

**Submitter :** Mrs. Karen Heller  
**Organization :** Greater New York Hospital Association  
**Category :** Hospital

**Date:** 11/20/2007

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-1533-FC-80-Attach-1.PDF



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**Greater New York Hospital Association**

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555 West 57<sup>th</sup> Street / New York, N.Y. 10019 / (212) 246 - 7100 / (212) 262 - 6350

Kenneth E. Raske, President

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November  
Twenty  
2007

Kerry N. Weems  
Administrator  
Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
Hubert H. Humphrey Building, Room 443-G  
200 Independence Avenue, S.W.  
Washington, D.C. 20201

Subject: Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates; Final Rule with Comment Period, *Federal Register* 72, No. 162 (August 22, 2007): 47130-48175. [CMS-1533-FC]

Dear Mr. Weems:

On behalf of the more than 150 hospitals that make up the membership of the Greater New York Hospital Association (GNYHA), we appreciate this opportunity to comment upon the Centers for Medicare & Medicaid Services' (CMS's) final rule with comment period for the Federal fiscal year (FY) 2008 inpatient prospective payment system (IPPS). The subject of this comment letter is CMS's proposal to phase out the indirect medical education (IME) adjustment in the capital PPS. In our June 8, 2007, comment letter on the FY 2008 IPPS proposed rule, we strongly recommended that CMS retain the capital IME adjustment based on both a theoretical and empirical analysis of the adjustment. We are attaching that analysis to this comment letter.

In the FY 2008 IPPS proposed rule, CMS proposed to eliminate the 3% large urban add-on and requested comments on the merits of continuing the IME and disproportionate share hospital (DSH) adjustments in the capital PPS. CMS's rationale for proposing and contemplating the elimination all three adjustments was that large urban, teaching, and DSH hospitals (inner-city hospitals) had sustained high capital PPS margins. We argued that CMS's analysis was too narrow, that it failed to consider and appreciate the appropriate ways in which inner-city hospitals are using their capital PPS funding, and that eliminating the adjustments to inner-city hospitals would have deleterious consequences for Medicare beneficiaries' access to care in those communities.

From a technical perspective, we believe that CMS should continue to set capital payment policy based on a total cost regression model, as it did when it established the capital PPS in 1991 and as it does in all of its other prospective payment systems. The theory of prospective payment is that hospitals receive a lump sum per case and deploy their resources to optimize patient care. If CMS believes that capital payments should only be spent on capital cost, it should request that Congress allow the Agency to repeal the capital PPS and return to cost-based reimbursement. We would support that policy.

In the context of a PPS, however, we know that technology and practice patterns evolve over time, making it appropriate to periodically update the total cost regression model. Thus, in the proposed rule comment period, we conducted preliminary research in this area based on 2004 data. In so doing, we found that the large urban, IME, and DSH adjustments were still substantial and statistically significant, although different from the 1991 adjustments. The IME coefficient was lower than it was in 1991—as the Medicare Payment Advisory Commission has observed—but the DSH coefficient was higher and the labor share increased significantly, from 68.48% to roughly 85%. If CMS wishes to revise the capital PPS adjustments, then we recommend, again, that CMS update its total cost regression model and propose changes to the capital PPS adjustments based on the results of that empirical model.

From a policy perspective, we interpreted CMS's discussion in the FY 2008 final rule to mean that CMS was proposing to eliminate the IME adjustment in the capital PPS because it wanted to wring excess IME payments out of the operating PPS. CMS has the authority to change capital PPS parameters but not operating PPS parameters. We disagree that this is a desirable goal and urge CMS to reconsider.

There is no doubt that the IME and DSH adjustments in the operating PPS are higher than the empirical levels. The difference is characterized as "policy" payments. The presence of policy payments is not an unfortunate legacy of an outdated regression model, but an expression of Congressional intent. Congress maintained those payments knowing that they did not reflect Medicare inpatient cost per se because it recognized that the recipient hospitals needed the payments to maintain services with no dedicated funding stream. Historically, Medicare payment policy has been crafted to cover Medicare program costs and to maintain access to services for Medicare beneficiaries. When we reviewed the 2004 margins for Medicare inpatient services alone and for total operations, we observed that inner-city teaching hospitals continue to receive and use Medicare policy payments to subsidize unfunded services and yet they still have the lowest—and dangerously low—total margins in the hospital industry. (See attachment.)

In fact, inner-city teaching hospitals not only rely on Medicare inpatient surpluses, but on inpatient surpluses derived from all payers. The unfunded services that require the greatest subsidy are inpatient services for the uninsured, outpatient services for the uninsured and all other patients, and the standby costs of emergency, trauma care, and regional referral centers, such as perinatal centers. Health care financing in the United States is so incoherent that it is a patchwork of surpluses and deficits. The most that can be asked of providers is that they do their best to sustain necessary but underfunded services. Inner-city teaching hospitals are the best exemplar of providers striving to do just that. CMS should not ignore the purpose and use of the policy payments to maintain such services for Medicare beneficiaries.

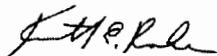
Furthermore, when CMS observes sustained high capital margins for inner-city teaching hospitals, it must understand that those hospitals are not overpaid for capital but are under-investing in capital, again to subsidize more urgent needs. The analysis we conducted demonstrated that the hospitals losing money under the capital PPS are doing so because they are increasing their capital investment more than other hospitals—i.e., they are fortunate to have total margins that support capital investment beyond their Medicare payments. Inner-city teaching hospitals lag far behind other hospitals in information technology, including electronic medical records, and other critical quality and patient safety technology.

