 11/20/2007

Organization : Cooper University Hospital

Category : Hospital

Issue Areas/Comments

Capital IPPS Payment Adjustments

Capital IPPS Payment Adjustments

Cooper University Hospital #31-0014 welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS or the Agency) final rule with comment period entitled "Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems [IPPS] and Fiscal Year 2008 Rates." 72 Fed. Reg. 47130 (August 22, 2007).

Cooper is a major teaching hospital in Camden, NJ, which trains over 300 residents a year and serves a disproportional low income Urban population and receives a material amount of Medicare reimbursement under the CMS IPPS system. As specified in the rule, our comments are limited to section V, "Capital IPPS Payment Adjustments."

See Attachment for more details

GENERAL

GENERAL

See Attachment for details

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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. Gina Ramsey

Date: 11/20/2007

Organization : North Carolina Baptist Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1533-FC-73-Attach-1.DOC

November 20, 2007

Mr. Kerry N. Weems, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: (CMS-1533-FC)
200 Independence Avenue, S.W. Room 445-G
Washington, DC 20201

Dear Mr. Weems:

North Carolina Baptist Hospital (NCBH) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) final rule with comment entitled, "Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems (IPPS) and Fiscal Year 2008 Rates; Final Rule with Comment, (72, No.85), August 22, 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.

At NCBH we fulfill a unique and critical role in the health care system by providing high intensity services, such as trauma and neonatal intensive care to the entire community and the eastern region of our state while ensuring that Medicare and Medicaid recipients and the uninsured have access to all medical services.

While NCBH supports many of the final rule's provisions, we oppose the proposal to eliminate capital indirect medical education (IME) payments that would result in an estimated annual aggregate cut to teaching hospitals of \$385 million. 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 August 22, 2007, CMS released CMS-1533-FC, which on pages 47400-401 discusses MedPac's recommendation that CMS seriously reexamine the appropriateness of the current capital IME adjustment, because in their judgment such adjustments may be too high. In response, CMS is proposing to reduce the capital IME payments by 50% in FY 2009 and 100% in FY 2010 and thereafter.

Impact:

If this proposed rule is enacted, NCHB estimates that it will lose \$11.25 million for the period FY 2009-13. These capital IME payments help NCBH sustain one of its core responsibilities as a teaching hospital--providing the clinical education of future physicians. Within a supervised patient care team of health care professionals, these medical residents provide needed care to Medicare and other patients as part of their training programs. Educating future physicians and other health care professionals has never been more important given the numerous studies predicting a physician shortage in the future. These capital IME payments are crucial to our ability to fulfill this mission as an academic medical center and without these funds, we will be forced to eliminate needed services and jobs.

Recommendations:

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 the proposed cuts to the capital IME program 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.

NCBH urges CMS to rescind this proposal. It remains committed to working with CMS, other health care organizations, such as the American Hospital Association (AHA), Association of American Medical Colleges (AAMC) 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 regulation.

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

Submitter : Mr. Rick Pollack
Organization : American Hospital Association
Category : Association

Date: 11/20/2007

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-1533-FC-74-Attach-1.DOC



**American Hospital
Association**

Liberty Place, Suite 700
325 Seventh Street, NW
Washington, DC 20004-2802
(202) 638-1100 Phone
www.aha.org

November 20, 2007

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

RE: CMS-1533-FC, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates; Proposed Rule (Vol. 72, No. 85), May 3, 2007

Dear Mr. Weems:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 37,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) final rule with comment for the fiscal year (FY) 2008 hospital inpatient prospective payment system (PPS).

CMS is required to pay for a portion of the capital-related costs of inpatient hospital services. These costs include depreciation, interest, taxes, insurance and similar expenses for new facilities, renovations, expensive clinical information systems and high-tech equipment (e.g., MRIs and CAT scanners). This is done through a separate inpatient capital PPS that adjusts payments by the same diagnosis-related group for each case, as is done under the operating PPS. Capital PPS payments include indirect medical education (IME) and disproportionate share hospital (DSH) adjustments similar to those made under the operating PPS. In addition, hospitals may receive outlier payments under the capital PPS for cases with unusually high costs.