We cannot overemphasize the importance of maintaining the capital IME adjustment and all other payments critical to maintaining services in inner-city communities. In summary, our recommendations are as follows:

- CMS should update its empirical regression model of case-mix standardized total cost per case and include all the independent variables included in the 1991 model—i.e., the wage index, a dummy variable for large urban hospitals, the ratio of interns and residents to the average daily census, and the disproportionate patient percentage.
- CMS should propose a revision of the capital PPS payment parameters based on the results of its updated regression model. That is, CMS should retain the empirical IME adjustment as well as the empirical large urban and DSH adjustments.
- In recognition of the use of IME and DSH policy payments in the IPPS to support public goods, CMS should exclude those payments (the amounts in excess of the empirical adjustments) when deriving: 1) the diagnosis-related group weights, 2) outlier payments, and 3) IPPS margins.

Again, we appreciate this opportunity to provide our views and recommendations to CMS and hope that you will consider them when developing the FY 2009 proposed rule. If you have any questions or would like further information, please contact Karen S. Heller, Senior Vice President and Executive Director of The Health Economics and Outcomes Research Institute (THEORI), who can be reached at (212) 506-5408 or at [heller@gnyha.org](mailto:heller@gnyha.org).

Sincerely,



Kenneth E. Raske, President

Attachment

## **Greater New York Hospital Association Analysis of the Medicare Inpatient Prospective Payment System Fiscal Year 2008 Proposed Policies and Rates for Capital Related Costs and Recommendations for the Final Rule**

*(Recommendations are presented in bold and italics.)*

What is most interesting about the capital PPS is that it is not actually a capital PPS. It would more correctly be described as an empirically-derived PPS for total inpatient acute care costs, with the standardized amount truncated to 7.8% of the total standardized amount. In 1991, after exhaustive research, CMS concluded that the appropriate way to reimburse capital costs under the PPS was to add them to the operating PPS and then revise the regression model to develop empirical adjustments based on total cost rather than operating costs alone.<sup>1</sup> This is how capital costs have been incorporated into all the other prospective payment systems.

The reason why CMS did not combine the operating and capital PPS systems after the 10-year capital transition period was that it did not have authority to change the operating IME and DSH adjustments, since they are set in statute. The Agency did not want to apply the statutory IME and DSH adjustments to capital costs because they include “policy” adjustments, which are payments above the empirical level.

Nevertheless, the large urban, labor share, IME, and DSH adjustments in the capital PPS reflect empirical adjustments from a total cost model, as well as CMS’s updated thinking regarding variable specification.

### **Proposed Cuts are Excessive and Not Empirically Based**

While CMS still does not have the authority to change the operating PPS adjustments, it retains its authority to update the total cost model used for the capital PPS. For FY 2008, CMS has proposed to make two major changes to the capital PPS: it would eliminate the inflation update for urban hospitals for two years and eliminate the 3% large urban add-on altogether. CMS also requested comments on reducing or eliminating the IME and DSH adjustments. The savings generated from these proposals would not be reinvested in the federal rate, but taken as Medicare program savings.

Unfortunately, these changes are not empirically-based. Based on our own empirical analysis conducted during this brief comment period,<sup>2</sup> ***we believe that the cuts that CMS is proposing to urban and large urban hospitals, and the cuts that CMS may be contemplating for teaching and DSH hospitals are grossly excessive and we strongly oppose them.***

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<sup>1</sup> Prospective Payment System for Inpatient Hospital Capital-Related Costs; Final Rule, *Federal Register* 56, no. 169 (August 30, 1991). [BPD-681-F]

<sup>2</sup> We are not describing our models and presenting results with these comments because our research was necessarily limited and was conducted solely to determine whether the large urban, teaching, and DSH adjustments were still warranted. Our data sources were the 2004 cost reports, the FY 2004 MedPAR file for which we derived cost per case for last year’s comment letter, and the FY 2007 final rule Impact file. We used the same dependent and independent variables as the 1991 capital PPS regression model, and the same functional form of both the model and the variables.

We believe that if CMS wishes to update the capital PPS, then it should do so by revising its total cost regression model. If the Agency did that, we predict it would find that the large urban, teaching, and DSH variable coefficients are all still substantial and statistically significant. While the IME coefficient is lower than it was in 1991, the DSH coefficient is higher and the labor share is much higher, in the area of 85%.

### **Margin Analysis was Too Limited**

The impetus for CMS's proposals to eliminate the urban update and the large urban add-on, and to request comments on the IME and DSH adjustments, was that the Agency observed that large urban, teaching, and DSH hospitals had higher-than-average capital PPS margins from 1996–2004, which led to a concern that perhaps the payment adjustments were too generous. We also replicated CMS's margin analysis and determined that it was too limited to form the basis for the Agency's conclusions and proposals.

While we observed the same 8-year margin trend in the capital PPS, we also examined the trend in the combined operating and capital PPS margin—both with and without the operating PPS policy adjustments<sup>3</sup>—the trend in the total (all payer) margin, and the trends in unit price and cost growth. We present these results in Tables 3 and 4.

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<sup>3</sup> Our data source was the HCRIS file, so our IME payments include payments made on behalf of Medicare Advantage enrollees. The proper way to identify the empirical IME and DSH amounts would have been to apply the capital PPS IME and DSH adjustments to the operating and capital PPS base payment amounts. Then the policy-related IME and DSH amounts would be the difference between the total payments and the empirical amounts. We did not have time to assemble the database we would have needed to properly derive empirical IME and DSH amounts, since the capital IME and DSH adjustments were not available on the cost reports for all hospitals during the capital PPS transition period and we do not have Impact files dating from FY 1998 (corresponding with 1996 cost report data). Therefore, we defined policy-related DSH payments as all operating DSH payments and policy-related IME payments as the amount of operating IME payments represented by the declining constant on the IME formula. Our shortcut both understates and overstates the policy amounts.

Table 3. Comparative Medicare and Total Margins, 2004

	Medicare Inpatient Acute Care Margins			Total Margins (All Payers)	
	Capital	Operating and Capital, <u>with</u> Policy Adjustments	Operating and Capital, <u>without</u> Policy Adjustments	<u>With</u> Medicare Policy Adjustments	<u>Without</u> Medicare Policy Adjustments
All Hospitals	5%	0%	-10%	5%	3%
Large Urban	8%	2%	-10%	4%	2%
Not Large Urban	3%	-2%	-11%	6%	4%
High DSH	7%	4%	-10%	4%	2%
Other DSH	1%	-8%	-11%	6%	5%
Teaching	11%	4%	-8%	4%	2%
Non-Teaching	-3%	-6%	-14%	5%	4%
Large Urban, High DSH, and Teaching	12%	9%	-8%	3%	0%
Not Large Urban, High DSH, or Teaching	-9%	-11%	-13%	6%	5%

Table 4. Compound Annual Growth in Unit Price and Unit Cost, 1996–2004

	Medicare Capital		Medicare Operating and Capital <u>With</u> Policy Adjustments		Medicare Operating and Capital <u>Without</u> Policy Adjustments	
	Price	Cost	Price	Cost	Price	Cost
	All Hospitals	0.1%	2.1%	2.1%	4.4%	2.1%
Large Urban	-0.4%	1.4%	1.4%	3.9%	1.5%	3.9%
Not Large Urban	0.5%	2.7%	2.7%	4.7%	2.5%	4.7%
High DSH	0.0%	1.8%	1.9%	4.3%	2.0%	4.3%
Other DSH	0.0%	2.4%	1.9%	4.4%	2.0%	4.4%
Teaching	-0.4%	1.0%	1.3%	3.6%	1.5%	3.6%
Non-Teaching	-0.1%	2.8%	2.3%	4.7%	2.0%	4.7%
Large Urban, High DSH, and Teaching	-0.5%	0.8%	0.8%	3.5%	1.4%	3.5%
Not Large Urban, High DSH, or Teaching	0.8%	4.4%	2.8%	5.2%	2.7%	5.2%

We believe that it is not appropriate to examine capital PPS margins alone to ascertain whether the capital PPS adjustments are excessive because the adjustments were derived from a total cost regression model. That is why we looked at the combined operating and capital PPS margins.

What we observed was the following:

- *The combined operating and capital PPS margin was zero in 2004. Therefore, if CMS revises its capital PPS adjustments, they should be budget neutral.*

- When removing the IME and DSH policy payments, the combined operating and capital PPS margin was significantly negative for all classes of hospitals, including large urban, teaching, and high-DSH hospitals, which we defined as hospitals having a disproportionate patient percentage of at least 17.5%. Therefore, the cuts enacted in the Balanced Budget Act of 1997 (BBA) were excessive. Furthermore, hospitals receiving IME and DSH policy payments are now having to divert some of those payments to cover their Medicare inpatient losses rather than using all of them to help finance their social missions.
- Even with the Medicare IME and DSH policy payments, the total margins of large urban, teaching, and high-DSH hospitals were lower than the margins of other hospitals. Without the policy payments, hospitals with all three characteristics would have had a zero total margin compared with a 5% total margin for hospitals with none of these characteristics. Therefore, targeting large urban, teaching, and DSH hospitals for cuts, as CMS proposed and is otherwise considering, is not only wrong because the cuts are not empirically justified, but also wrong because they could lead to access problems for Medicare beneficiaries.
- Large urban, teaching, and high-DSH hospitals have all experienced slower capital unit cost growth than other hospitals over the 8-year study period. This may be because these hospitals have been in a lower-spending phase of their capital cycle than other hospitals. This is possible, since the capital cycle is roughly 20 years, far longer than the 8-year study period. To the extent that this is the case, cutting the payment adjustments would violate the promise of the capital PPS, which was that hospitals could accumulate surpluses during their low-spending phases to supplement merely average payments when they re-entered the high-spending phase.

We know for a fact that our member hospitals, which are virtually all large urban, teaching, and DSH hospitals, are in the low-spending phase of their capital cycle because they underwent major modernizations at the same time in the early 1990s. They were put on the same capital cycle by the New York State Department of Health (DOH), when DOH imposed a moratorium on major modernizations in the 1980s. When the moratorium was lifted, the backlogged projects were all initiated at the same time.

Another possible explanation for the lower capital unit cost growth of large urban, teaching, and high-DSH hospitals could be that since Medicare capital payments are no longer tied to Medicare capital costs, these hospitals have the flexibility to spend their scarce resources on their most pressing needs, which might overwhelm the need for continued growth in capital investment.

We know that our member hospitals are not investing in information technology and funding their depreciation at the rate of other hospitals, since those needs must compete with unfunded priorities, including: complying with new state laws on charity care and services to patients with limited English proficiency; reducing outcome disparities between majority and minority communities; complying with quality improvement and quality-related data reporting requirements; maintaining primary care, standby capacity for emergency and trauma care, and other money-losing services; subsidizing losses from private payers who inappropriately deny payment for medically necessary services; and paying the enormous and ever-growing cost of medical liability insurance.