While CMS did not adopt its proposal to eliminate the Medicare capital payment update for FY 2008 for urban hospitals, it did eliminate the 3 percent add-on to capital payments for hospitals in large urban areas – a \$600 million cut over the next five years. In addition, CMS finalized a new provision to phase out the IME adjustment to capital payments by reducing payments by 50 percent in FY 2009 and then providing no IME payments beginning in FY 2010.



Kerry Weems
November 20, 2007
Page 2 of 2

Eliminating the IME adjustment from the capital PPS will reduce payments to teaching hospitals by \$1.3 billion over five years. The AHA opposes these unnecessary cuts to teaching hospitals, which rely on IME funding to help cover the costs of training our nation's future physicians. Medicare's capital payments, including the increased payment to cover the costs of IME, are vital to medical education, investment in the latest medical technology and ongoing maintenance and improvement of hospital facilities. We will continue to work with Congress to reverse these cuts.

CMS has gone well beyond its charge by finalizing these arbitrary and unnecessary cuts in this FY 2008 rule. These backdoor budget cuts will further deplete scarce resources, ultimately making hospitals' mission of caring for patients even more challenging. We urge CMS to reverse course in the FY 2009 proposed and final inpatient PPS rules by removing the pending cuts to the IME adjustment to capital payments.

If you have any questions, please feel free to contact me or Don May, vice president for policy, at (202) 626-2356 or dmay@aha.org.

Sincerely,

Rick Pollack
Executive Vice President

Submitter : Mr. Michael Rossi

Date: 11/20/2007

Organization : University of Pennsylvania Health System

Category : Hospital

Issue Areas/Comments

Capital IPPS Payment Adjustments

Capital IPPS Payment Adjustments

See Attachment

GENERAL

GENERAL

See Attachment

CMS-1533-FC-75-Attach-1.PDF



Office of Corporate Finance

November 20, 2007

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

Attention: CMS-1533--FC

Dear Mr. Weems:

The University of Pennsylvania Health System (UPHS) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) final rule with comment period entitled "Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems [IPPS] and Fiscal Year 2008 Rates." 72 Fed. Reg. 47130 (August 22, 2007).

Our Health System is comprised of three large urban teaching hospitals (Hospital of the University of Pennsylvania, Penn Presbyterian Medical Center, Pennsylvania Hospital) located in the Metropolitan Philadelphia area. Combined, our hospitals provide inpatient acute care services to over 15,000 Medicare Part A Beneficiaries and over 8,000 Medicare Part C Beneficiaries on an annual basis. Our hospitals train over 900 residents each year in more than 30 accredited medical education programs. As specified in the rule, our comments are limited to section V, "Capital IPPS Payment Adjustments."

According to the final rule with comment period, CMS seeks to eliminate the capital indirect medical education (IME) adjustment beginning in federal fiscal year (FFY) 2009. According to the rule, the IME adjustment would be reduced by 50 percent in FFY 2009 and eliminated altogether in FFY 2010 and beyond. If implemented, this decision would result in an annual aggregate payment cut to our teaching hospitals of over \$4 million in Medicare Part A payments alone. This cut would also have an un-intended consequence of reducing our Medicare Part C payments as well since many Part C payers pay claims in a manner identical to Medicare. With the Part C penetration in the Philadelphia region continuing to grow, the \$4 million cut in Part A payments could be duplicated in Part C payments. A payment cut of this magnitude is not warranted. We urge CMS to reconsider this decision and retain the current IME adjustment level in the capital PPS system until a more thorough examination is conducted.

In the final rule, CMS states that the Agency agrees with the Medicare Payment Advisory Commission (MedPAC) that the "appropriateness of the teaching adjustment should be seriously reexamined." Yet, the very next sentence reads "the record of high and persistent positive margins for teaching hospitals indicates that the current teaching adjustment is unnecessary . . ." (72 Fed. Reg. at 47401).