Given these burdens, it is absolutely essential that CMS not target arbitrary cuts at large urban, teaching, and DSH hospitals. *Furthermore, when or if CMS does update its total cost regression model, then we believe that the Agency should publish its results for public comment before proposing changes in the payment system.*

**Submitter :** Ms. Walter Wyatt  
**Organization :** Albert Einstein Healthcare Network  
**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 Albert Einstein Medical Center 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).

The Albert Einstein Medical Center is an active participant in the education of new physicians, offering graduate medical education programs spanning twenty Accreditation of Council for Graduate Medical Education (ACGME) accredited medical specialties and one American Osteopathic Accredited (AOA) internship as well as three American Dental Association (ADA) accredited dental residencies and a Council on Podiatric Medical Education (CPME) accredited podiatry residency. Our programs are design to provide the scope, expertise and hands-on experience it takes to prepare the next generation of physicians for a career in the ever-changing world of modern healthcare delivery. Albert Einstein Medical Center has 368 residents and fellows enrolled in graduate training programs throughout our Network and trains 33 residents per year through affiliated residencies in ENT, hematology/oncology, neurology, neurosurgery, ophthalmology, orthopaedics, psychiatry, child & adolescent psychiatry and P,M&R.

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. The negative financial impact to AEMC alone is \$1.2 million per year.

Any decision to cut Medicare capital IME payments should not be viewed solely from a Medicare perspective. The IME capital dollars received from the Medicare Program represent a significant portion of our total operating margin. AEMC currently loses approximately \$27.0 million dollars serving Medicaid patients and provides an additional \$18.0 million of charity care to uninsured patients. Over 76% of our patients are covered by Medicare/Medicaid federal sponsored programs. Payment cuts from any source will affect the fiscal condition of AEMC, which influence all aspects of our operations. In addition to the education programs summarized above, we also provided an environment in which clinical research can flourish, offering highly specialized tertiary patient care such as trauma and cardiac care, and transplant services. Any reduction to our capital IME payments will serve as an obstacle to preparing the next generation of physicians for a career in the ever-changing world of modern healthcare delivery.

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.

If you have questions concerning these comments, please do not hesitate to contact me at (215) 456-7315, or at wyattw@einstein.edu.

Sincerely,

Walter G. Wyatt Jr.  
Director, Budget & Reimbursement

**Submitter :** Ms. Millie R. Gomez  
**Organization :** Public Health Trust of Miami-Dade, Jackson Health  
**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:

This provider welcomes the 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).

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 initial payment cut to this hospital of \$650,000 in the FY 2009 and subsequent annual cuts in excess of \$1,200,000 thereafter. 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).

As the Association of American Colleges stated in its comments to 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.

A decision to cut Medicare capital IME payments should not be viewed solely from the Medicare perspective. This hospital, like many other urban 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 like in the case of this provider, Jackson Memorial Hospital, provides a safety net to all uninsured residents of Miami-Dade County who have no access to medical care unless it is through our hospitals and primary care centers.

Our hospital provides education for all types of health care professionals, offering an environment in which clinical research can flourish; and offering highly specialized tertiary patient care such as burn care, all levels of trauma care, cardiac care, and transplant services. This is also the community first responder to bio-terrorism, chemical attacks and other critical situations, which requires funds. We urge you to reconsider the ramifications of cuts to IME payments.

Thank you,  
Millie R Gomez, Manager, Cost and Reimbursement  
Public Health Trust of Miami-Dade County  
Jackson Health System

**Submitter :** Ms. Karen Fisher

**Date:** 11/20/2007

**Organization :** Assn of American Medical Colleges

**Category :** Hospital

**Issue Areas/Comments**

**Capital IPPS Payment Adjustments**

Capital IPPS Payment Adjustments

See attachment

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**Association of  
American Medical Colleges**  
2450 N Street, N.W., Washington, D.C. 20037-1127  
T 202 828 0400 F 202 828 1125  
www.aamc.org

**VIA ELECTRONIC SUBMISSION**

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 Association of American Medical Colleges (AAMC) 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). The Association's Council of Teaching Hospitals and Health Systems (COTH) comprises nearly 300 general acute nonfederal major teaching hospitals and health systems that receive Medicare payments under the IPPS. The Association also represents all 126 accredited U.S. allopathic medical schools; 94 professional and academic societies; 90,000 full-time clinical faculty; and the nation's medical students and residents. 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 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.

Kerry Weems  
November 20, 2007  
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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).

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. 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.

Kerry Weems  
November 20, 2007  
Page 3 of 3

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If you have questions concerning these comments, please do not hesitate to contact me or Karen Fisher, Senior Associate Vice President. We may be reached at (202) 828-0490, or [rdickler@aamc.org](mailto:rdickler@aamc.org) and [kfisher@aamc.org](mailto:kfisher@aamc.org).

Sincerely,



Robert M. Dickler  
Senior Vice President  
Division of Health Care Affairs

cc: Karen Fisher, AAMC

**Submitter :** Mr. Michael Gramaglia  
**Organization :** Health Alliance Of Greater Cincinnati  
**Category :** Hospital

**Date:** 11/20/2007

**Issue Areas/Comments**

**Capital IPPS Payment Adjustments**

**Capital IPPS Payment Adjustments**

To Whom it may concern, The Health Alliance of Greater Cincinnati is an alliance of six acute care hospital. One hospital is University hospital, which is the safety-net hospital for the greater Cincinnati area.

Our comments are prompted by our concern over the financial impact of the proposed changes to the IPPS to eliminate the capital component of the calculation of indirect medical education (IME). We believe that for CMS to begin to look at individual components of a large and complex system of reimbursement is bad policy and does not keep faith with the hospital provider community. We have attached a file that details the Medicare capital costs and Capital reimbursement, the estimated reduction in IME payments resulting from the proposed rule and the reimbursement short fall on our Medicare Outpatient reimbursement, for our four teaching hospital. You will note that two hospital receive higher capital reimbursement than costs and two receive less. Also note, that the reduction in reimbursement does not matchup very well with either the over or underpayments of capital. Please note that based on our 6-30-06 Medicare cost reports that our Medicare shortfall on Medicare Outpatient reimbursement is significantly higher than the overpayment on capital. Based on our analysis and our believe that Medicare Reimbusemnt should not be vived and analyze component by component, we urge CMS to reconsider this dcision, and more closely examine all aspects of the payment system, before making damaging cuts to a particular segment. Thank you for your consideration of these 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

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 :** Mr. James Tomlinson  
**Organization :** Sanford USD Medical Center  
**Category :** Hospital

**Date:** 11/20/2007

**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. But, more specifically, it would reduce payments at our institution, Sanford USD Medical Center by over \$100,000 annually. 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.

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.

**Submitter :** Mr. Tom Fisher

**Date:** 11/20/2007

**Organization :** University of Tennessee Medical Center

**Category :** Hospital

**Issue Areas/Comments**

**Capital IPPS Payment Adjustments**

Capital IPPS Payment Adjustments

Capital IPPS Payment Adjustments

**GENERAL**

GENERAL

See Attachment

CMS-1533-FC-86-Attach-1.PDF



University Health System, Inc.  
1520 Cherokee Trail, Suite 200  
Knoxville, TN 37920-2205  
Main: (865) 544-6097  
FAX: (865) 544-9429

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

**RE: CM-1533-F; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates – Final Rule**

Dear Mr. Weems:

The University of Tennessee Medical Center (UTMC) is a 581-bed teaching hospital and Level 1 trauma center located in Knoxville, Tennessee. UTMC appreciates the opportunity to submit comments to the Centers of Medicare & Medicaid Services (CMS) regarding the proposed changes to capital IP PPS as put forth in the FY 2008 IP PPS Final Rule.

Capital IP PPS Payment Adjustments:

Medicare is required to pay for the capital-related costs of inpatient hospital services. These costs include depreciation, interest, taxes, certain lease payments, insurance and similar expenses for new facilities, renovations, expensive clinical information systems and high-tech equipment (e.g., MRIs and CAT scanners). The payment is made through a separate capital payment. Under the current capital inpatient PPS, payments are adjusted for each case, as is done under the operating PPS. Capital PPS payments also are adjusted for indirect medical education (IME), disproportionate share hospital (DSH) and outlier payments.

In the FY 2008 Proposed Rule (CMS-1533-P), CMS requested comments on the appropriateness of the IME capital adjustment. After receiving public comments, CMS has indicated in this final rule that they will use their discretion to eliminate the IME over a two-year period beginning in FY 2009. CMS will also not increase the standard Federal capital rate to account for the savings from IME capital phase-out. CMS bases their decision on the persistent positive capital margins of the past several years.

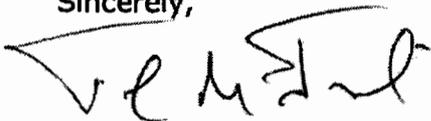
UTMC believes that capital payments should not be looked at in isolation. MedPAC, itself, estimates average hospital Medicare margins will fall to a negative 5.4% in 2007. The situation is likely to worsen in 2008. Given the

overall negative Medicare margins under the current payment system, making cuts to capital payments will only result in further shortfalls. These additional shortfalls will be difficult to make up and come at a time when facilities are trying to both keep up with swift-moving technological advances in diagnostic and therapeutic equipment and to move to information systems that can support CPOE and EMRs. Elimination of the IME Capital adjustment will reduce UTMC's payment from Medicare by approximately \$4.5 million over the next five years

As a teaching hospital and trauma center, incurs higher costs than other non-teaching facilities. Additionally, significant expenditures are needed to keep teaching hospitals, which provide more complex and costly care, technologically advanced and up-to-date. In creating IME payments (both operating and capital), CMS recognized the additional expenses incurred by academic facilities. In order to remain on the cutting-edge of medical research and treatment, it is vital that UTMC have the necessary funds to make additional capital investments. Reducing any of the medical education reimbursement components will put additional pressure on the system and weaken the education experience that UTMC is able to provide its residents. In a time of increasing physician shortage, it would seem obvious we need to invest more resources in the training of the physicians who will provide care in the increasingly technologically-dependent future.

We encourage CMS to re-think the elimination of IME capital. Teaching hospitals, especially those operating Level I trauma centers, continue to struggle under the burden of underpayments from governmental sources while the uninsured population continues to expand. Pressed from all sides by reductions in reimbursement, hospitals will be forced to cut back on the updating of facilities and the purchase of improved diagnostic and therapeutic technologies - providing fewer choices to patients and fewer opportunities for learning to those who will be tomorrow's physicians.