We believe that any decision that results in the complete elimination of a payment adjustment should not be entered into lightly. This is particularly true in the context of IME payments. An analysis by Vaida Consulting shows that eliminating the capital IME adjustment would result in an aggregate capital margin that is only 1.7 percent for major teaching hospitals-and this analysis is based on capital payments and costs in 2004, a year that many observers believe is part of a lower-spending phase of the capital cycle (which results in higher margins). If this analysis were conducted during a higher-spending period of time, eliminating capital IME payments would likely result in a negative aggregate margin. Consequently, we believe it is unwise to determine that the adjustment should be reduced or even eliminated at a time when capital spending could be at, or near, its nadir. Rather, like MedPAC, we urge the Agency to do a more complete reexamination of this adjustment before making any IME reduction determinations. Given that the capital cycle is roughly twenty years, such an examination should include modeling the impact of IME cuts under various "capital spending" scenarios (ie, higher-spending periods versus lower spending periods).

We strongly dispute CMS's views that teaching hospitals' capital PPS payment levels are "too high" (72 Fed. Reg. at 47401). Positive margins are necessary and a desirable outcome of the capital PPS and, in our view, reflect that teaching hospitals are acting responsibly in terms of preserving payments for future capital needs.

Moreover, a decision to cut Medicare capital IME payments should not be viewed solely from a Medicare lens. Because major teaching hospitals' total margins (from all payment sources) often hover near zero, payment cuts from any source affect the fiscal condition of these institutions, which influence all aspects of their operations. Operations that include providing education for all types of health care professionals; providing an environment in which clinical research can flourish; and offering highly specialized tertiary patient care such as burn care, trauma and cardiac care, and transplant services. Most recently, major teaching hospitals are looked to as front-line responders in the event of a biological, chemical, or nuclear attack and require sufficient financial resources to fulfill that role.

We urge CMS to delay a final decision regarding whether to cut IME payments, and by how much, until more analyses are conducted. If CMS rejects this comment, we believe that rather than eliminating these payments altogether, the more prudent course of action would be to implement a much smaller reduction in FFY 2009 and monitor the policy over time to determine whether additional reductions are warranted. Given the fragile overall financial condition of many major teaching hospitals, if further reductions are contemplated, they should be accompanied by a significant transition period.

We again thank you for the opportunity to comment on such a critical aspect of our Medicare payments and appreciate the time and effort given by the Agency to such critical issues. If you have questions concerning these comments, please do not hesitate to contact me by phone (215-662-6335) or by e-mail (Michael.Rossi@uphs.upenn.edu).

Sincerely,

A handwritten signature in black ink, appearing to read "Michael Rossi". The signature is fluid and cursive, with the first name "Michael" and last name "Rossi" clearly distinguishable.

Michael Rossi
University of Pennsylvania Health System
Director of Governmental Reimbursement

Submitter : Mr. Brian Day
Organization : Vanderbilt University Medical Center
Category : Hospital

Date: 11/20/2007

Issue Areas/Comments

Capital IPPS Payment Adjustments

Capital IPPS Payment Adjustments

Please see attached document for comments from Vanderbilt University Medical Center.

CMS-1533-FC-76-Attach-1.DOC

Submitter : Larry Gage
Organization : National Association of Public Hospitals (NAPH)
Category : Hospital

Date: 11/20/2007

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 : Larry Gage
Organization : National Association of Public Hospitals (NAPH)
Category : Hospital

Date: 11/20/2007

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1533-FC-78-Attach-1.PDF



1301 Pennsylvania Avenue, NW
 Suite 950
 Washington, DC 20004
 202 585 0100 tel / 202 585 0101 fax
www.naph.org

November 20, 2007

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

Ref: CMS-1533—FC — Medicare Program; Changes to the Hospital Inpatient Prospective Payment System and Fiscal Year 2008 Rates; Final Rule with Comment Period

Re: Capital IPPS Payment Adjustments

Dear Mr. Weems:

The National Association of Public Hospitals and Health Systems (NAPH) appreciates the opportunity to submit comments on the above-captioned Final Rule with Comment Period.¹ NAPH represents more than 100 metropolitan area safety net hospitals and health systems. Our members are deeply reliant on government-sponsored health programs, including Medicare. Approximately 20 percent of our revenues comes from Medicare, and overall, NAPH hospitals rely on government sources, including Medicare, Medicaid, and state and local subsidies, for 69 percent of their revenues. Approximately 21 percent of the inpatient services provided by NAPH members is to Medicare beneficiaries, another 38 percent is provided to Medicaid recipients and 23 percent to uninsured patients. NAPH members provide critical inpatient services, with NAPH hospitals averaging 2.4 times as many inpatient admissions as the hospital industry average.