Sincerely,



Thomas M. Fisher  
Sr. Vice President & Chief Financial Officer

/gk

**Submitter :** Mr. Gary Husband  
**Organization :** Mary Hitchcock Memorial Hospital  
**Category :** Hospital

**Date:** 11/20/2007

**Issue Areas/Comments**

**Capital IPPS Payment Adjustments**

Capital IPPS Payment Adjustments

RE: Capital IPPS

The purpose of the letter is to comment on the CMS Final Rule concerning the Hospital Inpatient Prospective Payment System as published in the Federal Register of Wednesday, August 22, 2007. We would like to take this opportunity to express our concerns with the proposed change to the Medicare Capital Payment System.

By way of background, the Dartmouth-Hitchcock Medical Center (DHMC) is comprised of Mary Hitchcock Memorial Hospital, a 337 bed teaching hospital, the Dartmouth-Hitchcock Clinic, a large academic group practice, Dartmouth Medical School, and the Veterans Administration Hospital. Mary Hitchcock is the only academic tertiary care hospital in the state of New Hampshire, and is one of only a few major rural teaching hospitals in the country.

As part of the final rule, CMS is proposing to eliminate the Capital Indirect Medical Education adjustment factor. CMS has based its proposed reduction on a margin analysis that was limited only to Inpatient Capital. We recommend that CMS refrain from using margin analysis as the basis for reductions, unless there is also a discussion on overall hospital margins. We strongly urge CMS to include hospital outpatient costs (operating and capital costs) in any future margin analysis related to Indirect Medical Education payments. The indirect costs related to Medical Education are spread across the organization, and thus the margin analysis should not be isolated to the Inpatient setting.

In MedPAC's testimony to Congress on May 15, 2007 indicated that overall hospital margins have become even more negative in recent years. MedPAC is projecting a -5.4% (negative) Medicare margin for FY07, compared to a -3.3% (negative) Medicare margin in FY05. Based on MedPAC's testimony to Congress, we are very concerned about the adequacy of the current payment system and its potential impact on Medicare beneficiaries.

Thank you for consideration of these comments.

**Submitter :** Dr. James McDeavitt  
**Organization :** Carolinas HealthCare System  
**Category :** Hospital

**Date:** 11/20/2007

**Issue Areas/Comments**

**GENERAL**

GENERAL

Our comment is an attachment, please see attachment.

CMS-1533-FC-88-Attach-1.DOC

November 27, 2007

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

**ATTN: CMS-1533-p**

Dear Administrator Norwalk:

Carolinas Medical Center (CMC) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule entitled "*Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems (IPPS) and Fiscal Year 2008 Rates.*" 72 Fed. Reg. 24680 (May 3, 2007). Carolinas Medical Center is a community teaching hospital program, hosting 207 residents representing 14 specialties. This proposed rule contains major revisions to the Medicare case payment classification system in the effort to replace the diagnosis-related groups (DRGs) with the Medicare-Severity DRGs (MS-DRGs), as well as significant reductions in Indirect Medical Education (IME) payments. For these reasons and the affect on CMC's ability to adequately fund its large graduate medical education program, we urge CMS to 1) provide a transition period for the DRG to MS-DRG transition; and 2) rescind the proposal to adjust the IME and DSH payments.

We support the implementation of the MS-DRGs, but are concerned that there is no transition period for such a dramatic change to the manner in which teaching hospitals like CMC are reimbursed for the very complicated cases handled in our facility. Given our positive experience with transition periods dealing with the IPPS and the charge-based methodology being changed to a costs-based one, we urge CMS to provide, at a minimum, a three year transition period.

The proposed rule modifies the methodology for counting the physician resident full time equivalent (FTE) used in calculating IME and direct medical education (DGME). This change in policy potentially accounts for \$645,000 to CMC's graduate medical education program. In addition to the significant financial loss, the proposed change in calculating how teaching hospitals account for resident vacation

and sick time would impose significantly burdensome administrative requirements. The tracking burden would impose on CMC administratively and would create an equal burden for CMS. Furthermore, we anticipate that local residency program growth will create a truly meaningless calculation burden that will eventually have no financial impact. For these reasons, we urge CMS to maintain the current methodology for calculating vacation and sick time in the IME and DGME payment.

CMS also seeks input regarding potential changes to the capital PPS. The value of those adjustments to IME and DSH adjustments within the capital PPS are significant to CMC, worth \$.94 million (100%) FY 2010 and \$4.27 million FY 2009-2013. These cuts, without any direction from Congress, are unprecedented and unwarranted. A cut of this magnitude will affect hospitals' abilities to meet their existing long-term financing obligations for capital improvements. For this reason, we urge CMS to rescind the proposals related to adjustments to IME and DSH through the capital PPS.

We appreciate the opportunity to comment on these significant changes to Medicare payment methodologies affecting Carolinas Medical Center.

Most sincerely,

Dr. James B. McDeavitt

**Submitter :** Mr. WILLIAM GALINSKY  
**Organization :** Scott & White Memorial Hospital  
**Category :** Health Care Provider/Association

**Date:** 11/20/2007

**Issue Areas/Comments**

**Capital IPPS Payment Adjustments**

Capital IPPS Payment Adjustments

See Attachment

**GENERAL**

GENERAL

See Attachment

CMS-1533-FC-89-Attach-1.DOC



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:

Scott and White Memorial Hospital (SWMH) 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). SWMH is an academic medical center in Central Texas supporting approximately 350 medical residents annually in a wide array of specialties. 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 teaching hospitals, in general, of \$375 million and over \$1 million annually for SWMH. 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).

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. 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.

Additionally, IME adjustments, whether operating or capital, are by definition targeted to compensate teaching hospitals for costs incurred in training residents that are not directly otherwise attributable. To eliminate the IME adjustment from the calculation of Capital PPS would require teaching hospitals to find other funding sources or curtail certain teaching programs due to inadequate funding. CMS has acknowledged that indirect costs exist in the resident training environment and should continue to support those efforts.

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. If warranted, a significantly longer transition period would seem appropriate in order to minimize the impact to any single fiscal period.

Sincerely,

William Galinsky, CPA  
Director of Finance  
Governmental and Regulatory Affairs

**Submitter :** Mr. James T. Kirkpatrick  
**Organization :** Massachusetts Hospital Association  
**Category :** Health Care Professional or Association

**Date:** 11/20/2007

**Issue Areas/Comments**

**GENERAL**

GENERAL

Attachment

CMS-1533-FC-90-Attach-1.DOC



Massachusetts Hospital Association

November 20, 2007

Kerry M. Weems
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1533-FC
7500 Security Boulevard
Baltimore, Maryland 21244-8012

Re: CMS-1533-FC, Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates; Final Rule with Comment Period; Capital IPPS Payment Adjustments

Dear Mr. Weems:

The Massachusetts Hospital Association (MHA), on behalf of our member hospitals wants to take this opportunity to comment on the Medicare Inpatient Prospective Payment System (PPS) phase-out of the Indirect Medical Education (IME) adjustment related to capital payments.

MHA objects to any proposed capital cuts related to IME which would potentially reduce payments to Massachusetts teaching hospitals by over \$74 million over five years. CMS' proposal to eliminate these payments ignores how vital capital payments are to the ongoing maintenance and improvement of hospitals' facilities and technology. MHA strongly encourages CMS to reevaluate the ramifications that such dramatic cuts to capital payments will have on the use of technology and the quality of a hospitals infrastructure. Reducing capital payments would make buying the advanced technology and equipment that patients need much more difficult for Massachusetts hospitals along with other teaching hospitals across the nation, and could potentially slow the advance of clinical innovation.

Despite comments from MHA and others, CMS eliminated the three percent large urban add-on for capital payments in federal fiscal year (FFY) 2008. CMS based this provision solely on their own analysis that indicated an increase in capital margins over a nine year period (1996-2004) in urban areas. From this, CMS concluded that the capital rates for urban facilities are too high. In addition, CMS sought comments on the elimination of the IME adjustment for capital payments beginning in FFY 2009. MHA strongly objects to any proposed capital cuts including a reduction to the IME adjustment in future years.

The IME adjustment currently applied to capital payments was determined by an empirical analysis as reported in the 1991 capital rule. In that rule CMS defended the regression model that was used to determine the adjustments as “the only way we know to provide an empirical basis for these decisions and to avoid highly subjective judgments.” CMS has no valid empirical basis for the proposal to eliminate the IME. These harmful cuts should not be made based on a subjective judgment that capital margins seem to be high. Eliminating the IME adjustment will threaten the financial viability of teaching hospitals in Massachusetts, and will also impose a threat on future physician supply creating access problems for Medicare beneficiaries. **MHA urges CMS to remove this proposal and to continue to provide IME adjustments related to capital payments in order to ensure that teaching hospitals are able to provide residents with access to training using the latest high-tech equipment and technology.**

We hope you will give serious consideration to the concerns we have outlined. Thank you for your attention to these important issues. If you have any questions regarding our comments, please contact me at (781) 272-8000 or [jkirkpatrick@mhalink.org](mailto:jkirkpatrick@mhalink.org).

Sincerely,

A handwritten signature in black ink, appearing to read "James T. Kirkpatrick". The signature is fluid and cursive, with a large initial "J" and "K".

James T. Kirkpatrick  
Vice President, Health Care Finance and Managed Care

**Submitter :** Mr. Stephen Harwell  
**Organization :** Healthcare Association of New York State  
**Category :** Health Care Provider/Association

**Date:** 11/20/2007

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-1533-FC-91-Attach-1.DOC



Healthcare Association  
of New York State

November 20, 2007

Kerry M. Weems  
Acting Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1533-FC  
7500 Security Boulevard  
Baltimore, Maryland 21244-8012

**Re: CMS-1533-FC, Medicare Program; Changes to the Hospital Inpatient Prospective Payment System and Fiscal Year 2008 Rates; Final Rule with Comment Period; Capital IPPS Payment Adjustments**

Dear Mr. Weems:

The Healthcare Association of New York State (HANY), on behalf of our more than 550 hospitals, nursing homes, home health agencies, and other health care providers, welcomes the opportunity to comment on the Medicare Inpatient Prospective Payment System (PPS) phase-out of the Indirect Medical Education (IME) adjustment related to capital payments.

**HANY objects to any proposed capital cuts related to IME that would potentially reduce payments to New York State (NYS) teaching hospitals.** CMS' proposal to eliminate these payments—which would reduce payments to NYS hospitals by more than \$60 million over two years—ignores how vital capital payments are to the ongoing maintenance and improvement of hospitals' facilities and technology. HANY strongly encourages CMS to reevaluate the ramifications that such dramatic cuts to capital payments will have on the use of technology and the quality of a hospital infrastructure. Reducing capital payments would make buying the advanced technology and equipment that patients need much more difficult for NYS teaching hospitals and other teaching hospitals across the nation, and could potentially slow the advance of clinical innovation.