NAPH members, approximately 85 percent of which are teaching institutions, have expressed deep concern over the proposed elimination of the adjustment to capital payments that currently is provided to teaching hospitals. CMS has stated that Medicare Payment Advisory Commission (MedPAC) data demonstrates that teaching hospitals are receiving “excessive payments levels” and a cut to capital payments is warranted. However, hospital capital margins are not indicative of overall hospital health. Overall hospital margins continue to drop, despite any positive Medicare capital margins. Even with this adjustment to their capital payments, NAPH members operate at margins well below the industry norm, making them particularly vulnerable to the proposed cut.

¹ 72 Federal Register 47130 (August 22, 2007).

Significantly, CMS has conducted no analysis of the impact that this cut will have on teaching hospitals and has ignored the fact that the cut likely will compromise these hospitals' ability to continue providing high-quality care and essential services to their communities. Specifically:

- Teaching hospitals are heavily reliant on their Medicare capital payments to ensure a stable revenue source for capital improvements. The unpredictable and often insufficient revenue streams associated with bearing the high costs of running teaching programs has made it difficult for some teaching hospitals to access affordable capital financing. As a result, many have had to postpone the necessary capital improvements, including plant and facility upgrades and investment in key technology, that are essential to maintaining competitive, high-quality services for Medicare patients. Cuts to Medicare reimbursement for capital investments will disproportionately harm those hospitals that have the least options for alternative funding sources.
- Positive capital margins are essential if our member hospitals are to continue investing in health information technology (HIT). The federal government has repeatedly emphasized its support for the expanded use of such technology, including electronic health records. HIT is particularly important to the kind of quality improvement efforts and accountability measures that CMS has been promoting. The proposed cuts will drastically limit, if not eliminate, our member hospitals' ability to continue investing in this important technology.
- Many NAPH members are the only Level I trauma center or only trauma center of any level in their communities. Member hospitals also provide a disproportionate share of burn care services and pediatric and neonatal intensive care in their communities and are the first receivers during catastrophes such as chemical spills, fires, disease outbreaks, and natural disasters. A reasonable and steady stream of Medicare capital payments is crucial in ensuring that our member hospitals are able to maintain the readiness infrastructure that is so essential to their communities.

Although CMS has proposed to implement this cut over a 3-year transition period, CMS has simultaneously finalized its proposal to eliminate the adjustment to capital payments for hospitals in large urban areas (the large urban add-on). Many hospitals that are eligible for the adjustment for teaching hospitals are also eligible for the large urban add-on. CMS' data does not predict the capital margins for these hospitals after elimination of the latter adjustment, nor does it consider the practical effect of eliminating both adjustments over an extremely short time period. We urge CMS to withdraw this proposal in the rulemaking for fiscal year 2009 and suspend its proposal to eliminate the adjustment for teaching hospitals until the effects of eliminating the large urban add-on have been thoroughly analyzed.

NAPH appreciates the opportunity to submit these comments. If you have any questions about these comments, please contact Lynne Fagnani at (202) 585-0100.

Sincerely,

A handwritten signature in black ink, appearing to read "Larry S. Gage". The signature is fluid and cursive, with the first name "Larry" being more prominent and the last name "Gage" following in a similar style.

Larry S. Gage
President

Submitter : Mr. Ronald Grousky

Date: 11/20/2007

Organization : Mayo Clinic

Category : Hospital

Issue Areas/Comments

Capital IPPS Payment Adjustments

Capital IPPS Payment Adjustments

According to the final rule with comment period, CMS seeks to eliminate the capital indirect medical education (IME) adjustment beginning in federal fiscal year (FFY) 2009. According to the rule, the IME adjustment would be reduced by 50 percent in FFY 2009 and eliminated altogether in FFY 2010 and beyond. If implemented, this decision would result in an annual aggregate payment cut to teaching hospitals of \$375 million. A payment cut of this magnitude is not warranted. We urge CMS to reconsider this decision and retain the current IME adjustment level in the capital PPS system until a more thorough examination is conducted.