Despite comments from HANY and others, CMS eliminated the 3% large urban add-on for capital payments in federal fiscal year (FFY) 2008. CMS based this provision solely on its own analysis, which indicated an increase in capital margins over a nine-year period (1996-2004) in urban areas. From this, CMS concluded that the capital rates for urban facilities are too high. In addition, CMS sought comments on the elimination of the IME adjustment for capital payments beginning in FFY 2009. **HANY strongly objects to any proposed capital cuts, including a reduction to the IME adjustment in future years.**

Kerry M. Weems  
November 20, 2007

Page Two

The IME adjustment currently applied to capital payments was determined by an empirical analysis as reported in the 1991 capital rule. In that rule, CMS defended the regression model that was used to determine the adjustments as “the only way we know to provide an empirical basis for these decisions and to avoid highly subjective judgments.” CMS has no valid empirical basis for the proposal to eliminate the IME. These harmful cuts should not be made based on a subjective judgment that capital margins seem to be high. Eliminating the IME adjustment will threaten the financial viability of teaching hospitals in NYS, and will threaten future physician supply, creating access problems for Medicare beneficiaries.

**HANYS urges CMS to remove this proposal and to continue to provide IME adjustments related to capital payments to ensure that teaching hospitals are able to provide residents with access to training using the latest high-technology equipment and technology.**

HANYS appreciates having the opportunity to comment on this provision. If you have any questions regarding our comments, contact me at (518) 431-7777 or [sharwell@hanys.org](mailto:sharwell@hanys.org).

Sincerely,

Stephen Harwell  
Vice President  
Economics, Finance, and Information

**Submitter :** Mr. Santiago Mu?oz

**Date:** 11/20/2007

**Organization :** UC Health System

**Category :** Hospital

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-1533-FC-92-Attach-1.PDF

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92

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OFFICE OF THE PRESIDENT  
1111 Franklin Street  
Oakland, CA 94607-5200  
Phone: (510) 987-9071  
Fax: (510) 763-4253  
<http://www.ucop.edu>

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

**SUBJECT: CMS-1533 - FCC "Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems [IPPS] and Fiscal Year 2008 Rates"**

Dear Administrator Weems:

Thank you for the opportunity to comment on the Medicare Inpatient Prospective Payment System (IPPS) final rule with comment period entitled "Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems [IPPS] and Fiscal Year 2008 Rates." These comments are submitted on behalf of the University of California (UC) Health System and its academic medical centers (AMCs) located at Davis, Los Angeles, Irvine, San Diego, and San Francisco. 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. We believe a payment cut of this magnitude is unwarranted and we respectfully request that these reductions be eliminated from the final rule.

The UC clinical enterprise is the fifth largest healthcare delivery system in California and the leading provider of certain specialty services and medical procedures. Annually, the UC clinical enterprise includes patient care services valued at over \$4 billion. In

alignment with their patient care work, the UC AMCs also play a critical role in a number of broad public-policy goals, including the education of health professionals and the advancement of medical science through cutting-edge research. Specifically, the UC clinical enterprise offers services that are essential to the health and well being of Medicare beneficiaries and all Californians including a broad array of highly specialized services, such as cancer centers, geriatric and orthopedic centers of excellence, organ transplant programs, and world class primary and preventive care.

The UC is extremely concerned with the decline of its Medicare payments given our role in serving extremely high-cost Medicare beneficiaries. UC continues to urge Congress to provide adequate Medicare payments to its hospitals and urges CMS to ensure the Congressional intent of hospital payment updates are fully implemented on a programmatic level. Further, while UC's comments address the most significant areas of concern for its AMCs, it is generally concerned with the decline in Medicare rates and urges CMS to amend the proposed rule to prevent further reductions.

Concern about adequate Medicare payments extends to the UC AMC's work in educating physicians as well. Medicare's graduate medical education payments contribute to UC's offering of more than 300 residency programs and training for nearly half of California's interns and residents. UC academic medical centers sponsor more than 300 residency training programs in all recognized specialties and subspecialties of medicine and surgery — over 3,900 resident physicians participate annually in these programs.

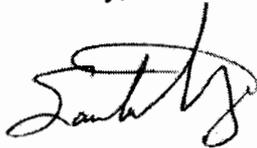
We believe that any decision that results in the complete elimination of a payment adjustment should not be entered into lightly. This is particularly true in the context of capital-IME payments. For the UC Medical Centers, we anticipate the reduction would total nearly \$10 million per year. Over time capital cuts of this magnitude will disrupt our hospitals' ability to meet their existing long-term financing obligations for capital improvements. Hospitals have committed to these improvements under the expectation that the capital PPS would remain a stable source of income. Reducing capital payments would create significant financial difficulties and amounts to Medicare renegeing on the full cost of caring for America's seniors and disabled. CMS has provided no analysis of the impact of these proposed changes on the high-caliber medical education of our future physicians and the community-wide services the UC medical centers provide.

The UC Health System respectfully requests that the reductions in capital-IME payments be eliminated. Rather, like MedPAC, we urge the Agency to do a more complete reexamination of this adjustment before making any IME reduction determinations.

Kerry Weems  
November 20, 2007  
Page 3 of 3

Thank you for the opportunity to comment on this Medicare rule. If there are questions or if I can provide any additional information or input, please contact me at 510-987-9062 or [santiago.munoz@ucop.edu](mailto:santiago.munoz@ucop.edu).

Sincerely,

A handwritten signature in black ink, appearing to read "Santiago Muñoz", written in a cursive style.

Santiago Muñoz, Associate Vice President  
Clinical Services Development

c: Medical Center CFOs